Dr. Julius Hellenthal, M.D.

The sensational medical revolution on the brink of the 21st century

2nd publication: Pandora’s box opens a crack; the health-care system peeks out (1999)

3rd publication: Pandora’s box opens a bit wider: connections become more clear (2001)

4th publication: What is the goal: true causal therapy or mere makeshift selective repair activity? (2002)

5th publication: "Regarding medicine’s best-kept secret" according to Dr. Pekar (92 years of age) (2003)

To live 40 years longer in good health, to live to be 120 years old, still swimming and riding a bicycle at age 110, no Alzheimer’s, no arteriosclerosis, no heart attack, no headaches, no stroke, no backache, no malignant tumors, to simply be hardy both physically and mentally to the good finish, with the help of long-term antibiosis, vitamins, trace elements, nutritional and life-style adjustments, vaccines, and immunomodulations.
After the first publication with just over 1000 copies (1997) was rapidly sold out, it was necessary to produce some new and greatly expanded editions:

2nd publication: Pandora’s Box opens a crack; the health-care system peeks out (1999, 3,500 copies)

3rd publication: Pandora’s Box opens a bit wider: connections become more clear (2001, 2,500 copies)

4th publication: What is the goal: true causal therapy or mere makeshift selective repair activity? (2002, 1,000 copies)

5th publication: Regarding medicine’s best-kept secret according to Dr. Pekar (92 years of age) (2003, 1,500 copies)

Translated from the German by Emily Walzer, Alpha Übersetzungen, Frensdorf, Germany

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Chapter 1: Introduction

1.1. References

1.1.1. Dr. Wolfgang Lenz, M.D.

Excerpt from a letter dated December 14, 2000, from Dr. Wolfgang Lenz of Dillingen, Germany:

In his book, our fellow physician Julius Hellenthal approaches in no uncertain terms a subject which has surely been a source of unease for some time now for many physicians. At a time when the administration of antibiotics causes wariness among doctors and patients alike, he demonstrates through his own examples successful therapies which would have most likely been inconceivable without massive antibiotic treatment.

Clearly, the correlation between chronic, often scarce-definable illnesses and pathogenic agents can no longer be denied. The work of our peer, Dr. Julius Hellenthal, is doubtless a contribution to this subject as meticulous as it is remarkable, representing a new approach to microbiology.

1.1.2. Dr. rer. nat. Dr. med. Jürgen Kania

Excerpt from a letter (2000) from Dr. rer. nat. Dr. med. Jürgen Kania of Donauwörth, Germany:

This article by ophthalmologist Julius Hellenthal speaks out against the anti-antibiotic mentality of our time.

Numerous chronic illnesses which have been considered to be independent occurrences must now be viewed in relation with a chronic infection caused by pathogenic agents.

By means of successive applications with astounding therapeutical success, Hellenthal has succeeded in demonstrating that we are not at the end, but at the beginning of a new microbiological era.
1.1.3. Dr. Erika Frank, M.D.

Excerpt from a letter dated December 5, 2000, from Dr. Erika Frank, M.D., of Überlingen, Germany:

With their often astonishingly successful treatment of diverse chronic illnesses, Dr. Hellenthal’s casuistics deliver an insistent message, and should encourage a discussion of this unusual kind of therapy – and its application to similarly affected patients. I am convinced of its future success.

1.1.4. Dr. Joachim Ruf, M.D.

Excerpt from a letter from December 5, 2000, from Dr. Joachim Ruf, M.D., of Pfungstadt:

In his most recent report, the ophthalmologist and researcher Dr. Julius Hellenthal from Günzburg shows that chronic illnesses must be seen as linked to chronic infections with pathogenic microbes.

With many interesting individual case studies, Hellenthal reveals successful treatments which should be cause for consideration among physicians: this is a new therapeutical approach for many illnesses, and it should be seriously pursued.

1.1.5. Dr. Helga Petsch, M.D.

Excerpt from a letter from January 2001, from Dr. Helga Petsch, M.D., of Lauingen:

In my years of practice – beginning in 1965 – many acute illnesses were successfully treated with the antibiotics then available. For example, in Germany we no longer had syphilis, no tuberculosis, and none of the so-called primitive epidemics (such as the plague, cholera, typhus, leprosy, etc.). However, since the side effects of antibiotics were not sufficiently taken into consideration, regarding things such as nutrition during treatment, and food supplements for additionally fortifying the immune system (certain vitamins, trace elements, and other supplements), the course of treatment was often too brief, not leading to a final recovery. This was a factor in the way that antibiotics came to be absolutely scorned, and were quite nearly forgotten for a long time. Unfortunately, cortisone came to be the treatment of choice for all kinds of inflammatory conditions in which viruses and bacteria played a role without being specifically detectable (only 1.6% of bacteria are known to date). This brought about temporary palliative effects on symptoms of inflammation such as pain or swelling, but without any causal treatment, and the overall immune system was completely distressed. More and more great and initially impressive surgery techniques were developed for all organs (heart, kidneys, stomach, joints). In this deeply-rutted cycle of independent medical specialties, Dr. Julius Hellenthal was the first to establish that a different route can lead to the cure. To do this, he had to struggle with
the deep-lying prejudices of his peers from all manner of special medical fields. Thus, he very nearly came to be a lone “voice in the wilderness” of medicine. His treatments were ignored during the early years of his first publication, dismissed as some quirk of the author’s, since he didn’t have some major university hospital or laboratory to cover his back or to provide clinical proof with their examinations. To his merit, he has not been swayed by this strong counter current, but has continued unwaveringly to develop specific antibiotic therapies according to the known pathogenesis of illnesses, with an additional regimen for maintaining and strengthening the immune system of each patient. To this end, an enormous amount of research is required, as the literature available thus far on this subject needed to be studied and evaluated. Years of research have made him an authority, capable of providing treatment for diseases from very diverse medical fields. Meanwhile, since his first publication in 1993, his guidelines for treatment have been adopted by leading professors at university hospitals, who in turn are publishing their positive results. Thus the validity of his therapy is confirmed, as is the fact that Dr. Julius Hellenthal is on the right track.

1.1.6. Prof. Dr. Hans Kornhuber

Excerpts from a statement (2000) of the famous German neurologist Prof. Dr. Hans Kornhuber (who has been nominated by the German committee for the Nobel Prize):

Dr. Hellenthal is not only an ophthalmologist, he also has a grasp on the subject of infectious diseases. In this regard, his publication is of definite competence. What he says about arteriosclerosis is true. Mounting evidence points towards a chronic infection, particularly involving chlamydia pneumoniae, the agent which is so often transmitted by the respiratory secretions connected with the common cold. The agent establishes itself most often in a patient’s early years, leading to a lifelong arterial inflammation. An absolute specialist in this field is the infectiologist Prof. Dr. Stille (Frankfurt am Main, Germany).

Regarding multiple sclerosis, things become more difficult. This illness is already often treated using antibiotics, as MS patients often suffer from urinary tract infections which require antibiotic treatment.

But not all antibiotics are the same. Dr. Hellenthal's publication does not state clearly which antibiotics were involved in his successes. Possibly, others were used than those normally given for an MS patient’s urinary tract infections. The positive effect of the latter is limited to urinary tract infections; they don’t cure MS.

The early stage of MS is a special issue, and one that has not yet been sufficiently studied. At this stage, it may be entirely possible to achieve better results through the use of antibiotics. This is what Dr. Hellenthal is referring to when he lists his successes. These are, of course, individual case reports and not prospective double-blind controlled tests. Such tests are very expensive and are not his task: Dr. Hellenthal merely wants to provide the stimulus for further research, which is at any rate necessary.

At first manifestation, as in the case of optic neuritis Dr. Hellenthal treated, one is dealing with the triggering of an episode, not the actual onset of the disease. If it could be treated at the actual time of onset in childhood or youth or, better yet, could be prevented by vaccine, that would probably be the most effective protection against this disease. At any rate, Dr. Hellenthal
The sensational medical revolution on the brink of the 21st century

points the issue in the right direction. This is certainly the case particularly where it concerns arteriosclerosis, which is the cause of heart attacks.

Whether this is equally effective for treating MS is a completely open question. In any case, Dr. Hellenthal’s publication should be regarded as a useful suggestion. He does not stand alone. There are others who heartily share his viewpoint, such as Prof. Stille in Frankfurt (renowned European infectiologist, author’s comment). I personally am also of the opinion that infections play a role in Alzheimer’s disease ... through primary damage done to the capillaries (fine blood vessels). In this way, the brain’s defense system is damaged, and chronic infections follow. The use of antibiotics could provide a way to try to help in these cases as well...

One thing is certain: antibiotics can help decisively in the event of such a chronic infection. This has already been proven concerning heart attacks. It has also been proven that people who receive antibiotic treatment for other reasons have a lower rate of heart attacks (provided they were given antibiotics that are effective against Chlamydia – not just any antibiotics, but specifically macrolides or tetracyclines).

1.1.7. Dr. MG

Excerpt from a letter from January 6, 2001, from a doctor of natural sciences who works in the medical field, Dr. MG, (name known to the author):

Medical researcher Dr. Julius Hellenthal is practice-oriented and has both eyes wide open as he fights against the current anti-antibiotic mentality (especially prevalent in Germany). Here, it seems the negative consequences of chronic infections caused by pathogenic agents are supposed to be mainly operated away (heart, knee-joint, hip, discs, prostate, tendons, carpal tunnel syndrome, hemorrhoids, heel spur, etc.). It is hardly likely that all of the pathogenic bacteria (only 1.5% of all bacteria have been identified) are also eradicated by surgery! On the contrary, antibiotics are regularly administered for a duration following heart surgery. Why not begin with them in the first place and see if surgery might be thus prevented?

The extent and depth of his successes are amazing. And, as usual when a great step forward is taken, afterwards everything seems to have been so simple!

1.1.8. Dr. Ingeborg Quasthoff, M.D.

Excerpt from a letter dated January 17, 2001, from Dr. Ingeborg Quasthoff, M. D., Osterreinen, Germany:

As a doctor specializing in natural remedies, homeopathy, and anthroposophic medicine, my attitude towards all antibiotics has been very critical and sceptical, and especially the notion of long-term antibiotic therapy was nearly inconceivable to me.

After being introduced to the revolutionary ideas and therapies of Dr. Hellenthal, and having tested them successfully for my own benefit, the subject has taken on a new dimension for me which is absolutely in harmony with other therapeutic approaches.
1.1.9. Dr. Marion Kunert, M.D.

Excerpt from a letter dated January 17, 2001, from Dr. Marion Kunert, physician for general medicine and natural remedies, of Asbach-Bäumenheim:

His keen observation, sense for detecting correlations, and courage to go unconventional ways have made Hellenthal a medical pioneer of the kind otherwise found only in a bygone era.

His view regarding the bacterial origin of illnesses has meanwhile increasingly gained a slot in medical research, which must be perceived as recognition for his sometimes ridiculed, uncomfortable views.

1.1.10. Dr. R.

A letter in favor of antibiotics from an out-of-town medical peer from October 2001 (name known to the author):

Dear Dr. Hellenthal!

I came to know your pro-antibiotics „crusade“ (in certain cases) through a mutual patient. My own experience confirms your conviction. The sole effective therapy for my ten-year-old case of arthropathy, marked by severe relapses, caused by Chlamydia in the wake of an insufficiently treated case of Reiter’s disease, was to take high doses of quinolones (3x1 Ciprobay 500), that is, 3x500mg/p.d. for three months.

Not only your name reminds me of Mr. Hackethal, whom I once experienced as a convincing expert witness in court. I have found his theses to be very often (not always) confirmed in my practice.

Kindest regards,

Dr. R.

1.1.11. Dr. Pekar

(November 2001)
Enclosed are a few lines from one of the most renowned and successful researchers and cancer therapists, Dr. Rudolf Pekar of 4820 Bad Ischl/Austria.

Dear Dr. Hellenthal,

Just a few words concerning your publication “The Sensational Revolution on the Brink of the 21st Century”: 
Congratulations on the publication of your “The Sensational Revolution on the Brink of the 21st Century”, with the best wishes that it will soon cross the threshold into the realm of common knowledge. I am convinced of the validity of this publication!

I am sure it will meet with resistance before finding recognition. Still, where would medicine be today were it not for occasional genuine non-conformists with their new ideas and findings?

Best wishes for your future,
Your peer,

Dr. Pekar
(Also known from Jürgen Fliege’s talk show as aired in October 2001)

I am deeply impressed by the scientific research mentality, the profound philanthropy, and the modesty of the great Dr. Pekar, pioneer of electrotherapy for eradicating tumors. His electrotherapy achieves a nearly 100% success rate in treating malignant melanoma (skin cancer, black melanoma), breast cancer, and prostate cancer, without major surgery. Dr. Pekar has consistently found thousands of protozoa (unicellular organisms) in the tumor tissues he has examined. Trichomonads, malaria agents, and amoeba are examples of protozoa.

As I have been dealing for many years now with long-term antibiotic therapy, immunostimulation, and immunomodulation in the context of highly varied illnesses; and, because I am of the opinion that the vast majority of malignant tumors come from bacteria a/o viruses a/o fungi a/o unicellular organisms (helicobacter pylori → gastric carcinoma), I would like to say a word about this causal, tumor-averting, and possibly tumor-treating therapy (Clont (Metronidazole) 0.25 2x1, Trimethoprim 160mg, Sulfamethoxazole 800mg each two p.d. for 8-10 days) in combination with the electrotherapy developed by Dr. Pekar.

1. In France, ranked number 1 by the World Health Organization WHO, antibiotic use per capita is 270% higher than in 25th-ranked Germany, even though the French live in a warmer and more protozoan-laden climate than the Germans. One can, for example, also treat river blindness (particularly widespread in Africa, responsible for app. 22 million cases of blindness worldwide) with antibiotics (as the worms which cause the disease live in symbiosis with bacteria that succumb to antibiotics).

2. Further, according to Luc Montagnier (discoverer of AIDS), AIDS can only break out in connection with bacteria (such as chlamydia), the more so since a number of bacteria weaken the immune system and abridge life, and are found, for example, in water; even the ancient Romans made clean drinking water a high priority, as the aqueducts attest.

3. Due to the toxicity of long-term antibiosis, so-called antioxidants are of the utmost importance (examples: Uña de Gato, vitamin C, vitamin E, and OPC plus).

4. For immunostimulating purposes, there are a great many medications or food supplements, such as multivitamins and trace elements.

December 2001
1.2. The main condition for a long and healthy life

...is a good immune system to defend us against bacteria, viruses, fungus, parasites, and environmental toxins, and a minimal rate of infection (including as low as possible duration of exposure) with the above.

In order to understand this, I first had to spend a quarter century working in medical sciences. Because, in my opinion, 90% of all illnesses (including tinnitus, back pain, heart attack, high blood pressure, hemorrhoids, headache, abdominal pain, infertility, foot and knee pain, psychiatric abnormalities, etc.) are caused by bacteria, parasites, and the like, eradication of the above-mentioned villains – bacteria, fungus, etc. – gains a position of top priority (namely, through long-term antibiosis, immunostimulation, etc.).

Simultaneously, the body’s own immune system must be invigorated, making vitamins necessary. For example, a daily dose of 3 grams (!) of vitamin C – not the previously recommended dose of 75mg, or even the tripling of that dose to 225mg as recently suggested by the German Society for Nutrition Sciences, and not in a single dose of a powdery form, as vitamin C is quickly eliminated (within 10-30 minutes) when not taken in a time-depot form; vitamin E: 500 international units.

• Did you know that vitamin E will lose its antioxidant or free radical effect within 40 minutes of consumption if not bolstered by vitamin C?
• Did you know that in experiments with animals a combination of vitamin E and C prolonged life by 56%?
• Did you know that experiments with animals show that life can be prolonged by 40% just by not taking in further nutrition after 12 o’clock noon?
• Did you know that low-level hyper oxygenic exercise – the opposite would be oxygen deficit – can increase the oxygen supply to the brain by up to 100%; and that cerebral circulation is not a constant, as was taught in medical textbooks as late as 1993?
• Did you know that, without great financial expense, cerebral arteriosclerosis can be a) prevented, b) largely reversed by growing new vessels; and that degeneration of the neuronal network, the synaptic connections of individual cerebral nerve cells and the cause of Parkinson’s and Alzheimer’s diseases, can easily be turned back by 12 years (as is visible under a microscope).
• Did you know that smokers reduce their life expectancies by a statistical average of 22 years, even considering that passive smokers are also included in statistical averages?
• Did you know that, through a chronic infestation of bacteria in the cells - for example, the cells of the sinuses, the stomach membrane, e.g. stomach cancer due to resident heliobacter pylori, or the uro-genital tract -can cause modifications of the chromosomal cellular hereditary material, which can in turn lead to the formation of malignant tumors. In this context, it must be readily understandable how beneficial the timely use of antibiotics and immunostimulating therapy can be for avoiding malignant tumors.

May 1998
1.3. First: a word about antibiotics

1. **Causal** therapy (not the treating of symptoms) for infectious diseases – the goal, which is largely attainable, is to eliminate the bacterial agents which cause the illness.

2. Approximately 10% of all Germans suffer (or, as taken from pathology reports, suffered) from rheumatic fever – the pathologist detects, for example, rheumatic nodules (Aschoff nodules) around the patients’ heart walls, or else the patients developed an inflammation around the heart valves. Preferable treatment would be an average of 5-10 years of **uninterrupted** antibiotic therapy.

3. In December 1997, I read in a medical report: in a field test done by the University of Nebraska (USA), 46 **rheumatoid arthritis** patients were daily given a single antibiotic; these patients took minocycline (related to doxytetracycline), an antibiotic that is relatively toxic for the liver if taken over a long time.

   Results: After 6 months of antibiotic therapy, these patients displayed a 65% rate of healing. By the end of 3 years of uninterrupted minocycline therapy, 44 of the 46 participants had a healing rate ranging from 75-100%! Thus for them, the necessity to undergo relatively toxic, ongoing therapy for rheumatoid arthritis was passé (expensive, lifelong therapy).

   Which leads me to the following conclusion: If I want causal treatment for rheumatoid arthritis, then I absolutely **must** give long-term antibiosis a try.

   Reasons for such an approach:

   a. The illness is caused by either identified or unidentified bacteria (bearing in mind that only an estimated 1.5% of all bacteria worldwide have been identified, and of those known, only 50% can be established conclusively under thorough examination).

   b. These bacteria have already settled so deeply into the patient’s body, they’ve not only settled into the painful joints, they are also in the tendons, cartilage, and bones. Bacteria only abandon these last three types of tissue very slowly, whereas antibiotics can only penetrate such bradytrophic tissues (tissues with low-level circulation) with difficulty, and cannot develop a sufficiently bactericidal effect or reach bacteriostatic concentrations. Only long-term antibiosis provides for a definitively high rate of healing success, as opposed to standard symptomatic arthritis therapy (cortisone, gold salt, methotrexate, resochine, etc.) with all of its toxic side effects which also weaken the immune system. Under standard therapy, the pathogenesis (bacteria) remains untouched; only the symptoms improve.

4. What happens when animals are intensely fattened? In a fattening unit, animals such as chickens, calves, and pigs are kept in very cramped space, packed in together. (Chickens, for example, often have such limited space that they cannot turn around to know whether they’ve laid an egg or dropped manure – I for one would not hold up for two weeks under such conditions). And in Germany they seem to fare better than in the rest of Europe. To keep these animals from dying prematurely, they are constantly given antibiotics with their feed; it is only with
the help of antibiotics that such animals can be kept alive for a median length of
time, and can attain a relatively decent size and keep their health despite
miserable feeding and living conditions. The news magazine Focus, no. 23/98
dated 30 May 1998, reported on page 284 under the caption, “European
Commission aims to Critically Examine the use of Medications in
Stockbreeding”:

“In addition to the European Parliament, Sweden is also calling for a ban on the
systematic use of microbicides (that is, antibiotics, author’s comment) in animal
feed. Their concern: that microbicides could lead to resistance among microbes,
so that antibiotics become ineffective for human use in treating serious illness.

Most Secretaries of Agriculture support the use of antibiotics.”

What we can discern from this, is:

a. Even the majority of the agricultural secretaries in European countries
   support the use of antibiotics, referred to in the above article rather
euphemistically as microbicides, and

b. That it is standard practice in the European Union to mix antibiotics
   (microbicides) into animal feed.

All of these examples point out how very beneficial long-term antibiosis can be.
The argument that premature resistance to the antibiotics could result is much
less a problem for individuals as for the population. Particularly in highintensity
stockbreeding, constant use of long-term antibiotics fosters the development of
resistant strains of bacteria which also effect the human population, so that
people in the area can find themselves dealing increasingly with antibiotic
resistance. It is known, for example, that in former East Germany, in an area
with approximately 5 million inhabitants, and where for many years
stockbreeding was maintained through the massive use of only the cheapest
tetracyclines, the local population found that tetracyclines were useless
antibiotics for them. (In the meantime, after avoiding use of tetracyclines in
stockbreeding in this area, tetracyclines are beginning to “work” again with the

5. In the USA – the country with the world’s most strict health-related laws –
antibiotics are available in supermarkets prescription-free. This tells us
something about the low toxicity of antibiotics.

What follows from the above is: antibiotics are, all in all, a help in reducing illness, extending life
expectancy, and living better; why, then, should the greatest creature on earth – humans – do his
best to avoid them for fear of possibly becoming resistant to them? Why should people rather
require surgery following an inflammatory, degenerative illness? (Knee, hip, heart; I suspect
they receive antibiotics during and after these surgeries anyway.) Why do we choose this point
(why not earlier, at the stockbreeding level) to insistently declare: developing resistance must be avoided…? If no attempt was made at long-term antibiotic therapy before settling for surgery, some bright person might just take it into his head to ask, for whose benefit are we operating here?

April 1998

1.4. Revolution in the development of antibiotics

Thus far, there has been no real shortage of physicians or of lay persons who have admonished, “Do not take antibiotics, or else they won’t work for you later on”. In other words, if you take them now, they will not have any effectiveness left for later years.

In 2001, two new antibiotics were introduced, one called Zyvox and the other called Ketek. And any number of new antibiotics are expected for the near future, since the genetic code of one of the most significant bacteria for antibiotic production has been cracked, which should make an unprecedented arsenal of new active agents available.

According to a report in the May 12, 2002, edition of the newspaper Welt am Sonntag, English molecular biologists in Cambridge have successfully broken the genetic code of the ray-fungus Streptomyces coelicolor. By so doing, the researchers successfully gained a promising lead in the armaments race against disease agents. In breaking the genetic code of the ray-fungus, scientists have not only gained more possibilities for developing new medications for fighting cancer and manipulating the immune system; they’ve gained an incomparable new tool for preparing a substantial number of new antibiotics as well.

In recent decades, antibiotic resistance has been on the rise (especially due to the widespread, low-dose use of antibiotics in stockbreeding). This has become a significant problem in the world of medicine. It became necessary to develop ever more new active substances for medicines, as disease agents sometimes no longer responded to the accustomed substances.

According to the above report, we have now, after waiting for so long, a new opportunity to turn the tide in favor of life-preserving medicine.

“This is an extraordinary success after years of hard work!”, in light of the fact that these microbes (ray-fungus) are the “scouts among bacteria – they’re prepared for all kinds of contingencies.”

Two-thirds of all antibiotics produced today have their origins in these ray-fungi, which produce more than 9000 known biologically active substances, including many which kill other bacteria or halt their growth. For this reason, ray-fungi have been major suppliers for the pharmaceuticals industry. “For the future development of antibiotics, cracking the genetic code of the ray-fungus is of exceptional importance,” commented Julius Weinberg of the City University of London, concerning the work of his colleagues.
And so we can expect in the near future (the next few years) to see the development of many new highly-effective antibiotics. Those patients, however, who are putting off using antibiotics now, even though antibiotics ought to be used in treating rheumatism, Bekhterev’s disease, multiple sclerosis, possible heart attack, cardiac dysrhythmia, knee-joint and hip problems – these patients may no longer need the new antibiotics of the near future, if they die before then of heart failure, or if their rheumatism is so far advanced that their joints are already immobile. Or if their years-long bout of arthritis has developed by then into a full-blown case of arthrosis which can only be surgically treated.

May 2002

1.5. Antibiotics and livestock

If we are opposed to the use of antibiotics for humans, why then keep using antibiotics in keeping livestock, knowing that subsequent human use can trigger antibiotic resistance or pseudo-resistance? Such an antibiotic resistance finds its origin in the use of these substances in livestock.

The medical journal “Ärztliche Praxis”, in its no. 34 edition of April 6, 2002, calls on medical doctors and veterinarians to use antibiotics both more strategically and more sparingly. Fluoroquinolones, which were used first in treating humans in the 1980’s, are now processed into animal food by the ton, especially for feeding chickens; 120 tons p.a. are used for animals and only 2 tons p.a. for humans. Even so, fluoroquinolones are by no means the most common antibiotics, representing a mere 1 % of antibiotics used for livestock. Except in poultry farming, they are only rarely used prophylactically to prevent illness. What follows is the development of resistant disease agents among animals, and these resistant agents then wander effortlessly from animal to human. In Great Britain, 70 % of campylobacter strains (disease agent of stomach cancer) in poultry are resistant, compared with app. 20 % in humans; in Germany, the figure is around 40 % for both groups. But these resistances do not develop from using antibiotics in humans; rather, more than 90-95% of the time, they come from feeding antibiotics to animals. This is why it bothers me so much, and has for so long now, when I hear the silly line, “just don’t give people any antibiotics.” And it strikes me almost as mockery when an expert panel’s publication only lately (2002) comes out with the advice, “Use antibiotics for treating humans and not for livestock.”

May 2002

How does the medical journal “Ärztliche Praxis” (No. 36, dated 04 May 2004) recommend treating something such as chronic obstructive lung disease with its typical ragged breathing?

The authors conclude that such cases require that the antibiotics be repeatedly changed in order to help prevent resistance.
We’ve followed similar procedure in our medical practice for years now, in treating chronic borreliosis (spirochetosis, national epidemic no. 1, requiring longterm antibiosis for third-stage treatment).

July 2004

1.6. Use of antibiotics in Germany and in France

According to statistics listed in the “Ärztliche Praxis” on Sept. 24, Germany has an average of 36 physicians per 100,000 citizens, whereas France has only 30. But the French healthcare system is classified by the WHO as the best in the world. The key difference, clearly, is not the number of doctors, with Germany leading by 20% more doctors per capita than in France. France’s health-care system is decidedly different in that the French use a good 300% more antibiotics per capita than Germans do. And still their life expectancy is higher than that of the Germans, even if the French have 20% fewer doctors than their neighbors in Germany.

October 2002

1.7. My eye-opening experience with antibiotics

In 1975 I was a surgical medical assistant in a small hospital for surgery and internal medicine in the West Eifel area (not very far from Belgium).

One fine morning, our already extensive and overburdened surgery schedule was further stretched by the admission of an emergency patient. A 49-year-old woman was wheeled in, whose open fracture on her right lower leg was thoroughly dirty and covered with cow manure. The patient, a farming woman, had crashed down an embankment on her tractor; parts of the tractor had crushed her lower leg. She had just barely been able to drag herself back up to the roadside, where she had waited another two hours before attracting attention to her predicament, before finally being brought to our little hospital.

The patient was granted a slot on our already-full surgery list. Then, her very filthy flesh wounds and the protruding fractured tibia (shinbone) were given a rudimentary cleansing with a soap mixture dabbed on with a textile glove.

I can well remember what the senior consulting doctor thought of my efforts to clean the wound more extensively: “My dear Hellenthal, leave good enough alone; this leg is already lost below the knee.“ This barely-cleaned wound with its open tibia fracture (complete with large, black clumps of pasture) was then rinsed with a chloramphenicol solution, the lower-leg fracture was pinned in place, and the flesh wounds were stitched up.

Soon, the patient developed fever and had shivering fits. She was given doxycycline intravenously for 19 days. After that, her fever was gone, but she still had swollen lymph nodes in the right inner thigh, and she complained of occasional sharp and thumping pain around the fractured area. An internist was consulted, who recommended that all antibiotics be discontinued, as the patient showed no further serologic indications of infection (a laughable example of laboratory-chemistry backwardness); in opposition to the internist’s advice, and
behind our supervising surgeon’s back, I continued to treat the patient for another 12 days with the quite effective, though toxic chloramphenicol IV. The thumping pain around her wound disappeared, as did the swelling in her inguinal lymph nodes. After 4 ½ weeks, she was able to leave our hospital, on crutches, but walking; further inquiries revealed that she still had her leg 5 years later and could get around well with it. At any rate, she did not develop the then-expected festering case of chronic osteomyelitis, which would ultimately have made a lower-leg amputation necessary.

Conclusion:

Those who stubbornly believe in laboratory findings ought simply to try applying the absolute dictates of laboratory results on themselves!

April 1997

1.8. About the Author

1942 born in 66386 St. Ingbert.

1962 German universities’ required entrance exam abroad in Feldkirch/Vorarlberg, Austria, at the Stella Matutina, a renowned humanistic Gymnasium (college preparatory school) run by Swiss Jesuits.

1967 Completed degree in translating (French-English, at the Interpreters’ Institute of the University of Saarland); during which and thereafter teaching for 2 ½ years as foreign language teacher at the Gymnasium in Châlons-sur-Marne, Champagne, France, and at the public Gymnasium in Meppen/Em, Lower Saxony, Germany.
1969 through 1975 Medical school at the University of Bonn, the last years of which I spent in a work-study position in bacteriology; this was a most formative time, especially for increasing my understanding of bacteria in medicine, and for how bacteria work as „time bombs“ causing subsequent illnesses.

1977-1980 University Ophthalmology Clinic in Ulm; during and following this time, I also served as emergency doctor on call in and around the city of Ulm (day and night) for approximately 1000 assignments, a responsibility which fostered independent medical knowledge and skill.

As of March 1982 private practice as ophthalmologist in Günzburg.

Many thanks to my teachers at the Stella Matutina in Feldkirch/Voralberg, who sometimes seemed slow to me but who were very thorough, for whom achievement and discipline counted more than what meets the eye; also, I would like to thank the renowned neurologist Prof. Kornhuber of Ulm, from whom I learned how to get to the core of important correlations simply through logical thinking.

April 1998

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College Prep School, 1955-62 in Stella Matutina/Feldkirch, renowned school run by Swiss Jesuits; 1962 German universities’ required entrance exam abroad
Chapter 2: Case descriptions

2.1. Multiple Sclerosis

Tracking the primary trigger-mechanism of multiple sclerosis

2 cases of optic neuritis (optic nerve inflammation, a main symptom for the onset of MS), diagnosed and documented in a large hospital.

Contrary to what was recommended at the hospital, no cortisone therapy was administered; instead, therapy included various antibiotics in high doses and over a long period of time, plus vaccines, immunostimulants, and enzymes. Changes in nutrition and life-style habits were recommended, and measures were taken to improve circulation.

While undergoing therapy as described above, visual acuity improved in both cases from 0.2 to 1.0 within 14 days, and to ophthalmologically verifiable restitutio ad integrum (complete healing) within 6 weeks. Improvement was both subjective (disappearance of blurred vision) and objective (in terms of field of vision and corrected visual acuity).

Highly interesting as well is the simultaneous disappearance of the following initially reported problems: subjective cardiac dysrhythmia, nycturia, tactile dysfunction, and morning stiffness.

No relapse has occurred thus far, neither in the case which has been under observation for 7 months, nor in the other, under observation for 3 months.

One must assume that the problems described above were just results of a bacterial infection, which were cured when treated with sufficient antibiotic and immunostimulating therapy. Although both of these cases of neuritis were thoroughly documented at an external hospital (also with regard to a focal cause), it seems most probable that the causes were bacterial, especially if one considers that a vast number of bacteria have not been identified either clinically or serologically.

It is estimated that only approximately 1.5 % of all bacteria are known. Of those known, an optimistic estimate is that around 50 % can be serologically identified.

Supposing that approximately 90 % of all first-episode multiple sclerosis patients experience optic neuritis either exclusively or together with other symptoms, and assuming further that the bulk of these patients will be treated with high doses of oral cortisone, then it can’t surprise me at all that these cortisone-treated patients experience relapses, since cortisone therapy weakens the
immune system and thus opens the door wide for relapses. (One of the effects of cortisone is suppression of the immune system).

For example, it is sufficiently well-known that neither syphilitic spirochetosis nor Lyme disease (which is extremely difficult to diagnose serologically), nor florid tuberculosis, nor a florid herpes infection should be treated by cortisone in high doses, especially when no suitable antibiotic defense strategy is included in the therapy. If multiple sclerosis has a multiple genesis (perhaps partly viral and partly bacterial factors), then anti-bacterial therapy will always be necessary for its treatment. (Viruses also flourish under a weakened immune system; Luc Montagnier of the Institute Pasteur, who discovered the AIDS virus, has good reason for thinking that AIDS can normally only erupt if there is a simultaneous co-infection with chlamydia).

What a sensation if it were to turn out that one of the essential triggers of multiple sclerosis had thereby been discovered; namely, the disease might be triggered by treating the first episode of this kind of neuritis with high doses of cortisone, as is common, incorrect practice all over the world, with the immunosuppressive effects of cortisone then fostering a chronically relapsing state of cerebral infection.

Therefore, I find it conceivable that a different approach to initial therapy worldwide – an approach such as in the cases described above – could lead to a significantly lower incidence of multiple sclerosis.

Cases in which first cortisone was administered for years, and then Lyme disease was diagnosed 6 years after the initial MS diagnosis, at a time when the patient is already largely immobile and dependant upon a wheelchair – and antibiotic therapy could only affect marginal success at best – would then be a thing of the past (I know of just such a case).

April 1997

Addendum: Case description:

A 23-year-old patient develops optic neuritis seemingly out of the blue (unilateral optic nerve infection of the left eye), with the diagnosis confirmed in an external hospital. In searching for a focus for the infection, no medical specialist could detect any abnormality.

Before a cortisone therapy could be agreed upon, one final analysis of his spinal fluid aroused suspicion of a possible case of neuroborreliosis. Fortunately for the patient, he had not been given cortisone therapy, as cortisone has a suppressing effect on the immune system.

Simple immunostimulating measures, on the other hand, brought about within 4 weeks an improvement of his visual acuity (an excellent indicator of the degree of healing of optic neuritis) from 0.2 to 1.0, or from 20% to 100%.

That last spinal fluid analysis by a neurologist turned up a suspected case of neuroborreliosis, an inflammatory encephalitic condition caused by chronic bacterial infection with the agent of Lyme disease, a spirochete which is closely related to syphilis (infection normally occurs through tick bites or insect stings). Had he received high-dose cortisone therapy, as was common practice in all university hospitals until at least 1990 due to totally insufficient lab tests for Lyme disease at that time (they are still insufficient more often than not), then the immunosuppressing effects of cortisone would surely have sealed his fate with MS, frequent relapses included. (Especially if the patient were given a new, substantial dose of cortisone with each new episode).
Conclusion:

Every case of optic neuritis (or any other type of first episode of “MS”) should be considered and examined in search of any subjective abnormalities such as described above, even if the patient’s lab tests seem normal and the patient appears otherwise healthy, and treatment should by no means consist of cortisone in high doses (and under no circumstances without the protection of antibiotics). As I see it, MS is or can be triggered by current standard treatment. Further, we should question all MS patients regarding such initial symptoms as described above, and try treating them with one or more long-term antibiotic therapies, possibly using various kinds of antibiotics.

April 1997

According to medical textbooks, multiple sclerosis (MS) is defined as an autoimmune disease in which the body’s own defense mechanisms attack the protective myelin sheath of the nerve fibers, bringing destruction to the patient’s brain and spinal cord. Because of this demyelination, nerve signals are no longer properly transmitted within the nervous system, with such diverse consequences as muscular atrophy, moving disability, visual impairment, paralysis, slurred speech, and urinary and gastro-intestinal problems. (Looking back, multiple sclerosis begins with a case of optic neuritis and then impaired vision, normally involving just one eye, for app. 90% of the patients).

And in December of 1998 something hit the world of medicine like a bomb: According to the scientific branch of the German Press Agency (in the magazine “Frau im Spiegel” no. 53. of Dec. 1998):

Multiple Sclerosis Caused by Bacteria

According to the latest research in the US (Vanderbilt University, in Nashville, Tennessee), multiple sclerosis seems indeed to be caused by bacteria. Particularly the miniscule bacteria chlamydia pneumoniae are considered to be the culprits. Studies involving antibiotic therapy for MS patients are supposed to back up this theory. (Source: scientific branch of the German Press Agency).

At a scientific symposium held on the occasion of the 25th anniversary of the University Ophthalmology Clinic in Ulm in April 1997, the trigger mechanism described above was reported to several hundred doctors. My thesis, that MS is caused by bacteria, triggered by inappropriate cortisone treatment, and that this was proven ex iuvantibus by the treatment described above (this successful antibiotic therapy served as a means of proof for a bacterial cause of MS) led to mostly astonished reactions among my medical peers. They found it particularly hard to grasp why, as I claimed, the administration of cortisone should pave the way for subsequent episodes of MS (through the immunosuppressant qualities of cortisone).

I consequently initiated long-term antibiosis together with immune-system therapy for a 37-year-old patient who had already gone through 5 episodes of MS over the last 12 years. This antibiotic therapy trial has been going on for 6 months to date, and it seems to be a great success. I shall report more about this in my next booklet. The wide world of medicine will need to make up its mind about this in time.
Thus, a physician from Günzburg was, to my knowledge, the first in the world to present a successful, adequate, and documented long-term antibiotic therapy for MS, and this already two years ago.

Conclusion:

Initially, MS is a matter of destructive bacterial in the cerebral sphere, even if accompanied by viruses such as those of the herpes family. Disturbances to the immune system (brought on by excessive stress, financial problems, marriage problems, etc.) pave the way for an initial case of neuritis (first MS episode). Then, inappropriately administered, immunity-suppressing high-dose cortisone is enough to seal the MS fate, complete with its repetitive relapses. This continuous (“necessary”) administration of cortisone reminds me of a heroine addict who constantly “needs” a “fix”, but who will eventually become a physical wreck precisely because of that fix.

February 1999

Continuous, long-term antibiotic and immunostimulating therapy that goes on for years strikes me as very laborious, but also as the most promising method for successfully treating these patients.

January 2001

Addition:

In the 1990’s, some comparative research was undertaken regarding first-time optic neuritis (suspected to be the first episode of MS). One group of patients received cortisol, which inhibits inflammation but also suppresses the immune system; in the other group of affected patients no cortisol was administered.

The results: after one month with cortisol, the optic neuritis had improved quickly and radically, but long-term success was clearly better among those without cortisol; most particularly, those who were not given cortisol experienced practically no relapses.

Here, at the very latest, it ought to be clear to any physician that:

1. The cause of the supposed first episode of MS must be an inflammatory agent (such as bacteria).
2. Administering an immunosuppressant such as cortisol fuels on the infection so that repeated neurological/cerebral inflammatory relapses are scarcely avoidable.

The result in the long run is a wheelchair dependency brought about by cortisol. One more logical conclusion: To be assured of a steady supply of long-term patients – give them cortisol!

October 2001
In March 2002, the renowned medical periodical “The Lancet” published an article about the “best therapy for tennis elbow”.

In the process of researching which kind of therapy is most helpful for treating tennis elbow, a painful inflammation of the elbow, doctors at the University of Amsterdam reached the following conclusion:

When evaluating a brief span of only 6 weeks, the cortisone injection was the most effective, compared with physical therapy and also with non-treatment by any other medication. After 6 weeks, the evaluated success rate among those treated by cortisone was around 92%. In the long-term evaluation (one year), physiotherapy brought the highest rate of successful treatment (91%). Also, non-treatment led to an 83% improvement. The lowest rate of success in the long run came from cortisone treatment, with a success rate of just 69%. This clearly demonstrates the effects of cortisone: short-term anti-inflammatory success, followed by long-term suppression of the immune system. This can be seen in correlation with what is still common therapy for a first episode of MS, i.e., cortisone treatment. In plain language, non-treatment – also as regards multiple sclerosis – is more successful in the long run than the cortisone therapy which is still common practice in our country, even in our university medical institutions.

March 2002

2.2. Multiple Sclerosis - inflammatory and degenerative forms

In the estimation of Prof. Brück of the neuropathological Institute of the Charité, MS is probably a disease with multiple origins which cannot be explained simply in terms of immunopathological processes. Such is the result of research conducted by Prof. Brück in cooperation with other scientists from Vienna and Rochester (Mayo Clinic) in the USA, who reached the conclusion that the destruction of myelin sheaths and of nerve fibers are two separate and independent processes. So far, MS has been presumed to be simply the result of an autoimmune reaction in which the immune system turns against parts of the myelin sheaths and the nerve fibers, destroying their protective layers on a more or less large scale.

Yet immunological phenomena alone cannot account for the full scope of MS. This helps explain the fact that the immunopharmaceutical interferon only has a positive effect on approximately two-thirds of MS patients.

To me, this further proves the validity of a bacterial cause of MS (and possibly initially viral), which should not be treated first with cortisone, least of all if no high-dosed antibiotic protection is provided for simultaneously.

April 2002
2.3. Multiple sclerosis sexually transmittable

According to a British researcher, multiple sclerosis is sexually transmittable ("Ärztliche Praxis" no. 78 / 27 September 2002).

A British researcher is convinced he has found evidence indicating the above (JNNP 73 [2002] 439-443). Christopher Hawkes of the Institute of Neurology in London investigated prevalence patterns of MS. His conclusions contrast sharply with current teaching, according to which genetic or immunological mechanisms trigger this disease of the nerves.

Hawkes analyzed data concerning the higher frequency of MS cases and epidemics in the Faeroer Islands, Iceland, and the Orkney and Shetland Islands. He discovered that the number of MS cases always increased when military troops were stationed on the islands. “The increased incidences of MS in correlation with contact to military personnel indicates the possibility of a communicable agent,” concludes Hawkes. At the same time, he refers to the fact that primary progressive MS and tropical spastic paraplegia (TSP) run very similar courses.

TSP is primarily sexually transmitted, and is related to infections with the retrovirus HT-LV-1, argues Hawkes. Further, the researcher points out that the rate of MS incidences is higher among young, sexually active persons.

This corresponds with my conviction that MS is primarily transmitted by bacteria (and possibly by initial viruses), and that therapy must and should primarily begin with treatment of the bacterial superinfection or of the solitary bacterial infection, in form of long-term antibiosis together with immunomodulation and immunostimulation.

September 2002

2.4. Spirochetes - Elimination through use of statins (fat reducers)

In the medical journal "Ärztliche Praxis" No. 92, dated 15 November 2002, the use of statins for combating multiple sclerosis is discussed.

According to the article, researchers at the University of California in San Francisco applied the cholesterol-sinking drug Atorvastatin to mice that had MS, and succeeded not only in reversing paralysis in the mice, but also in protecting the mice from relapses. Thus was successfully demonstrated that statins have a potentially positive influence on the immune system’s reactions, claimed neurologist Dr. Scott.

I see this as further proof that MS is triggered by bacteria, particularly by spirochetosis; and as spirochetes settle especially in fatty tissue (cholesterol), they can be eliminated naturally, through the bowels, with the help of the above-mentioned cholesterol-reducing drug Atorvastatine. The necessary goal is to try to eliminate fat soluble enterotoxins (spirochetes) through the bowels, rather than having them constantly re-absorbed into fatty tissue through
enterohepatic circulatory processes; they should be eliminated possibly by using statins, but also through increased physical activity (which burns fat) or by using algae products.

The conclusion drawn in the scientific article mentioned above is one that I cannot recommend following. I can’t support simply administering a fat-reducing drug; rather, fat reduction should be brought about naturally through physical activity and suitable nutrition in order to eliminate the borrelia (spirochetes). This is especially important in treating fibromyalgia, neuroborreliosis, post-Lyme syndrome, and of course particularly MS, which I believe is caused by spirochetes.

November 2002

2.5. Multiple sclerosis is an infectious disease!

As can be determined by a defective gene

Since April 15, 2003, it has been clear for all to see – with 3 million blood samples serving as proof – that multiple sclerosis is an infectious disease (reported in the journal “Ärztliche Praxis” on April 15, 2003).

Excerpt:

BOSTON (rs) – The American military is not only useful for fighting wars: millions of blood samples were collected from soldiers for later use.

American military officials have collected and stored more than three million blood samples from their soldiers since 1988. These provided interesting data concerning antibodies, useful in the hunt for the causes of MS. A particular focus was placed on the Epstein-Barr virus (EBV).

Eighty-three cases of MS had been reported, all of which had blood samples in storage, in some cases multiple samples from different years. From the extensive file, two control cases were selected for each case of MS, matched with the MS patient not only according to age, gender, and race. The blood samples also had to have been taken in the same month. Then the IgA and IgG were determined in contrast with EBV capsule antigens as well as nuclear antibodies. Further, any cytomegalovirus infections were noted (JAMA 289 [2003] 1533 through 1536).

The results were enough to astonish the researchers: All blood samples – whether from MS patients or control samples (with only one exception) – were infected with the Epstein-Barr virus at the time the first blood sample was taken. But the MS patients had higher antibody titers (excepting IgA) – and that was years before the disease erupted.

The antibody patterns found by these researchers are also clearly different from those of immunosuppressed patients and from those who suffered from an EBVtriggered case of Burkitt’s lymphoma.
My comments:

Hopefully, by now any health-care professional can see that MS first appears in an episodal way (as I have described above), generally in the form of retrobulbar neuritis (infection of the optic nerve), which should by no means – or especially no longer – be treated by immunosuppressants such as cortisone. MS is not an autoimmune condition in which the body attacks itself so that the immune system must be suppressed; rather, as it is an infectious disease, the immune system must be strengthened by all means. Also, since (as I suspect) a viral trigger is involved as well, which generally leads into a bacterial superinfection, antibacterial and antibiotic therapy must also be administered – just as in the case of SARS, for example.

Whoever doesn’t do this makes himself guilty of gross malpractice. As it is, it will be extremely difficult to say to one’s MS patients, we’ve been giving you faulty treatment for the past 20-30 years. It will also be difficult to explain to the patients that Dr. Hellenthal, whom we have repeatedly maligned, was unfortunately right all this time, calling unwaveringly as he did like a voice in the wilderness with his claim that MS is not an autoimmune condition, but rather a process of infection.

May 2003

Why, do you think, is MS not found in third-world countries? I’ll tell you: it’s because they practically never administer cortisone there!

September 2003

2.6. An (almost) convincing “case of MS”

Typical course taken by a case of so-called multiple sclerosis, which erupted in 1980 and was not treated with cortisone or beta-interferon.

Brief anamnesis: male patient, 39 years old

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>Sinus infection</td>
</tr>
<tr>
<td></td>
<td>Stomach problems</td>
</tr>
<tr>
<td></td>
<td>Stomach pains</td>
</tr>
<tr>
<td>1980</td>
<td>MS symptoms following mercury accident</td>
</tr>
<tr>
<td>1982</td>
<td>Tinnitus (ringing, buzzing in ear)</td>
</tr>
<tr>
<td>1984</td>
<td>Eye problems (dry; blurred vision)</td>
</tr>
<tr>
<td>1985</td>
<td>Bladder and prostate problems, burning sensation when urinating</td>
</tr>
<tr>
<td></td>
<td>Painful joints</td>
</tr>
<tr>
<td>2002</td>
<td>Dental amalgamates replaced by synthetic fillings</td>
</tr>
<tr>
<td></td>
<td>Detoxification by means of green algae, wood garlic, vitamin C</td>
</tr>
<tr>
<td></td>
<td>Nutrition modifications: many vitamins and trace elements in high doses</td>
</tr>
<tr>
<td></td>
<td>No relapses since early 2002; however, remaining symptoms such as elbow and knee-joint pain. These remaining symptoms disappear almost 100%, temporarily, during 2-3 weeks’ treatment with antibiotics (doxycycline) for an acute case of sinusitis.</td>
</tr>
</tbody>
</table>
Never took cortisone or interferon for any episode so far
Average of 4 episodes p.a. until 2002
Patient is still walking after more than 20 years of “MS”, and is still full-time employed

As he is of the opinion that he could be healthy after a long-term antibiosis (at least 6 months, possibly longer), he has decided to undergo such a therapy under my supervision. Although focuses of demyelination were detected in this patient’s NMR tomography, and through other forms of diagnosis as well the neurological diagnosis MS was definitive, this patient could never be persuaded to take cortisone or betainterferon for his episodes. As he put it, he could not detect that other MS patients had any benefit from those medicines, nor did he see any benefit for rheumatoid arthritis patients. He observed repeatedly that patients who received cortisone treatment had no long-term benefits from it. I can’t argue with his conclusion.

After the first 2 weeks of antibiotic therapy, the patient felt fully rejuvenated and had no more pain whatsoever.

March 2004

As reported by an MS patient

For all people of good will, this is a typical indication of why multiple sclerosis simply must be caused at least in part by bacteria, and how it can be successfully treated by long-term antibiotics:

An MS patient who had been handicapped for years – driving down a highway in a specially-equipped car with hand controls – had a car crash after which he was placed under artificial coma and given decompression surgery (for treating cerebral compression and bleeding). For the next half-year, he was continuously given antibiotics because of an opening in his skull. When he awakened from the artificial coma, he was able to walk again without hindrance, something he hadn’t been able to do for years. He did, however, suffer from memory loss due to the cerebral compression.

This is yet another clear indication that MS is not an autoimmune disease – rather, it is caused at least in part by bacteria.

March 2004

2.7. When antibiotics can’t help anymore

When antibiotics can no longer help, and even I strictly oppose their use.

Around 12 years ago, I met a hard-working, physically fit and energetic retiree; we became better acquainted, and every now and then spoke of personal matters.
One day, as he was complaining of stenocardia (tightness in the chest) and cardiac dysrhythmia, I advised him to undergo long-term antibiotic therapy. My advice was based on experience gained since 1976, when I was a medical assistant and intern in a small hospital in Westerwald; and regularly treated all of my heart attack patients there with antibiotics – and with great success. (I was very active and most willing to work, so the hospital administrators placed me at the end of a “long leash” and let me work.) I was convinced early on that arteriosclerosis is of bacterial origin, and that the risk of heart attack or stroke, or a history of heart attack or stroke, are grounds for long-term antibiotic therapy. As much has since been confirmed, in April 1997 at the German Convention of Internists – at last, after 21 years. Their conclusion: we’ve got to completely re-think our strategies; heart attack, stroke, arteriosclerosis, and arthritis are caused mainly by bacteria and must be treated with long-term antibiotics. My acquaintance turned down my advice because his physicians (internist and cardiologist) considered it nonsense.

Shortly thereafter, my acquaintance suffered a heart attack. Again I advised long-term antibiosis, but no avail; he suffered another heart attack. Once again, I recommended a long-term therapy with antibiotics.

Then, I determined that this man also had low-pressure glaucoma. Only recently I had written, as a world’s first, in the medical journal “Ärztliche Praxis” about the correlation between chronic bacterial infections and low-pressure glaucoma. – And here and now – to my knowledge as the first worldwide – I wish to draw upon my years of experience with long-term antibiosis, to point to the connections between pigmentary glaucoma, primary chronic open-angle glaucoma (and, again, low-pressure glaucoma), and the long-term oral antibiosis plus immunomodulatory therapy necessary for successfully preserving the optic nerve.

Yet again, my advice to the above patient went unheeded; he was simply regularly prescribed special eye-drop medication for glaucoma.

Some time later, the patient began to have stomach problems. Due to my experience with the long-term use of antibiotics, I tried still again to convince him to try such a therapy (I suspected a helicobacter pylori infection). He underwent several gastroscopies, until a further gastroscopy in 1996 revealed stomach cancer. A 2/3 gastric resection followed, but the cancer metastasized into the esophagus, causing esophageal stricture. He could no longer swallow food, and an esophageal dilation was (again) attempted. Then, in 1996, when the patient was in a critical state, he and a close relative requested that I come to the hospital. He was receiving a ringer solution intravenously for nourishment, was fully mentally alert, and moved quite actively about his room (and to the toilet) with his IV hook-up attached. When his relative asked, “Can we still try to use the antibiotics?” I replied, “No, not anymore.”

Two days later, the patient was dead.

Conclusion:

The patient had always refused long-term use of antibiotics, in part on grounds that we shouldn’t use antibiotics now, but later, if things got serious -otherwise, the antibiotics could lose their effectiveness.

April 1997
2.8. Low-pressure glaucoma: cause and therapy

Cause and therapy of low-pressure glaucoma, pigmentary glaucoma, and open-angle glaucoma

It is becoming more and more evident that the most frequent form of glaucoma, namely chronic simple glaucoma, is mainly caused by circulation deficiencies; i.e., it can be traced back to arteriosclerosis (striction of the blood vessels). And since arteriosclerosis, in my experience with patients and according to the latest medical findings, is essentially caused by bacteria, long-term antibiosis and immunotherapy is imperative for bringing about genuine healing. This is contrary to present orthodox medical procedure worldwide, which treats the patient daily with medicine for sinking intraocular pressure – in other words, typical symptomatic treatment rather than causal therapy. If the cause is treated, the patient could probably do without daily pressure-reducing medicine, as is the expectation after long-term antibiosis and immunotherapy. I already stressed this in 1993, in the context of a borreliosis-related glaucoma case (see article “Low-pressure glaucoma in connection with Lyme disease”).

Addendum:

In my view, long-term use of antibiotics also prevents clogging in Schlemm’s canal and in the related drainage system for intraocular fluid, and when intraocular fluid can flow freely through the corneoscleral meshwork, this can normalize intraocular pressure while greatly reducing the probability of subsequent glaucoma-related damage. New way of thinking: long-term anti-inflammatory (= antibiotic) therapy prevents the development of inflammatory cells around the camera anterior bulbi and the iris – which would otherwise cause clogging of the corneoscleral meshwork.

April 2000

2.9. Why cardiac catheterization?

Why should cardiac catheterization always be Plan A, when there’s a less expensive and less invasive way?

Case:

A 23-year-old patient who had been known to have cardiac dysrhythmia since the age of 3-4 years was advised to have a cardiac catheterization.

When I first met this patient, he had extremely cold, clammy hands and feet, wrist pains, pimples across his forehead, frequent headaches, and migraine attacks (see also text on migraines, chapter 2.50, addendum May 2000) extensive enough to lead to complete temporary loss of vision. He suffered occasionally from symptoms of total paralysis. I treated this patient with antibiotics and immunomodulation for three months. Most of his problems disappeared
completely during this therapy, most notably the chronic mucous overproduction in his throat, as well as his cardiac dysrhythmia. Cardiac catheterization was no longer necessary.

The success of this therapy gives rise to the suspicion that the patient had an underlying bacterial infection; quite possibly rheumatic endocarditis, which is not always caused strictly by hemolyzing streptococci as presumed by some lab fanatics.

December 1997

2.10. A typical case in our “dear” health-care system

A 53-year-old female patient had been feeling dizzy for one week; the floor seemed to spin day and night – even when her eyes were shut – whether she was lying in bed or up and around. Otherwise, she felt perfectly well (no backache, no headache, no nightly urgent bladder, no knee-joint pain, no varicose veins or hemorrhoids, neither fever nor sputum – no further abnormalities), RR 130/70, pulse 68.

Anamnesis:

Paroxysmal tachycardia (sudden attacks of very fast heartbeat) up until 12 months ago, treated more or less successfully by the family practitioner with Isoptin (after a thorough examination including ECG).

These attacks of cardiac rhythm abnormalities disappeared, with no relapses since, after I treated the patient one year ago with a three-week antibiotic and immunomodulatory therapy.

In light of the anamnesis as well as of the patient’s current physical condition, I suspected that her dizziness resulted from an infectious cerebral condition – after just 3 days of oral antibiotics (Zithromax capsules, 1 p.d.) the dizziness ceased.

This very prompt recovery using antibiotics and immunomodulation confirms the diagnosis “inflammatory cerebral condition” ex iuvantibus.

And how many otherwise “necessary” expenditures were thus spared our “dear” (expensive!) health care system with its exploding, increasingly insupportable prices? General practitioner, internist, EENT specialist, ophthalmologist, neurologist (including CT and NMR tomography)….

What if all of these examinations had been ultimately inconclusive, as would have been likely in this case? Would this patient have been given expensive medicines for years to treat cerebrovascular insufficiency?

April 1997
2.11. Smoking weakens the immune system

How smoking weakens the immune system, promotes arteriosclerosis, and reduces life expectancy. How corrupt and decadent can our Secretary of Health, Mr. Seehofer, be when it comes to the nicotine industry?

One would think that it ought to be a Health Secretary’s top priority to apply himself towards the well-being of the population he serves. Yet in February 1998, when he had the opportunity to support a new ground-breaking ordinance or law (for example, banning smoking in public office buildings or at the workplace), he chose instead to tuck tail and belly-crawl before the “poor Secretary of Finance” and the nicotine industry. Still, it seems his conscience plagued him just a bit, because a few days later he polished his halo, applied his most “concerned” expression, and called on the people of Germany to all go get their flu shots. A man in Mr. Seehofer’s position knows very well that nothing shortens a life with more certainty than smoking; statistics tell us that a smoker in Germany shortens his own life expectancy by 22 years (yes, twenty-two), and the years left to his life are not years of good health. A smoker requires cataract surgery at an average age of 59, for example, whereas the average age for non-smokers (and possibly for passive smokers) is 83 (in cataract surgery, the eye is opened, and the cloudy lens gets suctioned away and replaced by an artificial lens). Smokers’ skin ages years faster; women who smoke go into menopause sooner and they are nine times more likely to be infertile than non-smoking women. A study in Canada, in which 625 first-grade children were observed, concluded that children who live in a smoker’s household have nearly twice as many ear infections as children in whose presence nobody, or nearly nobody, ever smokes; ear infections are not only painful, they can lead to partial or even total loss of hearing.

It may of course be remotely understandable that a financially challenged Finance Secretary Waigel, a nicotine-obsessed chain-smoker like Mr. Dressler (the Social Democrat Party’s designated successor for Health Secretary Seehofer), and Secretary Blum, who is plagued with an unsolvable federal pension (and maybe pensioners) problem, would together find the smoking consensus satisfying (because if people die younger, the retirement age might not need to be raised, and federal pensions may not require drastic reductions). Even so, a Health Secretary ought to take a stand for health, especially concerning children who, as passive smokers, take in up to 50% of the smoke around them, as the nicotine concentration in their urine reveals (several carcinogens are found concentrated there as well). I can’t be happy about the way children are forced to be passive smokers; they also passively inhale dioxins, which are among the worst poisons. Perhaps their nicotine-addict parents think that, if they themselves are already so arteriosclerosal and no longer able to think so well (a cigarette maximally constricts the arteries for 6 hours, so that a smoker could constrict his arteries for a full 24 hours with only 4 optimally-distributed smokes), then why should their children be more lucid than the parents – why should the kids have it better in life than we do? Why pregnant women and non-smokers in general (who perhaps have other health problems which motivate them not to smoke) should be subjected to unavoidable passive smoking is something I can’t and won’t understand.

March 1998
Just how dangerous smoking can be, and how we’ve been misled for decades by the evaluations of academic experts paid by the tobacco industry, is evident from a further evaluation reported in “Ärztlche Praxis” 19 March 2002.

According to this report, patients who suffer from immunohyperthyroidism (Grave’s disease, which can cause bulging of the eyes) should not by any means smoke. The report claims that smoking increases the risk of also developing endocrine ophthalmopathy (the specific name for the bulging-eye phenomenon) by a factor of 8 (800%)!

As if that weren’t enough: if the eyes are already affected, smoking greatly reduces the chance for successful therapeutic measures, as reported by Prof. Armin Heufelder at a convention in Stuttgart.

April 2002

It seems a decadent government to me, this social democratic / green party (environmentally friendly, they claim) government of ours, considering the way they blocked a directive proposal of the European Court of Justice in October 2000, which aimed at a Europe-wide ban on tobacco advertising. In May 2001, the commission presented a re-worked draft which still requires ratification from the European Parliament and Council. Enter Germany, the sole member state to block the measure, opposing tobacco-product labeling and the limitation of additives.

Consequently, EU Commissioner for Consumer Protection David Byrne has accused Germany of blocking European attempts at curtailing smoking. “Germany is crippling the EU Commission in its efforts, particularly those against tobacco advertising”, said Byrne in an interview with the “Berliner Zeitung” (according to “Die Welt” of April 3, 2002).

Here we see plainly how forked our politicians’ tongues are with their pre-election claims, and, in my opinion, how unambiguously corrupt they are.

April 2002

2.12. Smoking accelerates diabetic nephropathy

(Diabetic kidney disease)

According to the medical journal “Ärztlche Praxis” in its April 12, 2002 edition, when diabetics smoke, their kidney function suffers for it. Diabetic nephropathy (kidney disease) advances more rapidly for this group than among their fellow diabetics who do not smoke.

It seems that a progressive loss of kidney function is an unavoidable fate for diabetics. Scientists at the Texas Tech University Science Center set out to determine which factors influence the progression of diabetic nephropathy – the findings above are the result of their research.

April 2002
2.13. Life-threatening passive smoking


According to a study done in Canada, the lung tissue of 44 babies who had died of sudden infant death syndrome (SIDS) was compared with tissue from 29 babies who died of other causes (e.g. heart problems, meningitis, pneumonia, or acute trauma). Both the nicotine and the cotinine concentrations were determined. Cotinine is produced through the breakdown of nicotine. What the researchers found was that the lungs of the SIDS infants had a nicotine concentration of 20 ng/g, while the babies in the control group had a nicotine concentration of 9 ng/g in their lung tissue. This is hardly astonishing; children of smokers proved to have a higher nicotine concentration than children of non-smokers. What is noteworthy is that some of the lung tissue samples from the children of supposed non-smokers proved to contain quite a lot of nicotine. This could be an indicator that the parents of these children kept their smoking a secret.

As the babies were predominantly bottle-fed, the consumption of smoked food items can be disregarded as a possible alternative source of nicotine.

Among other things, this study confirms the suspicion that nicotine, or passive smoking, has a significant influence on sudden infant death, and firmly establishes how irresponsible it is for parents of newborns to continue smoking.

May 2002

2.14. Cigarettes make cancer aggressive

(“Ärztliche Praxis”, from July 5, 2002)

According to this article, young cigarette smokers develop more aggressive forms of prostate carcinoma. Such is the conclusion of William Roberts of Johns Hopkins Hospital, after having questioned around 500 patients of radical prostatectomies regarding their smoking habits. “One of the earliest signs of prostate cancer is the loss of the GSTPl enzyme, which detoxifies the carcinogens (cancer-causing substances) from cigarette smoke,” explained Roberts. If this enzyme is missing, then smoking consequentially has a detrimental effect on the genes.

This is further evidence of the danger of smoking. Not enough that 60% of all smokers die as a direct result of smoking; what about the indirect results such as loss of intelligence in the children of smokers, or intelligence loss in the smokers themselves?

July 2002

Texts regarding smoking, from Ärztliche Praxis no. 28; August 28, 2003

According to this article, people who start smoking as early as the age of 18 reduce their life expectancy by 23 years.
This is a fatal trend, considering that lung cancer is already the third most common cause of death among women. The article claims that 60% of smokers are addicted, and are not in the least likely to give up smoking.

March 2003

An article from an edition of Ärztliche Praxis from the year 2002 quotes Eva Prescott of the Ama Hospital. According to the article, cigarette smoking poses a greater threat to women than to men. Smoking 3 cigarettes a day doubles a woman’s risk of having a heart attack; men reach the same risk level after smoking 6 cigarettes. Further, the danger of dying prematurely of other sources is greatly increased by the consumption even of small amounts of tobacco.

October 2002

2.15. Passive smoking dangerous even for cats

According to a report from the medical journal “Ärztliche Praxis” from 2002, passive smoking is dangerous even for cats; that is, cats who live in smokers’ households are more than twice as likely to develop cancer as are “non-smoking” cats, as reported in the American Journal of Epidemiology.

In fact, cats that live with two smokers are at four times the risk of developing illness. It seems that the risk of developing cancer not only increases by smoke inhalation, but also by regular licking of the fur.

Here we have one way to prove who is a true friend of animals. And why should these findings not apply to other furry friends in our homes?

November 2002

2.16. Tobacco endangers even healthy kidneys

(From Ärztliche Praxis, December 20, 2002)

Smoking is a danger even to healthy kidneys, according to a study from Monash University in Melbourne: The more a person smokes, the more his kidneys suffer, even if his blood pressure and blood sugar levels are normal. Men are at a higher risk than women in this respect.

The scientists studied the renal function (kidney function) of kidney patients and of people with healthy kidneys.

December 2002
2.17. Cigarette smoking causes impotence

(from the journal “Ärztliche Praxis”, 14 March 2003)

Once again, a study has underscored the connection between cigarette smoking and erectile dysfunction (more commonly called impotence). In a study involving approximately 5000 Chinese Americans, Jiang He of the Tulane University of Public Health in New Orleans produced the clearest data to date concerning smoking concomitant diseases such as hypertension (high blood pressure) and diabetes. His data demonstrate that people who currently smoke have a 31% increased risk for erectile dysfunction (impotence) – the same is true for former smokers as well.

April 2003

2.18. No-smoking ordinances make the „heart demons” work much harder

Cardiac infarctions drop by 60% in no-smoking community
(from “Ärztliche Praxis” no. 30; April 15, 2003)

Heart-attack prophylaxis, American style: Ban heart attacks by banning cigarettes. A study of statistics gathered at the St. Peter Community Hospital near Helena, Montana, shows a 60% decrease in heart attacks. Such encouraging statistics are not the result of some innovative new therapy, but rather of a simple ordinance banning smoking in public buildings.

The 66,000 residents of the Helena area went for half a year without smoke in public buildings; then the ban was lifted after being challenged in court. Inspired by this smoke-free time, researchers Richard P. Sargent and Robert M. Shephard of the St. Peters Hospital conducted their research – the hospital treats nearly all cardiology patients in the Helena area. The researchers reviewed the data sheets of smoke-free Helena’s acute myocardial infarction patients, comparing them with the data of patients from other regions. Their results were presented recently at a conference of the American College of Cardiology.

Their research showed that the number of heart attack patients averaged 7 per month before the smoking ban. During the 6-month smoke-free period, the monthly average dropped to below 4 – a nearly 60% reduction! The number of patients from other areas who required heart-attack treatment at St. Peters, however, remained unchanged!!!! As Prof. Stanton Glantz of the Cardiovascular Research Institute of the University of California explained, the effect of passive smoking on cardiovascular functions is similarly dramatic as the effect of smoking actively. Within five minutes, the aorta becomes stiffer, thrombocytes are activated, vessels can no longer dilate (expand) optimally, and cardiac rhythm is disturbed. Glantz’s conclusion: “Protecting people from smoking’s toxins can have an immediate life-saving effect!”

April 2003
2.19. Higher risk of breast cancer for girls who smoke

(reporting in "Ärztliche Praxis" on October 15, 2002)

According to this report, a study in Vancouver has determined that girls who smoke increase their risk of developing breast cancer by 70%. Led by Pierre Brand of the British Columbia Cancer Agency, these scientists suspect that the reason for the higher cancer risk is that girls’ breasts have particularly sensitive tissue during development. The researchers examined 2000 women under the age of 75. Compared with non-smokers, girls who started smoking within 5 years of their first menstruation were 70% more at risk of developing breast cancer later on. (Lancet 360 [2002] 1044-1049).

May 2003

2.20. Children absorb and retain poisons

(such as the nicotine by-product cotinine) Passive smoking is especially hard on young bodies

The toxic (poisonous) substances in cigarette smoke have a long after-effect. In the USA, a no-smoking campaign has shown some success; for example, the burden imposed upon the average US citizen through passive smoking has diminished drastically in the past ten years. This mostly positive announcement from the Centers for Disease Control in Atlanta did include, however, one nearly inexplicable detail: in terms of age groups, the statistics showed that children have double the nicot ine concentration found in adults.

In their National Report Regarding the Influence of Environmental Chemicals on Humans, the CDC lists 116 substances found in blood or urine samples. These include heavy metals, a long list of polychlorinated biphenyls (PCB), dioxins, and herbicides such as DDT. This demonstrates, not for the first time, the long-lasting effects of this herbicide, which was banned in the USA and other industrial nations three decades ago but still manages to find its way into the human body. DDT, and/or its decomposition product DDE have been traced in the bodies of people born in the 1980’s.

Tobacco smoke contamination was determined by measuring the concentration of cotinine in the blood. Cotinine is created through the breakdown of nicotine, and remains much more constant than nicotine, making it traceable for a longer time. Blood samples were tested exclusively from non-smokers. For the decade 1990-2000, tests showed that cotinine concentrations in adults declined by 75%, while for youths and children aged three or more, the reduction was only by 58%.

As for the reasons why children are hit doubly hard by tobacco contamination, and why their reduction level of cotinine concentration was lower, the experts at the CDC could only speculate. It could be that children are exposed to more passive smoke because most of the efforts to reduce smoking over recent years have concentrated on areas relevant to adults, such as banning smoking at the workplace. Additionally, children’s bodies could be more susceptible for
absorbing nicotine. This is underscored by an examination of 307 German children ages one through five years, in which was demonstrated that the highest concentration of cotinine in the children’s urine was reached at age one. The air that an infant inhaled can contain even higher concentrations of toxic substances than what the smoker inhales directly. Even in rooms that are vigorously aired, harmful substances linger on in the air for a long time.

In an analysis of numerous international studies, Norwegian toxicologists came to the conclusion that children are more likely to have ear infections, pneumonia, or even die of sudden infant death syndrome, in proportion to the amount of tobacco smoked in the home. The reason is a weakening of the immune system, which in its weakened state can only inadequately protect the body from disease, and becomes more likely to develop allergic reactions to food products.

My comments on the subject: Here we have demonstrated just how silly the talk is about food allergies coming from increased air pollution. Food allergies are mostly the result of other causes, such as increased exposure to tobacco smoke, or mounting bacterial activity. (reported in the “Welt am Sonntag”, on February 9, 2003.)

May 2003

From the “Welt am Sonntag”, on September 24, 2003

At the German Lung Day convention in Hanover, specialists urgently warned anew of the dangers of smoking. Every 8 seconds, someone in the world dies from the consequences of nicotine. Children who start smoking by the age of 14 reduce their life spans statistically by 22 years.

May 2003

2.21. When mother smokes, higher risk of infertility for daughter

(from “Ärztliche Praxis” of January 7, 2003)

When women smoke during pregnancy, they reduce both the fertility and the reproductive phase of their daughters (the time of life in which women can have children), as English scientists have been able to prove. Daughters of smoking mothers develop fewer egg cells and enter menopause at a younger age.

Also, a male’s sperm cells suffer from tobacco smoke. Genetic damage together with reduced sperm production have been observed.

May 2003
2.22. Smokers and divorcees more prone to arthritis

(from the medical journal “Ärztliche Praxis”; October 15, 2002)

Not all risk factors for developing arthritis have been discovered. In addition to the known correlations between arthritis and age, excess weight, and low level of physical fitness, statisticians have determined that smoking and divorce have significant influence on the issue. Separation from one’s partner increases the risk of arthritis by 30%, while smoking increases it by 60%.

May 2003

2.23. 11 minutes per cigarette

(Source: British Medical Journal; January 1, 2002)

According to a report in the British Medical Journal, the life of a smoker is shortened by 11 minutes with each cigarette. This is taken from the projection of researchers at the University of Bristol. A pack of 20 cigarettes costs 3 hours and forty minutes of life, while 200 cigarettes cost 1 1/2 days. Their projection is based upon the difference in life spans of smokers and non-smokers, divided by the number of cigarettes smoked. By that measure, a man who starts smoking at age 17 and smokes an average of 16 cigarettes per day would have a life span reduced by 6 ½ years.

May 2003

2.24. When parents smoke

According to “Ärztliche Praxis” in its March 19, 2004 edition, children who have asthma are further punished by the stubbornness of parents who smoke.

A Canadian survey found that smoking parents of children who have asthma continue to smoke blithely, although they are doing the children great harm and are surely aware of as much. On the one hand, the number of smokers has decreased from 32% to 23% in the last seven years; on the other hand, parents who smoke are as unlikely as ever to refrain from smoking for the sake of their children’s illnesses.

April 2004
Danger: consumption of tobacco or alcohol

A report in the “Welt am Sonntag” from April 11, 2004 states that alcohol consumption is laden with as many health risks as tobacco use. Source: the renowned nature science magazine „Nature“.

April 2004

2.25. Smokers more likely to go blind than non-smokers

According to the magazine “Faszination Sehen” (1/2004), smokers are more likely to go blind than non-smokers. The article claims that smokers develop age-related macular degeneration an average of 10 years earlier than non-smokers do, and that there is a correlation between nicotine consumption and certain forms of cataracts as well as thyroid-related eye conditions. The most common cause of tobacco-related blindness is, however, age-related macular degeneration. Drawing upon scientific studies, physicians explain the connection between smoking and macular degeneration in that macular degeneration can result from oxidative damage to the retina. It is wellknown that smoking counteracts the protective effects of antioxidants.

My own commentary: If this oxidative stress is joined by additional stress in the form of vascular-related insufficient circulation (normally caused by microorganisms), then the situation becomes critical.

What we learn from this: while there is still time, practice long-term antibiosis plus immunotherapy against microorganisms, and stop smoking.

July 2004

2.26. Smoking, diabetes, etc.

From a report in “Ärztliche Praxis” no. 42, from May 25, 2004, according to which the risk of developing dementia is increased by smoking and diabetes, among other factors.

According to this report, a US study has shown that people in their middle years who have more than one cardiovascular risk factor in their lives are at twice the risk of developing dementia in their later years. Factors taken into consideration here were diabetes mellitus, cholesterol level, high blood pressure, and smoking. If all four risk factors are present, the danger of developing dementia is three times as high. Such was the conclusion of a study done at the Medical Center in San Francisco, with more than eleven thousand trial persons aged 40-44 years.
Conclusion:

Another reason why the co-factors should be eliminated through long-term antibiosis, immunmodulation and immunostimulation. Note: The primary cause of arteriosclerosis is always a bacterial infection!

July 2004

2.27. For a longer life

The following are some of the factors in favor of increasing life expectancy and improving the quality of life through use of antibiotics:

1. It is undisputed among physicians that no medical development has done more to prolong life than antibiotics.

2. People familiar with (former German chancellor) Adenauer have let slip that, in his elderly years, Adenauer swallowed antibiotics as lightly as some do cough drops.

3. America’s (in-)famous Tuskegee Syphilis Study, in which 399 syphilis patients were not given medication for 40 years (1932-72), and certainly no antibiotics, was reported on in the May 18, 1997 edition of the “Welt am Sonntag”. Finally, in 1972, or 25 years ago, the remaining, aging black
patients, who had been diagnosed with early-stage syphilis in 1932, were administered antibiotic treatment, long-term and repeatedly. At a White House reception on May 17, 1997, those study participants present included men aged 91, 95, and 110 (despite the fact that the average life expectancy of African Americans is significantly lower than that of their fellow citizens). This speaks volumes for the life-prolonging effects of antibiotics.

May 1997

Antibiotics prevent Alzheimer’s disease, from the pharmacy periodical “Apotheken Umschau” no. 42; Jan. 2001:
„Two antibiotics have proven effective against Alzheimer’s disease: the leprosy medication dapsone is currently being tested, because patients treated with dapsone did not develop the disease as opposed to participants in a control group. Also, doctors at Harvard were able to prevent the outbreak of Alzheimer’s disease in mice through use of the antibiotic clioquinolone."
Especially in an age of BSE – with perhaps many victims of BSE hidden behind the label Alzheimer – the therapy possibilities mentioned above take on new significance. I believe that such a therapy could do much to help people live longer.

January 2001

2.28. Antibiotic therapy for knee-joint problems?

Why not treat post-accident knee-joint problems with antibiotics and immunomodulation?

When knee-joint problems develop following an accident, and persist for years afterward, why not try to treat them first with long-term, high-dose antibiotics and immunomodulation before resorting to surgery?

Case description

A female patient had a skiing accident at the age of 15: by her own description, her knees were dislocated, turned up 180° in relation to her upper body. She suffered from extreme knee pain, and walking downhill was nearly impossible. A surgeon who viewed her x-rays ruled out the possibility of a knee-joint fracture. Ten years followed in which her knee-joint problems persisted with no significant change, and when the therapies attempted by her general practitioner proved ineffective, she sought help from an out-of-town orthopedic specialist. Following x-rays and arthroscopy of the more affected left knee, he recommended knee surgery, informing her that both knee-caps were shattered. A good old general practitioner, however, advised her to delay surgery for as long as possible to prevent worse problems later on. More years went by, in which
her knee-joint problems only worsened. In addition to chronic knee pain, she developed other problems such as shoulder-arm syndrome, with pain radiating from the cervical spine to her left shoulder and left fingers. She had practically no feeling left in her left little finger, ring finger, and middle finger. This paresthesia improved slowly after weeks of taking antirheumatic medicine which her stomach, however, could not tolerate. She experienced several relapses over the following years, plus excruciating pain in the lumbar spine region and recurring stomach pains (probably a side-effect of the antirheumatics). Her life often seemed unbearable. At age 30 she also began to have migraine headaches, every other month for three days, complete with extreme headaches and frequent nausea.

More time passed, and the above-mentioned symptoms became more pronounced, while other problems joined the list: night-time urgent bladder, sinus problems, nasal congestion, dental root problems, and abdominal pain. Capping them all, her knee problems worsened, and no therapy brought noticeable relief. Then at age 39, she began a high-dose long-term antibiotic and immunomodulatory therapy which she continued, with some interruptions, up to the age of 42. Gradually, all of the problems mentioned above improved, and by now she has practically no more headaches or knee pain. She can exercise again, which had been impossible for 24 years, can go down steps, ski cross-country, go hiking, swimming, and more. She says she is even jogging now 30 minutes per day!

Discussion:

A typical example for my theory:

1. Bacteria in the body were balanced and held in check by the immune system.
2. The patient’s accident was a destabilizing shock to the immune system, which enabled the bacteria in her body to proliferate excessively (at normal body temperature between 37°-38° Celsius, bacteria can theoretically double in number every 17 minutes, so that a single bacterium can have 50 million progeny within 24 hours, complete with all their toxic potential). Over the following years, inflammatory bacterial conditions developed not only in the areas affected by the accident, but in other body parts as well, such as in the cerebral aspect of her hearing apparatus (tinnitus; ringing, buzzing, hissing sounds in the ear). She also experienced nerve root irritations in the lumbar and cervical spine and sacrum.

This patient claims that now, at age 45, she feels more like a 30-year-old, whereas at age 30 she felt as if she were 50.

February 1998
2.29. Slipped disc

Why operate on a slipped disc when there are alternatives? (at least it’s worth a try)

Many talented physicians seem certain of one thing: a slipped disc requires surgery. I have been convinced for years now that a slipped disc is generally caused by bacteria (starting with borreliosis, followed by infection of the nerve root – then bacteria attack and destroy bones, cartilage, and joints). Thus, it must be a priority to eradicate the source, the borrelia; e.g., through long-term antibiotic therapy and stimulation of the immune system. As it turns out, my therapy approach is most often successful, despite the so-called “slipped” discs. And nowadays I read that even inveterate orthodox medicine physicians are using antibodies for treating slipped discs, as for example Gregor Godde of the Committee for Genetic Therapy of the German Orthopedic Society. As the medical journal “Ärztliche Praxis” (no. 24 from 25 March 2003) reported, doctors in Düsseldorf have been the first to successfully use the substance anti-TNF-alpha – an anti-inflammatory substance which can be injected or given intravenously – for treating slipped discs. To me, this is clear evidence that what we call a slipped disc is caused by infection, and it should be treated primarily with medications and therapies (such as antibiotics) which eliminate the infection.

March 2003

2.30. Rheumatism and neuralgic shoulder amyotrophy

Why not treat rheumatism and neuralgic shoulder amyotrophy, as well as a stubborn dry cough, corneal clouding, and lower-leg varicose veins (caused by borrelia) successfully, with high-dose, long-term antibiotics and immunomodulation?

Case description:

Female patient, now aged 50 years. She had been suffering for 7 years from rheumatism in several joints, as well as relapsing sinusitis, a stubborn dry cough, stomach pains, nycturia (excessive night-time urgent bladder), cardiac dysrhythmia, sharp pains in her left leg, cold hands and feet, and loss of the ability to lift things above her head (a necessary skill for her job). Interestingly, because of her ongoing dry cough she had been x-rayed, and her lungs showed atypical findings. And so, about one year ago, the patient was treated for three months with 3 different tuberculostatics, although there were no positive test results for tubercle bacteria. These
medicines were so hard on her liver, and the toxic side effects so unbearable (she lost nearly all of her hair), that therapy was simply discontinued after 3 months; x-rays of her lungs supposedly indicated complete recovery. Yet her hacking cough continued as before, as did all the other symptoms described above; in fact, she felt worse after this therapy, not better.

In late January 1997 I met this distraught patient; she was convinced that she would have to quit her job, and was already considering applying for an early pension.

After 2 1/2 months of antibiotic and immunomodulatory therapy, the patient felt completely recovered: no more dry cough, she could lift her arms above her head again, no more nycturia, no more cold hands and feet, her rheumatic symptoms disappeared, and even the fine starburst varicose veins in her lower legs were almost completely gone. She was able to concentrate again, and her stomach pains and cardiac dysrhythmia were, subjectively, completely gone. Interestingly, even the corneal clouding she had had in her left eye since early childhood healed completely, and her vision improved by 30%. A problem with dryness of the eye also disappeared.

For further thought:

With certainty, the patient described above was affected by several chronic bacterial infections (such as Lyme disease), all the more so as, in my experience, chronic relapsing shoulder-arm-neuritis has been seen in connection with Lyme disease over and over again, although I can’t remember having ever read about such a connection in any publication. Also, her chronic, lasting dry cough is an indicator of Lyme disease, as is the cleared corneal clouding (although, as far as I can tell, this also has yet to be dealt with in medical publications). I remember very well two other cases in which corneal clouding healed completely in the course of long-term antibiotic therapy; in one case, vision improved from 0.1 to 0.63, although an out-of-town ophthalmological clinic had listed this patient as a case of Vogt’s cornea, for which nothing could be done medically other than applying artificial tear liquid.

That the patient’s corneal clouding cleared up seems to me indicative of Lyme disease, though (so far as I know) no mention of such a case has been published; as mentioned above, I have witnessed at least three such cases myself, and in these cases, the cornea cleared completely following long-term antibiotics.

Further, this patient’s previous stomach pains, and especially the cardiac dysrhythmia, strike me as indicative of Lyme disease, and the cold hands and feet as well (normally a symptom of a circulatory disorder caused by vascular strictures; bacteria pave the way for arterial plaque containing cholesterol), not to mention the “rheumatism” pains.

Thanks to our successful therapy, this patient feels like a new person.

April 1997

Addendum:

In December 1997, the University of Nebraska (US) published a report about 46 patients suffering from primary chronic polyarthritis (also called rheumatoid arthritis) who were continuously treated with antibiotics for 3 years. Of these patients, 75% found complete recovery, and the other 25% experienced improvement.

May 2000
2.31. Rheumatism therapy increases risk of septic arthritis

According to rheumatism specialist Müller-Ladner, rheumatoid arthritis patients are at a significantly higher risk of developing septic arthritis (infected joints). Persistent and misdiagnosed bacterial joint infections in victims of rheumatoid arthritis place these people at a higher risk of suffering a serious decline in joint function.

According to the medical journal “Ärztliche Praxis” from April 9, 2002, immunosuppressants are popularly used for keeping the inflammatory processes of rheumatoid arthritis in check. Since rheumatoid arthritis patients are already at a higher risk of developing bacterial or mycotic (fungal) joint infections, immunosuppressant therapy increases their risk sharply. The main problem: despite having infected joints, the patient doesn’t appear to be particularly ill (he is already taking antiphlogistics such as aspirin or cortisone, which also help to reduce pain).

Assistant professor Dr. Udo Müller-Ladner argues that septic arthritis is often not diagnosed until it comes to cardiovascular dysfunction or failure (which may be too late). Nearly 70% of all joint infections result from bacteria that reach the joints through the bloodstream. This clearly emphasizes the need for long-term antibiosis for rheumatoid arthritis patients whose arthritis is caused by bacteria, in order to combat the cause and not just the symptoms (pain) as is done with cortisone or other antiphlogistics. For this kind of joint infection, Müller-Ladner himself recommends long-term antibiosis for more like 6 weeks instead of just two. Why not go ahead and use antibiotics preventively for patients whose joints are at such a high risk of infection due to immunosuppressive therapy?

April 2002

2.32. Successful Therapy for Tinnitus

Successful therapy for tinnitus (Tinnitus = ringing, buzzing, or hissing sound in the ear) in the case of a 44-year-old patient

Successful therapy for tinnitus (Tinnitus = ringing, buzzing, or hissing sound in the ear) for a 44-year-old patient who had been suffering for approximately 3 years under a very bothersome and highly fluctuating case of tinnitus (fluctuating in pitch and volume) which affected both ears in turn.

Additionally, this patient had high blood pressure, sinus problems, and the need to empty his bladder during sleep-phases; and in the area of ophthalmology, he was diagnosed with bilateral chronic episcleritis. The latter was marked by nasal redness in both eyes, which is an indication of focal activity (chronic bacterial infection which can be located anywhere in the body). As a result of his hearing problems, the patient visited 2 EENT specialists and a neurologist, where extensive tests were run, to no avail.
After several months of antibiotic and immunomodulating therapy, the patient no longer complained of the need to urinate during sleeping phases, his episcleritis (infection of the conjunctiva and sclera) was gone, and he felt subjectively that his sinuses were by and large in good condition. It is interesting that, during the course of this therapy, the tinnitus, which he subjectively found debilitating, disappeared almost completely, recurring only under stressful situations and in the form of a slight, barely noticeable ringing of the ears.

In such a case, it seems readily comprehensible that these tinnitus troubles are, to my understanding, normally of cerebral-bacterial origin. They cannot be treated with 1, 2, 3, or 4 weeks of antibiotic therapy. In the case of the above-mentioned patient, two months of uninterrupted antibiotic therapy were needed before the patient’s tinnitus slowly improved. From this, one can conclude that this case of tinnitus was of bacterial origin, and that this therapy and its results are fully in line with the conclusions of the Internists’ Congress in Wiesbaden (Germany), April 1997, where it was stated that

1. Cardiac infarction (heart attack)
2. Cerebral infarction (stroke)

must be treated with long-term antibiotics. Furthermore, it is absolutely necessary to treat the partner as well, in order to avoid a ping-pong effect and thus re-infection.

In my view, most cases of acute hearing loss are also of bacterial origin. A long-term antibiotic therapy seems absolutely necessary to me, and then, if after 2-3 months of assorted antibiotic treatments the desired results have not been achieved, only then should one assume that the condition is not of bacterial nature.

I have asked myself repeatedly why the last 20 years have seen such an increase in cases of acute hearing loss (2000% over the course of 20 years). I believe this is a result of the introduction of ovulation suppressors, and that it stands in connection with more liberal sexual practice (could this be the reason why Clinton already wears a hearing aid?). I am of the opinion that, within 10-20 years following the introduction of oral contraceptives, the female population began to experience a rapid increase in occurrences of acute hearing loss of bacterial origin, and I suspect that the bacteria in question can be transmitted sexually or by intensive kissing. I find no other explanation for such an explosive 2000% increase in cases of acute hearing loss within the past 20 years in comparison to the years before.

February 1998

Thus far, experts have considered tinnitus (ringing, buzzing, or hissing sound in the ear) to be a problem of either the inner ear or, according to more recent studies, a problem of cerebral origin (caused by damage to the brain).

According to an announcement made by American scientists after research done on rats’ ears, the cerebral theory seems to be accurate, as defective inner ear cells can regenerate: BETHESDA stereocilia, the hair cells in the inner ear, are constantly regenerating. This surprising fact was only recently discovered. According to these findings, the acting filaments in the growing cells grow 2.5m per day.

This leads directly to the conclusion that tinnitus is not an inner-ear problem, as this would promptly treat itself. Rather, it must be a matter of insufficient cerebral blood circulation, which is normally of bacterial origin; that is, those vessels of the brain which supply those areas responsible for the inner ear are damaged by bacterial infections.
Conclusion: tinnitus must, in most cases, be treated by means of antibacterial and antibiotic therapy, when possible in conjunction with an attempt at immunomodulating and immunostimulating therapy.

October 2002

2.33. Is tinnitus always of cerebral-bacterial origin?

Following extensive dental work including a tooth implant in the upper jaw, a 47-year-old patient suffered for months under an unbearably loud „paper-rustling“ sound in her ear, particularly at night-time. Interestingly, one early symptom following her tooth implant was persistent, heavy, thumping pain and feverishness. She also had the impression that her skull might burst. This, to me, was an indication of meningital infection, for which the dentist unfortunately did not prescribe antibiotics.

In case of persistent disruptive sound perception (Tinnitus), classical medicine offers several attempts at therapy:

• Costly, time-consuming contrasting noise for one of the ears (NOISER).
• So-called “recompression dives” (hyperbaric oxygenation) – extremely expensive).
• Infusion therapies involving circulation-stimulating substances, some of which are quite toxic (poisonous), for example Dusodril.

In the words of the very famous 91-year-old Dr. Pekar, “Parting with these essentially symptom-oriented therapy forms would mean a certain drop in business.”

Dental procedures (particularly those involving tooth implantation into bone) can result in an introduction of bacteria into the jawbone and from there to the sinuses, and to the spread of such infections to the cerebral membrane. In such cases of clearly infection-related causes of tinnitus, long-term antibiotic therapy together with corresponding immunotherapy (immunomodulation and immunostimulation) must be applied.

Following several weeks of such therapy, the above-mentioned patient found that her tinnitus came to a practically abrupt end.

September 2004
2.34. Cardiac Infarction Therapy

The difference between symptomatic ("curing the symptoms") and causal ("treating the cause") therapy

What is therapy like for infarction (heart attack)? Or for sclerosis of the cardiac vessels?

In most cases: diagnostic with cardiac catheterization and ultrasound, and symptomatic in the form of bypass operations, balloon dilation, or the implanting of arterial conduits. The costs for a bypass operation range from approximately DM 40,000 (German marks) to DM 60,000; for a cardiac catheterization exam approximately DM 2,000 to DM 4,000.

In April 1997, the German Internists Congress took place in Wiesbaden, and reached the following conclusion: The medical surprise of the century – cardiac infarction and cerebral infarction are essentially caused by bacteria. The guilty bacteria are called chlamydia; they are transmitted from person to person, making the illness contagious. Further, they are to be treated by long-term antibiotic and immunomodulatory therapy, as these vessel-threatening chlamydia are readily transmitted, e.g. via sexual intercourse, open-mouthed kissing, or through droplets (airborne across small distances, as through close standing in a subway or a bus). Thus, the logical conclusion would be to treat those thus endangered with long-term antibiotics, a therapy which should include the patients’ partners, as the condition is contagious. The costs for such causal therapy (i.e., treating the source), that is, treating the (bacterial) origin of cardiac infarction and of arterial sclerosis, would in my estimation amount to approximately DM 1,500 per person.

Oral antibiotic treatment (with pills) would be causal therapy, focusing on the source of illness, as opposed to operative treatment, as the antibiotic approach definitely (or at least to the greatest extent) relies on antibiotics and immunostimulants to eliminate the offending bacteria from the infected body. Thus, if the bacteria in question can be eliminated from the body, what you’ve accomplished is a causal (source-oriented) therapy with optimal results. The arterial
vessels do not continue to become clogged. Collateral vessels (substitute vessels), which are constantly developing, remain “clean” right from the start.

How do these two types of therapy differ?

With the symptomatic therapy, the cause of illness, the offending bacteria, remain in the body fully capable of doing post-operative damage -that is, after providing bypasses, or shortly after a balloon dilation of narrowed cardiac muscle or coronary vessels, subsequent high-grade stenosing (narrowing or obstructing) of the previously carefully expanded or positioned bypass vessels can occur. (A bypass operation is a very extensive procedure lasting many hours, 4-8 hours, requiring a heart-lung machine, and an estimated 8% of patients die during the operation itself or directly following; a further 12% of patients die during the following year as a result of the operation or of heart failure. With balloon dilation, the fatality rate is approximately 2%.)

It strikes me as particularly irresponsible when post-cardiac and post-cerebral infarction patients do not subsequently receive treatment based on long-term antibiotics and immunomodulators, even if the infarction was already many years ago. The same is true for their partners/spouses; otherwise, the chlamydia bacteria return to the former infarction patient ping-pong style, even after “just” a French kiss.

A patient treated with causal therapy (including treatment of the patient’s partner) would, in this case, have treatment costs of approximately DM 2,000 – DM 4,000. The patient who receives symptomatic therapy, i.e. a bypass operation, incurs costs to the health care system of circa DM 40,000 - DM 60,000. This is without counting the burden arising for the pension system if he requires early retirement. Yet if I try to imagine myself as a cardiac surgeon, around 50 years of age and with an annual gross income of 1 - 1.5 million, with a family of five (wife and 3 children) and a suitably luxurious home (the children take language courses abroad, go horse-back riding and take music lessons, etc., all of which I find admirable); and if I had, out of boredom, allowed some half-baked social-sponge real estate agent to impose upon me with 2, 3, or even 4 “tax break” properties which proved in the long run to be long-term money traps, it would go very much against my grain to tell my patients: I don’t do operations any more; we need to focus on the primary source of arterial sclerosis such as yours, namely bacteria, and from now on we are going to practice antibiotic and immunostimulating therapy such as I would choose for myself under similar circumstances. (Taking such a stand under the above circumstances would mean financial ruin and bankruptcy for myself and my family, for, although I have worked hard all of my life, starting in school, there would be no taxpayer-financed social cushion for me to fall onto, as there is, for example, for coal miners in Germany’s Ruhr area, where every job has been subsidized for years with an average annual DM 50,000).

Even from my current standpoint, I would find it tremendously difficult to admit past mistakes. Hence, for my own sake and my family’s, in order to avoid bankruptcy as well as the jeers of my peers, I would find it necessary to claim: this business about bacteria being the actual cause of heart attacks is by no means finally proven (as we have been hearing similarly from the cigarette and tobacco industry for so many years), we shall provisionally continue operating until we see absolute proof of causal correlations; in the back of my mind, however, I would be thinking: I am going to continue operating until I retire or until my financial clouds have fully cleared.

At the outside we would provide antibiotic therapy treatment to those patients who have already had an infarction and been operated on; at any rate, the operative results would then appear to look better.

Many years will pass before broad recognition is found for Dr. Willix Jr.’s findings – that cardiac surgery is “big business”. He was responsible for approximately 2000 cardiac bypass
operations; and when he left the cardiac surgery business, it was as one of the best-known and most successful cardiac surgeons in the US at the time. If one such as Dr. Willix says: **it's big business** (the operations serve the purpose of earning big money), and when such as he (Dr. Willix) maintains that a success rate of 100 % is possible without such a disfiguring operation, then people should long since be listening, particularly Health Secretary Seehofer or the chain-smoking Mr. Dressler (who will possibly be Mr. Seehofer’s successor from the Social Democratic Party, and who, notwithstanding his position as a role model in the field of health, guarantees that those around him must passively smoke in excess

– all at the cost of the communal health care system); these men should have been cured of their “in-patient operation mania” long ago, as is recommended by the OECD as well. (The OECD delivered a slap in the face to German health-related politicians over an excess of referrals for in-patient treatment in inefficient clinics, and over the lengthy duration of such stays in German clinics; according to the OECD, Germany’s hospital care system earns a poor grade.)

Further, the above-mentioned politicians should have long since developed a taste for ambulatory medical care, which is significantly more affordable. An inevitable result of this would be that doctors could prescribe expensive antibiotics for long-term treatment without fear of regress – antibiotics which, contrary to frequent claims, can even help support the immune system, as in the case of Clarithromycin (Klacid) –and could thus help prevent expensive stationary treatment and lengthy hospital stays.

December 1997

Addendum to this article concerning the difference between symptomatic and causal therapy following cardiac infarction:

After having published the previous article in the month of March, 1998, by chance I learned in April that an acquaintance of mine who suffered a cardiac infarction many years ago, but who did not subsequently receive long-term antibiotic therapy although I had repeatedly recommended it to him (he argued that all of the doctors on his case were against such a long-term antibiotic therapy) had now suffered a serious stroke (cerebral infarction). His in-patient treatment was long, including antibiotic therapy, and now he was in a large clinic near Munich for rehabilitation (where, unfortunately, the antibiotic therapy was discontinued).

I am absolutely convinced that, if this acquaintance of mine had received suitably long-term antibiotic and immunomodulatory treatment following his cardiac infarction, as I recommended above, he would never have had this cerebral infarction, which nearly destroyed his livelihood and himself and had grave financial consequences for his family and for the general population as well.

Particularly in cases such as these, it seems to me that Germany’s fear of antibiotics (one can really call it a fear of our own making) is more than grotesque.

March 1998

The patient described above is currently unable to work and is dependant upon a wheelchair.

December 1998
This patient’s company (his own company) has since been reduced from 50 employees down to 10. What a positive effect on our labor policies!

January 2001

There are some very credible reports which claim that the mortality rate among cardiac patients increases with the increased implementation of machines in hospitals (for example, “Peers scold high-tech cardiologists” /”Kollegenschelte für High-Tech- Kardiologen” in Ärztliche Praxis Nr. 1B 1045B), in which a cardiologist admonishes his technology-crazed colleagues to practice restraint. And a multi-center study introduced at a conference of the American Society of Cardiology purports that aggressive diagnostics and/or therapy (e.g., cardiac catheterization, balloon dilation, not to mention bypass surgery) doubles the mortality rate of those invasively diagnosed and treated patients, and that the number of those such treated who have subsequent infarctions is two to three times as high.

Which begs the conclusion: Who is benefiting from these expensive, invasive diagnostics and therapies?

I can’t help having misgivings here, particularly when I think of the expensive hospital system which accounts for more than 70% of costs within the German health-care system.

December 1998

In the magazine “Focus” No. 7 / 13 February 1999, starting on page 128, there was an article under the title “Pills as heart-attack protection?“:

“Verified by recent extensive studies in America: some antibiotics can help protect against heart attacks.”

The first part of this article cites the famous medical journal JAMA, in which Christoph Meier et al report from a very extensive hospital study. According to this study, cardiac infarction patients were treated in the 3 years prior to their heart attacks much less often with certain antibiotics (tetracyclines and quinolones) than comparative patients who had not had cardiac infarctions. These antibiotics are particularly effective against chlamydia (a certain type of bacteria). Additionally, this text mentions the Argentinean Enrique Gurfinkel, one of the few doctors who systematically tests using antibiotics for heart patients, albeit without having yet reached a final conclusion. As a medical practitioner at the Favarolo Foundation in Buenos Aires, the article says, he gave 102 patients who had had an acute cardiac infarction a one-month-long treatment with the antibiotic Roxithromycin, and an additional 100 patients were given a placebo.

30 days after the therapy, the antibiotic therapy appeared to be the winner: nine of the patients in the placebo group had had subsequent heart attacks, compared to just 2 from the antibiotic group. In the five months following, however, the figures seemed to be quite different. The number of heart attacks or other forms of degeneration of the patients’ conditions had more or less evened itself out between the two groups.

These figures helped lead Hugo Katus, a cardiologist at the University of Lübeck (Germany) to conclude: “Perhaps antibiotics only work temporarily.”

My commentary: for me, this second part, particularly the statements of the cardiologist in Lübeck, are only a thinly-veiled attempt to cover up the truth. From the field of bacteriology it is known that the elimination of chlamydia from the human body requires a continuous antibiotic
therapy of at least 2 months duration, merely in order to achieve a success rate of approximately 70%; and if this chlamydiabeleaguered heart patient has even just one active sexual partner, then the antibiotic therapy for riddance of chlamydia will, after 2 months of simultaneously treating both the heart patient and the sexual partner, have a success rate of only 50% – and what if one of these involved persons was involved with “just” open-mouth kissing with a third party?

In that case, this study, at least in its use as a long-term study (with its data evaluated regarding the time after 5 months) is worthless; have these super specialists never heard of a bacterial ping-pong effect? Anyone who learned as a medical student about gonococcus infections must surely have heard about the ping-pong effect.

My feelings regarding this matter are not of the jovial kind.

Should we only treat patients who have the clap, but not their sexual partners (even if these are practically symptom-free), so that the gonococci can rebound to the primary patient like ping-pong balls as soon as antibiotic treatment is discontinued? Perhaps, if only for reasons of logic, we should treat the partner(s) as well.

The consequences: cardiology, neurology, and internal medicine units, among other units, as well as hospital administration and insurance companies could all downsize (not only in terms of architecture); politicians would lose their reason for existing, they would have less reason for shuffling money and goods from A to B, and suppliers would have a drastic drop in business.

Note: Antibiotics specialists, immunologists (a branch of internal medicine) and bacteriologists have no qualms about administering antibiotics as an uninterrupted 4-month therapy if they deem it necessary, and if a cardiac infarction does not rank as “necessary” regarding such care, then I am left speechless.

Cardiac surgery damages the brain

(according to the Archives of Neurology, July 2/02)

Following bypass operations, 3-5 % of patients suffer strokes or other serious cerebral circulation problems. Additionally, as Martin Bendszus of the University of Würzburg (Germany) has found, one quarter of bypass patients will have lesser-grade strokes. These are manifested in disturbances in concentration and coordination, but are usually reversible.

July 2002

2.35. Feeble, inadequate pseudo-attempt at research, aimed at proving that chlamydia are not heart-killers

According to the September 2002 edition of the medical journal „Ärztliche Praxis“, Rolf Zahn and his assistants at the Cardiac Center (Herzzentrum) in Ludwigshafen/Rhein (Germany) reached the conclusion that, in the cases of arterial sclerosis, cardiac infarction (heart attack), and cerebral infarction (stroke), chlamydia are actually not the agents of evil they are widely perceived as being.
According to this report, Ralf Zahn and his assistants at the above-mentioned cardiac center took 900 men and women who had entered the clinic due to acute cardiac infarctions, and treated them for six weeks either with antibiotics for chlamydia, or with placebos.

After one year, the test subjects from the antibiotic group had not suffered significantly fewer subsequent infarctions than those subjects from the placebo group. The researchers thus conclude that bacteria are at least not a major contributor to the development of cardiac infarctions.

In this regard I would like to make the following clear: in order to free 70% of patients from chlamydia, antibiotics must be administered for at least a duration of three months. This means that a mere six weeks, as described above, are a wholly inadequate time span for antibiotic treatment. Only after antibiotic therapy, to be administered for three months and not for the ridiculous stretch of six weeks, can it be assumed that 70% of the patients so treated are free of chlamydia.

At the same time, the patient’s sexual partner, or partner with whom French-kisses are exchanged, needs to receive antibiotic therapy for a duration of three months. As this partner also faces (only) a 70% chance of being cured, then both partners together have a „chlamydia-free rate“ of merely 50% upon completion of this therapy. If either partner (even the one who is not a cardiac patient) has an “affair”, the success quota for chlamydia eradication sinks back down to around nil.

This so-called „scientific“ research is absolutely inadequately structured. It should outline in all clarity just how high the cardiac healing success rate was after three months, after half a year, and after nine months. It can readily refrain from analyzing how high the success rate was after one year, since – as detailed above – the success rate of chlamydia eradication after one year drops back down to zero (because, for example, the partner was not treated).

I would have preferred for this „scientific“ experiment to have been carried out somewhere other than at a cardiac surgery center. It doesn’t even mention which antibiotics were used. By no means are all antibiotics effective for treating chlamydia.

October 2002

2.36. Antibiotics said to ease apoplexy-related problems

Antibiotics, according to the medical journal “Ärztliche Praxis” No. 20, 9 März 2004, p.11, are said to ease problems resulting from apoplexy (stroke )

According to a report in the medical journal “Ärztliche Praxis”, a team experiment at the Berlin Charité demonstrates that administering antibiotics prophylactically lowers the mortality rate and even has additional benefits for those patients involved.

In experiments with animals, the use of antibiotics in stroke cases was a true success: following antibiotic therapy, not only was the mortality rate reduced, even the area of cerebral damage was reduced as well. Further, remaining functional disorders (paralysis) were demonstrably lessened.
This demonstrates once again, and with abundant clarity that, particularly in cases of cardiac and cerebral infarctions, and with other lesions as well, the use of antibiotics is unquestionably necessary.

March 2004

2.37. Antibiotics and Neurological Illnesses

In the June 1, 2005 edition of the pulp-journalism publication “Gäubote”, a recent article declared: “Penicillin may be able to slow illness of the nerves”. According to this article, researchers at America’s Johns Hopkins University in Baltimore were able to determine through research with animals that the antibiotic substances in penicillin and other related antibiotics (beta-lactam antibiotics) can slow the decline of nerve tissue caused by some nerve-related illnesses, including ALS (amyotrophic lateral sclerosis). Amyotrophic lateral sclerosis leads to total paralysis (one famous victim, for example – the painter Jörg Immendorff).

In my medical practice, we’ve been treating such neurological diseases including Alzheimer’s, schizophrenia, severe organic brain syndrome, as well as arteriosclerosis – successfully for years now with long-term antibiosis, because we’re convinced that they are essentially of bacterial origin.

June 2005

2.38. Can Antibiotics Protect a Weakened Heart?

The following text was printed in “Ärztliche Praxis” on April 26, 2005:

“Antibiotics obviously do not help to lower the risk of heart problems for coronary heart disease patients. This is the conclusion reached by researchers at the University of Washington in a study involving 4012 test persons who swallowed an antibiotic once a week (only! - my comment) for one year.”

My thoughts on this: it ought to be illegal to draw that conclusion based upon such a feeble, idiotic experiment. This simply proves to me just what “criminal” and unscientific measures some are willing to take in order to discredit antibiotic treatment for coronary heart patients. Very different results are achieved when antibiotics are administered on a daily basis.

Of course, there is much more money to be earned performing HEART SURGERY and CARDIAC CATHETERIZATION!

Which, of course, makes all further comment unnecessary.

June 2005
2.39. Rheumatism is Hard on the Heart

According to a report in the “Ärztliche Praxis” on May 31, 2005, rheumatism is hard on the heart.

The article reports that rheumatoid arthritis seems to increase cardiovascular risk. In a study at the Mayo Clinic in Rochester, Minnesota (Arthritis and Rheumatism 52 [2005] 722-732), doctors were able to identify three particularly high-risk factors: intermittently quickened sedimentation (>60 mm. in the first hour), concomitant vasculitis (vascular inflammation), and pulmonary rheumatic nodules (rheumatic nodules in the lung).

I find it astonishing that the most renowned diagnostic hospital, Rochester’s Mayo Clinic, could go public with such medical “findings”, as it must by now be common knowledge, not only for myself but for most of the medical world, that the cause of rheumatoid arthritis is nothing cosmic or mysterious; it is bacterial, often in form of Lyme disease. This is by now very widespread knowledge, and it has also already been documented that administering antibiotics over an uninterrupted period of three years leads to a dramatic rate of success/healing (75%); so I find it insupportable to act as if rheumatism had nothing in the world to do with bacteria. One need not research far into top medical opinions to conclude that rheumatism, as a rule, is of bacterial origin, to my knowledge normally caused by Lyme borrelia among others (at least as a co-factor); and Lyme disease and other bacterial infections very often lead to cardiovascular complications. Vessels constrict, cardiac dysrhythmia ensues, the speed of blood sedimentation is altered - as can be expected in connection with any infection – and rheumatic nodules develop in the lung.

With rheumatism, bacteria settle into the bones, cartilage, and joints, and slowly erode these tissues. This leads to alterations and deformations. To give the impression that rheumatism is not linked to bacteria, especially when that impression is published by the Mayo Clinic, seems to me an attempt at setting up a smoke screen in order to keep rheumatism’s cause under cover.

June 2005

2.40. Glaucoma therapy

No glaucoma-related reduction in vision (despite nearly marginal glaucomatous excavation of the optic discus) with long-term antibiosis

I would like to report the case of a female patient with glaucomatous aphakia (glaucoma, in which a lens extraction procedure has been undertaken). The patient had an optic disk excavation (papillary excavation, due to glaucoma damage) which had not deteriorated further over the course of 4 years, verticular and oval, c. 0.9 nearly to the margins on either side.

Since that time, the patient had no further reduction of vision, neither of visual field nor of acuity, despite her advanced age of 81 years, following 2 antibiotic and stimulatory therapies. There was no further deterioration of her papillary excavation, nor any further deterioration to be found in her electrooculography, according to the findings of a large optical clinic.
I must state here again firmly that, with various forms of glaucoma, particularly low-pressure glaucoma and pigmentary glaucoma, one must check systematically for any other general signs of infection (the patient described in this case had complained of a range of general signs of infection) and, should any be found, long-term antibiotic therapy must follow (without neglecting treatment of any sexual partner).

February 1999

Continued observation over time has still revealed no signs of deterioration.

January 2002

Helltenthal and Mr. Humbert Stoll with Ms. Magdalena Ochs (“with healing hands”), in Hattendorf near Alsfeld (Hessia)

2.41. Low-pressure glaucoma in connection with Lyme disease

A case of Lyme disease, clinically diagnosed by means of anamnesis and serology, together with low-pressure glaucoma.

Lyme disease is a widely disseminated illness; in Southern Germany, between 11 and 30% of the population test positive for a raised level of antibodies, and in some regions of Bavaria the level is at 35% of the population (Schmidt et al 1986, Wilske et al 1985).

Most frequently the illness remains undiagnosed, as serological proof is still very problematic to achieve. The agent responsible for Lyme disease is a spirochete and thus closely related to treponema pallidum.
According to descriptions published to date, Lyme disease leads to nearly all the symptoms that are also caused by syphilis.

Case description:

A 72-year-old female patient, following left-sided ischemic papillitis (16 years ago) with at that time temporary vision reduction down to 0.1, vision currently 0.8cc right,

0.4 left, intraocular pressure between 12-15 mmHg on both sides; with verticular oval glaucomatous papillary excavation of 0.6 in the right eye and a loss of visual field on both sides (paracentral on the right, relative central scotoma on the left).

As low-pressure glaucoma frequently seems to stand in connection with Raynaud’s syndrome, this patient was also asked routine questions related to Lyme disease. The patient reported:

- “arthrosis of the hip joint”, on both sides
- “arthrosis” in the left upper arm (probably meaning neuralgic amyotrophy of the shoulder)
- problems in the lumbar spine region
- pain in the iliosacral area
- nycturia (twice)
- relapsing cephalalgia
- Dry eye
- Cardiac dysrhythmias
- Cold fingers and toes (Raynaud symptomatic)
- Increasing significant sensitivity to bright light

Because of this anamnesis, a serological examination for infections was undertaken, especially for Lyme disease. The diagnosis was Lyme disease in the third stage (antibodies for Borrelia Burgdorferi IgG 190, IgM-a. negative).

Antibodies against borrelia in the immunoblot IgG-a. against P 100 positive, IgG– a. against flagellin positive, IgG-a. against outersurface-protein positive, IgG-a. against protein C positive.

Discussion:

Due to the items listed in the clinical anamnesis, and to the serological examination for infections, it must be concluded that this is a case of Lyme disease in the third stage. There appears to be a noteworthy correlation between Lyme disease and low-pressure glaucoma, particularly under consideration of the pathophysiology of lues, which, as in the case of tertiary lues, includes infection of the medium and small arteries, most frequently in the form of endarteritis with intimal vegetations (Sandritter 4th edition 1971), and thus leads to a narrowing of the lumen in the retina and of the vessels which supply the nervus opticus.
This would be a pathological explanation for the development of low-pressure glaucoma, as a significant imbalance arises between oxygen supply and oxygen demand of the optical nerves and the retina, due to a narrowing of the lumen in the arterial vessels which supply them.

Date: 27 July 1993

2.42. Glaucoma caused by bacteria

Glaucoma most frequently caused by bacteria

68-year-old patient

**Previous diagnosis:** Chronic simple glaucoma, relapsing corneal edema (repeated swelling of the cornea), neuroradiculitis in the lumbar and cervical spine regions (irritation of the nerve root in the lumbar and cervical spine areas).

After his glaucoma was so far advanced that his right optic disk had an excavation of 0.9 = 90%, and the left eye had an optic disk excavation of 0.6 = 60%, I treated the patient with long-term antibiotics in the form of pills. Due to this therapy, within four months his facial rosacea and corneal swelling disappeared completely, as did his episcleritis (infection of the outer surface of the eye). Further, in the course of this therapy his neuroradiculitis of the lumbar and cervical spine regions disappeared. The patient felt significantly better with this immunostimulatory and antibiotic therapy, and by changing his nutritional habits, he also did away with his case of oral diabetes (diabetes which is treated by pills). The optic disk excavation improved to the level of 70% in his right eye and 50% in the left eye. Simultaneously, his vision improved from 50% to 63% in the right eye, while the left eye remained constant at a good 80%. By his own description, the patient felt 15 years younger following this therapy.

This is further proof that glaucoma (chronic simple glaucoma) is largely caused bacterially, a conclusion which up until 2 years ago was still doubted in the field of ophthalmology, so that hardly anyone believed that a chronic bacterial infection could be the main cause of decreased circulation in the vessels supplying the optical nerves and thus be responsible for the further development of glaucoma. Furthermore, this proves that the rosacea and the neuroradiculitis of the lumbar and cervical spine regions are of bacterial origin; that is to say, these are bacterial illnesses just as Lyme disease is, which is typically not proven under laboratory conditions in Europe no matter what the majority of general practitioners and orthopedic specialists may think.

What is decisive here, however, is whether the patient is demonstrably helped by this therapy, and whether it improves his/her quality of life for the following 10, 20, 30 years.

June 2000
Amaurosis Fugax Therapy

When confronted with **Glaucoma chronicum simplex** and the resulting carotid artery operation (following a case of relapsing **Amaurosis Fugax** (sudden blinding)) and a cup/disc ratio (papillary excavation due to chronic simple glaucoma) of 0.85 on both sides, why not treat this case with long-term antibiosis? By now, the whole world knows: arterial sclerosis is generally caused by a chronic bacterial infection and requires long-term antibiotic therapy in order for the condition to be reversed, and in order to avoid further sudden blindings and other infection-related problems.

This refers to a 72-year-old patient whom I know well.

October 2003

2.43. **Glaucoma damage is a vascular problem (that is, caused by bacterial vascular damage)**

According to one of the leading glaucoma researchers in the German-speaking countries, Prof. Flammer (of the Ophthalmology University Hospital in Basel, Switzerland) vascular dysregulation is the decisive risk factor for glaucoma damage.

This finding was an important breakthrough for Prof. Flammer’s glaucoma research. As he sees it, vascular dysregulation is the predisposition to react differently or more intensely to stimulation such as cold, psychological stress, vibrations, etc., in comparison with the general public. Such people have a diminished autoregulation (self-regulation) of their ocular circulation (circulation at the back of the eye) and therefore react more sensitively to **fluctuations in intraocular pressure** and in blood pressure.

According to Prof. Flammer, a further stimulus for vascular dysregulation is **migraines**. This would explain why in wide-range statistics such as the Blue Mountain Study or in the “normal tension glaucoma study”, migraines were found to be a risk factor for advanced development of glaucoma. As vascular dysregulation can lead to vasospasms (vascular spasms, such as in the small arteries in the hands and feet), the subject of vascular dysregulation covers a good deal of area.

On the one hand, it can lead to pathological expansion, particularly on the venous side, or a blood vessel can expand in a suboptimal way. In the eye, this takes the form of faulty autoregulation of the circulation, particularly at the back of the eye. Reduced circulation in the hands, as everyone knows, can last for hours or days. We have observed, for example, that silent ischemia (insufficient circulation that remains unnoticed) can normally only last for a few minutes. Other than just predisposition to such circulatory disorders, this is also dependant in part upon external stimulation. In the case of optical circulatory disorders, the arterial and the venous blood systems are involved.
My thoughts on this matter:

The Raynaud illness described above (cold fingers / cold feet) is also clearly a case of an infection. By my observations, which I have gathered over the years observing problematic cases, after months or years there is normally, following a suitable long-term antibiotic, immunostimulatory and immunomodulatory therapy, significantly improved circulation at the back of the eye and the vessels do not constrict again. This is also the stance that modern medicine takes regarding arteriitis (arterial infection). In particular, the migraines mentioned in this case as a risk factor for the further development of glaucoma point in the direction of a chronic bacterial infection (as I have postulated, for example, concerning borreliosis). I don’t know of any case of migraines that was not either cured completely or at least significantly improved within two to three months by undergoing long-term antibiotic treatment. This serves as a further indication that chronic simple glaucoma is of bacterial origin and that causal treatment can be simple in the form of antibiotics.

February 2005

2.44. Amblyopia can be significantly improved

Amblyopia can be significantly improved, even for the aged, by treating with immunostimulation and long-term antibiosis. In the case of a 61-year-old patient, vision in his weak eye improved from 40% to 63% over 2 months with the above treatment, after having lost vision in his stronger eye due to retina detachment.

February 2005

2.45. Asthma forever?

What shall we do if, as it is now becoming ever more clear, asthma is caused essentially by chlamydia? (This is according to a British study; source: Marion Roussel / Germany). Would this not necessitate long-term antibiotic treatment with, for example, macrolide antibiotics (such as Roxithromycin), and certainly not cortisone therapy (without long-term antibiosis), as is common practice. Cortisone therapy only leads to short-term relief, while compromising (damaging) the immune system in the long run. Bacteria multiply so much the better, leading inevitably to ever-recurring asthma attacks; and this remains the diagnosis, in most cases, for the rest of the patient’s life. Antibiotic and immunomodulatory therapy of this kind would cost approximately DM 2,000.00 (not including treatment of the partner). Under present conditions, the specialist (EENT) or general practitioner who prescribes treatment in this price range would have to pay for it out of his own pocket, as this would by far exceed his quarter-year budget for that quarter. What this means for the patient, unfortunately, is that everything remains as it ever was.

This cannot possibly be the purpose and intent of such an expensive health-care system as ours!

February 1999
Addendum:

In March 2002, the following article was printed in the medical publication “Infection and Immunity”, on the subject of chronic bacterial-triggered pneumonia as a predecessor of asthma. Dallas: Chronic asthma can be triggered by a lengthy bacterial infection of the respiratory tract. This is according to medical doctors at the University of Texas. The bacterium mycoplasma pneumoniae, which can cause severe pneumonia, can still be traced by laboratory tests even months after the patient seems to have recovered. Animal experiments involving mice have enabled researchers to determine that a chronic infection caused by this bacterium leads within 18 months to changes in the bronchial system that are typical of asthma.

This is further proof that asthma is normally caused by bacteria, and treating the mycoplasma (a particularly small sort of bacteria) requires at least 1-2 months (or as much as one year) of long-term antibiotic therapy using special antibiotics. Treating the partner must not be neglected, since mycoplasma are easily passed on by open-mouth kissing, possibly even by droplets in the atmosphere.

March 2002

Addendum:

In March 2002, the following article was printed in the medical publication “Infection and Immunity”, on the subject of chronic bacterial-triggered pneumonia as a predecessor of asthma. Dallas: Chronic asthma can be triggered by a lengthy bacterial infection of the respiratory tract. This is according to medical doctors at the University of Texas. The bacterium mycoplasma pneumoniae, which can cause severe pneumonia, can still be traced by laboratory tests even months after the patient seems to have recovered. Animal experiments involving mice have enabled researchers to determine that a chronic infection caused by this bacterium leads within 18 months to changes in the bronchial system that are typical of asthma.

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March 2002
2.46. Chronic, allergic hay fever

Does chronic, allergic hay fever disappear with long-term antibiosis?

Case description:

A 31-year-old patient had been suffering for several years under chronic allergic hay fever (pollen allergy).

Following an eyelid injury caused by a foreign object and requiring surgical removal of the foreign object, the patient suffered from a diffuse infection of the eyelid, which necessitated long-term antibiotic therapy (6 weeks).

An interesting side-effect: for the year following the therapy, the pollen allergy did not recur.

July 2002

I must state here again firmly that, with various forms of glaucoma, particularly low-pressure glaucoma and pigmentary glaucoma, one must check systematically for any other general signs of infection (the patient described in this case had complained of a range of general signs of infection) and, should any be found, long-term antibiotic therapy must follow (without neglecting treatment of any sexual partner).

February 1999

Continued observation over time has still revealed no signs of deterioration.

January 2002
2.47. Antibiotic therapy for Bekhterev patients?

Why not give Bekhterev patients, even years after their diagnosis, antibiotic and immunomodulatory treatment experimentally?

Case:

A 79-year-old patient has been suffering for approximately 20 years under Bekhterev’s disease. During this time, he has been treated with relatively toxic medications.

Following a 2-month antibiotic and immunomodulatory therapy, the patient has hardly any back pain; also, his other complaints attributable to Bekhterev’s disease disappeared. As a side-effect of this long-term, high dosage antibiotis, the patient’s papillary excavation due to glaucoma (0.8 bilaterally, verticular oval) did not further degenerate!

From this we can conclude that all Bekhterev patients should try a long-term antibiotic therapy; this can:
1. lead to a definitive cure,
2. and indirectly one can also prove hereby, that Bekhterev’s disease is caused by bacteria. I personally am convinced that this is the case in approximately 80 % of all
Bekhterev cases diagnosed thus far.

Further, other disorders of bacterial origin also disappear, as in this case the patient’s chronic simple glaucoma, which was progressing, as the bacterial-based disease caused the vessels which nourished the optical nerve to constrict, similar to a cardiac infarction, cerebral infarction, and Alzheimer’s disease. These illnesses are all very likely normally of bacterial origin; according to more recent research, caused by chlamydia (or borrelia and/or additional, as yet unknown bacteria).

October 1998

2.48. Bekhterev's disease without relapses

Is it normal for a case of Bekhterev’s disease, 26 years after diagnosis, to go for 7 years without relapse?

Is it normal for a case of Bekhterev’s disease which has been diagnosed for more than 26 years, and is marked by relapsing (constantly recurring) fibrinous iritis (infection of the iris), following long-term antibiotic treatment, immunostimulants, and immunomodulatory therapy, as well as changes in nutrition and lifestyle, to be relapse-free for 7 years now, although Bekhterev’s disease is considered in medical circles to be incurable? (Only the symptoms and results can be eased).

Example case:

A patient who is now 66 years old, and who has had Bekhterev’s disease for more than 26 years now with relapsing iritis, partially fibrinous, has been free for seven years now of relapses and of symptoms of the illness (although he had suffered about 5 relapses per year until then); his last rheumatism episode with fibrinous iritis (1991) was treated for nearly 4 months with oral antibiotics and the other above-mentioned medications. Since then, the patient had not needed to take any more medicine for rheumatism and is, according to his own account, totally free of pain, and this although he had, until then, suffered frequently from excruciating iliosacral pain (lower lumbar spine area) which disturbed him at night and especially in the early morning hours. According to my experience – I cannot yet prove this scientifically-I believe that around 80 % of all Bekhterev patients would respond to such a therapy in a similarly positive way; and, so that the success may be lasting, it seems important to me that the partner be treated simultaneously. This is because I believe that these cases are, among other things, caused (if only in part) by one or several illness-inducing bacteria, which can be passed on ping-pong style, even if the partner is (almost) free of symptoms.
In my opinion, Bekhterev’s disease is most often not an incurable, chronically episodally progressive auto-immune disorder, as current medical teaching claims; the case described above demonstrates the opposite; (this patient, by the way, used to frequently visit major far-away clinics because of his problems with rheumatism).

November 1998

2.49. Faith in laboratories

Thoughts concerning an article about borreliosis - after reading an article from the medical publication “Tips for properly treating tickbite patients”, by an M.D. and lecturer, a medical specialist writing for medical professionals, I couldn’t help but add a few thoughts of my own.

The neurologist has no high opinion of prophylactic antibiotic treatment following tick bites:

“Aside from the risk of unwelcome side-effects, this is intolerable from a financial point of view.”

The neurologist and lecturer also spoke out against recommendations to check ticks by means of PCR (Polymerase Chain Reaction) for borrelia carriers. This method, he claims, is not established, unaffordable, and there are cases of both false positive and false negative results. He also advised against ongoing serological examinations to check for further borreliosis infections in tick-bite patients, as the clinic decides in the long run – that is, the neurologist recommends therapy only after disorders have arisen which the clinic recognizes, such as erythema chronicum migrans.

It is necessary to clarify in this regard: borreliosis which is passed on e.g. by tick-bite is a spirochetosis, or illness related in type to syphilis, which can take on many pathological appearances, including backache and headache, chronic relapsing bladder and prostate infections, unilateral knee-joint bursitis, gouty symptoms in the metacarpophalangeal joint of the big toe, symptoms akin to MS (multiple sclerosis), glaucoma, chronically changing rheumatism symptoms (also destructive to the joints and triggering ischalgia), cardiac dysrhythmia, myocarditis, etc.

If, in Lyme-disease endemic areas such as southern Germany or the Cologne area, the ticks are infected with borrelia on average 10-60%, then I would wish for myself and those I care for that we by no means risk an infection with Lyme disease due to tick bites; I would always follow a tick-bite with antibiotics, for the following reasons:

1. Lyme disease cannot always be definitively contained by antibiotics once it has come to erythema chronicum migrans (circumscript migrating red patch); that is, it can already be too late at that point for definitively banishing borrelia from the body.
The sensational medical revolution on the brink of the 21st century

2. Erythema chronicum migrans can go undetected, or largely undetected, as a small whitish spot (as has happened), in which case the illness is only noticed a year later, when the borrelia have settled into the bones, cartilage, tendon sheaths, and joints, where – due to poor circulation in such areas – the usual antibiotic treatment of 3 weeks (it could be that an antibiosis of several years’ duration would be necessary) is not sufficient for containing the illness. Also, since blood tests (serology) are uncertain (as the neurologist above also agrees), a chronic illness pattern capable of destroying the patient’s livelihood can be the result.

3. I would much like to meet the “adventurous, educated neurologist” who, overcome by the feeling of the moment, goes for example into a brothel, has unprotected intercourse, and then – knowing that every third woman in a brothel has a flourishing case of syphilis – waits tranquilly to see if he develops a primary lesion which can be the size of a plum or of a pinhead, or may be completely lacking. I don’t think there is such an adventure-loving, tranquilly waiting neurologist in the world. (If syphilis surfaces 8 months later in its second stage, it can already be too late for a definitive cure.)

4. For myself, I would not wish such passive, wait-and-see behavior, for the reasons mentioned above, as this can have unforeseeable consequences of catastrophic proportion. Such wait and see tactics may be the norm when dealing with laboratory rabbits, but I wouldn’t choose them for myself or for my patients.

Günzburg, Germany; March 2000

Sharp Increase in Lyme Disease in the Forests of California

According to a WamS (newspaper) report dated 11 April 2004, biologists at the University of California have determined that, in the forests of that state, every third contact with a tree trunk, whether by sitting or leaning, results in “catching” a tick (the main transmitter of Lyme borreliosis).

April 2004

2.50. How to treat migraine pain?

What therapy should one apply for migraine pain: symptomatic, as is standard, or causal, as would be necessary?

1. If the cause of migraine pain (and thus, the cause of migraines, ed. remark), as claimed by the likes of Prof. Hartmut Göbel (Head of the
Schmerzklinik / Pain Clinic in Kiel) in the WamS newspaper (“Welt am Sonntag”) dated 27 February 2000 is, according to the most recent findings, an inflamed condition of the blood vessels in the cerebral membranes, the logical conclusion would be to treat this infection, as other infections, with antibiotics and through stimulation of the immune system with immunostimulants, immunomodulators, free radical catchers, enzymes and the like, in order to destroy the bacteria responsible for the infection of the blood vessels.

2. Not all antibiotics are suitable for this purpose; only those which can pass the blood-brain barrier. It could be that the use of several antibiotics simultaneously is necessary, as is the case with helicobacter therapy (stomach bacteria). Of course, these antibiotics must be “flooded” over a long stretch of time in order to reach as high a concentration as possible in the cerebral membrane blood vessels, so that the bacteria are destroyed.

3. It could also be necessary for the sexual partner to be treated simultaneously – even if the partner does not suffer from the same symptoms. (Bacterial transmission via French kiss and/or genital intercourse). In the partner’s case, the same bacteria can lead to other symptoms noticed elsewhere (heart, stomach, joints, bladder, etc.).

4. In my therapeutic experience, which I cannot prove here in scientific detail, approximately 95% of all migraine patients respond so positively to our migraine therapy that they usually do not have further migraine attacks or other attacks of headache for years, regardless of how these various types of headache were labeled thus far (i.e., stress, weather change, or cluster headache, etc.).

5. I therefore find it difficult to understand why we still don’t treat the cause of these headaches in modern pain clinics (by eradicating the bacterial source of the inflamed vessels), rather than treating the symptoms in a complicated and, in the long run, expensive manner, in part with poisonous (toxic) medications (such as Ibuprofen).

The disadvantages of our causal therapy:

1. One-off costs would arise amounting to approximately DM 3000. The general practitioner who prescribes such a therapy would, under our current health-care system, have to pay about 95% of these costs himself. The patient who has been visiting the doctor regularly in every quarter year would be lost (because he would be absolutely healthy).

2. The entire “health care apparatus” (hospitals, administration, social welfare distribution and surveillance programs, doctors’ offices), would be decimated by the loss (cure) of this and other such chronic patients (rheumatism, asthma, etc.), and the loss of so many employers would lead to hundreds of thousands more unemployed. The effects of cheap new software workers (60,000 from third world countries) could not compete with such a job loss. Not to mention that the long-suffering migraine patients’ nearly 300 % higher
risk of cerebral infarctions would be reduced in the long run down towards zero through a successful, destroy-the-infection-root vascular therapy.

3. Small wonder that politicians of every stripe would rub their brows in dismay at the thought of the expected life span of pensioners and future pensioners being increased by about 10 to 15 years, in light of shrinking pension funds and a social welfare system on the brink of collapse barring drastic elementary reform – and such change would need to be very soon, not several decades away as the politicians keep claiming. 

What nonsense; these pension program changes can be expected by the year 2005, and this despite the sloppy manner of dealing with BSE-triggering prions (even if we can expect at least 100,000 cases of human BSE patients over the course of the next 20 years).

Günzburg, Germany; March 2000

2.51. Metastasized Malignant Melanoma

Stabilizing the condition, and increasing the life expectancy, of a now 75-year-old female patient whose malignant melanoma had already spread (1993), by improving her “environmental conditions”

Anamnesis (History of illness):

The patient had already had a malignant melanoma in 1979 on the right side of the nose; this led to an operation including a skin transplant from her forehead. Nearly 2 years later, the cancer returned at the same spot, this time including the tear duct, necessitating a further operation. Approximately 2 years later, she again had a relapse around the tear duct, and was again operated on.

In 1993, a distant metastasis was found in the left calf, and was operated on. At that time, the patient was first introduced to me. I attempted to investigate her health environment, as I am of the opinion that malignant melanoma does not strike out of the blue, but rather that such a serious health-related event announces its arrival long in advance, following a weakening of the immune system and through other maintained illnesses. As I questioned her in detail, she complained of pain in her back, knees, and sacrum, and also of headache. In her lower leg, around the metastasis, she had an inflammatory, itchy reddened area; surgery had not yet been undertaken, but it was planned, and – although the survival rate is normally only a few months following a distant metastasis – I felt it was worthwhile to undertake an attempt at therapy with long-term antibiosis and immunomodulatory substances, starting before the operation and continuing thereafter, which I consider to be very important and decisive concerning the possibilities of

1. a definitive cure, or
2. for preventing further spreading of metastases through the planned surgery.
(A major principal of surgery is: do not operate into an inflamed area); thus, it was my goal to dispel the reddened infection around the distant metastasis before the operation, through the systematic use of antibiotics and additional immunomodulatory therapy.

What followed were 2 long-term antibiotic therapies including immunostimulants, one before surgery and one afterwards. Since that time, the patient once again enjoys life, feels motivated again, looks forward to the four seasons. As a result of my therapy, the pains in her back, sacrum, and knees, as well as the excruciating headaches, have disappeared.

I’m convinced that, generally speaking, a malignant tumor must have suitable “turf” upon which to grow, suitable ground – with one or more different bacterial initial illnesses. Thanks to antibiosis, the probable bacterial origins were most likely eradicated, e.g. in the areas of the back, knees, and head. At the same time, the immune system was sufficiently strengthened so that there has not been a relapse of such a malignant and easily-spreading melanoma since 1993.

I must admit here as well, that this therapy was sensationally successful for the patient, but admittedly not for our social system and pension system, which are on the road to a breakdown.

April 1997

Addendum concerning patients with malignant melanoma including distant metastasis

Such patients must, of course, remain under observation and testing, particularly regarding their immune systems (also after surgery, very close observation). If outside events (such as a car accident with physical injury and significant financial loss) or inner, emotional trigger-events (e.g., arguments with loved ones, or death in the family) lead to trauma, this can readily result in a weakening of the immune system, marked by all symptoms of a resurgence of inner bacterial infections, such as back or knee pain, headache, “allergic” skin rashes, increased pollen allergies, even pseudopollen allergies (these allergies normally disappear for years following a lengthy antibiotic therapy), compulsive urge to urinate at night, morning stiffness in the hands and lumbar spine region, etc.

In the case of the patient described above, her immune system was significantly traumatized in 1997 due to the death of a beloved daughter-in-law, resulting in a recurrence of back pain and strong itching in the spots where she had previously had malignant melanoma, on the right side of her nose as well as the distant-metastasis area on the left calf. Further, she developed shoulder-arm neuritis of the right arm – I have seen this repeatedly in connection with a suspected case of borreliosis. These ailments disappeared very soon after long-term antibiosis and immunomodulatory therapy.

Conclusion:

Operations concerning tumors, no matter of what kind, should by all means be preceded and followed by antibiosis and immunomodulation. To my knowledge, this is not the current practice anywhere in the world, not even in university hospitals.
This appears to be incredibly simple; it is indeed so simple; I hope, that this influences generations of doctors – the older ones, those presently practicing, and those to come. Even if this method (that is, consultation) generates scarcely any income, which is particularly irksome as the dear, well-meaning doctor who prescribes the antibiotics and immunostimulants is bound to clash with our “mean standard” health care system; in the end, such a doctor will receive his own terminal treatment from Seehofer, Dreßler, Ms. Andrea Fischer (or, added May 2000: whoever the smart-appearing Secretary of Health may be), since each is concerned about keeping his/her job (including, of course, the voters) in stationary state care (providing x-rays, computed tomography, NMR tomography, surgery, lab work, chemotherapy, etc.)

April 1997

As of the year 2001, the patient described above is still alive, and, apart from minor discomforts, is doing very well.

January 2001

2.52. Treating malignant melanoma

Belated breakthrough in successfully treating malignant melanoma (black melanoma; skin cancer)

According to the medical journal “Ärztliche Praxis”, No. 42 dated 25 May 2004, a new infrared laser has been developed which recognizes skin cancer in its early beginnings. This is according to Dieter Leupold of the “Max Born Institute for Nonlinear Optics and Short-term Spectroscopy”. The researcher claims that this innovative procedure uses a so-called femtosecond laser, by which means the skin-coloring agent melanin is stimulated to show a weak but characteristic glow. The typical color fluorescence provides detailed information about which stage the malignant skin irregularity is in. He further claims that this device, which is still being clinically tested, is so simple to use that a doctor is hardly necessary for its application. This marks a gigantic novum in the treatment of malignant melanoma.

Thus far, there have been two possibilities for treating malignant melanoma: either by excision, or by Bio-Electrotherapy in the manner of Dr. Pekar (Bad Ischl, Austria; public appearances e.g. on the TV-talkshow „Fliege“), and still practiced at IFIBET, Dr. Pekar’s successor institute in Bad Ischl in the Salzburg area). When, as has been the case thus far, a patient’s potential melanoma has been excised and then confirmed as malignant, that patient’s chance of not dying as a result of the melanoma was around 10%. With the other possible treatment, using Bio-Electrotherapy, the survival rate was over 90% according to Dr. Pekar. A disadvantage of this method was that, due to the electrotherapeutic removal of the tumor, one could not be 100% certain that it was a malignant melanoma rather than a pre-stage of malignant melanoma, or even some other type of tumor. Standard practice among our university hospitals and dermatologists has led to a histologically certain diagnosis; on the other hand, if that diagnosis was “malignant melanoma”, the prospects that the cancer would not spread were a
mere 10%. Survival chances were equally low, also because of the risk of dissemination from the tumor, even if excised far into the healthy flesh.

What does this show us?
Please think calmly and logically

1. If malignant melanoma is suspected à coagulate bioelectrically.
2. by no means allow an excision which draws blood, as this normally results in dissemination.

July 2004

2.53. Left-sided Cephalalgia

Successful treatment of a 30-year-old case of left-sided cephalalgia

Successful treatment of a 30-year-old case of strong left-sided cephalalgia (headache – already examined in terms of radiology, neurology (CT), general medicine, EENT, urology, and dental medicine) in the case of a 76-year-old patient with, in his own estimation, a “pain-killer addiction”.

In addition to pain-killers, the patient only used, for years, Isoptin 2x1 for attacks of cardiac dysrhythmia, and Novodigal 1x1 (pulse rate 60/minute.)

This patient had a noticeable case of mild bilateral episcleritis in connection with chronically dry eyes, which an ophthalmologist had diagnosed 14 years previously and which was treated in the standard way, with tear-replacement drops to be used as needed.

Upon further questioning, the patient complained of chronic pain in both knees, backache, the need to urinate during the night (3-5 times on average), and cardiac dysrhythmia which remained despite taking Isoptin and Novodigal. He accounted these discomforts mostly to his age.

After two months of uninterrupted antibiotic therapy with various antibiotics, immunostimulants, vaccines, and a change in his nutritional and life-style habits, all of this patient’s above-named discomforts were gone. Bit by bit over the course of therapy, there came a gradual halt to the chronic back pain and knee pain, and by the end the patient hardly ever had to get up at night to go to the toilet; then his cardiac dysrhythmia disappeared, and (finally) 2 months later his very annoying, 30-years-on (!) constantly persistent headache disappeared (which the patient scarcely dared to believe even after 14 days).

This is indirect ex iuvantibus proof that all of these complaints were traceable to a bacterial infection (as in the case of Lyme disease). Perhaps this long-term antibiosis will spare him from suffering cancer in his later years, considering that chronically inflamed cells can undergo chromosomal changes; not to mention the heavy costs which now need not burden our already barely solvent health-care system. No mention either of the risk he no longer runs of suffering from sudden gastric bleeding (through constant use of pain-killers such as aspirin) and, in time, possibly suffering from gastric ulcers followed by perforation of the stomach.
Addendum concerning this patient

I am well aware that, upon reading this text, the great medical “wise guys” will say that these successful results could have come about just as well by chance or by simply handing out vitamin B candies. Of course success could have just happened, but why just now after 30 years, and why did it wait to happen in direct connection with this therapy, and why this degree of success – success that the mentally sound patient could scarcely believe during the first six weeks. His head pains ceased, by the way, long before he stopped taking Isoptin and had lasted for many years before beginning with the Isoptin therapy; thus, they have nothing to do with going off of this calcium antagonist used for clearing up supraventricular cardiac dysrhythmia.

Now as ever, but particularly now in such a case, the saying “he who heals, proves right” applies, and not the “wise guy” who works with a sharp tongue or a spiked pen.

April 1997

To this day, the one-sided headaches have not recurred.

January 2001

2.54. Unfortunate consequence of not treating asthma and headache

Unfortunate consequence of a case of asthma which, for years, did not receive causal treatment (most commonly caused by bacteria – should, therefore, receive antibiotic treatment), and of headache, also without causal treatment (Cephalalgia, also normally of bacterial, inflammatory origin – and should also be treated with antibiotics). In short, lack of long-term antibiosis and immunotherapy in the case of a student whom I have known since his 21st year; eight years later diagnosed with a brain tumor (neurilemoma; tumors are, as a rule, caused by infections). This patient died in that same year, aged 29. His parents cannot be comforted; whether they understand cause and effect, I do not know. Hence:

CAUSE:

Years of chronic a/o subchronic infection

EFFECT:

devvelopment of malignant tumor if not treated soon enough by antibiotic and immunotherapy

April 2004
2.55. Bacterial Cause of Epilepsy

Epilepsy most often caused, at least in part, by bacteria, even if it develops after accidents?

Can long-term antibiosis help to avoid the use of toxic antiepileptics, or can a person, by means of long-term antibiosis, completely do without consumption of these relatively toxic medications? (And the antiepileptics are more toxic than the antibiotics; or, from another perspective, imagine a 28-year-old epileptic who wants very much to have children – should she follow the anti-antibiotic spirit of the times and opt to take her antiepileptics during pregnancy, including the first trimester, or should she perhaps rather try a definitive antibiotic therapy before becoming pregnant? Should she maybe wait till she turns 90, when she has both “sooner” and “later” behind her, just to abide by the old wives’ tale that antibiotics should be held off till the very end?) Here, at the very latest, those who have been “slow of hearing” should perk up and listen, and break with the old faith.

Case:

A female patient, currently aged 73, had a car accident when she was c. 50 years old (1977) from which she suffered a severe craniocerebral trauma. Since then she has epilepsy with grand mal seizures. The patient required repeated stationary treatment under medication because of her epilepsy (normally with 3 antiepileptics simultaneously).

Findings:

This patient also had most noticeably
- Kruckenberg spindle (dust-like corneal film on the inner cornea; in her case, in both eyes)
- Strong headache
- Strong backache (known in borreliosis research as Bannwarth syndrome)
- A particular sensitivity to bright light, which is an indicator of neuroborreliosis – a chronic cerebral infection in its third stage, following a tick bite in earlier years (affecting up to c. 30% of the population of Bavaria)

Further, the patient also complained of
- Stiffness of the neck, and a morning stiffness in the fingers
- Frequent urge to urinate
- And an exceptionally frustrating globus feeling, including gag reflex, in her throat.
Because of this globus sensation (“as if something big were stuck in my throat”), the patient had already visited several EENT specialists and had traveled to a good sized EENT University Clinic, in vain. Her exceptional sensitivity to bright light had also been the cause of many futile visits to ophthalmologists.

By the end of six months of continuous antibiotic and immunostimulating therapy, the patient could, for the first time in many years, do without her three antiepileptics, and was seizure-free for months. The same with her other ailments: backache, headache, outstanding sensitivity to light, morning stiffness of the cervical and lumbar spine areas, and most especially her disturbing gag reflex (together with the feeling that something large was in the throat) all disappeared.

Probable Pathogenesis

(see particularly my text regarding: “Why use antibiotics after an accident?”, p. 94)

Like anyone else, the patient had a good many bacteria in her body before her accident occurred. As a result of her severe craniocerebral trauma (1977), her immune system completely collapsed, and the bacteria (toxin producers) which were latent in her head (and body), but which had been held at bay by her thus-far functional immune system, multiplied rapidly.

These were the actual cause of a chronic “brain infection”, resulting in occasional grand mal seizures which were visible in her EEG. In another part of the brain, a chronic infection focus set off the frequently recurring globus sensation (which the EENT specialists were powerless against). The procedure was similar with the toxinproducing bacteria around the vascular base of the pia mater (see migraine text), and with the bacteria around the nerve roots of the cervical and lumbar spine.

In the wake of this publication, I would consider it to be crass medical malpractice for a doctor not to undertake a similar long-term antibiotic therapy using antibiotics which can access the cerebrospinal fluid, and including the other above-mentioned supportive products, with every epilepsy patient.

He who heals, proves right

Is there a destructive alliance between various influential groups of doctors who are afraid of losing long-term patients – between labor unions who are afraid that an empty hospital would certainly destroy their own living – between certain insurance bosses, whose financial magic carpet would be pulled from beneath them – and between parts of the pharmaceutical industry, out of fear of losing their best customers if those customers got cured? And let’s not overlook the politicians in this regard; they attempt hypocritically, in the name of the common good, to play their own ballgame on this field as well.

Günzburg, Germany; September 2000
2.56. Facial nerve paresis (facial paralysis)

Is facial nerve paresis (paralysis of one half of the face) caused, as a rule, by bacteria?

If this has not yet been treated by long-term antibiotics, why not now, after 10 years, attempt such a therapy?

Case description:

80-year-old patient suffered, 10 years ago, a facial nerve paresis of the left side, with iridectropium. The patient’s ophthalmological condition was also marked by episcleritis and a “dry eye”.

Upon further questioning, he also complained of back pain, knee-joint pain, itchy skin (especially on his back; my personal diagnosis: chronic atrophic dermatitis), headache, and a pronounced night-time need to urinate (nycturia). In the course of a 2-month antibiosis including immunomodulatory therapy he experienced successively a revitalization of the facial nerve (the left side of his face, which had thus far been completely without feeling began to respond to cold, warmth, and pain – and this after ten years!). Further, the patient, who had been an avid whistler by his own description before the facial nerve paresis incident (ten years back) – with puckered mouth and pressed lips – and who had not been able to whistle at all for 10 years, began slowly and laboriously to whistle again; his back pain, knee complaints, and excruciating headache disappeared in succession. According to the personal spoken words of the famous neurologist Prof. Kornhuber in Ulm, Germany, in his estimation approximately 90% of facial nerve pareses are caused by Lyme borreliosis (that is, by bacteria); hence, why not treat such cases – even if the serological findings are negative – ex iuvantibus with antibiotics even at a later date, what with serological findings often “leaning”; even if – especially if – the paresis incident occurred in the “pre-Lyme diagnosis and treatment era”? (Lyme disease was not discovered until 1983). The first major treatments for Lyme disease in Germany began around 1989 to 1991. It is simply a medical sensation that this case of facial nerve paresis, even after 10 years, for the most part receded under suitable – that is, antibiotic – therapy, and this in the case of an 80-year-old whose immune system was no longer “fresh” and intact.

Note: 80-year-olds are also glad for any improvement in their health and living conditions.

Günzburg, Germany; April 1997

The patient described above is still doing very well.

Günzburg, Germany; January 2001
At the age of 86, the patient described above suffered from intermittent claudication of the right leg (heavy pain in the right thigh); he could only walk for 10 meters without needing to stop. After receiving an angiography in a hospital, bypass surgery was planned (probably implementing a tube in the vicinity of the right abdominal aorta.) Although his surgery date was set for within 14 days, this patient preferred to undergo long-term antibiotic and immunostimulating therapy at our practice. After c. 2 months he could already walk for 2-3 hours pain-free. Other positive side-effects of this therapy: his headache, dizziness, and a stubborn cough also disappeared.

Disadvantages:
1. The hospital had one less patient.
2. The state pension office will probably remain burdened with this patient for another 15 years.
3. The patient had to foot the costs for this therapy himself.

I am convinced that this highly intelligent patient will live to enjoy another 15 years of a good and happy life. There is a high probability that he will live to be 100 years old.

October 2001

2.57. How to treat the pain of shingles?

How should one treat post-zoster (shingles) pain?

Following a case of shingles (herpes zoster), there is frequently subsequent pain in the affected skin segment; in the case in point, there was subsequent pain in the left lumbar spine region of a 74-year-old patient who had had an acute case of shingles 2 years previously, for which he had had to receive stationary treatment. Since that time, the patient had suffered constantly from agonizing, oppressive pain in this region, radiating belt-like from the spine; he had come to consider this pain as being from God, as no person could help him.

What happened next? The patient developed a case of lower-lid phlegmon (a diffuse eyelid infection). I gave him special, highly effective oral antibiotics (in tablet form), with the result that, after just three days, all of his post-zoster pain (which he had put up with for two years!) disappeared.

Conclusion:

Long-term antibiotic therapy should be tried as treatment for all post-zoster pain, as zoster can be triggered and maintained by bacteria which weaken the immune system (e.g., borrelia), even if the ultimate cause is to be found in persistent (existing) herpes zoster viruses which are nearly impossible to determine.
2.58. Therapy for long-standing zoster

Therapy for a long-standing case of zoster in the trigeminus I region (shingles, left temple) including the cornea and with accompanying iritis (iris infection, affecting anterior chamber cells).

Case description:

A 64-year-old patient with a long-standing case of zoster in the trigeminus I region, including the cornea and with accompanying iritis. This case of zoster (shingles) was treated in the standard manner with local and systemic antiviral medications and mydriatics (medicine for enlarging the pupil); when the corneal descemet membrane showed scarcely any tendency towards improvement, antibiotics were also administered systemically (orally).

What followed was prompt improvement of the corneal descemet membrane and of the accompanying iritis; then, after taking vaccinating substances – against his simultaneous chronic paranasal sinus infection – as well as taking further immunostimulants, and changing his nutritional habits and general lifestyle, his headaches disappeared completely, as did his attacks of paroxysmal tachycardia and his backache, and his corneal clouding cleared completely.

We can deduct from the anamnesis (medical history) that this patient had already suffered for years under a chronic infection involving his cardiac regulation system, his paranasal sinuses, and an infection of the nerve roots of the spine. Due to these chronic infections, his immune system was eventually so weakened that the zoster viruses which were triggered in childhood by the chickenpox, and then left latent in the body, were again able to multiply and cause a case of shingles around his temples.

Because of a therapy geared towards strengthening him in general, as well as towards largely eliminating the bacterial agent at the root of his maladies, the result was this prompt multifaceted recovery (of the heart, paranasal sinuses, backache).

Conclusion:

In every case of zoster, one should by all means check for other symptoms of illness (as in the above-mentioned case), and by all means – even though zoster is itself triggered by virus – treat it simultaneously with long-term antibiotic and immunomodulatory therapy!

April 1997
What to do for cornea illness and concomitant iridocyclitis (infection of the anterior chamber and vitreous cells)?

I can’t quite understand why patients with relapsing iridocyclitis are lately being treated with cyclosporines (a potent immunosuppressant which is also used for transplant cases), considering that, under the use of cyclosporines, cancer develops 5-6 times more often than with patients whose immune systems are not suppressed by cyclosporines. Long-term antibiosis and immunomodulation appear to me to be a bit more advantageous.

Early March, 1999

2.59. The myth of irreversible constant pain after an amputation

Concerning the nonsensical talk about constant pain being etched into the brain cells, as it is of late taught at our universities

Here is a typical example of so-called phantom pain, as it tends to occur following amputation of a limb.
Case:

A 52-year-old self-employed pharmacist from out of town, whose right lower leg was amputated after a car accident. For the past four years, he has suffered increasingly from phantom pain that could not be brought under control by pain medicine or other medical aids (local injection of cortisone).

- Increasing back pain in the cervical and lumbar spine areas, including shoulder-arm syndrome (disk surgery has been considered for three years at this point)
- Nycturia (strong urge to urinate at night, 4-5 times on average
- Attacks of paroxysmal tachycardia
- Cardiac dysrhythmia
- Tendency towards high blood pressure
- One-sided headache (cephalalgia)
- Increased sensitivity towards bright light
- Increasingly intolerant of alcohol
- Relapsing asthma attacks
- Morning stiffness in the hands and other joints
- Itchy skin on the back

After only 12 days of antibiotic, immunostimulating, immunomodulating therapy, plus a radical turnabout in his eating and lifestyle habits (including a total of 25 different natural remedies), the patient no longer complains of any of the maladies described above.

Probable pathogenesis: Particularly in the case of the problems listed above, there must have been a chronic bacterial process involved which weakened the immune system, caused especially by bacteria in the nerve root areas.

Thanks to our therapy – one that strengthens the immune system and kills bacteria – this incredible success was attained, which was thus far not reached despite all the medical help received over the course of years.

Yet it would clearly be wrong to break off this therapy before three months time, especially if the sexual partner is not treated as well.

Conclusion:

I am highly skeptical of the recent trend at our medical universities to teach this nonsense about pain-memories being etched into our immunological memory.

Is it hoped that this will lead to a new wave of chronic consumption of pharmaceuticals?

See in this regard my publications on a thirty-year case of cephalalgia (chapter 2.53) and on epilepsy (chapter 2.55).

Not to be overlooked: the myriads of jobs in psychotherapeutics which were supposed to have been created only recently, in order to treat chronic gastric and duodenal ulcers: since the introduction of triple antibiosis to treat the cause (helicobacter pylori), that feeble legend from academia-land has been silenced.
He who heals, proves right, even if those who stand to lose from it hate him for it.

Günzburg, Germany; September 2000

2.60. All that talk about hereditary hair loss

Concerning supposedly hereditary hair loss and the efficiency of our state-run forced medical system

Case:

A 31-year-old patient complains for weeks about losing his hair by the handful; he goes to a dermatologist specialized in hair treatment; this specialist
1. runs his hand briefly through the hair at the front of the patient’s head, and has a handful of hair in his hand,
2. then runs his hand through the hair at the back of the head and has no significant amount of hair in his hand.

His conclusion, “Well, it can’t be an infection, because then the hair loss would be distributed evenly,” appears logical.

As the question whether the father also went bald was answered in the affirmative, then the fate of this patient with his “hereditary” hair loss would have been sealed, had he not by chance asked me as well.

From me, the patient received assorted multivitamins and trace elements (including silicon) together with recommendations for a change in nutrition and lifestyle, particularly regarding his drinking habits.

After only two weeks, his hair loss had halted, no more tufts fell out; after eight weeks, according to the patient’s observation, all of the hair had grown back.

This highly intelligent patient (who had two college degrees with a high grade average) commented: “I can see that, in a system in which a medical specialist is only paid DM 12.00 before taxes to do such an examination and consultation, and has to endure so much forced regulatory administrative work (only to clear a mere DM 1.80 after expenses and other forced fees) – such a system cannot provide sound medical care. No wonder more and more people are flocking to non-medical practitioners and other specialists, like hair specialists, to find help.”

Günzburg, Germany; September 2000
2.61. Circular hair loss

Circular hair loss on the chin – caused by bacteria?

A 33-year-old patient in my ophthalmological practice caught my attention because of his eyelid phlegmon (diffuse infection in the tissue). To me, this is most often a sign of a deeper-lying infection. Upon further questioning, the patient also mentioned dealing with back pain in the lumbar spine region, stomach problems, an ongoing, 10-year-old chronic paranasal sinus infection, and circular hair loss on his chin.

Following an appropriately long-term antibiosis, all of the above-mentioned problems, particularly his stomach troubles, back pain, sinus infection complaints, and circular hair loss, were for the most part gone.

This is a further indicator that circular hair loss can be of bacterial origin.

July 2002

2.62. Infections of the stomach and duodenum

Stomach and duodenum infections in connection with an attack of helicobacter pylori

Why, repeatedly, in every quarter of the year, “swallow tubes” (when a helicobacter pylori infection is suspected – responsible for as much as 90% of relapsing duodenum ulcers)? Even though these plastic tubes cannot be optimally sterilized? Cui bono? Even though these bacteria are suspected of triggering arterial sclerosis, cardiac infarctions, and other infections such as tendosynovitis. Why don’t we do the financially less strapping breath test? Why should a majority of gastroenterologists shrink back from a gastroscopy should they have gastrointestinal problems, preferring for themselves, as a rule, an indirect diagnosis in conjunction with antibiotic therapy (diagnosis ex iuvantibus)?

In the course of an 8-week antibiotic and immunomodulatory therapy (3 of those weeks geared towards helicobacter: a combination of 4; 1 acid-blocker and 3 antibiotics simultaneously), total cure was achieved, no more stomach or back pains, no more headache, no nycturia, no more tendosynovitis, and no more plaster cast.

In her own estimation, this female patient felt like a 20-year-old after her therapy. She is aged 32.
Discussion:

The maladies described above are indicators of a chronic attack of helicobacter in the stomach and duodenum, with inflammatory consequences in other parts of the body. These helicobacter had already been determined to be present by an internist. Unfortunately, according to a survey among medical professionals, a suitable triple therapy (triple antibiosis) is only undertaken in about 7% of the cases in this country.

Dated: April 1997

Addendum:

The above is a prime example of our current health-care system. Rather complicated examinations such as gastroscopy can be billed individually and are individually recompensed; but the logical conclusion to be drawn from this illness (very possibly straight off, without complicated examinations, just through logical thinking) – from my point of view and that of any attentive patient – that medication should be prescribed, which would cost approximately DM 350 to 400 (because of the bacterial ping-pong effect, the marriage partner should also be treated similarly, doubling the original DM 350 – 400) – this solution was not prescribed and probably won’t be in the future.

Why ever not?

When a doctor who works within health-insurance guidelines issues prescriptions to an amount that exceeds his peers’ average (too expensive), he risks liability proceedings with all possible judicial consequences, which is at the very least time-consuming, not to mention the ubiquitous psychological pressure – he could even have his permission to operate within the planned health care system revoked (equivalent to losing his medical license, bringing probable bankruptcy), just because he had too big a heart for his patients.

Why not more concern over the economically significant time that companies lose when employees require sick leave?

What this means:

As an ophthalmologist, I am allowed to prescribe an average of DM 13.00 worth of medications per patient and quarter (anything beyond that comes out of my pocket).

A cautious reform plan – aiming to provide the patient possibly the most innovative and effective medication for his ailment (thus, most often the more expensive) – in which the patient should pay part of the medication costs himself, was recently retracted. What can we do that is good for the future in light of increasing German disindustrialization, which is due to globalizing markets, wages and additional wage costs that are too high on an international scale, and Germany’s growing percentage of pensioners (look at the age pyramid)?

January 1999
2.63. Sour stomach - can antibiotics cure it?

According to an article in the April 12, 2002 edition of the medical journal “Ärztliche Praxis”, laboratory mice are helping to show the way to treat gastritis.

Not too much gastric acid (it isn’t the amount that counts), but rather infections of bacterial origin seem to be the cause of burdensome gastric ailments. This is the result of tests performed on mice at the Howard Hughes Medical Institute of the University of Michigan.

Giving antibiotics heals the inflammatory altered state of the gastric mucous membrane. However, when proton pump inhibitors are used (which are frequently given as an expensive additional medicine for gastric ailments, or are often used alone), the inflammatory condition of the gastric mucous membrane smolders on, and the bacterial colony even becomes more dense. This is the conclusion reached by researchers at the above-named university in their experiments with laboratory mice, including some genetically altered mice. In these experiments, the helicobacter pylori, which are found in c. three quarters of gastritis patients, had already been eliminated. What remained were primarily lactobacilli, enterobacter, and staphylococci. In the above-named experiment, mice with gastric infections received either 20 days of antibiotic therapy, 2 months’ treatment with proton pump inhibitors, or a combined therapy.

Afterwards, their gastric tissue cells and the bacterial condition of their stomachs were examined. Only those animals treated by antibiotics had gastric membranes which remained undamaged. Mice who had received Omeprazol (proton pump inhibitor) displayed increased signs of infection and growth of bacterial colonies.

This shows once again how important long-term antibiosis is for treating gastric ailments – no matter whether the agents are helicobacter pylori or, as in our cases, other agents such as staphylococci, enterobacter, or lactobacilli. The bacterial cause is insignificant. Further, this also indicates that a patient who has not been found to have helicobacter should still definitely receive a trial long-term antibiosis. Additionally, it shows that proton pump inhibitors are inappropriate in such cases and serve only to escalate costs for the health-care system.

April 2002

2.64. Ulcerative Colitis, or Crohn’s Disease

In the summer of 2001, a 36-year-old patient who had been diagnosed years previously with ulcerative colitis (Crohn’s disease), and who had an appointment for intestinal surgery in one week’s time in an out-of-town hospital, received antibiotic, immunostimulatory, and immunomodulatory therapy over a course of 6 weeks. Since then, 2 years have passed and the patient has no further intestinal difficulties. Additionally, the problem with cold feet, which he had always had before, disappeared. He used to have migraines, but these were also gone. Another problem he had mentioned, cardiac dysrhythmia, was also gone. His case of hemorrhoids had significantly improved.

Here we see clearly that this state of illness was no autoimmune condition, but must instead be a bacterial/viral illness, which must be treated essentially with antibiotics, immunostimulation, and immunomodulation, by no means with cortisone. An article in the newspaper “Stuttgarter Zeitung” dated 17 June 2003 is highly interesting; it states that researchers at the Robert Bosch Hospital in Stuttgart have determined the origin of this intestinal malady. Their research
indicates that those who suffer from Crohn’s disease have a deficiency of natural antibiotics (those produced within the body for the body’s defense).

In conclusion, such patients must be treated long-term, or at least mid- to longterm, with antibiotics and immunostimulants; not with cortisone, which destroys the immune system. By no means should the infected intestinal system be mutilated by surgery (or worse, by being given an artificial anus).

September 2003

Addendum

In the December 23, 2003 edition of “Ärztliche Praxis”, there is a report about Crohn’s disease triggered by refrigerator germs. According to French researchers, Crohn’s disease is said to be triggered by yersinia and listeria, both of which thrive in refrigerators. In line with the researchers’ suspicion, there are close correlations between the spread of intestinal maladies and the growing prevalence of refrigeration. Thus postulates the French researchers and Dr. Jean-Pierre Hugot of the Service de gastroenterologie de hôpital Robert Debré in Paris, that the significant increase of Crohn’s disease in the second half of the 20th century stands closely related to the increased use of refrigerators in the same time span.

Hugot and his colleagues contribute a further aspect to the discussion surrounding these risk factors in the recent edition of the renowned medical journal “Lancet” (362 [2003] 212-215): “All of our results indicate that refrigeration technology presents a potential risk factor regarding Crohn’s disease,” these French researchers write.

The cooling-unit hypothesis starts from the assumption that psychotropic bacteria (those which multiply best in refrigerator temperature) such as yersinia and listeria are involved in the development of this illness. These germs are mainly found in beef, pork, poultry, sausages, cheese, and lettuce.

Of particular interest: These bacteria have also been identified in Crohn’s disease lesions. Once again we see how important antibiotic therapy is, and how thoroughly wrong it is to treat an illness of bacterial origin with immunosuppressing cortisone.

January 2004

2.65. Better long-term antibiotics than long-term immunosuppressants

Concerning how the practice of orthodox medicine in Germany thus far, as it is recommended regarding Crohn’s disease, can lead to

1. serious changes in blood count (leukocytopenia – not enough white blood cells)
2. and the significantly higher risk of forming malignant neoformations (tumors), due to the medications recommended thus far, i.e. azathioprine or methotrexate.
This is based upon an article in the January 27, 2004 edition of the medical journal “Ärztlliche Praxis”, which claims that azathioprine should be prescribed for at least 4 years.

This I cannot fathom, considering that the word has been going around for at least a year that ulcerative colitis (Crohn’s disease) is an infectious disease. It follows that immunosuppressants, which are known for their ability to trigger cancer, are completely out of place here and contribute in no way towards a definitive cure.

July 2004

2.66. Crohn’s Disease

According to the 03/15/05 edition “Ärztliche Praxis”, the newspaper “Bild am Sonntag” expresses the view of several international experts that the mycobacterium avium paratuberculosis (MAP) is one of the greatest single health dangers worldwide, particularly for causing Crohn’s disease. Opponents of the overwhelming evidence in this regard, however, counter that an autoimmune condition is proven by the fact that immunosuppressing medicines are beneficial for treating the condition.

My comments on this matter:

If you desire that a patient should be prevented as far as possible from getting well, and that his future risk of getting cancer increases many times over, prescribe immunosuppressants and cortisone, especially for treating Crohn’s disease – and operate on him as often as possible!

By no means should you treat him with long-term antibiotics! That could result in his complete recovery.

For more overwhelming evidence about the futility of immunosuppressants in the treatment of Crohn’s disease, see “Ärztliche Praxis” in its 03/04/05 edition. There, it says: even though recent years have seen an increase in the use of immunosuppressants for the treatment of Crohn’s disease, this could not lower the rate of intestinal resections. Also, it did nothing to decrease complications such as strictures and perforations. This is the result of a retrospective study of various collectives from 1978 to 2002 involving a total of 2573 Crohn’s disease patients. Whereas immunosuppressants were not used for treating Crohn before 1982, from 1998 to 2002 every second Crohn patient took them. The percentage of operations and the frequency of both strictures and perforations did not change over the entire time span of this study.

My comments:

If the therapy didn’t help anyway, why does anyone stubbornly insist even now on using immunosuppressants, and claim stubbornly even now that Crohn is – just like multiple sclerosis – an autoimmunological process?
Even if Rainer Schneichel, the Vice President of the Rhineland-Palatinate State Veterinary Chamber, considers the uproar over a bacterial cause of Crohn’s disease to be reasonable: there is overwhelming data pointing to a connection between MAP (mycobacterium avium paratuberculosis), Crohn’s disease, and transmission via raw milk, vegetables, and drinking water. The present administration in Germany (in particular the Secretary for Consumer Protection, Renate Künast) does not seem to find the matter of particular interest.

Who is concerned in the complete recovery of our patients? Who bothers with a causal approach to therapy? Who benefits from what? Why can’t we finally shelve the senseless claim that Crohn’s disease is an autoimmune condition?

Naturally it is correct that costly operative medicine would draw the shorter straw compared to causal therapy. The latter, however, would be much, much, much more cost-efficient and humane.

Who’s backwards here?

March 2005

2.67. Pseudomembranous Colitis Cured

This pseudomembranous intestinal ailment rarely strikes – but particularly if antibiotics have been administered over a long period without a daily colibacillus substitute (such as Omniflor, Mutaflor, or Paidaflor), and if the patient has not adhered to a diet strictly avoiding sugar, chocolate, and sweets. An antibiotic resistance develops towards clostridium difficile, and can only be countered by use of expensive medicines such as vancomycin enterocaps. This is an illness with a poor prognosis (diarrhea with pus, blood, and mucous, together with pseudomembranous alterations in the intestines.)

Case description:

A 40-year-old woman suffered for 2 ½ years from this life-threatening ailment. After undergoing our therapy with an active specific autoserum and nutritional changes, the patient has been definitively cured of this serious illness for four months now.

August 2005-10-05
2.68. Administering Antibiotics after an Accident?

What is there in favor of a lengthy dose of antibiotics and immunotherapy following a long-ago accident (1994)?

When an accident results in surgery, and the following problems then emerge (or even come to stay), such as morning stiffness in the hands and the back, tinnitus (humming, buzzing, hissing sound in the ear), cardiac dysrhythmia, a widely bulging varicose vein in the left calf, dental root pain, and the sensation of constant fatigue, then one should definitely consider long-term antibiotic and immunotherapy.

The 28-year-old female patient had a horseback-riding accident in 1994, resulting in a comminuted fracture (fractured break of the left thigh) with 3 subsequent operations:
1. Intermedullary pin, left thigh
2. Left meniscus operation, and
3. Surgery to remove intermedullary pin.

Following immunomodulatory and antibiotic therapy, all of the patient’s above listed complaints disappeared completely; even the very visible varicose vein on the side of her left calf was no longer there.

What we can learn from this: the patient had bacteria in her body before her accident, but her immune system was at that time intact enough to keep them at bay, so that these bacteria could not wreak any real havoc. The accident, and the clearly stressful operations, led to a weakening of the immune system and a subsequent “ballooning” of bacterial infections (when, after an immune-system breakdown, as caused e.g. by shock, bacteria are then no longer held at bay by sufficient antibodies, then these bacteria can multiply exponentially in the warm breeding ground of our bodies. By doubling in number every 17 minutes, a single bacterium can foster 50 million toxin-producing (= poisonous) bacteria within 24 hours – added May 2000), thus triggering the subjective and objective complaints listed above.

One might be tempted to think this is simply a case of problem seen, problem solved, so why shouldn’t all future patients who have such pre- or post-operative problems receive this kind of long-term antibiotic and immunomodulatory therapy. But this isn’t reckoning with the power of policymakers (here, the names would include Seehofer, Dreßler, or other such political decision-makers as, e.g. Andrea Fischer added May 2000). As operating is still reasonably profitable, so that for a surgeon an operation still pays, an increasingly large percentage of the medical budget flows into hospitals which carry out surgery (both the operation itself and post-operative care), meaning that none is left for other “lesser” activities such as time-consuming consultations performed by general practitioners or specialists – least of all for prescribing medications (if done by practitioners not working for hospitals). This simply means that heart surgery, for example bypass, which costs the insurers between DM 40,000 and DM 60,000 on average, and which I consider to be no more than treating the symptoms, will still be covered financially, whereas necessary pro-active and causal therapy (antibiotics in high dosage and over longer periods of time, and immunostimulation, which costs perhaps only 1/100 to 1/1000 of the bypass price) won’t be covered because no money remains available for it.

Thus, in the future we’ll see more and more that hospital services (generally operative or post-operative) will remain basically well-paid, will flourish, whereas those in the ambulatory...
The sensational medical revolution on the brink of the 21st century
care sector will need to cut costs in view of the enormous and rising costs in the health sector as a whole. In hospitals (public and semi-public), little can be done to cut costs, as cost-cutting there would necessitate massive personnel cuts. Our political decision-makers and representatives, namely Seehofer, Dreßler (Social Democrat), Andrea Fischer (Green; added May 2000), or others like them, would lose their constituents from among hospital personnel, as it would come to a major eruption among those constituents if there should be such a reduction in hospital personnel.

Facetiously speaking, are we going to become a post-op society (those who have had heart, knee, disc, or hip operations – the latter is practically an industry of its own – or tonsil, sinus, finger joint, tennis elbow, and tendon-sheath surgery, the latter particularly in the hands)? Will a post-op society be incapable of meeting pension payments for the growing numbers of the aged and the post-operated? Is it hoped that the hard-working German contributor to the national product be operated into needing an early pension, so that the state pension system will collapse sooner?

There will be progressively less, and in the end perhaps nothing at all left over for ambulatory health care, which is essentially more important and is the best way to either avoid or to improve upon surgical care, sometimes surgical carelessness. It appears as if ambulatory medical care will become an item which the insured will need to cover on their own within the next few years.

Naturally, whoever points out such developments does not win friends among hospital personnel, labor union members, or politicians (who keep a constant eye on their constituents).

November 1997

2.69. Who needs an artificial knee-joint?

Why implant an artificial knee-joint, when there are other options?

Why implant an artificial knee-joint, when there are other possibilities besides such an extensive and drastic operation, possibilities which also cost only a fraction as much, and above all maintain a high quality of life.

A patient who is now 60 years old had already made an appointment for January 1996 to have an artificial knee-joint implanted in his left knee, after having undergone several surgeries on that knee. Fortunately – as we know now – the patient did not show up for the operation, which was to have been in a large out-of-town hospital. Now, after more than six months of uninterrupted antibiotic and immunostimulating therapy, the patient has no problems whatsoever in his much-operated-on left knee. Also, a particularly troublesome, tormenting itch around the left ankle disappeared as a benefit of this therapy.
Conclusion:

In this case as well, the problem seems to have been a chronic bacterial process. In future, similar cases, it must be recommended that first an attempt is made to treat it by long-term antibiosis and immunostimulation; only if such an attempt proves inadequate should such a serious operation be considered, and then only when it is the very last option left.

The tormenting itch must have been an eclipsed “allergy”, brought out by a bacterial infection, which suddenly disappeared when its bacterial origins were attacked. I experience something similar with near regularity concerning so-called “paranasal sinus pollen allergy” patients; when treated by such a therapy as described above, they are freed to a large extent from their “pollen allergy”. One 78-year-old patient comes to mind who had a distinctive allergy towards eye drops (because of a chronic eye illness, she must diligently take 3 different types of eye drops regularly).

When her conjunctiva became increasingly red and swollen due to an “allergic reaction”, and even a large out-of-town hospital could offer no further help, I prescribed antibiotic and immunostimulating medications (and not immunosuppressants, as is normally the case for allergies), with successful results; since then, the patient has had no compatibility problems with her usual eye drops.

Even if one left aside the advantages of having a natural knee joint, one should consider – among other things – the financial aspect of such an expensive operation with all of the post-operative measures that become necessary (e.g., rehab, early retirement).

I can’t help drawing unusual conclusions here.

June 1998

In February 2001, the patient was still going for his regular walks in the forest – but with his natural knee joint. “What a miracle?!!!“ (What other patient got that artificial knee joint instead?)

2.70. Osteochondrosis Dissecans (degeneration of bone and cartilage)

Successful therapy for a case of osteochondrosis dissecans, diagnosed 2 years previously

Successful therapy for a case of osteochondrosis dissecans, diagnosed 2 years before (“aseptic” bone degeneration) (Köhler's bone atrophy) in the case of a female patient who also had further immune-system-damaging health problems caused by bacteria.

Case: 43-year-old female patient had experienced pain around her left ankle for 2 years. The patient could no longer go for walks; running errands in her small part of town became torture; hikes and other outings had to be cancelled, which naturally did not have a positive effect on her
quality of life. After substantial orthopedic and NMR tomographic testing, she was diagnosed with osteochondrosis dissecans stage I in the medial and cranial surface of the talus (left foot), and underwent extensive, ultimately futile orthopedic therapy, without any improvement of her condition.

By the time the patient visited my office, she was in total despair. Before my treatment began, she complained of headaches, circulatory dysfunction in the hands and feet (cold hands and feet), low blood pressure, nycturia (frequent, compulsive nightly urination) at least 2-3 times per night; she complained of an increasingly worsening short-term memory, and of the pain in her left ankle as described above, particularly when any pressure at all was applied to the foot. After five months of uninterrupted antibiotic, immunomodulatory, circulation-improving, and immunestrengthening therapy, all of the pain and problems mentioned above were nearly completely gone. Best of all: the patient has been able to walk trouble-free for three months now, and feels no more pain in the left foot joint, even when applying pressure!

**Discussion:** This **sensational** recovery points directly towards a bacterial origin of this supposedly “aseptic” bone degeneration, which had not, until then, responded to any attempted therapy.

As for the future, I don’t expect these results will lead to any conclusive consequences on the part of our health-care system. All will remain as is. The expensive branches of medicine, those favoring hospitals and technical gadgets, will continue to flourish no matter how low their chances of success may be; therapy which is origin-based, causal, medicinal, ambulatory, and prone to success is, so it would appear, “too expensive”, and the medications it requires will hardly come from the ambulatory side.

April 1998

### 2.71. Senile Macular Degeneration

Text regarding senile macular degeneration (retinal degeneration; degeneration where vision is sharpest, on the retina, the yellow spot)

Is this, as a rule, of bacterial origin? An infectious illness, as is at last generally accepted with regard to cardiac and cerebral infarctions, after many years, by top medical professionals; upon viewing the records of my last 13 patients who had this affliction, I cannot escape this conclusion. As of yet, the cause of this affliction, which strikes most often at an advanced age, remains a mystery. Recently, Australian researchers claimed to have determined that all patients with senile macular degeneration (one of the primary causes of blindness in the industrial states) had suffered for years previously under increased sensitivity to bright light (caused by years of subchronic meningoencephalitis?). This is consistent with the accounts of all 13 of my macular degeneration patients. Frequently, macular degeneration is labeled by many colleagues a “circulatory disorder of the retina”; particularly nonophthalmologists label it thus, and then it is treated by vascular dilatation and infusions, which often aggravate the situation further (because a case of “moist” macular degeneration, for example, then is particularly susceptible to profuse pre- or sub-retinal bleeding). There are also efforts to treat macular degeneration by laser irradiation.
of the retina, with more or less great success. Occasionally, cobalt irradiation of the retina is said to be undertaken (radiotherapy for macular degeneration). As of late, there are also invasive retinal operation methods (retinal rotation). All of which promise doubtful and in some cases only short-term results!

As I see it, based upon the anamneses of the 13 above-mentioned patients, macular degeneration is a bacterial vascular problem; that is, macular degeneration is in my opinion of bacterial origin, as are cardiac and cerebral infarctions (as, by now, is accepted by most of the upper crust of the medical profession worldwide). All of the above patients had several other medical complaints, which I saw as mostly of bacterial origin, such as back pain, knee joint problems, cardiac dysrhythmias, headaches, nycturia, hypomneses, chronic relapsing paranasal sinus infections, and arterial sclerosis. In order to support both my thesis and findings, it seems imperative to me to do a large field test involving hundreds of patients with this illness, asking them specifically about just such “well-being disruptors” (such as back pain, knee joint problems, nycturia…), and if they have such subjective “wellbeing disruptors”, they should be treated with a suitable high-dose, long-term antibiotic and immunomodulatory therapy; then, I would observe whether the progression of their macular degeneration is stopped, as my experience leads me to suspect. I am utterly convinced that senile macular degeneration will be halted in the future by practicing such a “simple” therapy. This therapy would also have the advantage of simultaneously healing or at least protecting the patients by and large from cardiac infarction, cerebral infarction, tinnitus, and infection-related back pain and knee joint problems; they would also need fewer appointments with neurologists and orthopedic specialists, and they would be spared many operations (bypass).

The disadvantage to it all would be particularly this: that our overstretched pension and social welfare system (our eurosclerotic social system) would not be affordable, not even for the near future, if healthy patients lived longer lives.

Senile macular degeneration – once it has begun – is irreversible (the degenerated retinal areas cannot be replaced by new retina tissue).

My rudimentary attempts at treatment thus far have led me to the firm conclusion, that the illness’s progression is hereby brought to a standstill. Stopping progression would be of particular importance in cases where the illness has only affected one eye, so that the other, healthy or nearly healthy eye can be spared through prophylaxis.

July 1998
One of the most successful German horseback riders, former European champion, German champion, four-time champion of Lower Saxony.

2.72. Dry Maculopathy

Does dry maculopathy only occur among polypathics (patients with several illnesses)?

Dry maculopathy is a condition in which a dry degeneration of the retina affects the area of the eye where vision is sharpest, so that there is a substantial reduction in central visual acuity.

Case:

A 78-year-old patient had been suffering for years under increased sensitivity to bright light. In her early youth, she had tuberculosis, which was supposedly healed. Four years ago, she received stationary hospital treatment for double pneumonia. Since that time, she has suffered from cardiac dysrhythmia, chronic bronchitis, she has complained for many years about cold fingers and feet (poor peripheral circulation), she struggles with the compulsive need to urinate during the night (3 times; chronic bladder infection) – implanting an artificial left hip joint was recommended – she has suffered from tinnitus for several years (a ringing, buzzing, or hissing sound in the ears). Due to her case of dry maculopathy (degenerative alterations where the eye has the sharpest acuity in the retina) the patient’s vision after correction is only 32% on the right side and 25% on the left.

Whoever has read my previous texts, also considering that on the genesis of dry maculopathy, must come to the conclusion that these illnesses, including eye illnesses, which are not brought about as a result of accidents, are the results of a general bacterial occurrence which compromises the immune system, taking many years to develop and to slowly pick up steam, so that it ultimately reaches various trophy organs; eyes, heart, hip joint, knee joint, spinal column,
and bladder – where typical infection-related alterations take place. An attempt is made to treat these changes selectively in a medical repair shop, as my near-namesake Prof. Julius Hackethal has described it; this is certainly not the optimal route to take – naturally, it would be better to treat patients causally from the beginning, right then when their first symptoms emerge, such as chronically cold fingers, cold feet, back pain, knee joint pain, stomach problems, subjective cardiac dysrhythmia, attacks of cardiac dysrhythmia (paroxysmal tachycardia), buzzing and hissing sounds in the ear, chronic bronchitis, or paranasal sinus infections, etc.; these patients would receive causal treatment right from the beginning, and as bacteria are the cause, the patients would receive relatively expensive antibiotic and immunostimulants over a long period of time for a successful therapy.

This would only be possible with the help of general practitioners or equally willing specialists. As this, however, does not seem to be at all desirous to our politicians of any stripe, I’m left to ponder whether this has to do with our totally insufficient state pension system; if we don’t fight and master such illnesses by prescribing relatively expensive antibiotics, expensive immunostimulants, and extravagantly lengthy medical consultations, the result will necessarily be much more expensive operations and technical applications, such as in cardiology with its cardiac catheters and bypass operations, or hip-joint operations, expensive diagnostics such as NMR tomography for headaches, computed tomography, constant gastroscopic examinations for stomachache (possibly every quarter year); in short, we will have positively lavish and invasive examinations and treatment methods which do not solve the problem at its root. And, whereas cardiac infarction, for example, is of bacterial origin, I do not see, as a rule, that the patient receives prophylactic treatment or long-term antibiotic treatment following an operation; I certainly do not see that the sexual partner of this patient receives corresponding long-term antibiotic care, which would certainly be clearly necessary according to what we know, since we must assume that the causal bacteria in question are infectious and can be transmitted from person to person.

Thus, these politicians (no matter from which political party) push medicine in the completely wrong direction: medicine can only develop that which is financially covered, and if an early-onset prescription of antibiotics and immunostimulants doesn’t get paid for, then it can’t be prescribed; if, however, operations which themselves cost many times more are paid for, then there will be no money left over for such a simple therapy at the onset of an illness or for a therapy aimed at eliminating the bacterial causes. How can this be the right path to take in national health, unless the deeper, inhumane desire is that the patients should not reach a very old age in good health; if that is the ultimate meaning and purpose of our state directed national health care, then I should keep silent in the future, as in that case our health insurance companies, protected as they are by the social system, are simply there to hoodwink the people.

Supplement:

Dry maculopathy in the case of a 67-year-old patient with 0.1 vision in both eyes; after long-term antibiosis, immune-specific vaccines, and immunotherapy, improved from 0.1 to 0.25 (from 10% to 25%) within 2 months.

September 04
2.73. Can senile macular degeneration be cured?

Answer: Yes, or at least stopped

A 57-year-old female patient (closely related to two medical professors) with a case of progressive, early-onset senile macular degeneration; in terms of orthodox medicine no effective protocol for treatment – at best stoppable, reliant upon methods with doubtful prognoses, such as using verteporfine. This is also consistent with the opinions of so-called experts, as was recently asserted in the “AZ” newspaper in its April 16, 2005 edition.

This patient was examined in November 2004 and again in April 2005 in one of the better German university ophthalmology clinics. Twice, she was examined by means of an intravenous fluorescein dye test (fundus examination), in which pictures were also made of the eye ground.

In her right eye, her corrected vision in 2004 was 0.5 (50 %), vision in her left eye was “hand in front of the face”, no longer measurable in percentages. The patient could no longer drive a car, and could only read with some difficulty and then only up close and when using a newly developed super-strength optical aid.

After five months of a suitable therapy (as described above): corrected vision in the right eye was 1.25!!! (125%), compared with the previous 0.5 (50%), and in the left eye 0.8 !!! (80 %) as opposed to “hand in front of the face”.

On April 21, 2005, I took this patient back to the above-mentioned university ophthalmology clinic to be meticulously re-examined by two professors, most notably by the managing director (comparisons were made with the pictures of her eye ground and fluorescein dye test from December 2004 and April 2005). The degenerative eye ground alterations of the right eye had completely disappeared, and had nearly disappeared in the left eye! The managing director/professor congratulated me over this tremendous success.

Now, the patient can once again drive a car, and can read using her former reading glasses. This was, however, not a singular success on my part; as a rule, I have been able to see similar success with patients receiving treatment of this kind for many years now, as has been published in my brochures since 1998.

April 2005
2.74. Less diabetic hemorrhaging thanks to antibiosis

Can fundus hemorrhages (bleeding of the eye ground) among insulin-dependant diabetics be positively influenced by antibiotics?

A patient who was born in 1939 has had insulin-dependant diabetes since 1977. I have known the patient since 1991. He has suffered from changes in his eye ground since that time (small, widely dispersed pinpoint-sized hemorrhages, due to diabetic retinopathy grade I); in the course of 6 years, this condition has not substantially worsened. In 1997, the patient experienced a sharp sensation of pressure around his heart after doing intense forestry work – that is, he complained of stenocardiac discomfort under pressure, accompanied with back pain. He underwent a (longterm) two-month antibiotic and immunomodulatory therapy, and three months later his diabetic eye ground alterations (pinpoint hemorrhages) disappeared for the most part, as did the pain in his back.

It would be a further medical sensation – not known to me in medical literature – namely, that eye ground hemorrhages related to diabetes mellitus, and other such symptoms (such as back pain, and cardiac dysrhythmia) which can indicate a bacterial genesis, can be largely eliminated.
The advantage of this therapy would also naturally be that an early laser therapy for the eye ground might be avoided, thus avoiding having up to 90% of the retina lasered away.

This kind of antibiotic therapy can
1. be repeated again and again, and
2. it has the advantage of being less troublesome than laser therapy, and
3. it has the tremendous advantage that the possible risk of going blind can thus be delayed and perhaps even fully prevented.

At the same time, this therapy has a positive effect regarding cardiac infarction, arterial sclerosis, nerve root infections, and other infections in the body; such infections can even be largely eliminated (see text p. 53, regarding cardiac and cerebral infarction, which should be treated by long-term antibiosis and which can be prevented).

One thing, however, is clear: that this treatment helps to avoid other invasive and expensive kinds of therapy, e.g. cardiac catheterization, or expensive examinations with complicated medical gadgets such as ultrasound, ECG, or cardiac catheter and laser work. This could help cut health care costs, particularly in stationary care. Whether our health representatives in politics want still more people to suddenly be released from their jobs is, of course, questionable. The consequence would be that the patients’ life spans would increase, and whether this is beneficial for the current state pension problems is still another matter.

Günzburg, December 2000

Addendum:

In 2005 an article appeared in the medical journal “Ärztliche Praxis”, dated May 17, citing Penn State College: Only half as many diabetic retinal hemorrhages following antibiotic application of minocycline.

Why not sooner?

Why not 5 years ago, when, as anyone can see, I published it? Why does medical university research take 5 years to follow my lead?

Shouldn’t such a tremendous achievement be worthy of the Nobel prize? Why do I receive instead rather tremendous kicks to the backside, although I already published findings 5 years ago that are just now being discovered by a university in the US?

May 2005
2.75. Relapsing intravitreal hemorrhaging

Relapsing intravitreal hemorrhaging of one eye (following retinal thrombosis in the case of a female patient, born in 1921)

Should vitreal surgery be undertaken (as recommended by an out-of-town eye clinic over 2 years previously)? Vitreal surgery entails opening the eye and, deep inside it, sucking off the vitreous body; or, as in our case, successful conservative treatment, over a long period with oral antibiotics, immunostimulants, medications and measures to improve circulation, dietary changes, and vaccinations.

Case description:

A female patient, now aged 75, had a retinal thrombosis of the right eye several years ago, and in 1994 she suffered a vitreal hemorrhage of the right eye, accompanied by reduced vision (reduced acuity of corrected vision) to the “hand before the face” level (not measurable in percentages); although an out-of-town ophthalmology clinic recommended that she have vitreal surgery, the patient chose not to be treated surgically.

After months of standard conservative ophthalmological therapy (mydriasis, and local application of cortisone), which brought no improvement to her vitreous opacity or her visual ability, the patient, now aged 75, opted for antibiotic therapy as described above, which was carried out over a time span of 3 ½ months; through this therapy, she slowly experienced a clearing of the vitreous body, and her vision improved to 0.32 (32%). Of extreme interest also are her accompanying illnesses; although she had been thoroughly examined by a general practitioner and an internist who could determine no focal cause for her eye problems, during the course of the therapy described above, the following symptoms also came successively to a halt: chronic paranasal sinus problems, cold feet, headache (her excruciating headaches had been a problem for many years until then), pain in the right knee, wrist pain, and twice-a-night nycturia (compulsive need to urinate during the nighttime!)

Because of the success of the antibiotic and other therapy, we can assume ex iuvantibus (indirectly) – that there was one or more chronic bacterial systemic focus(es) of infection here; considering that the patient’s vision in both eyes is now as good as it was 7 years ago, and that her other problems as listed above have disappeared; and, above all, that the patient was spared a surgical procedure which could have been very serious or even fatal, but which, in light of these “new aspects” was not justified. As a side effect, our health care system was spared substantial costs (12 days of stationary care in a specialized clinic), not to mention the costs of postoperative ambulatory care. Admittedly, what was saved in terms of health care costs will probably be more than made up for by increased pension claims resulting from a longer, happier life.

April 1997
Post script:

Because of the bacterial ping-pong effect, the husband also underwent a similar therapy. By January 1999, the patient’s good condition was unchanged.

January 1999

2.76. Acute Vitreal Bleeding

Acute vitreal bleeding, accompanied by iritis, in the case of a 57-year-old man.

Due to the above problems, the patient had received medications for pupil dilation and a local cortisone preparation from an out-of-town ophthalmology clinic; this is perfectly standard ophthalmological practice, when, as in this case, a focus of infection was sought but without any concrete conclusion.

Upon my intense questioning, the patient mentioned having back pain, paranasal sinus problems, tinnitus (buzzing, humming, hissing sound in the ear), ischialgia on the left side (pain around the sciatic nerve left), knee-joint problems, and nycturia (nighly urinary problems). After 1 ½ months of antibiotic therapy, all of the problems mentioned above, i.e. nycturia, tinnitus, sinus problems, and back pain, had all disappeared, and simultaneously all of the problems in his left eye as well.

In conclusion:

This must have been a case of a generalized bacterial infection. Otherwise, the many above-listed problems would not have all disappeared over the course of long-term antibiosis and immunotherapy.

Post script:

The wife of the patient described above, who had similar general ailments, was treated simultaneously, successfully (at least temporarily). This is because many bacteria are transmitted through close physical or sexual contact.

This is a further example of successful conservative vitreal therapy, and is at the same time an indicator that vitreal bleeding is, as a rule, of bacterial origin, even if the usual lab tests don’t seem to display abnormalities. Thus, a patient should always be questioned diligently concerning common problems such as back pain, knee-joint problems, cardiac dysrhythmia, skin rash,
allergies, morning stiffness in the hands, tinnitus, headache, etc., and where these problems are found, they should be treated as above with antibiotic and immunomodulatory therapy.

February 1998

2.77. Retinal and vitreal bleeding

Although vitreal surgery was already planned in an out-of-town university ophthalmology clinic due to 1½ years of relapsing retinal and vitreal bleeding, successful treatment was achieved instead using only conservative antibiotic, immuno-modulating, and immunostimulating therapy.

Case:

A male patient, now 42 years old, suffered blunt trauma of the right eyeball 18 months ago; since then, he has had relapsing intravitreal hemorrhaging, and his corrected vision was last tested at 0.2 (20%) in the affected eye. Interestingly, the patient was polyopathic; blood pressure 250/180, 25 kg. excess weight, heavy snoring, nycturia twice, attacks of tachycardia, morning stiffness in the hands, cephalalgia (headaches), paranasal sinus problems, swollen feet, night-time sweating around the neck, tinnitus.

Although there were all these problems, indicating with certainty a very deeplying bacterial infection, he was to be treated symptomatically, with ophthalmological surgery. One might consider asking, why? “Idiocy”, “sloppiness”, or perhaps “malice”, acting out of base motives.

After c. 3 months of conservative therapy, the above nightmare was over. No excess weight, no nycturia, no more expensive sleeping mask, no more expensive sleep laboratory, no more vitreal bleeding, corrected vision 0.9 (90%) in the affected eye, and most interestingly: no more retinal wrinkling at the point of sharpest vision, and morning stiffness was also gone.

The ophthalmologist in private practice who had at first called my plan of conservative therapy “risky and far-fetched”, was in the end astonished, and ventured to the patient in question that this was a case for scientific publication.

As soon as I heard that, I decided to produce this publication.

November 2001

2.78. Is retinal detachment caused in part by bacteria?

Retinal detachment as a rule caused, in part, by bacteria? Yes! This cause is simply not normally recognized as such and thus not treated accordingly, anywhere in the world!
After reviewing my last 15 cases of surgically-treated amotio (retinal detachment), I came to the compelling conclusion that all 15 amotio patients suffered from at least one chronic systemic bacterial illness, probably Lyme disease.

What is the probable pathomechanism?

1. At first, there are early chronic bacterial systemic infections, which, in everyday language, “pick up speed” and connect with subjective problems such as back pain, knee-joint problems, headaches, cardiac dysrhythmia, urgent bladder, sleep disorders, skin eruptions (sometimes intermittently), paranasal sinus infections, possibly pollen allergies, chronic headaches, in some cases relapsing migraine attacks, oversensitivity to light, stomach problems, abdominal pain, “rheumatism”, tinnitus (humming, ringing, hissing sound in the ear), cold fingers, cold feet, and many other maladies. This also (especially also) if all blood tests thus far have turned up negative, without any clear results.

2. Due to the particular immunological reactivity of the eye, there arise antigen-antibody reactions especially in both the conjunctiva/sclera section (the white of the eye, quite simple for the layman to see in immunopathologically healthy children) and the vitreous body of the eye, with clumping in the vitreous body and possibly retinal tacking and vitreous liquefaction and, in the long run, a pulling/tugging of the retina (the patient experiences occasional flashes), and following motion or blows it could come to retinal tears or holes that can lead to a detached retina which can in turn, if not surgically treated in time, result in total blindness. This bacterial origin is never, or only very rarely, recognized or prophylactically treated in university eye clinics worldwide.

It is my conviction, and has been my repeated experience, that our “planned care” health care system nearly never provides real prophylactic care, but rather waits to perform emergency repairs on organs which are already damaged. Even the most intelligent secretary of health will not be likely to see beyond this – thus, the problem will, in the long run, only get worse in light of a collapsing economy, the shifting of hard-to-finance jobs to other countries, increasingly frequent early retirement, and an ever higher percentage of the elderly in the population.

Conclusion:

A patient with symptoms of impending amotio must by all means receive prophylactic treatment – and in the event of relevant subjective, credible indicators of illness (such as back pain, headache, cardiac dysrhythmia, acute hearing loss, etc.), he should receive long-term antibiotic and immunomodulatory care until his health problems have completely or at least for the most part disappeared. And, as the suspected bacterial agents are usually transmittable from person to person, a similar therapy should also be extended to the patient’s partner.

April 1997
2.79. **Bacterial origin of corneal transplant clouding**

Clouding of corneal transplant, with subsequent secondary glaucoma – caused by bacteria

What is to be done if, following a *corneal transplant* (foreign transplant), even after many months or as long as 2 years the transplant is still edematous, swollen, and cloudy, and a vascularisation seems to be “just around the corner”, including the danger, that the whole transplantation was for nothing. What do you do, in order to make such a cloudy corneal transplant clear again (particularly if a thorough, standard local therapy with steroids, antibiotics, and mydriatics fails), so that the transplant recipient can see clearly again? Should a further corneal transplant be attempted, as was already being considered by the major university eye clinic treating a now 75-year-old patient in this case? Two years after receiving a donated cornea, the transplant was still cloudy (relapsing edemas of the epithelium and cornea, and warning signs of transplant rejection); or should one rather provide longterm oral antibiotic and immunomodulatory therapy, in order to make the cornea clear and functional again? Even 75-year-olds are glad to see clearly, particularly if it can be brought about without further surgery, which would entail higher risks.

Case: A male patient, now 75 years old, who had had poor vision in both eyes since early childhood due to corneal clouding.

As a further complication, this patient suffered under what is known as narrow angle glaucoma, with rapidly rising pressure levels in mydriasis (widening of the pupils), necessitating a bilateral iridectomy in 1984 (an iridectomy is an operation in which holes are made into the peripheral iris, so that intraocular fluid can flow better). That was how his intraocular pressure was regulated at the time. In 1985, he received a corneal transplant for the right eye (after which he then already received repeated long-term oral antibiotic therapy), with a very hesitant tendency towards healing and clearing vision. Later, he developed secondary glaucoma (increased intraocular pressure). Then, early in 1995, he underwent a keratoplasty (corneal transplant from donor) of the left eye, followed later by secondary glaucoma in the left eye as well (increased intraocular pressure up to 45mm Hg, with 10-21mm Hg as the normal range of pressure), in this case traceable to a chronic infectious postoperative condition. After again undergoing long-term oral antibiotic therapy, his eye pressure was successfully reduced to normal levels (between 15 and 20 mm Hg).
At the same time, his previously cloudy corneal transplant displayed a tendency towards clearing under this therapy. Then, the same eye was operated on for cataracts, with an artificial lens implanted in 10/95, and subsequently he experienced near-total corneal transplant clouding. It was not until approximately 2 years after the left-eye corneal transplant, after which he underwent a renewed longterm, 4-month oral antibiotic and immunomodulatory therapy, that he experienced successive corneal clearing with visual ability at 0.4 (40%) in this second, his left eye. In the time that I have known him, the patient has never had better vision. For the patient also this success is a sensation, as he has had poor vision since earliest childhood, due to corneal clouding.

Interestingly, other perceived maladies, such as knee-joint pain, back pain in the cervical and lumbar spine areas, cardiac dysrhythmia (cardiac irregularity), hip pain, and nycturia (compulsive night-time urge to urinate) largely disappeared in the course of this therapy.

Conclusion:

In view of the subjective symptoms of illness as listed above, it must be concluded that the patient described here has had one or more lasting illnesses due to bacterial infestation of the organs and joints mentioned, going on for many years (possibly since his birth); bearing in mind that these bacteria have a tendency to attack the nerve roots (thus, for example, his backaches), joints, tendons, bones and cartilage (therefore hip problems), the cardiac regulation system (impulse-transmitting system based in the autonomous, impulse-giving center; hence his cardiac dysrhythmia), and the kidneys and bladder (cause of his frequent urination) – the same way that Lyme borreliosis bacteria attack; these often go undetected in the blood despite claims to the contrary.

Therefore:

In every case of

1. post-operative increase of intraocular pressure,
2. and particularly every corneal transplant which has not cleared within 2-3 months post-op, in addition to the otherwise standard local therapy, should be treated with long-term (for months) oral (i.e., with tablets) antibiotic and immunomodulatory therapy, above all if such subjective complaints as those listed above are also part of the broader picture (back pain, for example).

In the pathophysiology of this case, one must also assume that illness-inducing bacteria have also infested the corneal transplant, the same as helped cause the perceived problems listed above. Germs may infest the cornea or corneal transplant (bacteria such as Lyme borrelia, for example, have a preference for striking bradytrophic tissues – tissues with a slower metabolism, such as tendons or corneas).

April 1998
2.80. The Chronically Dry Eye

What therapy to employ? The broad standard treatment (also standard for universities), with tear-replacement mixtures (artificial tears), or causal therapy (treating the cause) by applying long-term antibiotics?

When eyes are chronically dry, this comes about, in our opinion, in connection with a chronic or subchronic infection of the paranasal sinuses (frontal sinuses, maxillary sinuses, ethmoid cells, or sphenoidal sinuses).

In the course of this illness, the three anatomically layered mucous membranes of the paranasal sinuses are affected. In the same way, the three layered mucous membranes of the ocular connective tissue fibers, which are in conjunction with the membranes of the paranasal sinuses, are affected as well. Simultaneously, the tear ducts, which lie under the eyelids and produce a watery, oily secretion, are also affected. In the course of such a light continuous infection, lasting for years, the tear ducts press together (they shrink), so that the formation of tear secretion is qualitatively reduced, or even halts completely, as the tear ducts become chronically infected.

As a rule, a long-term, local application of antibiotics will bring about a near complete restitutio ad integrum (healing), even when 50-to-70-year-old patients are involved. A long-term antibiotic therapy requires an application of at least 3 to 6 months.

March 2002

2.81. Progressive scleroderma

Progressive scleroderma: an autoimmune condition (incurable), or a curable illness of bacterial origin?

Definition:

An autoimmune condition of the vascular and connective tissue systems (origin unknown), which can be a part of a progressive systemic sclerosis (systemic = affecting the entire human body; sclerosis = hardening).

According to an individual account, it could develop from a localized form, circumscribed scleroderma. Interestingly, circumscribed scleroderma frequently accompanies Lyme disease (caused by bacteria, most often transmitted by tick bites).
Signs of progressive scleroderma:

Madonna fingers, youthful facial features (skin pulls up taut), plastic induration of the penis, progressive pulmonary fibrosis, Raynaud symptoms, possibly dermatomyositis (part of the spectrum of rheumatism), purse-string mouth, narrowing of the esophagus, acrosclerosis, infected state of the blood vessels, dysfunction of the lungs: coughing, breathlessness, myocardial insufficiency, cardiac dysrhythmia.

Therapy:

Difficult to influence: symptomatically with glucorticoids (anti-inflammatory) and acetylsalicylic acid (improved vascular microcirculation).

The items listed above have been a part of medical knowledge for many years; more recent is the realization from about 10 years ago, that sometimes a circumscribed form of scleroderma manifests itself in connection with Lyme disease; and, considering progressive systemic sclerosis can develop from the circumscribed form, it seems that no one in the medical world has yet drawn the prize-winning conclusion of examining this “auto-immune disease” in search of its true origin and – insofar as caused by bacteria – to search for a definitive cure (through long-term antibiosis).

Case description:

A male patient, now aged 58, has been suffering since 1976 (that is, for 23 years) from what was “academically” diagnosed as an auto-immune disease, progressive scleroderma, which was treated mostly by cortisone; in my capacity as an ophthalmologist, I had suspected low-pressure glaucoma since 1989, diagnosed with certainty in 1993 with paracentrally compromised field of vision.

At this point I would like to point out what, to my knowledge, is the worldwide first published reference to a connection between low-pressure glaucoma and progressive scleroderma (caused by insufficient circulation in the optic nerves, a result of simultaneous general vascular sclerosis; see also my publication concerning low-pressure glaucoma, chapter 2.41).

Consequence:

All patients with this diagnosis should be checked for low-pressure glaucoma (= normal-pressure glaucoma); according to my theory, this illness must lead sooner or later to glaucoma, complete with damaged optic nerves and corresponding reduction of visual field.

And now the extra big surprise: after having successfully convinced the patient of the benefits of a long-term antibiosis and immunotherapy, he now reports that he feels significantly better following this single 70-day round of antibiosis and immunotherapy than he has felt at any
other time in the last 10 years, and that the pain in his knees, thighs, and cervical and lumbar spine, as well as his morning stiffness, cardiac dysrhythmia, and frequent night-time urination are either completely or largely passé. (Indirect proof of an underlying bacterial illness).

Conclusion: It should be recommended to all progressive scleroderma patients that they, like the patient above, undergo such a therapy (even when their health-care plan does not cover the costs); the data listed above point toward a bacterial genesis, which cannot be causally treated by cortisone (which weakens the immune system) or with medicines to sink intraocular pressure, as has been standard practice worldwide, but should rather be treated by long-term antibiosis and immunotherapy.

Disadvantage:

Following recovery, there is a rapid decline in the use of cortisone, further symptom oriented medicines, and prescribed eye-pressure-sinking medicines; the average life expectancy continues to rise, and social security plans sooner reach the point of not being financeable (actually, they are already at that point), and all this despite the ingenious brainstorm

1. namely, of disposing of used mineral oil (that is: disposal of the super-poison dioxin) by incorporating it into chicken feed (as in Belgium), and
2. the simultaneous incorporation of dioxin into the human food chain, with the dubious purpose of shortening life expectancy and thus trimming the social security system which is no longer affordable, proven by, among other things, months of being hushed up by government officials, although these knew the full truth for many months. (It must be clear to any logically-thinking person that months of avoiding to inform the public must lead to the deaths of thousands of people, mostly through the growth of malignant tumors, and this with full impunity).

December 2000

2.82. The cause of gestosis

In search of what causes gestosis, or, what happens if gestosis is not cured after pregnancy?

It is generally accepted that gestosis, or toxemia of pregnancy, is an illness of unknown origin. Occurring during pregnancy, gestosis brings with it (reversible) symptoms in the mother (such as high blood pressure and/or diabetes mellitus, and/or protein in the urine). As a rule, these symptoms return to normal post partum.

It is my understanding, and my postulate, that these occurrences during pregnancy must be of bacterial origin,
1) because the patients, whom I questioned specifically following such cases of gestosis, all suffered from a string of subjective sensitivity disorders (as I see it, indicators of illness), e.g., dizziness, migraines, headaches, backaches, urgent bladder, cardiac dysrhythmia, knee problems, ankle problems, “heel spur” feeling, humming sounds (or hissing or ringing) in the ears, eczema, blurred vision, etc. All of these “subjective sensitivity disorders” are, in my view, compatible with illnesses of bacterial origin.

2) Also, it caught my particular interest that these patients, when treated long-term with antibiotic, immunostimulating, and immunomodulating therapy, lost on average 95% of their supposed “subjective sensitivity disorders”, which I see as a clear indication of underlying bacterial illnesses (perhaps also with viral overlappings). Naturally, I can’t prove this in any strictly scientific sense; I’m just a small-time ophthalmologist in private practice, who deals day in, day out with the fundamental care of patients (in 19 years, I’ve never missed a day due to illness); I’m no government official or employee in public or parapublic service with a fully-financed contract for university research, or for research at some other institute subsidized by public funds.

3) Hence, to me the logical conclusion is: this illness of thus far unknown origin must, in light of the “sensitivity disorders”, have a bacterial background/origin, and must receive immunostimulatory and antibiotic therapy, particularly post partum. Due to the infamous ping-pong affect, simultaneous treatment of the patient’s sexual partner is imperative.
   a) In part, in consideration of subsequent pregnancy, so that it might run its course free of gestosis.
   b) Also, so that the gestosis patient does not, years later, suffer from a bacterial illness triggering heart failure or a stroke.

Günzburg, April 2000

2.83. Long-term antibiosis in connection with corneal laser correction

Why to combine long-term antibiosis with corneal laser treatment for the correction of short-sightedness

Why is laser-refractive surgery, particularly PRK (photo-ablative refractive keratectomy) followed, in about 30% of all cases, with central corneal haze lasting up to half a year? Why should this method not be recommended specifically for those who also suffer from rheumatism or allergies?
My postulate:

administer substantial amounts of antibiotics; and if you have read the above text concerning corneal transplants (see chapter 2.79), you will understand why I assume in this context (especially concerning rheumatism), and concerning most other allergies, that there is a chronic bacterial condition of the bradytrophic corneal tissue involved.

In sum:

My postulate: in case of corneal clouding and problems with corneal infection – especially following refractive laser treatment – administer long-term antibiotic and immunostimulating therapies to help insure success and in order to clear up hazy corneal clouding.

This is not presently known to ophthalmology, yet it would significantly lessen the length of recovery time and therapy.

July 1999

2.84. The globalization and ”pensionization” trap

Germany in the snare of 1. Globalization, and 2. Pensionization

The most basic reasons for our continued and pre-programmed downfall are the key reasons listed above; read on for further details.

Regarding Point No. 1:

Anyone can grasp that, if our average cost of labor (including additional wage costs) amounts to app. DM 48.00 per hour, whereas the average cost of labor in a place like Chile (not to mention India or China) only adds up to about 3 % as much, namely DM 1.60 per hour, then every business with a worldwide view will note it with interest, and, in order to survive (not just maximize profits) in light of competition, must have an interest in transferring as much of his labor and administration costs as possible to other countries where these services are cheaper. Over the years, this will lead to wage adjustments which, due to the population balance, will eventually settle around DM 7.00 per hour rather than DM 14.00 per hour. With German wage levels sinking (whether due to the devaluation of the German Mark or Euro, or because of nominally reduced wages per hour in Germany), this would mean that real estate prices would drop and perhaps not settle until they reach a standstill at 30 50% of current prices. Similarly, real estate prices in the lower-wage countries could quadruple or more in view of wage increases; in this scenario, the world’s “financial blood”, its liquid cash, will flow there to where higher
returns can be expected, thus bringing “financial transfusions” here at home more and more to a halt.

Attempts to stabilize the world’s currencies – tendencies towards fulfilling the Euro-Maastricht criteria (or to fulfill current German Federal Bank criteria) will not only reinforce the tendencies listed above, they will amplify them.

Regarding Point No. 2:

Germany’s judicially built-in snare, its leaning first towards granting the status of civil servant, and then towards sending its workers off into state-run pensions and retirement plans, lends a TURBO-spin to the above problematics.

In Germany, there is an exceptionally high percentage of civil servants and of those in quasi-public service (which percentage is exceptionally “performance oriented”, as the whole of the former Eastern bloc has clearly demonstrated for us – and this is merely a mildly oblique description of the cumbersomeness and non performance orientation of the public sector).

Having once attained civil servant status, I also would no longer strive to achieve, not unless the sword of Damocles – in form of bankruptcy – were continuously hanging over me, would I be on the constant search for new approaches (and then, day and night); I would not work myself to the fatal limit for the good of the people, nor have any concerns for my own financial survival. Rather, I would be able to lean back on my pension-pillow – on average by German standards, at age 52. But as it is, at age 55, I have been working at my present job for more than 15 years, with no absences for sickness, working by day, night, and on weekends, without time off in lieu, little chance of being sent off to the health spas or other health-promoting programs, for four years straight without vacation (for reasons of office renovation or the like), and for the rest of my life I have no other perspective. I feel like our social security and tax systems are wringing me out, sucking me dry, and all this in the pseudo-name of social justice; in the future I can plan, according to my practitioner’s budget, to gross app. DM 30.00 for a standard-care patient per quarter annum, and for every second visit by the same patient an additional DM 5.00; no skilled laborer would flinch a rear muscle for that amount of gross intake, and would certainly not take it with a smile. Why, then, should German intellectual and physical power (the performance elite) stay here any longer?

In light of an average retirement age of 56, how can we make good on guaranteed pensions and retirement plans, if not by further increasing government debt (which must, of course, be reimbursed), and by increasing additional wage costs, and this in conjunction with higher life-expectancy rates (which have not decreased even with the help of AIDS and BSE) and lower birth rates?

Just take a look at the roughly drafted approximate graph of German life expectancy for now, and for five years from now.

February 1997
The sensational medical revolution on the brink of the 21st century

The Stand in 1997

100 years

Around 25 to 35% of these unemployed, "deadbeats and hypos", welfare recipients, immigrants, sanatorium patients, etc.; also make-work program participants (whose work is to paint the Black Forest alternately blue or green)

56 years average German age (not life expectancy) and coincidentally also the retirement age

22 years Average work entry age

Stand in 2002 (5 years later)

100 years

Average German age (not life expectancy), (risen in the meantime by 2.3 years)

58.3 years Still the average retirement age (maintained only by sweating blood)

56 years

22 years Average work-entry age

Around 28-34% here are unemployed, "deadbeats and hypos", etc.; this number has increased in the meantime due to the loss of jobs to cheaper locations abroad. That is, jobs which were cut by those who were not willing or able to tolerate/suffer a higher degree of personal financial blood-letting. And if there is still anyone who can claim that our system is on the right path, our pensions are guaranteed and are just for the social and antisocial alike — well, may that person be the recipient of the Nobel Prize for Hogwash.
2.85. Is cancer risk increased by unprotected promiscuous behavior?

According to the 15 June 2001 edition of the American Journal of Epidemiology, a man’s risk of developing prostate cancer doubles if he has had unprotected sex with more than 30 women over the course of his lifetime (according to a study by the University of Illinois).

Probable correlation: Germs are transmitted through sexual contact, and are the cause of chronic bacterial or viral infections and – in my view – are also the main cause of cancer. (In some cases, a one-time contact with a “heavily loaded” bacterial carrier is enough.)

In this context, I am reminded of a papal statement made several years ago. The story was spread that the pope had claimed, in essence:

Having intermittent sexual contacts increases a woman’s risk of getting uterine cancer.

This greatly displeased the Italian association of gynecologists. In its essence, however, I believe this papal statement was correct.

July 2001

2.86. History of an illness with no antibiotic therapy

Glimpses into the history of an illness

At the age of 45, a female patient began to suffer from painful joint problems; I had a lengthy conversation with her, recommending long-term antibiosis together with immunotherapy – unfortunately, in vain.

What followed then was her first hip surgery with the implantation of a hip prosthesis; this required replacing one year later. Still another year later, the second hip joint received an implanted prothesis; then, the patient’s husband chose a younger partner and opted for divorce.

Years later, the artificial-hip patient had a new partner, and as the bacteria (which are easily transmitted from person to person) are still able to wreak havoc, this new partner developed a pronounced case of muscular rheumatism (from my standpoint: caused by bacteria, i.e., the same bacteria which had caused the above female patient hip-joint infections followed by surgery for artificial hip implantation).

This male rheumatism patient found it necessary to retire early, aged 52.

Further, the female patient now needs carpal-tunnel surgery (in the wrist); as I see it, this also is part of a chronic bacterial process, one which led to a hip-joint infection in the above female patient. At that time – unfortunately, in my opinion – no causal (origin-oriented) treatment was undertaken.

July 2001
2.87. Is Ménière’s disease caused by bacteria?

A 41-year-old female patient had been suffering for 5 years under increasing attacks of dizziness and visual difficulties, due to Ménière’s disease (according to the dictionary: attacks of rotatory vertigo in connection with some inner-ear maladies, together with nausea, ringing of the ears, and ocular tremors). She had already been on sick-leave for more than five months at a stretch. Retirement at age 41 was not out of the question. In this situation, the patient grasped at every sliver of hope. We attempted a long-term therapy of antibiotics (with alternating antibiotics; at some points, three at a time) and immunostimulation, immunomodulation, and circulation boosting therapy. Her antibiotic therapy lasted for a bit more than 4 months. After initiating antibiotic therapy, and after completion of overall therapy – over nine months have passed thus far – the patient has not had any relapse; that is, no more attacks of Ménière’s disease. She is once again integrated into the work process.

September 2001

No deterioration as of January 2002

2.88. Painful jaw closure (lockjaw)

Should painful closure of the jaw (while chewing) be treated causally, or symptomatically and at higher cost through extensive orthodontic adjustments (planing the teeth and placing crowns)?

Case:

A female patient, then aged 44 years, underwent long-term antibiotic, immunomodulating, and immunostimulating therapy due to back pain in the cervical and lumbar spine areas, knee-joint problems, headache, urgent bladder, cold fingers and feet, and especially due to pain in closing her jaw on the left side. Her therapy lasted more than six months.

Nine years later, this patient is doing very well, and she no longer suffers from any of the problems listed above.

The crystal clear conclusion in this case is that, certainly where extensive, expensive orthodontic work looms ahead (particularly in the course of which also healthy teeth are to be planed and crown-covered), one must first query about causal bacterial conditions, which can be manifested in the form of back pain, knee-joint problems, cold fingers, cold feet, etc., and especially in such a case, one must strive for long-term antibiotic (multiple antibiotics) causal treatment.
And this, completely independently of those much-cited lab findings; we are, after all, not laboratory rats.

October 2001

2.89. How should we treat psychiatric illnesses?

Symptomatic therapy with **psychotropic drugs**, or causal therapy of the underlying bacterial infections?

A female patient had been suffering since 1997 from back pain, knee-joint problems, migraine pain, nycturia (night-time urgent bladder), morning stiffness of the hands, cardiac dysrhythmia since 1991; since 1999, her entire body had burned like fire.

After laboratory tests for Lyme disease seemed to turn up negative, the patient was given **psychotropic drugs**. She had the feeling of constantly being in a fog; observers described her as seeming to be under “remote control”.

Following a lengthy telephone conversation with the specialist for neurology and psychiatry who was handling the case, in which we discussed the problem that Lyme disease is not easy to prove by lab tests, my relationship to that specialist was left on very wobbly terms.

The patient underwent long-term (1½ year) antibiotic, immunomodulatory, and immunostimulating therapy under my care, by the end of which time she was doing extraordinarily much better. For 2 years now, she has been able to get along without any psychopharmaceuticals, she is largely free of medical complaints, and considers herself healed.

Of particular interest in connection with this subject are the research findings of Professor Bechter, according to which approximately 70 % of all psychiatric patients test positive for echoviruses (transmittable through mice, rats, and cats.)

As I see it, the following correlation is of the greatest, most **fundamental importance**: viruses are precursors of bacterial superinfections, and these bacterial superinfections can be treated by **antibiotics**, even if viruses often do not respond directly to medication.

This allows us to dissociate ourselves in the future from the **therapeutic nihilism** which has been practiced to date, e.g., if we couldn’t combat echoviruses directly by means of orthodox medicine, we thus far have resorted to a symptomatic therapy, placing the patients in a “fog”, at times suppressing the central nervous system with psychotropic drug therapy, although Luc Montagnier’s proposition applies adequately here: if the bacterial superinfection is defeated, the echoviruses lose their power. In consequence: psychiatric patients would be healed in 70 % of the cases. Who cares about this therapeutic bombshell?

November 2001
2.90. Should depression call for stationary treatment?

Why should depression receive stationary psychiatric care – particularly if bacterial illnesses are at the root of it?

Case:

A 63-year-old female patient had already undergone stationary psychiatric treatment, first for 2 weeks, then 4 weeks, then 10 weeks, in vain. Because it was suspected that she had neuroborreliosis and thyroiditis, her general practitioner had given her a 20-day treatment with Rocephin (intravenous antibiotic). This antibiotic treatment was apparently not long enough, and was not given in conjunction with supportive medicines (such as vitamins, trace elements, etc.; such supportive medicines are not covered by standard health care programs).

After undergoing a year-long antibiotic, immunostimulating, and immunomodulating therapy, the patient was again doing quite well. Her depressions had simply vanished, no more nycturia, no more knee-joint problems or backache, no more fatigue, no more feeling bloated, no stomach pain or headache, no more sciatic pain and no more heel spur. Even the swelling in her feet was gone, and plans for a cardiac catheterization examination could be abandoned.

Now, the patient’s only problem was her frustration, that her insurance was unwilling to pay for the relatively expensive antibiotic medication, whereas it would have paid for expensive stationary psychiatric treatment and other forms of therapy such as cardiac catheterization (at a cost of 2000 to 4000 DM).

November 2001

2.91. Is cervical cancer avoidable?

Carcinogenic alterations develop, in my view and that of many of my fellow physicians as well (also, that of the Roman Catholic pope), essentially from chronic infections (possibly through bacteria or viruses which are sexually transmitted); for instance, it is now considered a proven fact that HPV (human papilloma virus) is the main cause of cervical cancer in women.

In order to prevent this type of cancer from thriving, each year millions of woman are painstakingly given a preventive gynecological cancer examination.

If the visual and cytological (cell) cervical findings are suspicious (leukoplakia), hundreds of thousands of women are made nervous and sent to undergo more rigorous testing. In the course of such a viral cervical membrane condition, normally a bacterial superinfection occurs, and thus (as viruses are precursors of bacterial superinfections) the actual genesis of this chronic infection reaction (with a whitish surface).

I wondered, regarding a 35-year-old patient with just such a condition of the cervical membrane, whether this condition might not be reversible. And so it was; after long-term
antibiosis and a suitable immunotherapy, the irregularities disappeared; repeated later examinations were still negative after a 10-year observation period.

Hence:

When cervical examination results show irregularities, before undertaking a conization or even more invasive cancer surgery, these patients should receive long-term antibiotic and immunostimulating therapy; this, however, does not really seem to be desired, with medical coverage not extending to cover this simple and elegant therapy.

December 2001

2.92. Modern offices present the greatest risk of infection

Air-conditioning systems are breeding grounds for bacteria

According to an extensive study, many germs now live in air-conditioning and ventilation systems and can be spread by means of these systems’ circulating air. In a computer simulation, American scientists placed a tuberculosis patient on the ground floor of a large office building.

The air-conditioning unit, which conformed to manufacturing norms, had spread so many germs after eight hours that by then a person on the tenth floor stood a 33% chance of contracting tuberculosis.

Only regular cleaning and maintenance, but above all the use of high-quality filters, can prevent having such units turn into germ and virus-flinging machines.

This is further proof of what difficult, modern conditions we live in, and how important the use of antibiotics is in tackling today’s problems.

April 2002

2.93. Blindness or long-term antibiotic use?

According to the medical journal “Ärztliche Praxis” in its edition from 19 March 2002, it appears that river blindness (source of blindness for c. 24 million people worldwide) is caused by bacteria. For decades, specialists for tropical illnesses have suspected that threadworms and their larvae cause river blindness (onchocerciasis). Researchers now believe that recent findings indicate that bacteria enter the body together with the threadworm, and these bacteria are the true villains that cause river blindness. Identified by scientists as Wolbachia, these bacteria can be successfully countered by using the widespread and inexpensive antibiotic doxycycline (a liver toxin).
Before anybody starts in with the usual “just don’t take any antibiotics “ nonsense, let him offer instead to financially support these estimated 24 million worldwide, so that these poor victims can meet their own most basic needs. As it is, these victims are dependent upon the younger, future victims – their children (this is the case in major segments of Africa), to lead the adults with their canes to the rice fields every morning, where they, the blind, work the land by laboriously groping along ropes to find their way around, to be led home again in the evenings by those young people who still have sight.

April 2002

2.94. Can antibiotic use prevent the development of esophageal carcinoma?

According to a report in the “Ärztliche Praxis” no. 88, from 1 November 2002, there is an increased occurrence of esophageal carcinoma formation following a wart virus infection (human papilloma virus, high-risk strains HPV 16 and 18) due to the wart virus. Hence, an attack of these viruses possibly increases one’s risk of getting esophageal cancer (see J. Med. Virol. 68 [2002], 412-416).

Researchers at the University of Shantou in China believe that this is the case at least for the province of Guangdong, where this form of cancer frequently occurs.

The researchers stated that the incidence of the virus’s high-risk strains (HPV 16 and 18) correlates particularly with this carcinoma tissue. Thus they conclude that the human papilloma virus is one of the most significant risk factors worldwide for esophageal cancer.

To me, the logical, compelling consequence of this is to give continuous antibiotic treatment to HPV-infected patients, and especially to give long-term antibiotics, immunomodulators, and immunostimulants to patients who have already contracted esophageal cancer, in order to

1. possibly achieve a cure, or
2. at least to improve and possibly to extend the patient’s remaining time.

One thing, however, is indisputable: that every viral infection leads into a bacterial superinfection (this **viral** infection, according to bacteriological common knowledge, should be treated by antibiotics). And it is not true, as so many pseudomedical “blabbers” repeatedly claim, that sniffles, for example, is simply a viral infection, against which antibiotics are supposedly useless, thus no antibiotics are used; rather, the case here is the same anywhere in the body – that viruses are forerunners of bacterial superinfections (and of further illnesses, especially cancer), and as these viruses are injurious to the endothelium and epithelium, in the course of a viral illness a prolific bacterial condition always arises which requires antibiotic treatment.

November 2002
2.95. BSE epidemic - grossly underestimated

Another advantage of long-term antibiosis

According to a report in the medical journal “Ärztliche Praxis” no. 88, from 1 November 2002, the BSE (mad cow’s disease) epidemic has been grossly underestimated. It claims that between 1980 and 1990, 1.9 million British cattle, as opposed to the previously estimated one million, were infected with BSE.

This is according to research at the Imperial College in London. In following with their data, 1.6 million of these infected animals made it into the food chain. The illness only becomes apparent much later than the infection itself, possibly after 25-30 years, and its human form is generally mistaken in the elderly for Alzheimer’s disease. On the other hand, another article from the “Ärztliche Praxis” (from 13 August 2002) reports that these BSE cattle prions (the cause of BSE) can be halted through the long-term use of tetracyclines (antibiotics). Thus, it becomes quite clear what a good and preventive effect the long-term use of antibiotics could have regarding an outbreak of a BSE epidemic.

It should by no means be left unsaid that a good many renowned researchers, such as the famous neurologist Prof. Kornhuber, are of the opinion that Alzheimer’s disease is of bacterial origin and should be treated by antibiotics. I agree with the professor completely.

November 2002

2.96. How should we treat endometriosis?

Should one go along with the suppositions of classical orthodox medicine, and rely on the “hormonal scalpel”, or use long-term antibiotics and immunostimulants?

A report carried by the newspaper “Welt am Sonntag” on 29 September 2002, which refers in turn to a report by doctors at the George Washington University, claims that one out of ten women of child-bearing age suffers from endometriosis. This is a condition in which, we’re told, cells of the uterine membrane resettle in the wrong places, such as in the peritonium, the bladder, the ovaries and the fallopian tubes, causing great pain.

The above-mentioned doctors believe to have determined that those women affected by endometriosis suffer significantly more often than others from so-called “auto-immune conditions”, such as allergies, asthma, hypothyroidism, fibromyalgia (to me: “post-Lyme-disease syndrome”), or chronic fatigue syndrome. The researchers did not determine whether endometriosis facilitates the development of these other conditions, or is rather a consequence of them.
I am convinced that endometriosis is a result of the above-named conditions, and of one illness in particular – namely Lyme disease. Thus, it should be successfully treatable by long-term antibiosis and immunotherapy, as I have observed in one case.

September 2002

2.97. Tarsal tunnel syndrome

(Compression of the tibia nerve (a foot nerve))

An article in the medical journal “Ärztliche Praxis” no. 88, dated 1 November 2002, reports that tarsal tunnel syndrome (of the foot), analogous with carpal tunnel syndrome (of the hand), is not caused by trauma, but is very probably of bacterial origin, particularly Lyme borreliia.

Several researchers have already shown that carpal tunnel syndrome (of the hand) frequently coincides with systemic Lyme borreliosis. This seems to be the case with tarsal tunnel syndrome as well.

After questioning many people, I came to the conclusion that this must be the actual cause, and I believe that a high percentage of patients who have acute foot pain, and whose anamnesis does not allude to accident or trauma, are suffering from tarsal tunnel syndrome (nerve entrapment syndrome) and should therefore not be operated on (and should certainly not be treated locally by cortisone injection), but should rather be treated over a long stretch with antibiotics (as the condition is caused by bacteria, as a rule).

November 2002

2.98. Recommended therapy for a female patient

In accordance with this day’s thorough examination and very detailed anamnesis, the following pattern of illness has emerged:

1. Chronic episcleritis with an underlying bacterial infection,
2. Dry eye,
3. Early senile macular degeneration (resulting from circulatory problems of the lesser vessels),
4. Bacterially-generated asthma, sinopulmonary syndrome, and tinnitus,
5. A condition of the lumbar and cervical spine, with chronic neuroradiculitis and lumbar stenosis (and fibromyalgia already diagnosed) due to persistent borreliosis, cystitis, arthritis, attacks of cardiac dysrhythmia, and Raynaud symptoms due to circulatory disorders of bacterial origin.
Due to these findings and diagnoses, it is of the utmost importance, also (particularly) in hopes of avoiding blindness, to prescribe a therapy of long-term antibiotics, immunostimulants, immunomodulants, and detoxification, and additionally to use vitamins (in addition to those in regular food intake) and maintain a strict diet.

May 2003

2.99. The nonsense about ALLERGIES being caused by too much cleanliness

As reported in the medical journal “Ärztliche Praxis” no. 76, dated 20 September, pigeons are suspected of being an allergy source of heretofore unknown proportions. The report claims that as many as ten percent of pigeon breeders suffer from asthma-like allergic alveolitis (“bird-fancier’s lung”).

It is my conviction that this is primarily caused by a typical form of chlamydia infection, in particular one which can be transmitted by pigeons.

This chlamydia infection appears to me to be the most logical explanation for the rapid increase of asthma attacks in former East Germany after 1990. Before the fall of the Berlin wall, films from the West (with open-mouth kissing and free love) were disdained. Following reunification, this changed drastically for the large, nongoverning lower class of society. In my view, this is the essential cause of the drastic rise of asthma cases in the bulk of the “East German” population. This is despite the fact that former-East-Germany’s air pollution related to driving Trabant cars or from factory smoke has been reduced following reunification.

This, in turn, is another good argument for long-term antibiosis, which is the only causal therapy (anti-chlamydia, and thus anti-allergic), as opposed to the long-term cortisone treatment propagated by some.

September 2002

2.100. Prostate cancer: Is the scalpel more effective than patience?

A study conducted by Swedish neurologists, involving around 700 patients, has led to the following conclusion: out of a group of 695 recently-diagnosed prostate carcinoma patients, one part of the group was merely subjected to observation, while the rest of the group received prostatectomies (the prostate was removed).

Over the course of the following 6.2 years, 53 patients from the operation group died, compared with 62 deaths in the comparison group. This, however, does not consider the fact that those in the operation group very likely received high doses of antibiotics, probably for 3-6 weeks, and again whenever they suffered relapses, as 80% of those operated on suffer from impotence, infections, and incontinence. As I see it, this oversight is decisive, and renders the study highly misleading. These post-operative problems are, as a rule, treated with antibiotics, even in orthodox medicine. Such problems only arose among 45 % of those not operated on.
This means that those who did not receive prostatectomies retained a significantly higher quality of life for the remainder of their lives.

However, since long-term antibiosis, or else repetitive use of antibiotics, leads to a longer life expectancy, as the French health-care system demonstrates (with its 300% higher usage of antibiotics per capita), one can scarcely conclude that those in the operation group had any advantage over those not operated on. On the contrary, as the results differ only minimally, it seems rather that, if the group of those not operated on had received antibiotic treatment similar to that of the operation group – long-term and repeatedly – then those not operated on would probably have had a decisively higher survival rate than that of the operation group.

October 2002

2.101. Postmenopausal estrogen

Why should postmenopausal women here still receive estrogen supplements, given that these women have a higher risk of stroke?

As reported in the medical journal “Ärztliche Praxis” no. 23, from 19 March 2004, another research program in the US concerning the use of estrogen for postmenopausal women had to be abandoned prematurely. This is because the test subjects were subjected to a higher stroke risk, according to the National Institute of Health (NIH). Further, the NIH claimed that hormone therapy does not provide any protection against heart problems.

Word of this does not seem to be getting out in Germany; here, postmenopausal women are still being treated with estrogen.

April 2004

2.102. Can intelligence be fostered by long-term antibiosis in the childhood years?

According to an article in „Ärztliche Praxis“ in its 15 June 2004 edition, a British study claims that children who have had pneumococcal meningitis are four times more likely to have an IQ of less than 85, and are seven times more likely to visit special-education schools than children from a control group. The farther back a case of pneumococcal meningitis was, the more pronounced was the reduction in intelligence. Furthermore, ten percent of kids who had had meningitis were deaf, compared with just one percent in the control group.

These children were riddled with bacteria and did not receive suitable antibiotics in time or in an adequate amount. When strong antibiotic therapy is not given promptly to treat meningitis, this can lead to a lowered IQ; in fact, the probability is quite high, particularly in case of chronicity (my own remark).

In long-term antibiotic therapy, the bacterial burden is reduced in general, not only in the cerebral area (the calvaria, which is closed to the outside, is not a “splendid British isolation island”, but rather is connected to the rest of the body through the circulatory system).
How is it on hog farms, where 98% of the animals constantly receive antimicrobial (antibiotic) substances? The result: after only seven months, these animals are ready for the meat market. Normally, nearly twice as much time would be necessary. And meat from these not-so-fat animals still remains tasty. Just as their muscle tissue remains visibly high-quality, so does their brain tissue as well (despite their coming from a “despicable” animal breeding environment).

I observed a similar situation in the case of a close acquaintance whose children received repeated long-term antibiotic treatments. These children are now highly intelligent, although this would not otherwise have been expected under “evolutionary” aspects.

October 2004

2.103. How do so-called university scientists work?

As they see it, an open FORAMEN OVALE (an open hole in the heart wall between the right and left ventricles) is responsible for many migraine attacks. According to the findings of this advanced-medieval study, the frequency of migraine attacks sank by an average of 54-62% after a surgical closure of the heart-wall hole (Neurology 62 [2004] 1399-1401).

This is according to a report in the journal “Ärztliche Praxis” no. 51, dated 25 June 2004.

It seems we are supposed to draw the following conclusion:
Migraine attacks => check for an open foramen ovale => open up the rib cage and surgically close the hole in the heart wall (which is itself possibly of no circulatory consequence).

What a massive undertaking!!!

One must consider that, as a rule, antibiotics are used after such major surgery to assist the healing process! And this is the decisive reason why migraine attacks generally retreat after such a massive operation. But if the goal is for the leaky medical-care ship to sink to a watery grave, then I “recommend” to go ahead with major operations followed by subsequent antibiotic use. It would be much too economical, too easy on the budget if one were to avoid major surgery, and to provide causal, long-term antibiotic treatment instead.

This, of course, would interfere with business.

September 2004

2.104. Typical letter from a borreliosis patient in search of help:

Dear Dr. Hellenthal,

while looking for help for my health problems, I found your publications in the internet. From them I conclude that you have experience with many types of illnesses, and I want to ask if I might turn to you with my medical problems, as no one has been able to help me thus far.
I was born in 1955, have two grown children, and have been a widow for two years. I am employed. No history of serious illness, no operations; I was always full of energy and ideas. I used to be able to fall asleep quickly and sleep well. I neither smoke nor drink alcohol.

In March 2004, I had a bladder infection. Since I thought at first that it would go away by itself, it wasn’t until 3 weeks later that I went to my doctor. There, I was given a prescription for Filin, and my bladder problems went away after 3 days. What remained were my feelings of weakness, tingling feet and hands, a burning sensation of the skin, sleeping problems, and I see small print either double or blurred, only able to discern part of it if I concentrate very hard. At first I perspired during the nights, then I started to feel very cold. So I went back to my doctor, and told her all of these things, but blood and urine tests came back negative. I felt like I could not go on this way. She prescribed first rudotel (an antibiotic), and later insidone (a psychotropic drug). Six weeks later, she prescribed ciprofloxacin at 750mg., 1 per day for 10 days, without success.

Since none of this helped, I went to see different doctors. The gynecologist found nothing, the dermatologist ran all kinds of allergy tests, without finding anything. I also took an HIV test, which came back negative. I visited an internist, but she also found nothing. The end of the road was a referral to a neurologist. After searching for weeks to find a neurologist who accepted new patients, I got an appointment which lasted for ten minutes. He “could tell at first glance that I no longer had any purpose and that I was also afraid of growing old”. I was given a prescription for two tranquilizers. Then I was to receive further, psychological help. There, over three visits, I told the doctor what problems I am aware of, but his opinion was – without as much as touching my cold skin – that I should tell myself that I am on the beach in Greece, lying in the sun, and then I would be nice and warm. We went on to deal with childhood issues. After that, he saw no need for further sessions.

All of this started with that bladder infection. I don’t know if it was caused by bacteria, fungus, or viruses, but something is in my body and it is robbing me of my energy. My skin is pale and feels cold, although I always had a healthy teint and tended rather to perspire. My arms and legs have serious muscle loss, although I go through the same routines as before. I have lost 5 kilograms in this year. My doctors say I need more exercise, but really I’m getting enough now, taking care of my house and a yard of 3000 sq. meters.

Although I have learned autogenic training and know how to use it well, it just isn’t enough right now to tell myself “I am totally relaxed….”. Before my illness, this was already enough to get me to fall asleep, and although I have my house and garden to care for and also work full-time, I can’t sleep anymore. Falling asleep is not such a problem, but after no more than 3 hours I wake up and can’t fall back to sleep.

Add to this the feelings of burning skin and coldness, especially on the knees, thighs, elbows, arms, nose, and the entire face. For three months now, I have been losing hair. Showering and washing my hair have become unpleasant. I don’t feel well at all, and always feel cold. Even in the summer I needed socks, a jacket, and sometimes a heating pad to be able to sleep. My throat feels as if everything is inflamed, I am very sensitive to smells, every scent is unpleasant and causes my nose and throat to burn all the way down to my stomach. Last week, a murmuring sound began in my left ear.

Three weeks ago, I got a cold and again a bladder infection, which was treated with 250 mg. of ciprofloxacin for 10 days. Afterwards, I developed a red spot of about 8 centimeters on my left upper arm, itchy and hot, with a light fever. My doctor said it looked like it could be a tick bite. This was treated for ten days with 100 mg. of doxyhexal (antibiotic) once a day, which also
helped my infection; a bluish spot remained. While receiving this treatment, the burning sensation on my skin improved somewhat. The feeling of constant coldness remains.

My doctor thinks that I should boost my immune system with zinc, and otherwise we should just wait and see what I seem to be developing and what becomes of it. I am taking vitamin B supplements.

But this cold skin, particularly around the knees and on my face, scares me and I can’t just wait and see; I feel too poorly for that. I really don’t know what to do now, and I hope that you might have some way to help me

I would be glad to get an appointment with you.

Sincerely,

R. Å.

30 November 2004

2.105. Eczema

As reported by a man now aged 90 years, aged 77 at the time of illness.

I had been suffering for seventeen years from a growth on the glans (penis). Because of the problem, I went to 10 different doctors, including 8 dermatologists and a university clinic. Nothing helped at all.

Then, I went to Dr. Hellenthal, where I was given long-term immunostimulating and immunomodulating therapy, including antibiotic treatment. For 13 years now, I have had no more penile eczema.

May 2005
Chapter 3: Cancer and Tumour therapy

3.1. Concerning Medicine’s best-kept Secret

According to Dr. Pekar:

In a rough estimate, around 300 types of tumours are known to medicine. But each individual tumour has a characteristic antigen (illness-inducing cause). As for therapy, this means that each requires its own treatment protocol. An impossible goal, were it to be attempted.

But all tumours have a vulnerable spot, an Achilles’ heel, so to speak; that is their unexploited electric potential and their polarity reversal which plays a significant role in their camouflage ability.

No matter what type of tumour, it’s enough to use a bio-electric direct current (Bio-Electrotherapy) to increase its potential. This changes its cell metabolism, removing its camouflage, and the immune system recognizes it immediately as “not self”, setting into motion a swarm of defence mechanisms. Result: the cancerous situation heals itself. And this is medicine’s best-kept secret. It would mean a revolution in re-thinking the course and the results of the disease, but also a certain narrowing of the business side.

Cancer is no mystery. Its living microbiological source is given to us as a sort of inheritance before we’re even born. If and when a tumour develops is dependent upon a person’s constitution and his lifestyle – so-called hereditary factors, such as the frequent occurrence of breast cancer among relatives, make a rare exception. We see that cancer is a biodynamic process. Regrettably, the medical establishment keeps the patient in the dark about tumours – that his tumour is not itself cancer, nor the beginning of cancer, but rather the last stage after many years of silent illness (cryptogenic, chronic infection undermining the body’s defenses). Hence, even when a surgeon removes a tumor with the utmost skill, he leaves the source of the illness behind, which will sooner or later strike again. The patient who receives such treatment does not know that he is only seemingly cured, and that he is still afflicted with cancer.

For the world of medicine, a biological microscopic factor (promoter) is taboo – and hence remains a mystery, receiving only symptomatic treatment. This is, at present, the protocol for treating cancer – for now and evermore, amen.
See literary sources: “Die perkutane Bio-Elektrotherapie bei Tumoren” (“Percutaneous Bio-Electrotherapy for Tumors”), and “Krebs – die biologische und medizinische Tragödie” (Cancer – the Biological and Medical Tragedy)

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October 2003

Comments:

An article in the medical journal “Ärztliche Praxis” in its 22 February 2005 edition reports that cancer patients have an increased risk factor of 6.7 for venous thromboembolism.

My commentary on the above:

Yet this does not mean that cancer causes thromboembolism. Quite the contrary; cancer is caused by chronic infections, which are in turn caused by the patient’s being chronically attacked by bacteria, viruses, and especially by single-celled organisms. In every cancerous growth, hundreds of thousands of single-celled organisms can be found, which are the source of that cancer.

This means:

Cancer – and this is the only scenario that makes sense – is preventable through combating these chronic infections; that is, through long-term antibiosis, auto-immune vaccines, strengthening the immune system, etc.

February 2005
Chapter 4: Patient reports

4.1. Stomach surgery - all for nothing?

The following is a letter from a very satisfied patient:

Dear Dr. Hellenthal,

I, a retiree, was “strolling” through the internet when I suddenly noticed your homepage and your “A New Perspective Concerning Infections and their Proper Treatment”, which reminded me of the stomach problems I had from 1985 to 1990, and the cases of paranasal sinusitis I’ve had in recent years.

Case study no. 1:

Frequent stomach pains, eructation, irregularity, acid and acid indigestion, all of which suddenly disappeared when I took antibiotics for colds with infections. My improved condition would last for about 2 weeks, then return to the same old maladies. My doctors took note of the situation, but simply said, “Then your intestinal flora changed, that’s all!” In 1990, I required a gastrectomy due to non- Hodgkin’s lymphoma. If they had dealt with my earlier helicobacter with a longer use of antibiotics, I would probably still have my stomach. But they didn’t believe that at the time, because “stomach acid kills off bacteria”….

Case study 2:

I woke up one morning with a serious case of paranasal sinusitis, and noticed that, with my eyes closed, I saw large, light spots that didn’t go away. I could see by daylight, albeit with somewhat shadowy vision. As soon as there was much darkness, I was unable to look straight at
my own clock and tell the time; I had to take a sideways glance to see it. After five days of taking antibiotics, these visual phenomena had improved considerably, and the spots I had seen in the mornings were gone completely. My doctors said they “can’t imagine why this should be”. Then I was diagnosed as being in the early stages of **macular degeneration**. Now, I am convinced that this resulted from the sinus problems I’ve had in recent years, which were probably never completely healed after five days of antibiotics.

I am glad that you are dealing with such cases, and are looking among your peers for others to join actively in this work. Surely, much can still be changed in this area. At any rate I’m glad that, for the first time, I can see a logical new system that can bring about real, genuine healing rather than fostering medication resistance.

Keep up the good work!
Sincerely,

H. B.

May 2004

### 4.2. Heydi Castillo: Epilepsy

When I was 10 years old I was diagnosed with the disease of epilepsy. That’s when for me a life with medication and frequent visits to doctors started.

With 16 I started taking a medical product called Atemperador, which as I was told by the doctor I would have to take for the rest of my life. Since then I passed 10 years taking it, but two years ago I got to know Dr. Julius Hellenthal and he told me of his umbilical cord blood stem cell treatment. And so, four months ago I decided to undergo this treatment. Thank god and thanks to Dr. Hellenthal today I am well, with good health, enjoying life again and being very active doing many things like any normal person. The treatment didn’t only cure my epilepsy, but also helped my gastritis, headaches and fatigue.

Today it’s two months without Atemperador, and it seems like a dream to me, but I realize it’s reality and that makes me very happy.

July 2009

### 4.3. Silvio Hartleb

I was actually healthy and not apparently lacking anything, but Julius Hellenthal nevertheless recommended to me a stem cell therapy with his umbilical cord stem cell auto immune vaccine. As I was experiencing small issues with my body, e.g. strong body odor, frequent urge to clean
my throat, chronic fatigue and also concentration problems. Starting the therapy I didn’t feel big changes, but after the seventh injection certain changes began to show. I felt my energy level rise and also an improvement of my posture, what could be confirmed by my mother later on. Approximately two months after starting the therapy and the additional diet also the other health issues disappeared and since then I feel very much better.

Thank you very much!

July 2009
Chapter 5: Appendix

5.1. Letter from Robert E. Mayer-Picard, psychologist

The following is a reader’s response letter from the committed psychologist Robert E. Mayer-Picard, concerning Germany’s standard treatment for borreliosis.

Letter to the editor in reference to “Test of Strength” and “Pills for the Dead”, from the 22 January 2003 edition of the Süddeutsche Zeitung.

The Federal Association of National Health Doctors (Kassenärztliche Bundes Vereinigung = KBV) is the address to which physicians are supposed to turn for those deficiencies supposedly not caused by the KBV itself. It is clear, however, that the compensation system for medical services gives rise to malaise, given its indirect multilevel style: the insured pays his health insurance premiums, health insurance pays into overall compensation fund, associations of the national health doctors pay the individual doctor a percentage from the overall compensation fund based upon constantly changing compensation scales. Not only the financially shackled health-service members are dissatisfied, so are the insurance companies, who have to ignore what they are specifically contributing to the compensation fund for. And doctors also have reason to complain when the compensation scale drops like a bad stock for no clear reason, causing some doctors true financial distress and leaving them wondering why they should stay with their profession. Only the Association of National Health Care Insurers, and the national health doctor associations under their auspices seem to be fully pleased with their roles as public corporations, as they have been since they were legally recognized as such in 1955.

The genie that was released from the bottle at that time ought to be banished back into the bottle, because the many nebulous financial reshufflings blur the tendency towards corruption and dead-end lobbyism; they certainly do not strictly serve to maintain the financial autonomy of the doctors’ decisions, as was originally intended by the law. One must ask whether institutions
that have been established for decades ought not to be phased out, to be replaced by more financial clarity between givers and receivers of medical care. Social Secretary Ulla Schmidt (Social Democratic Party) clearly supports this. A further question is whether dismantling the national health doctor associations, and thus making doctors’ actions increasingly dependant upon economic considerations, would mean a gain or loss in quality. This is difficult to foresee, as the system involved is highly complex.

Our health care system has thus far brought about a disproportionate emphasis on what is sometimes exaggeratedly curative medical care: terminal machine-centered care such as cardiac catheterization, bypass surgery, hip surgery, expensive and sometimes senseless procedures such as MRT, computed tomography, and frequent gastroenteroscopic examinations. In the meantime, basic preventive care has shriveled down to such a pathetic state that logical medical measures are scarcely considered, much less practiced: refusal to cover antibiotic eradication of helicobacter upon positive diagnosis; no preventive antibiosis for chlamydia-induced cardiac insufficiency. Thus, the health care system has been jostled into the wrong direction, and one can only hope that the planned reforms will help to bring basic preventive medicine out of its present wallflower state, while thoroughly questioning the efficiency of and the rationale for machine-minded medicine. That such a fundamental re-structuring will cause a few ulcers for those who profit from existing conditions is understandable, but ultimately unavoidable.

Every socio-cultural artifact – in this case, the national health doctors associations – can at some point come to endanger continued development, because the original form proves to be disadvantageous in a later developmental stage: the current health-care system, with its bent towards terminal machine-medicine, has as its consequence that even people with a relatively good income receive poor medical coverage by today’s standards. Many chronically ill patients, including several hundred thousand affected by borreliosis – borreliosis is the ubiquitous malady caused by tick-bites which includes autoimmune, psychiatric, and degenerative sequelae – pay far more than a tenth of their gross incomes into mandatory health insurance plans. What follows are medical measures in the form of a short-term, high-dosage infusion therapy which normally is noted for its failure, because the immune system is seriously weakened and no appropriate preventive measures are taken, e.g. long-term oral antibiosis, immunostimulants (vitamins, minerals, trace elements, amino acids). This means that a borreliosis patient is completely on his own in terms of necessary preventive measures for strengthening the immune system. These people, insofar as they are even aware of the need to take such measures, must constantly be paying for the preventive medicine which their malady necessitates.

Appropriate informative and preventive measures such as would be the responsibility of general medical care, are currently boycotted by the health-care system; a ridiculous outrage which would make the Social Secretary’s initiative towards reform seem even more urgent. Our present health-care system does not provide for all possible treatment forms – ruling out preventive borreliosis therapy, among other things. What it does still cover is the selective treatment of specific, often terminal illnesses which can be clearly diagnosed, and then only those treatment forms which the health-care system finds agreeable; i.e., predominantly exorbitant one-off therapy expenditures are covered, such as infusions and operations, but not reasonably priced long-term medications.
In terms of evolution, every social organism – which would include today’s health-care system – destroys its habitat and itself if it usurps its habitat of too much energy. Pumped full with premiums, it wastes its resources, giving recipients of medical care operations that don’t cure them, and treatments that kill. A great many health-care recipients receive no treatment at all: the chronically ill who lose their jobs and have to step down the social ladder because of preventive non-treatment hardly pay any premiums then. Thus begins a downward spiral; the willingness to discuss issues and make changes, even the will to listen and think at all diminishes when resources continually diminish. Nobody finds an escape from the dilemma of how to financially enable more preventive therapy measures. But if prevention were the major goal in dealing with chronic illness, payback would come in the form of insured patients who stay healthy and productive. All those affected by this state of affairs should be encouraged to further the debate, in hopes of reducing and financing the pressing need for therapy for the chronically ill.

May 2003

5.2. Dr. Hellenthal guest of Jürgen Fliege on channel ARD

On August 21, 2001, the ophthalmologist Dr. Julius Hellenthal of Günzburg was the guest of talk show host Jürgen Fliege, discussing the subject “Insect Attack”. He was interviewed on the subject of Lyme disease. Dr. Hellenthal has dealt with the subject of this disease in detail since 1987, and has published several items on the matter.

Lyme disease is a widespread (in Bavaria, up to 30% of the population is affected), but under-diagnosed, chronic illness – generally not showing up in laboratory tests, contrary to
The sensational medical revolution on the brink of the 21st century

popular medical opinion. According to Dr. Hellenthal, it is essentially only diagnosable in terms of its clinical symptoms.

The illness, triggered by spirochetes, is normally transmitted by ticks and by large stinging and blood-sucking insects. Spirochetes can cause or mimic nearly all known pathological manifestations, including rheumatism in various forms, gout, hair loss, skin eruptions, multiple sclerosis, heart attack, stroke, glaucoma, Alzheimer’s disease, psychosis, arthritis (meniscus and disk problems), headache, migraines, high blood pressure, cardiac dysrhythmia, hemorrhoids, facial paralysis, carpal tunnel syndrome, reduced short-term memory, general varicosis, general vascular sclerosis, heel spur, chronic osteomyelitis, Menière’s disease, to name a few.
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Multiple sclerosis is Lyme disease: Anatomy of a cover-up

Perhaps the biggest ongoing medical scandal of the past hundred years is the fact that it has been known since 1911 that Multiple Sclerosis is caused by a bacterium, and that the Big-Pharma-controlled medical-industrial complex covered this up in order to make money selling symptom relievers to MS patients. At the lower levels there is no cover-up at all, but simply human nature at work, as we wrote about here, to dispel the notion that we are “conspiracy theorists”. Since 1911, overwhelmingly much medical research has been conducted where living Borrelia bacteria were found in the brains of people who were diagnosed with MS.

**** I spent more than 100 hours writing and researching this article. This article does not “need to be spread further”, esp. not by people who turned plagiarism into a business model. This article is here for everyone to easily find and read. Anyone can link to it. We always submit a DMCA takedown notice to hosting providers when this article get plagiarized. We regularly search for violations. The previous plagiarist lost their hosting. ****

Time and time again. By at least a dozen medical researchers. In at least ten countries. Since 1911 – the past one hundred years. Several older but also recent autopsy findings linked to in this article found that all deceased MS patients’ brains harbored living Lyme spirochetes. Even when tests, notorious for their large percentage of false negatives were used on living MS patients, staggeringly many tested positive for active Lyme borreliosis.

Then why isn’t this common knowledge? Surely, those thousands of MS experts and MS researchers can’t be all wrong?

Let’s examine the reality on the ground.

1. Multiple Sclerosis Societies.
Every Western country has at least one MS Society. Each of those tax-exempt societies typically receives tens of millions of dollars in funding from various sources, year after year. The people running those societies usually award themselves CEO-level salaries and run them as one would run a highly commercial corporation. Advertising is used to solicit funds but if you don’t read ads then you’ll bump into them, one day, begging you for money on the street. For all those billions that have been pumped over the decades in those hundreds of MS societies worldwide, not a single one has ever done anything really useful for MS patients. The worst that could possibly happen for the bosses of those setups is that the cause of MS would become known. A known cause would either mean the development of either a cure or at least better symptom relievers, and that would rapidly result in the obsoleteness of their money making machine – the chicken that lays the golden eggs if you will. Such MS societies are working in concert with MS “researchers” employed by Big Pharma.

2. Big Pharma.

Multinational pharmaceutical corporations are the only ones doing MS research nowadays, mainly using donations to MS societies. Those multinationals decide which researchers get the cash. Researchers wanting to test the postulation of bacterial etiology of MS are shunned as if they were crackpots. Big Pharma makes billions a year on MS symptom relievers and they trickle millions down to their footsoldiers, the “MS experts”. A cure would be a severe financial blow. Even more so, because there is strong evidence that many other neurological illnesses are caused by germs as well. Because due to the phenomenon of immune privilege there is an inadequate immune response in the brain and spinal cord, making these organs the ideal place for certain slow-dividing spirochetal bacteria to entrench, multiply and cause lesions. The entire concept of antibiotic-resistant, hard-to-test-for chronic CNS infections leading to a plethora of neurological syndromes
has to be suppressed and what can’t be suppressed will be craftily discredited. Better to
give every expression of a neurological infection its own name such as “MS”,
“Alzheimers”, “Parkinsons,” “ALS” and “Fibromyalgia”. And fund armies of ignorant
“experts” to obfuscate the issue, whilst boycotting, firing, censoring, smearing and suing
those few real experts that refuse to stay in line. Big Pharma is in business to make money,
and money is made when people are ill, not when they’re healthy. Anyone standing in
their way is relegated to the sidelines. Patents are being bought and shelved so that cures
will never see the light of day.

3. Patient advocacy groups.
MS patient groups are, without exception, populated with clueless individuals for the
simple reason that those who did their homework and read the relevant research have
been ostracized by the group. They always were and they always will, because that’s how
group dynamics works. As soon as you insist on voicing an opinion outside of the
mainstream, no matter how well argued – you’ll be an outcast, a pariah. They don’t want
rogue activists, “lone nutters”, giving them a bad name. Also the advocacy groups are
raking in the dough and are run by folks whose main concern is that membership dues
are paid in time. No MS, no advocacy group. Of course if there ever will emerge a lobby
group insisting on more microbiological research pertaining Multiple sclerosis, they’ll be
branded “lunatic fringe” and their efforts will be in vain.

4. MS “experts”.
Those “experts” get away with calling themselves thus, because Big Pharma gives them
their seal of approval in the form of research grants and medical media exposure.
However they are only experts in doing exactly what Big Pharma wants them to do:
Obscuring the cause of Multiple Sclerosis! In return, the “experts” get regular cash
injections for their “promising research” and other goodies such as all-in holidays to
exotic destinations. There never will be a cure for MS until the scandal breaks and new
antibiotics are developed that work better than the few currently available antibiotics that
cross the blood-brain barrier. As it stands, it has been more than twenty years ago since
any new antibiotic was developed. As soon as it was found that Minocycline helped with MS, its manufacturer, Lederle, tripled its price.

After long consideration I came to the conclusion that at least a crucial part of this debâcle was due to a real conspiracy – mainly a conspiracy of silence of those few MS researchers bright enough to realize that the cause for MS has been known for at least a hundred years. As is always the case with medical cover-ups, it continues to exist due to a mix of ignorance, indifference, cowardice and corruption. The saying goes: “Do not attribute to malice that what can be adequately blamed on ignorance”. All the “experts” really are interested in is being “experts”, not curing Multiple sclerosis. However it still is a conspiracy. It is completely normal for conspiracies to succeed because the lion share of the people who could point it out don’t care, are too lazy to get educated or feel too intimidated to stick out their necks. Microbiologist Tom Grier calls them cowards. The fact that most conspiracies are silently facilitated by an army of “useful idiots” with a stake in it being kept under the rug does not make it any less a conspiracy.

**Evidence for a conspiracy of silence**

Now I’ve given my opinion. You may find it harsh – I call it mild.

You don’t have to believe *me*, when I say there is a conspiracy. Believe Alzheimer and Parkinson’s disease expert Dr. Alan B. MacDonald M.D., Staff Pathologist at the St. Catherine of Siena Medical Center. He wrote:

(published online 10 July 2006 in Volume 67, Issue 4, page 819-832 in Medical Hypotheses)

“*Conventional thinking about spirochetal cyst forms is divided between two polar spheres of influence; one a majority community that completely denies the existence of spirochetal cyst forms, and a second group of academically persecuted individuals who accepts the precepts of such antebellum scientists as Schaudinn, Hoffman, Dutton, Levaditi, Balfour, Fantham, Noguchi, McDonough, Hindle, Steiner, Ingraham, Coutts, Hampp, Warthin, Ovcinnikov, and Delamater. Microscopic images of cystic spirochetes*
are difficult to ignore, but as has been the case in this century, academic “endowments” have nearly expunged all cystic spirochetal image data from the current textbook versions of what is the truth about the spirochetaceae. If the image database from the last century is obliterated; many opportunities to diagnose will be lost. Various sized cystic spirochetal profiles within diseased nerve cells explain the following structures: Lewy body of Parkinson’s disease, Pick body, ALS spherical body, Alzheimer plaque. Borrelia infection is therefore a unifying concept to explain diverse neurodegenerative diseases, based not entirely on a corkscrew shaped profile in diseased tissue, but based on small, medium and large caliber rounded cystic profiles derived from pathogenic spirochetes which are hiding in plain sight.”

Note how he claims that the majority of researchers deny the existence of spirochetal cystic forms. Denial is defined as knowing that something exists, but deliberately refusing to acknowledge it for ulterior motives. By putting “endowments” between question marks, he implies that Big Pharma bribes universities and publishers into censoring the very existence of spirochetal cysts from medical textbooks.

And if you think Dr. MacDonald is a lone loon, read the fascinating and terrible personal story and Lyme-vs-MS lecture by microbiologist and Borrelia expert Tom Grier. He says MS is merely a symptom of Lyme disease and not a disease onto itself. And he says the medical establishment is arrogant, ignorant and corrupt:
Also listen to the below audio. Tom explains in these MP3’s all you need to know about Lyme disease – including why Lyme tests routinely come back false negative – it’s all deliberate and it’s getting worse. Medical politics. And remember that Tom as a microbiologist sticks to the traditional textbook curriculum on the transmission of Lyme – by ticks. However, it has been established that a wide variety of bugs can at least carry the disease – and that it even is found in human semen, blood, urine and saliva. This would explain why MS statistically ever-so-slightly can “run in the family”. It may partially be caused by a genetic propensity for not being able to clear the infection, but it may also be because bed bugs, fleas, lice, mosquitoes and sexual intercourse or even mere kissing can possibly transmit the bacterium to a lesser extent as Ixodes ricinus ticks can. However, medical research shows that while on antibiotics, no human-to-human transmission is likely.

(60, 50 and 72 MB)

But surely, there must be evidence of this corruption? There is, but it is hard to find and one has to read between the lines. We discovered some evidence, by chance, in training material not intended for the general public. We found on a Dutch radiology site a lecture, in English by Frederik Barkhof, M.D. Mr. Barkhof has been on the receiving end of a lot of Big Pharma money for his research into MS, research severely prejudiced against the infectious theory of MS. I’m not saying that he deliberately researches the wrong things, I’m saying that Big Pharma cherishes those who do. His lectures are used to “educate” the country’s radiologists, who are sternly warned to tow the party line when it comes to the cause of brain lesions:
What we found is deeply worrying. Note how the person writing the recommendation does not even know the name of the disease and calls it Lyme’s disease. **The radiologists are instructed in ominous, derogatory language never to disagree with the “suspicion of MS”**. So when the doctor says: “I think it should be MS”, the radiologist should just shut up and agree, even if he disagrees and thinks it’s Lyme disease. So that later, when it turns out to be Lyme after all, the doctor can say: “*But the radiologist also thought it was MS!*”. The result is that Lyme as a cause for MS will remain denied – by orders from above, citing statistics of “Lyme causing MS-like symptoms is rare, so never diagnose the cause as Lyme”. Statistics based on false assumptions, statistics used to disallow rectifying those same faulty statistics. So the actual evidence inside the brain, seen by the radiologist who scrutinizes those pictures all the time and is qualified, by his training and vast experience and feedback of actual diagnoses from hundreds of doctors treating thousands of patients, is thrown into the garbage. Ignored. We now know that it is national policy in the Netherlands to intimidate radiologists into keeping silent about their own diagnoses of Lyme neuroborreliosis when their instructions are “MS”. It’s usually the infectious disease specialist that gives that instruction, voiced as a “suspicion”. The ID specialist is urged to “suspect MS” by his hospital, which is contractually bound to “suspect MS” by their insurance company. Whether it’s private or government insurance is of no consequence because both are under the control of “advisory boards” controlled by Big Pharma. Big Pharma “owns” key politicians as well. There is plenty reason to believe that the Dutch policy is set from above and reflects in fact EU and US policy. The Dutch were just sloppy enough to leave a trace. Because this rare piece of evidence may be removed, we mirrored the lecture [here](#).
The instruction to new radiologists literally is: “There must be other ways to impress your colleagues”. As in: “Don’t be a wise guy and know your place”. They must have had “trouble” with “wise guys” before. A Radiologist’s Lyme diagnosis is of no value and has to be self-censored when the MD that requested the MRI suspects it is MS. Otherwise the Radiologist is just looking for attention, “trying to impress his colleagues”. Because “Lyme is much rarer than MS”. Yeah. Based on the opinion of doctors, based on statistics those doctors made up out of thin air, based on their baseless opinions. Not on actual scientific research. The actual research always finds spirochetes in MS’s patients brains. Except when this “research” is paid for by companies selling symptom relievers for MS and other neurological syndromes. We found 25 (twenty-five) studies where living Lyme bacteria were found in the brains of Multiple Sclerosis patients. We list twenty in this article and we make an additional five of the most recent research studies available for download as PDF’s further on. I remind you that even when taking the “debunking” studies at face value, absence of evidence in some studies is not at all evidence of absence in the real world (spirochetes in the brain of MS patients), especially not because of the simultaneous presence of undeniable evidence, shown in the studies summarized later.

“Ruling the medical machine by decree” is the norm everywhere. Dissidents must have mental issues, they’re “trying to impress their colleagues”. Noone in the modern western medical machine cares, or is allowed to care, about medical science. Everything is geared towards maximizing Big Pharma’s profits and paying tribute to the royally remunerated “experts” in their ivory towers. Doctors have degenerated into vulgar drug pushers with a veneer of professional legitimacy. The grim reality is that Western doctors are wholly disinterested in their profession or their patients’ wellbeing and even if they are, they lack the guts to stand up against the machine. And even if they would, they would get crushed like those few that do rebel and find themselves made examples of.

Millions of people suffer from “Multiple sclerosis”. It slowly rots the central nervous system. And that’s when you’re lucky. Because it can also kill quickly. Quick or slow, it
is a most horrible way to die and the fact that this suffering is wholly preventable and that this fact has been willfully suppressed and ignored for ten decades is a scandal worthy of reconsidering the remarkable, undeserved immunity that the medical world enjoys. Only in the most egregious cases of direct medical negligence are there usually mild consequences for the offender. But what about the preventable deaths and suffering of countless thousands of MS patients every year? Wikipedia, citing this study, says: “Two thirds of the deaths in people with MS are directly related to the consequences of the disease”. That’s a 66% mortality rate, making MS one of the deadliest diseases – more lethal than HIV infection and cancer. This Norwegian study puts it at at least 34% but says that how much more than 34% is hard to say because the coroner puts “misleading information” in the death certificate instead of MS. And of course they could not follow the entire group to their deaths, so more will have died due to MS after the study ended. About one in a thousand people in geographically affected area’s have MS. Conservatively, that amount to at least ten million people, of which around six and a half million will die due to the disease. A wholly unnecessary, Holocaust-size scandal of agony and death, repeating over and over again – and it’s getting worse.

The painful truth is: There is no such thing as Multiple Sclerosis. It’s the name of a symptom. A symptom of a disease of “unknown” cause. But the real cause has been known for a hundred years: The spirochete Bb s.l., Borrelia burgdorferi, the bacterium that causes Lyme neuroborreliosis, Lyme disease. MS doesn’t exist. MS is Lyme neuroborreliosis. MS is Lyme disease. It’s a bacterial infection you can get from a tick bite, amongst many other suspected infectious pathways.

No one in the MS patient advocacy community or in the MS research community, let alone the self-appointed “MS expert” doctors will react favorably when you mention the proven cause of MS – Lyme spirochetes. MS patients don’t like to see themselves as “infected with a tick bacillus”. A worrisome concept indeed, and of course even though the cause of MS is officially “unknown”, the “expert” will dismiss any involvement of bacteria in the strongest of terms. Those “experts”, knowing full well that they have no
clue, fear any challenge to their authority and often choose the attack as their best defense. They know all too well their only task is to prescribe useless pills. Big Pharma would like to keep their monopoly on symptom relievers till there are no humans left on this planet to cheat out of their money. The MS advocacy groups and societies will politely ask you to keep your rather unpopular opinion to yourself. You’ll be at best considered eccentric and at worst a delusional nuisance.

But were those 15 researchers who said they found living Lyme bacteria (spirochetes) in the brains of a great majority of Multiple sclerosis patients all lying?

1911 Buzzard E F Spirochetes in M.S. Lancet 11:98 1911
1913 Bullock W E (now Gye) MS agent in Rabbits Lancet 1185 1913
1917 Steiner Spirochetes The Cause of MS. Med Kih
1918 Simmering Spirochetes in MS by Darkfield Micro
1918 Steiner G. Guinea Pig Inoculation with MS infectious agent from Human
1919 Steiner MS Agent Inoculation into Monkeys
1921 Gye F. MS Agent In Rabbits Brain 14:213
1922 Kaberlah MS Agent In Rabbits. Deutch Med Works
1922 Sicard MS Spirochetes in Animal Model. Rev Neurol
1922 Stepanopoulo Spirochetes in the CSF of MS Patients
1923 Schlossman MS Agent in Animal Model. Rev Neuro
1924 Blacklock MS Agent in Animals. Journal of Path and Bac
1927 Wilson The Rat as A Carrier of MS. British Med Journal
1927 Steiner G Understanding the Pathogenesis of MS
1928 Steiner Spirochetes in the Human Brain of MS Patients
1933 Simons Spirochetes in the CSF of MS Patients
1939 Hassin Spirochete-like formations in MS
1948 Adams Spirochetes within the Ventricle Fluid of Monkeys Inoculated from Human
Even publications trying to debunk the spirochetal etiology of MS had to face the inconvenient facts:
Can we trust these old studies? Critics sneer that since some other researchers failed to culture the spirochete, the bacteria found, photographed wriggling under the microscope must have been Fata morgana’s. What to do with those pesky scientists, “trying to impress their colleagues”? In the end, the noisy negativists just don’t believe the results. This is a common phenomenon in science: The establishment hates to step from their pedestal and will, due to disinterest, incompetence and stake at a failed outcome botch reproducing research, to announce that the original publication wasn’t worth the paper it’s printed on. They had the chutzpa to do this with dozens of scientists who found spirochetes in MS patients’ brains. This kind of monkey-behavior is the norm in science. I refer to Pons and

Steiner and Kuhn (86) again reported finding spirochetes in the brains and spinal cords of people who had died of MS. Adams (87) found spirochetes when looking at the CSF from monkeys injected with MS tissue, and the spirochete looked similar to that of Steiner and Kuhn. No one could culture the spirochete, however, and there was general skepticism in neurologic circles despite the enthusiasm of the proponents of this theory and observations. Attempts to culture the spirochete from patients’ CSF failed, but reports of a spirochete would continue to appear. Rose Ichelson of Philadelphia reported in 1957 that six years previously she had devised a culture medium that grew a few spirochetes from MS CSF, but modification of the culture resulted in a heavy growth of spirochetes in a few days (88). She reported that 59 of her 76 cases (78 percent) had positive cultures, whereas 100 percent of the normal controls were negative. The organism was a spiral organism with a loop at one end, or sometimes resembled a tennis racquet. She said it was similar in appearance to that of the *Spirocheta myelophthora* of Steiner.
Fleischman – now thoroughly vindicated – but their field still suffers from lingering ridicule – and even legalized boycotts by Big Oil.

We now know that it’s devilishly hard to culture spirochetaes, and that they simply weren’t able to do it in those days.

If MS patients really do have living Lyme bacteria in the brain, surely there must be recent findings too, from respected researchers in a variety of Western countries, using state-of-the-art methods? There must be high-resolution photographs of the actual, living Borrelia spirochetaes cultured from the brains of those people?

Sure there are! In spite of the ongoing onslaught against such investigations, there still are researchers naive or brave enough to venture into the career-destroying terrain of rediscovering the cause for diseases that have become major money makers for their exploiters. So yes, there are plenty of modern studies, reporting live Lyme bacteria in the brain of MS patients.

**Medical research hidden from the public**

I had to purchase two of these studies under the condition that I would not make them available in any way, shape or form. This is a standard condition, when buying the right to read it from an online database. The research is “eyes only”, so to speak. Not intended to become known to the plebs. They may get nervous, see. Becoming a nuisance and all.

It was only recently, that the entire world’s scientific research has become locked up in databases owned by multinational publishing giants, asking ridiculous fees for a few pages copied from a journal. So I had to commit the crime of violating Copyright Law, because the two I purchased ($48,- and $31,-) were the most interesting ones – one included pictures of the actual pathogen – the Borrelia bacteria in their cysts, and Borreliae expelling their DNA granules. Note how the research that MS has nothing to do with bacterial infection is**freely available** on the web. This research is copied and pasted freely by its proponents, and the medical databases – publishers owned by Big Pharma – don’t seem to mind the violation of Copyright. Done by a MS disinfo-expert from a EU country. Interestingly, the only countries publishing recent research into the
link MS – Lyme are a outside the iron fist of mainstream medicine – outside the EU. Norway is not in the EU. Neither is Switzerland. Neither were Poland and Romania, at the time the research was done. It’s a familiar pattern. Helicobacter Pylori, the cause of 95% of all peptic ulcers, also was discovered in 1958 by a “rebel” from a country at the fringe of mainstreamness – Greece. He barely got away with experimenting with antibiotics without being revoked their medical licenses for “malpractice”. John Lykoudis was fought every step of the way by the establishment:

“He encounter[ed] formidable obstacles in convincing the medical establishment, the Greek regulatory authorities and the pharmaceutical industry. In fact, Lykoudis spent the rest of his life engaged in incessant activity to propagate his treatment of PUD and gastritis. His archives, some made recently available by his family, make it clear that he was fully aware of the importance of his discoveries. They also convey an almost suffocating sense of frustration…”

“[He was] completely shunned by the medical establishment of his time, or at best, considered an eccentric provincial physician…”

...he was referred for disciplinary action to the Athens Medical Association, of which he was a member, ‘because (a) he prepared and distributed an unapproved medicinal preparation...and (b) he made his method publicly known to attract patients’…On 6 November 1968...the Disciplinary Committee, presided over by a neurology professor, fined him 4000 drachmas...

A more serious problem for Lykoudis was his indictment in the Greek Courts.

“In 1966, Lykoudis attempted to publish his observations in the Journal of the American Medical Association, but his manuscript entitled “Ulcer of the Stomach and Duodenum” was rejected...Unfortunately, no copy of this manuscript survives for re-evaluation in the light of current knowledge.”

In the latter instance numerous former patients came to his support; one of them testified that Lykoudis “treated also many poor ulcer patients free of charge.” We are not told the outcome of the indictment.

Lykoudis died in 1980 without knowing that he would soon be vindicated.

It’s a familiar fate of innovators in medical science – victims of the Semmelweis reflex, an expression of mob behavior amongst primates. Ignace Philipp Semmelweis met a similar fate, as well as many others before and after him. The problem with medicine is
the fact that it’s based on dogma’s, adhered to by people of mostly barely above-average intelligence.

Here is recent research showing that MS is in fact Lyme disease – download them, print them and show them to your “expert” – likely to no avail:

1986 (USA): Relapsing fever/Lyme disease – Multiple sclerosis. Medical Hypotheses, volume 21, issue 3, pages 335-343

Synopsis: In MS, the plaques have their origin around veins in the central nervous system. This corresponds with the lesions found in neuroborreliosis. The geographical spread of MS correlates strongly with mean annual temperature. The geographical distribution of the ticks that transmit Lyme disease have a similar geographical distribution. There have been MS “epidemics” in the past where 40 times more cases of MS occurred than normal. Those epidemics appear to correlate with the large-scale introduction of dogs or other animals that are hosts for ticks. Postulates that Borrelia spirochetes may be acting as the trigger in MS, setting off an autoimmune reaction in which patients produce antibodies that attack their own nerve fibers. Mentions that Borrelia eat myelin as well. Notes how many particular and peculiar Lyme symptoms are shared with MS symptoms. Mentions a small study in which two out of eight MS patients tested positive for Lyme disease.


Synopsis: 10 out of 26 MS patients tested positive for Lyme borreliosis. Notes how it is virtually impossible to make a distinction between late stage Lyme disease and Multiple sclerosis, not even with MRI. Diagnosis of MS vs. late stage neuroborreliosis are guesswork – there are no reliable tests for either. Conclusion: Multiple sclerosis may often be associated with Borrelia infection.

Synopsis: Borrelia cysts were found in all ten out of ten patients diagnosed with Multiple Sclerosis. No bacteria were found in a control group. The most modern methods such as a transmission electron microscope were used by a specialist in this narrow field – this may explain why a 100% infection rate was found by Brorson, as opposed to lower rates in other research. The cysts turned into spirochetal bacteria when cultured. Remarks that the bacterial infection theory of MS was abandoned because antibiotics did not help. Remarks that Borrelia bacteria have mechanisms to evade the immune system and survive antibiotics, and offers research evidence for that. Concludes that all ten MS patients have been infected with a spirochete. Dismisses the common criticism that “all those MS patients were also infected with an unrelated Lyme disease” by pointing out how unlikely that is, especially seen the ample research evidence for a spirochetal cause of MS. Concludes that MS could very well be a chronic infection. Points out that there is microbiological and clinical evidence that spirochetal bacteria could be the cause of MS. Notes that the spirochetes may not necessarily be of the genus Borrelia burgdorferi. The chance that 100% of MS patients would also have Lyme neuroborreliosis is astronomically small – about one in 1000^10, a smaller chance to find a speck of dust lost in the Universe. Epidemiologically speaking, Brorson’s findings are near-absolute proof that MS is caused by spirochetal bacteria.

2004 (Switzerland): Chronic Lyme borreliosis at the root of Multiple sclerosis – is a cure with antibiotics attainable?

Synopsis: Notes that worldwide, MS prevalence parallels the distribution of the Lyme disease pathogen Borrelia burgdorferi, and in America and Europe, the birth excesses of those individuals who later in life develop MS, exactly mirror the seasonal distributions of Borrelia transmitting Ixodes ticks. No other disease exhibits equally marked epidemiological clusters by season and locality. Cites research whereby spirochetes were found in the brains of MS patients as early as 1928, and that in over 250 control cases of
diversified diseases there never were spirochetes found. Notes that this research has been successfully replicated decades later by different scientists. Points out that a considerable body of clinical evidence supports the concept that cystic L-forms of Borrelia Burgdorferi may cause MS. Dismisses skepticism towards this concept with science-based arguments. Dismisses the hypothesis of genetic origin of MS using scientific research data. Includes graphs showing a direct correlation between the number of MS patients and the number of ticks transmitting Lyme disease. Dismisses the “environmental toxin” hypothesis of MS using scientific research data. Explains how Borrelia could cause all MS symptoms. Recommends trials with antibiotics for MS patients.

2009 (Romania): Controversies in late Neuroborreliosis and Multiple sclerosis – case series

Synopsis: Found a significant percentage of people diagnosed with MS in fact having neuro-Lyme. Concludes that it is probable that MS is caused by an infectious agent and recommends testing MS patients for Lyme disease.

Bacteria are the cause of Alzheimer’s as well

So much more could be written about this subject. Such as the fact that spinal cord lesions together with a lesion in the cerebellum or brainstem is very rare in neurological diseases and almost exclusively occurs in only MS and Lyme disease. There is a lot of hard evidence that Fibromyalgia, Parkinson’s, CFS, Lupus, Crohn’s ME, Pick’s disease (FTD, Frontotemporal dementia), Alzheimers’ disease and ALS (Amyotrophic Lateral Sclerosis) are also caused by spirochetal bacteria. 14 out of 16 deceased Alzheimer’s patients had living Treponema spirochetes in their brain. Please people – it is not normal to have bacteria in your brain! The only result can be brain damage of a type and pace commensurate with the type of bacterium and the state of your immune system and personal genetics. Countless millions of people dying the most horrific slow deaths due to infections that are near-impossible to detect with currently employed diagnostic methods, but certainly treatable in the sense that further deterioration can usually be stopped and often even reversed in clinical trials and anecdotal evidence:
(Patients with ALS and MS improved on antibiotics)

These graphs show a worldwide, strong, direct connection between the number of ticks transmitting Lyme disease and the birth excess of MS patients. The evidence is everywhere and we should demand proper treatment for MS: Antibiotics. The Swiss study has a geographical map with MS prevalence that explains why for example the Sami and the Inuit don’t get MS: It’s too cold for ticks in Lapland. But Big Pharma keeps searching for a “genetic” or “auto-immune” cause.

Isn’t it strange that the geographic mortality rate for MS is nearly identical to that of Lyme disease? With near-identical hotspots for both diseases, even in areas with a low population density (but high tick density):
In the heydays of medical and general scientific research, anyone with enough money, time and skill could test a postulation in their own lab. You only fully realize how dependent we are on Big Pharma to do our research for us when faced with the fact that it is a criminal offence to culture bacteria without a license (“Terrorist bioweapon production”). And it’s a criminal offence to sell antibiotics without a license. And it’s a criminal offence for a pharmacy to sell anyone with antibiotics without a prescription. And it’s a criminal offence to smuggle antibiotics into a country. And it’s a criminal offence to give medical advice without a license. Even though it’s a fact that antibiotic resistance emerged due to under-use, not over-use, of antibiotics. Tuberculosis is an example of that. Doctors don’t understand microbiology and antibiotics are too extortionally expensive to be used long enough to cure many infections. They merely entrench into the CNS where they emerge as serious syndromes, years later. In short: It is a criminal offence for any non-MD to find the cure for MS. And MD’s who try will be sued for “malpractice” – “over-prescribing of antibiotics”.

**Rent-seeking pharmaceutical multinationals**

We’re being increasingly curtailed, medically. In the year 2000 the Netherlands proposed making the import, without a license, of a test that can test for potentially deadly diseases a criminal offence punishable by at most two years in jail. I was flabbergasted when I heard it and I do not know whether that law actually silently went on the books, to be used as a trump card when some millionaire tries to sue some “experts” for malpractice. Big Pharma’s enforcers need to feel safe. To Big Pharma, you are most profitable when
you die very slowly – but silently! God forbid you’d be able to prove in court that you’ve been misdiagnosed! Tiny US protectorates such as the Netherlands and Norway are at the forefront of implementing Big Pharma’s dictates. Norway implemented the full Codex Alimentarius ruleset decades ago, based on the recommendations of an advisory board, staffed with people with daytime jobs in the pharmaceutical industry. All vitamins and minerals are restricted drugs in Norway, requiring a license to import. No company except the largest corporations are granted such a license to import in clinically significant amounts. Making it a criminal offence (max. three months in prison) to import a significant quantity of vitamin C. “Statens Legemiddelverk” will always decline a license and casually mention that attempting to import any commercially significant amount of vitamin C is a criminal act. I have their letter to prove it.

**What can you do to get proper “MS” treatment?**

MS “experts” will keep resisting the truth to the point of absurdity. They will first come with the hilarious claim that every MS patient in the study also had Lyme neuroborreliosis and that both are separate, unrelated illnesses. When the statistical impossibility is pointed out to them, they’ll insist that finding living Lyme bacteria in people’s brains is perfectly normal. They will claim that antibiotics help MS patients because they “reduce inflammation”, but that Big Pharma has much better “inflammation reducers” (a few thousand times more expensive than generic, unpatentable Doxycycline). They’ll say that the few dozen scientists who published the above research are conspiracy nuts. Whatever it takes. They’ll lie, and say that a few weeks of antibiotics kills any bacteria in the CNS. A most hilarious statement, given that it takes even years to clear up acne with antibiotics, let alone the **immune-privileged** CNS, where no T-cells circulate and where most antibiotics can’t even reach. They’ll lie and say that their negative tests can be relied upon. They’ll lie, and say that a tick bite followed by a bullseye rash is the only way you can get Lyme disease. And perhaps in the very far future, when finally the truth can’t be suppressed any longer, they’ll shrug it all off as a technicality, a “we couldn’t have known because the research was flawed”, a misunderstanding, a non-issue and will reluctantly
prescribe some atrociously expensive antibiotic that will be the only one “approved” for MS.

When you have been diagnosed as having one of the CNS syndromes mentioned above, you or your loved ones should insist on the following:

– **The most reliable testing for Lyme disease attainable.** Beware: Even the best tests are woefully unreliable (false negatives due to deliberate test mis-design). If it means sending serum or lumbar fluid to another lab, your “expert” should allow this. If not, find another “expert”. Please understand that it is to be expected to test negative unless you do a so-called “antibiotic provocative test”, explained in my book on ALS, freely available at [www.als-cure.com](http://www.als-cure.com).

– **When testing positive for Lyme, insist on the best treatment attainable.** In most cases this means open-ended treatment. At least years, but likely a life-long regimen of high-dosed blood-brain-barrier penetrating antibiotics. If your “expert” won’t go along with this, find another “expert”. Threatening legal action is useless – MD’s spend a lot of time in University learning all the dirty tricks on how to cover their ass.

– **Ask your “expert” to do a trial with oral antibiotics.** Do not get fooled into taking only abx that can’t reach the CNS! Doxycycline can be used if you don’t get much sun exposure, otherwise Minocycline is about the sole other oral option. If your “expert” doesn’t agree, find another “expert”. However they’re a dime a dozen and they’re nearly all useless. You may have to seek diagnosis and treatment abroad. Please note that people with serious CNS involvement (such as ALS patients) can easily be killed by a strong Jarish-Herxheimer reaction, so please do your homework before starting antibiotic therapy. Since antibiotic resistance is very uncommon in Borreliae, a very slow increasing of the antibiotic dosage should be done, to keep the “herx” within safe bounds. Be advised that antibiotic therapy often causes new lesions initially, while others diminish in size, so symptoms may first exacerbate before they get less. All this takes months, so don’t get discouraged prematurely. You likely will have to be on antibiotics for the rest of your life and progress is measured month-by-month, on an overall, average basis.
– If you are completely unable to obtain proper diagnosis and treatment, you can, as a last resort, source Doxycycline from one of the few countries where it still is not a criminal offence to sell antibiotics without prescription. You’d have to commit the criminal offence of smuggling it into your own country – but your life may depend on it. Treating yourself with such antibiotics is not an offence – yet – but it may land you a psychiatric diagnosis of “severe delusional parasitosis endangering the patient’s life” if your doctor finds out. People have been locked up in asylums and force-medicated (unfortunately with the wrong medications) for less.

**Lyme misdiagnosed as MS: Antibiotics cured “MS”:**


**Medical studies that show antibiotics help against Multiple Sclerosis**

There are a few studies (such as this [PDF about Minocycline against Multiple Sclerosis](#)) that show that antibiotics work, so that’s not too controversial any more. What remains controversial is why antibiotics work. People, including medical doctors, like to interpret facts in such a way that their world view doesn’t get demolished. Doctors like to believe that infections are not the cause of neurological problems. That simply is too disturbing a thought. So when antibiotics are proven to stop and even reverse the symptoms of MS, they are quick to deny any relation to bacteria, but claim: “It must be some antiinflammatory effect of the antibiotics”. The first study shows that antibiotics as a treatment for MS work:

**Targeting leukocyte MMPs and transmigration: Minocycline as a potential therapy for multiple sclerosis.**

Brundula V, Rewcastle NB, Metz LM, Bernard CC, Yong VW.
Department of Clinical Neurosciences, University of Calgary, Canada. Multiple sclerosis is characterized by the infiltration of leukocytes into the CNS. As matrix metalloproteinases (MMPs) facilitate the passage of leukocytes across matrix barriers, we tested the hypothesis that targeting MMPs could attenuate neuro-inflammation. We report that minocycline, a widely used generic drug with a good safety record, inhibited MMP activity, reduced production of MMP-9 and decreased the transmigration of T lymphocytes across a fibronectin matrix barrier. In addition, minocycline was efficacious against both mild and severe experimental autoimmune encephalomyelitis (EAE) in mice, an animal model of multiple sclerosis. When severe EAE was produced, minocycline pre-treatment delayed the course of the disease: when maximal disease activity occurred in vehicle-treated EAE mice, minocycline animals were relatively normal and had minimal signs of inflammation and demyelination in the CNS. When tested in mice afflicted with mild EAE, minocycline attenuated the clinical severity of disease throughout the course of treatment. These results indicate that minocycline may constitute a safe and inexpensive therapy for multiple sclerosis.

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UPDATE:

—> I wrote a book on how Lyme disease is a major cause of ALS. It is freely available as a PDF Here: When ALS is Lyme.

"I know that most men, including those at ease with problems of the greatest complexity, can seldom accept even the simplest and most obvious truth if it be such as would oblige them to admit the falsity of conclusions which they have delighted in explaining to colleagues, which they have proudly taught to others, and which they have woven, thread by thread, into the fabric of their lives."  -Tolstoy
Dr. Hellenthal visits Dr. Pekar with spouse (left). To my mind, one of the very best for treating cancer (see chapters 1.1.11 and 3.1).

Office staff with the “singing deacon” Hopfenzitz (of local renown).