

Explore! For the Professional

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Multiple Sclerosis

(A Case History)

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History

C.B., a 32 year-old woman was diagnosed with Multiple Sclerosis in January, 2004, initially presenting with optical manifestations. Her symptoms began as a central smudging effect, which evolved into complete loss of vision in the right eye and severely compromised vision in the left. Consultation with a neurologist resulted in treatment with steroids and Interferon, resulting in her vision “clearing a bit.” Following this episode her sight remained cloudy. In the autumn of 2005 she experienced several acute attacks manifesting as visual symptoms as well as tingling in the legs, which later led to difficulty with walking. She also developed abdominal spasms. She was treated with a 12-day course of steroids, which brought a slight improvement followed by worsening after Christmas. During December she also developed spasm in her hands with a sensation of sandpaper. Treatment with intravenous steroids brought about a minimal improvement.

Initial Presentation

At the time of initial presentation at Paracelsus Klinik in January, 2006 her vision remained compromised enough to prevent reading. Right eye vision was restricted to the perception of dim light and in the left eye; vision was restricted to extremely large objects. She also complained of pain in the left arm and shoulder accompanied by paresthesias following an ulnar nerve distribution.

In addition to the visual findings, physical examination revealed acute tenderness in the left stellate ganglion, left submandibular gland, left vagus and mastoid area, as well as left optic ganglion. Examination of the shoulder was consistent with a brachial plexus syndrome instigated by weakness in the shoulder musculature and pressure on the ulnar branch of the brachial nerve.

Lab Findings

Pertinent laboratory findings include a DMPS provocation test for heavy metals that revealed a mercury level of 106.98 mcg/g (asymptomatic less than 20 mcg/g typically), tin 58.1 mcg/g (Normal < 15) and Palladium 186.1 mcg/g (normal < 5). This patient had only a few small fillings and no easily identifiable origin for the massive Palladium level. She lived for several years in the vicinity of mine and metal smelting plant in Canada, and thus far this remains the most logical origin of the Palladium burden.

Bacterial antibody testing revealed abnormally elevated IgM levels of *Hafnia alvei*, *Pseudomonas aeruginosa*, *Morganella morganii*, *Pseudomonas putida* and *Citrobacter koseri*. *Pseudomonas putida* also had an elevated IgA. The IgM for *Klebsiella pneumoniae* was borderline elevated.

Stool analysis revealed deficient flora and diminished digestive capacity. Fatty acid metabolism was slightly deficient for Omega 6 EFA's and Omega 3 EFA's were within the normal range.

The Darkfield Blood Examination showed moderate rouleaux formation, endobiont infestation of the erythrocytes, and significant filit formation. There were no high valence symbionts seen. The Dried Layer Test emphasized digestive system problems, confirming dysbiosis, heavy metal burdens and hyperacidity.

Treatment

Treatment was conducted at Paracelsus Klinik Lustmühle over a four week period in January, 2006 and consisted of milieu regulation with alkaline infusions, local hyperthermia using the Indiba device, Matrix regeneration therapy, Colon hydrotherapy and Neural therapy, among the various treatment modalities.

Terrain management was guided with the use of the Biological Terrain Management(BTM)* system. The initial test of urine and saliva revealed a deficiency of urine NO₃, indicative of a bacterial/parasitic burden. She was in Zone 9, indicating a triple warmer meridian theme. This was specifically treated with Pefrakehl, Fortakehl, Probiotics and Ornithine given as oral supplementation, as well as neural therapy with Berberis / *Urtica urens* and *Glandula suprarenalis* Injeel on the kidney and adrenals segmentally. Retesting indicated normalization within 3 days. BTM was used several times in order to fine tune terrain metabolism, as well as to localize the dynamic issues of the meridian themes. These results were utilized to develop a variety of neural therapy strategies leading to a restoration of alkaline reserves and improving tissue drainage.

Neural therapy was performed on the eye segment repeatedly with restoration of vision on the left side beginning almost immediately after the first treatment. An interesting pattern emerged. Rather than experiencing the "lightning effect", the vision improved every night in the early evening, and worsened in the morning. This pattern gradually improved with repeated neural therapy as well as supplementing the infusions with a lipid exchange program utilizing intravenous Phosphatidyl choline and Glutathione.

Vision subjectively improved from the beginning of treatment. Following the very first neural therapy her vision improved dramatically in the left eye and by the next day it remained 15-20% better. This pattern repeated itself throughout the clinic stay, i.e., there was a step-wise gradual improvement with smaller and smaller regressive incidents during the daytime. By the end of the clinic visit vision was improved to the point of being able to read typical printed text as in books and newsprint. Changes in the right eye were minimal until this point in time. She was discharged with an outpatient regimen of oral medications, neural therapy and infusions.

Heavy metal detoxification was treated with NDF, starting with 10 drops twice daily and increasing as per tolerance to 2 pipettes daily. Sanum remedies including Mucokehl eye drops, Pefrakehl, Recarcin and Utilin were administered, as well as Conjunctisan A eye drops. I have also prescribed Regeneresen RN13, Regeneresen Linse and Regeneresen Bindegebe (Dyckerhoff Pharma) on a rotating basis. Neural therapy was performed on a weekly basis, as were the alkaline infusions. Gradually vision in the right eye began to return. Plans were made for a return visit to the clinic.

Second Visit

The patient returned in June, 2006 with vastly improved vision in the left eye, with only brief periods

of “cloudy” vision. Sight in the right eye had improved enough that she was able to read large print formats. Almost all of the sensation of paresthesia in the arms was gone, accompanied by an increase in strength and endurance. There were no complaints of spasm, fasciculations, weakness or pain in the legs.

Once again a DMPS heavy metal challenge test was performed with a rather dramatic outcome. The patient had only utilized NDF as the detoxification agent. The test revealed a Mercury level of 26.32 mcg/g, Tin at less than 1.0 mcg/g, and Palladium at less than 2.0 mcg/g. The elapsed period of time between the two tests is slightly less than 6 months.

DMPS Challenge Results Pre and Post NDF Chelation Therapy:	January, 2006	June, 2006
Mercury	106.98 mcg/g	26.32 mcg/g
Tin	58.1 mcg/g	< 1.0 mcg/g
Palladium	186.1 mcg/g	< 2.0 mcg/g

At this point in time there continues to be gradual improvement in muscle strength, endurance and visual acuity. The left eye has only short periods of diminished visual acuity that have continued to resolve. The right eye remains more compromised, but is clearly recovering visual capacity.

Summation

This case of Multiple Sclerosis appears to have surfaced from a multi-causal milieu disturbance with both elevated heavy metal findings as well as an ongoing bacterial disturbance supported by the finding of elevated IgM levels. It is our clinical experience to find that these results are often seen together and represent an overburdened and decompensated immune system. NDF was utilized exclusively as an agent for heavy metal detoxification. It not only provoked no side effects, but also provoked a rapid detoxification effect documented by follow-up laboratory testing. BTM testing was used throughout to efficiently guide terrain management on a corrective course. It is the author’s experience that the BTM test was of inestimable assistance in defining the meridian theme in a dynamic and immediate manner, repeatedly guiding the therapy on a corrective course. The BTM can be used in an extremely flexible manner, adaptable to the therapy style of the practitioner. We have been able, as a consequence, to understand intriguing and highly individualized treatment models that are easily re-directed with the use of the BTM as a guiding force. This case illustrates a particularly rapid capacity to re-compensate from a catastrophic symptom pattern, guided by this unique terrain-based metabolic approach.