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One Reader at a Time...

FREE

# PUBLIC HEALTH ALERT

Vol. 4, Issue 7 | Investigating Lyme Disease & Chronic Illnesses in the USA | July 2009

## In This Issue



# *Mycoplasma* - Often Overlooked In Chronic Lyme Disease

***by Scott Forsgren***

Those of us with chronic Lyme disease are quite familiar with the names of the better known Lyme co-infections. *Babesia, Bartonella, and Ehrlichia* have become everyday words. As much as we would like to rid ourselves of these illness-producing pathogens, they have become a part of our daily struggle to regain a sense of health and wellness. Unfortunately, these are not the only co-infections seen in chronic Lyme disease. For some reason, *Mycoplasma* infections are not only lesser known by patients, but seemingly often overlooked by doctors as well. It is important for us, as patients, to educate ourselves on the topic of *Mycoplasma* and to ask our practitioners how we are being evaluated and treated for these infections.

In 1987, Dr. Garth Nicolson, PhD was a professor at the University of Texas at Houston when his wife, an instructor at Baylor College of Medicine, became seriously ill and nearly died. She was diagnosed with a *Mycoplasma* infection, treated, and later recovered. A few years later, their daughter, who had served in the Gulf War, returned from active duty quite ill. Not only was she sick, but the symptoms that she exhibited were very similar to those that Dr. Nicolson's wife had expressed years earlier.

At that point, Dr. Nicolson had the idea that his daughter's illness could be the result of an infection and started to investigate his theory further. As his work progressed, he looked at *Brucella, Borrelia, Ehrlichia,* and other chronic intracellular infections that have the potential to cause illness and present with overlapping signs and symptoms. In Gulf War veterans that were being evaluated, approximately 45% of those that were ill had *Mycoplasma* infection. It was found that the infection was a particular type of *Mycoplasma,* namely a peculiar species called *Mycoplasma fermentans.*

Very little was known about this particular species of *Mycoplasma* at the time except that the Armed Forces Institute of Pathology and the Army had been doing research on the


***Professor Garth L. Ncolson is the President, Chief Scientific Officer and Research Professor at the Institute for Molecular Medicine in Huntington Beach, California***

organism. Once this likely causative agent of Gulf War Illness (GWI) had been identified in about one-half of the GWI cases, Dr. Nicolson recommended that the *Mycoplasma*-infected Gulf War veterans be treated with Doxycycline. He then found himself the target of vicious attacks for making the connection between the illness and *M. fermentans*. Dr. Nicolson shared that "even talking about

***"Mycoplasma" ...cont'd pg 6***

# Lyme Disease Often Resides in the Mouth

***by Mary Budinger***

Holistic, natural medicine tends to overlook what is probably the number one source of the body's toxins - the mouth. The infectious mechanism was initially documented by Dr. Weston A. Price, chairman of the Research Section of the American Dental Association from 1914-1923. History tells us the ADA, however, wanted to promote root canals as a new service and never moved forward with Dr. Price's well documented research.

Some biological dentists have studied Dr. Price's work, including Dr. Andrew Landerman of Sebastopol, California. He finds that Lyme and many other chronic diseases are fed by the unique bacteria that develop in root canals and where teeth have been extracted. Dr. Landerman granted us an interview:

**MB**: Do you see a lot of people with Lyme disease?

**AL:** I probably have a high proportion of people who are chronically ill. And a high proportion of people who have chronic illness have Lyme.

**MB:** How do you determine that?

**AL:** Some people of course come with the diagnosis. In others, I see Lyme in their symptoms. They may have swollen joints and other chronic conditions that are suggestive of Lyme. It is not the same with everyone. It depends upon their weak spot. Where they have a weak link, Lyme will affect that area. It is my experience and that of many others like me, that Lyme at this point in time is not a pathogen that can be eliminated. Rather we must seek to manage it holistically.

**MB:** Are Lyme bacteria in the teeth?

**AL:** Not in the enamel, but in the dentin and tubules. Every tooth has some three miles of tiny tubules that spirochetes love to occupy. Antibiotics, even the extended courses that some chronic Lyme patients use, do not get into these tubules. Lyme gravitates toward some teeth. It is my experience that Lyme gravitates especially to the upper and lower centrals, and to the upper and lower first molars. That's eight teeth.

**MB:** How do you test the teeth to determine where the spirochetes are hiding?

**AL:** I devised a method of percussion, a slight tapping of the tooth to give it a tiny shock. I use an electrodermal screening device to measure how the tooth responds. When you see a pattern of low or high current flow, that tells me the tooth is underperforming or overperforming. When the energy level is abnormal, that can indicate Lyme. I have not seen any amount of herbs or antibiotics get these teeth to change their readings for the better.

**MB:** Can you get rid of the Lyme in the mouth then?

**AL:** Mostly. It took me almost 15 years to figure out how to test for it in the teeth and how to devise a homeopathic remedy to address it. Teeth breathe. Healthy teeth push fluids out; that is the way they keep bacteria and such out just as skin keeps harmful things out. But with stressed teeth, the flow reverses and fluids go into the tooth. Recognizing that, I devised a mix of homeopathic remedies that go into stressed teeth and knock down the Lyme. I don't think you can ever get rid of Lyme completely. We just have to learn to live with it. The homeopathic remedies I formulated will eliminate most of the Lyme and its co-infections from the teeth. I find that if there is too much Lyme in a person's mouth, cavitations do not heal unless we address the Lyme first. Energy transference of homeopathy is not like a chemical transference. When a tooth is treated, regardless of whether it has a crown, the tooth seems to respond.

**MB:** You are one of a mere handful of dentists in the country who uses electrodermal testing, why?

***"Dental Issues" ...cont'd pg 7***

# FEATURE

# At The Feet of The Master

## My Week With Dr. Charles Ray Jones

***by Ginger Savely, DNP***

Remember when you were a child and an illness or injury prompted a visit to your doctor's office? Chances are you dreaded the experience and were bribed with the promise of a treat afterwards, especially if needles were to be involved. Now enter the waiting room of pediatrician and Lyme disease specialist Charles Ray Jones in New Haven, Connecticut. Here children play video games, watch movies and look forward to seeing the man they view more as a lovable grandpa than as a doctor.

Charles Ray Jones has been treating children with Lyme disease since 1968, before the disease was named for the town in Connecticut where the first outbreak was described. He currently estimates that he has treated about 15,000 children with Lyme and other tick-borne diseases. Health care providers from all over the world call him daily for advice and he generously gives of his time and his expertise. I was honored to spend a week with him in March of this year, observing his style of interaction with children and parents, learning his examination techniques, and generally taking in the pearls of wisdom that only a healer with many years of experience can provide.

A shy, soft-spoken man, Dr. Jones has never been motivated by prestige or money. He is the consummate old-fashioned pediatrician whose love for children and a calling to heal have been his impetus to forge ahead, swimming against the tide. The humble doctor claims that he was the "ugliest, dumbest and least likely to succeed" in his family. He accepts his notoriety with reluctance and even a bit of bemusement. Nevertheless, it is clear that he is touched by the attention and adulation heaped upon him by scores of grateful patients and their parents.

Shunning the professional look of a lab coat, Dr. Jones prefers to wear a bright blue warm-up suit when he sees his young patients, a uniform that has become his signature. "Dr. Charles Ray Jones" is embroidered across the back of the jacket with the words: "Keep marching to fulfill the dream" under his name. His receding hairline merges with long, thick, salt and pepper hair that falls into ringlets at his shoulders. If you were to trade his large, thick glasses for a pair of pince-nez spectacles, you would swear you were looking at Ben Franklin in modern garb. Like Franklin, Dr. Jones is a maverick, a humanist with a wry sense of humor, a man of deep common sense who is not afraid to challenge conventional wisdom and the powers-that-be.

His fraternal twin brother's battle with bone cancer and tragic death at the age of 16 undoubtedly influenced Dr. Jones' desire to pursue medicine. In fact, his pre-Lyme calling was pediatric oncology and in those days, he says, there was little to do but watch children die. With a background that includes a Bachelor's degree in Philosophy and Psychology and a stint at the Theological Seminary at Boston University, Dr. Jones has an artistic sensibility and appreciates music, poetry, and painting. An intuitive man, he truly practices the art of medicine, with solid science as his foundation but ultimately his senses as his guide.

His office is located on the ground floor of an apartment building in downtown New Haven, in the shadow of Yale University, the epicenter of Lyme denialism. Dr. Jones lives in a top floor apartment in the same building, with his daughter, the 10 year old son she adopted from Guatemala, and too many dogs and cats to mention. Dr. Jones loves to talk about his Guatemalan grandson whose "Incan" mind, he claims, operates on a higher spiritual plane than the average person's. This precocious boy accurately predicts the future and writes poetry with sophistication and insight beyond his chronological age. Dr. Jones is clearly fascinated with his grandson's mystical mind and proud to regale the listener with anecdotes of the boy's musings.

Despite his 80 years, Dr. Jones puts in hours that would exhaust someone half his age. He works seven days a week, seeing patients Monday through Saturday and conducting telephone follow-up visits on Sunday. A typical weekday starts at 8 a.m. and ends at 8 p.m. with a lunch break just long enough to wolf down some canned soup. The proximity of his dwelling to his office makes it all too tempting for this devoted doctor to return to his work after dinner, burning the midnight oil as he reviews medical records and prepares for the next work day. Dr. Jones' hard-working assistants - Bonnie, Lisa, Sabra, Tanya, Tina and Toi - are friendly and competent. They are clearly protective of and devoted to their boss, and a family feeling is quite evident in his casual office.

Not one to be guarded, the doctor speaks openly of some of the more intimate details of his life. However, the authenticity of his statements is not always reliable as a dry sense of humor and love of pulling the listener's leg are his modus operandi. There were times when I didn't know whether a claim was truth or fiction, although a devilish grin and glint in the eye were often, but not always, his giveaway.

In fact, his dry wit is an important aspect of Dr. Jones' style as a clinician. He teases his young patients, who all appear to enjoy it since the love behind it is clear. Some of his comments might at face value seem politically incorrect, but the children know that his goal is to make them smile. An example: A recovering 15 year old boy reported that for a long time he didn't want his friends to visit him. He was afraid they might be alarmed by the frightening motor disorder he was experiencing at the time. Dr. Jones' replied: "What do you mean? You should have charged admission!"

Every visit includes an affectionate moment with the good doctor, who hugs and caresses the children as though they were his own. He has an amazing memory of all of his patients, recalling details from a patient's medical history even if he had not consulted the chart for many months. He clearly loves them all. Dr. Jones is known to go above and beyond for his patients' families as well. On one occasion I saw him provide a patient's mother with a second opinion on the reading of her mammogram!

Lest you be tempted to hurry to the phone and call Dr. Jones' office for an appointment for your child, be forewarned that he gets up to 30 such calls a day. New patient visits are at least a 6 month wait. Since time is of the essence in treating children with Lyme disease, Dr. Jones' staff will happily refer you to other health care providers who treat pediatric Lyme with Dr. Jones' blessing.

***"The Master" ...cont'd pg 13***




## Public Health Alert

The PHA is committed to researching and investigating Lyme Disease and other chronic illnesses in the United States. We have joined our forces with local and nationwide support group leaders. These groups include the chronic illnesses of Multiple Sclerosis, Lou Gehrig's Disease (ALS), Lupus, Chronic Fatigue, Fibromyalgia, Heart Disease, Cancer and various other illnesses of unknown origins.

PHA seeks to bring information and awareness about these illnesses to the public's attention. We seek to make sure that anyone struggling with these diseases has proper support emotionally, physically, spiritually and medically.

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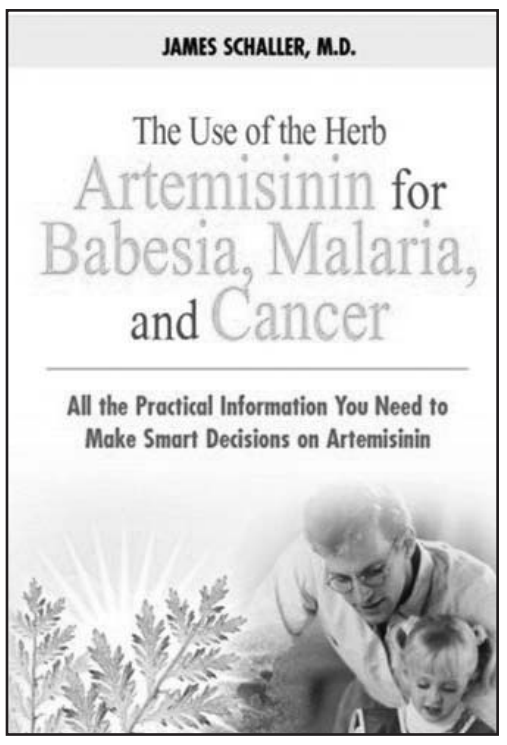


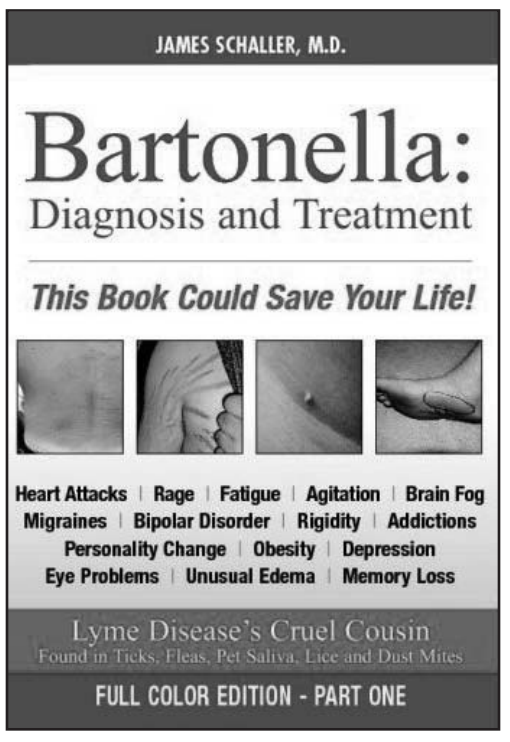


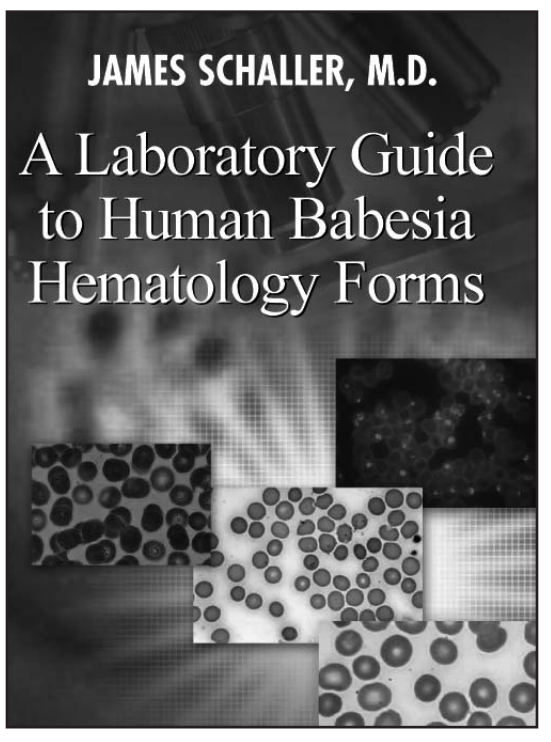


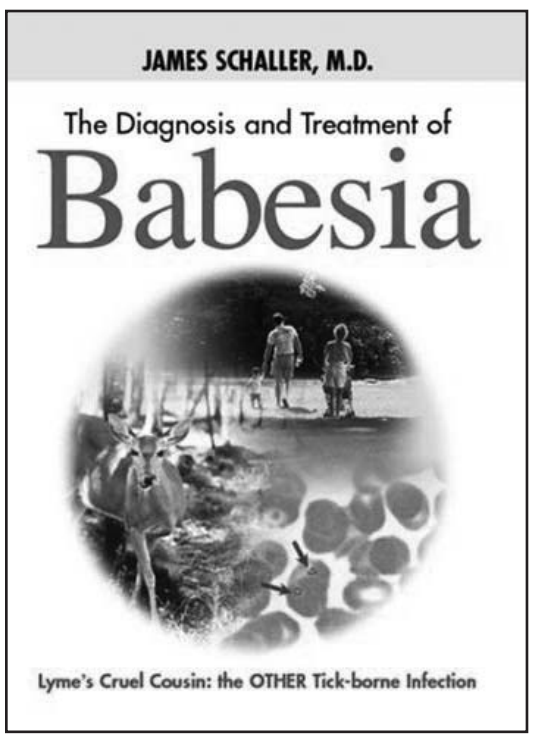


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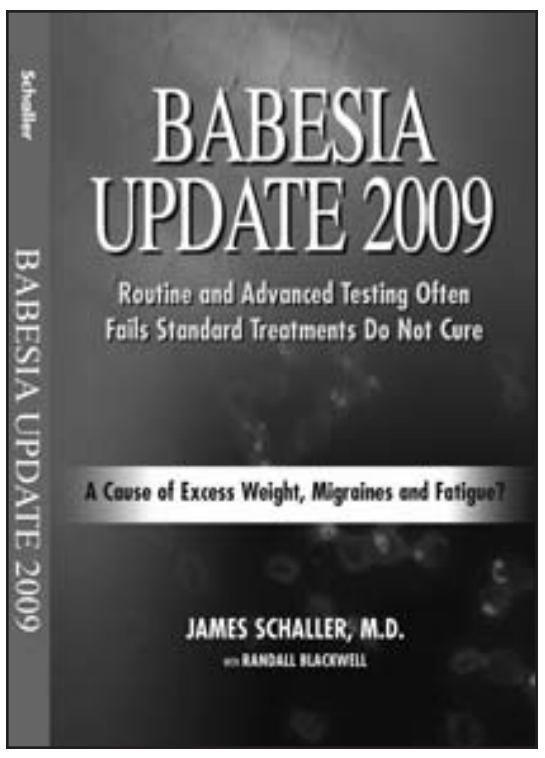


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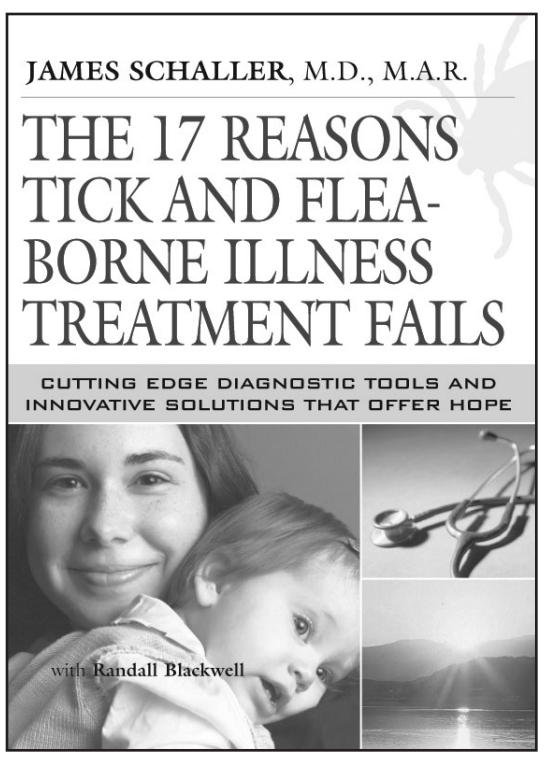



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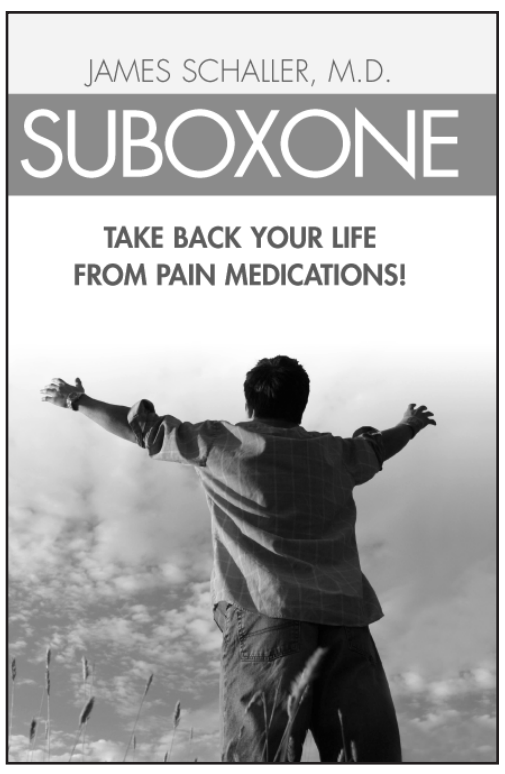
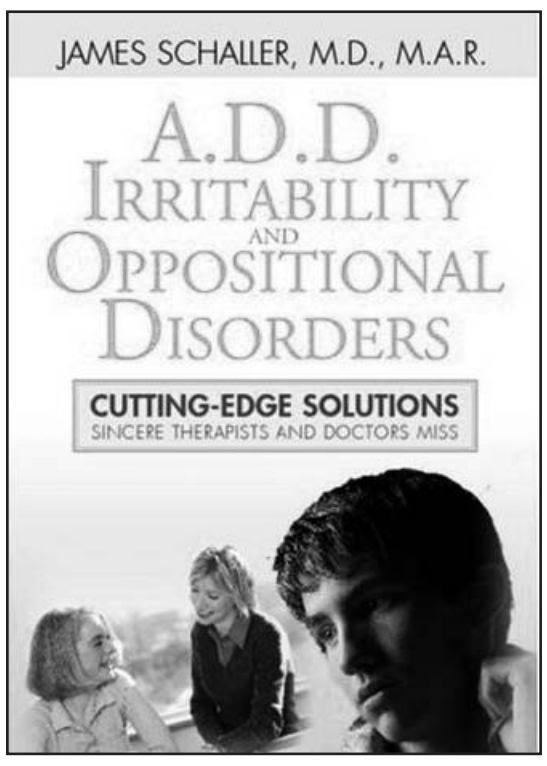
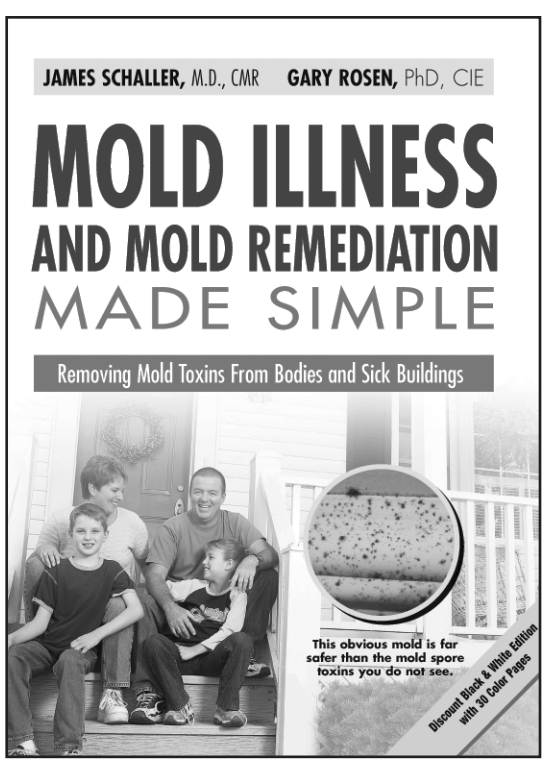
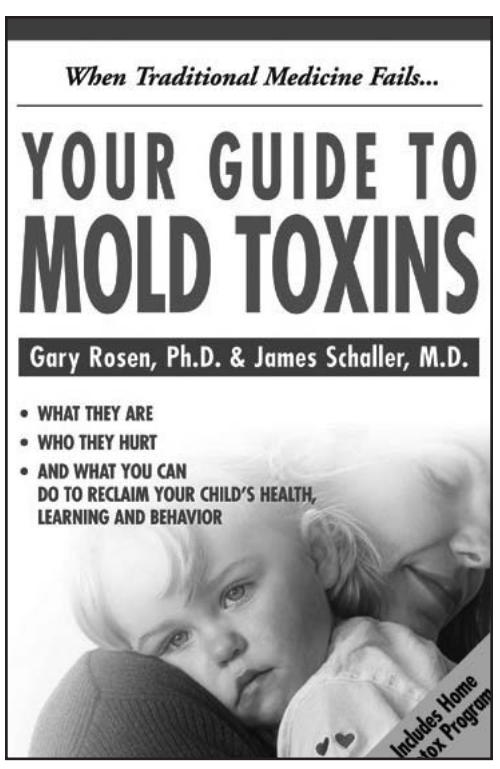


# Beauty from Ashes

*by Linnette R. Mullin*

Oh how we Lyme patients crave a normal life! I sometimes wonder what it would be like to wake up completely unaware of my body…to feel no pain. Wow! I can't begin to fathom it.

Chronic Lyme disease has plagued me from childhood. Mom always wondered at the fact that I rarely wore my waist-long hair in a ponytail - even during the hot, humid Missouri summers. She didn't know the pain it caused me to hold my hands above my head long enough to put it up. My chronic headaches were labeled sinus headaches caused by allergies to pollen. My fatigue and feeling cold all the time was a puzzle since my iron count was always perfect.

When I was 12, the eye doctor declared I had strained eye muscles and prescribed prescription glasses for when I did reading and school work. At the age of 38, I still have good vision. Oh, I contend with floaters and my eyes get sore when my body needs rest, but my vision itself is still good.

Growing up in the Mark Twain National Forest, deer ticks feasted on me yearly. I recall having a bad "flu" from time to time, but never a rash. I remember one summer spending a good week on the couch, sick with a high fever, achiness, and other flu-like symptoms.

In college, I spent more than a month in sick bay with the worst flu I've ever had in my life. I had high fevers, bone deep aches, and my body retained nothing. To my knowledge, nobody else got this puzzling "flu" other than the poor dorm mother who cleaned up after me.

In my chronically diseased state, I now care for my own Lyme-riddled family. No one knew I had Lyme. No one knew I could pass it on to my children. It's an unrelenting cycle. What can you do?

It's easy for others to throw out pat answers. "Keep trusting in the Lord. Remember, He works all things together for your good."

Sure. That's in the Bible. It's a promise I clung to for years. But, somewhere along the way it lost its impact. It became clichéd.

Don't get me wrong. It's still God's Word and retains its power. But, in my extreme circumstances, I felt at the time that I required something more.

I needed answers. I wanted to understand the "whys". I'm God's child, so why does He allow me to spend my life in suffering? Why can't I enjoy a normal life? What good am I to my family, friends, the church, and those lost around me when I can barely take care of myself? I hate being a burden or hindrance.

So, what do I do? Give up? As a child of God, that's not an option.

In desperation, I turned to the book of Ecclesiastes looking for the "under the sun" passage. Finding it in chapter three, I read carefully and made quite a discovery.

"For everything there is a season." I guess that includes affliction, right? But, that's not all I discovered. I realized that I'm not the only one who suffers. Affliction didn't begin with me, nor will it end with me. I already knew this, of course, but I need a bit of reminding from time to time.

As I read through chapter three and then the entire book, I found that I don't always have to know the "whys" of my life. God gave me a glimpse of His bigger picture and I began thinking of life as a puzzle.

When you look at a box of puzzle pieces, it's easy to become overwhelmed. All you see is a pile of different shapes, colors, and sizes. How will you ever get it put together? None of it makes sense.

As you lay out each piece, you find that some are beautiful, vibrant, and elaborately detailed. Many are muted, plain, and nondescript. Others, well, they're just plain ugly.

Some pieces display the butterfly alight on a flower, the golden hue of the sun, or a songbird perched in a tree. Other pieces show the craggy rocks that hold the mountains in place, the rusty hinge on which the cabin door hangs, or the ash heap of the campfire.

Though some pieces are attractive and seem more important than others, every piece is precious. Each one is part of the same puzzle. As you put them together, piece-by-piece, a glorious picture unfolds.

But if even one piece is missing, the entire picture is marred and incomplete.

The writer of Ecclesiastes says that God makes every thing beautiful in its time. As God puts together the puzzle of life, this is a promise to which I cling. Maybe my life is a piece from the ash heap, but I'm no less significant than the golden hue of the sun.

God loves me as I am. He placed me where I am. Whether I see it or not, He uses me even in the weakness and frailty of my flesh. And I know in some unfathomable way, God is producing something beautiful from the ashes of my life.

"For everything there is a season, and a time for every matter under heaven; a time to be born, and a time to die…a time to weep, and a time to laugh; a time to mourn, and a time to dance…a time to seek, and a time to lose; a time to keep, and a time to cast away; a time to keep silence, and a time to speak; a time to love, and a time to hate; a time for war, and a time for peace. What gain has the worker from his toil? I have seen the business that God has given to the children of man to be busy with. He has made everything beautiful in its time. (Ecclesiastes 3:1-11a; ESV)

These verses resurrected the power of Romans 8: 28-29 in my heart, "And we know that for those who love God all things work together for good, for those who are called according to His purpose. For those whom he foreknew he also predestined to be conformed to the image of his Son, in order that he might be the firstborn among many brothers." (ESV)

Many trials have plagued me in my short lifetime, and many more are sure to come. But, whatever God brings, I can hold on to this promise…EVERYTHING will be made beautiful in its time.

*pha*

# He Who Has Ears to Hear, Let Him Hear

*by Joan Vetter*

I love it when, in reading a passage of Scripture, it seems to jump out like I had never read it before. I know the Holy Spirit is endeavoring to tap me on the shoulder saying, "There's something here I want to reveal to you."

One day as I read about preparations for the Passover, I noticed Peter and John asked Jesus where He wanted them to prepare the Passover. His answer amazed me with the detail. Jesus responded, "Behold, when you have entered the city, a man will meet you carrying a pitcher of water; follow him into the house which he enters. Then you shall say to the master of the house, The Teacher says to you, Where is the guest room where I may eat the Passover with My disciples? Then he will show you a large, furnished upper room; there make ready."

I've often joked that I wish the Lord would download directions for my day like a GPS system (God's Positioning Service), but suddenly as I read the above passage I realized Jesus did speak very specifically to His disciples, even revealing what was to come. So I am His disciple, and the Word tells me that Jesus is the same today as He was then, and that His sheep hear His voice. That means I should expect to receive His counsel and instructions a lot more clearly than I do.

Like Hansel and Gretel, I follow the scattered crumbs to find my way. Since Jesus is the Bread of Life surely there will be a path for me. First I thought about a meeting I attended the first of the year. We wrote out scriptures, put them in a bowl and each person drew one, trusting the Holy Spirit to guide us to the one we needed for the coming year. Well, I drew Proverbs 3:5-6, "Trust in the Lord with all your heart, and lean not on your own understanding; in all your ways acknowledge Him, and He shall direct your paths." So, for a couple of weeks I would ask the Lord about many things, trusting Him to direct me. However, I didn't keep it up. As I began to think about His specific guidance, the words "all your ways" stood out. He didn't say when you just don't know what to do, but in everything.

Reactions to wanting the Lord to direct your path vary on the scale - from having no clue that there is a God who is vitally interested in our lives - to the imbalance of believing only mentally ill individuals hear God speak in bizarre ways. The plume line of the Word of God is our instructor.

However, we have all had traditional teaching that clouds the Truth. Therefore, we need to trust the Holy Spirit to be our compass, and open our hearts and minds to new understanding.

I have great delight in recalling an incident years ago where I heard the voice of God so clearly, but argued with him, coming close to missing out on a sweet blessing.

We were preparing to move to Ohio. "Lord", I complained, "I really thought there would be an opportunity for Ted to meet Tom." Tom was my Sunday School teacher who experienced a dramatic conversion, from a millionaire addicted to drugs, pornography and adultery to being so in love with the Lord that he poured his money into mission trips and shared how God had set him free to everyone who would listen.

"Invite them for dinner," I heard the Lord say. What? We only had a couple more weeks before Ted would be leaving and we had much to do. Also it was close to Christmas. I gave God all these excuses. "Ted doesn't even know him and would say no."
"It is Christmastime and I'm sure they are busy."
The clincher was, "God, They used to live in a 7 bedroom mansion, and we have a 1500 square foot house which is not even decorated much for Christmas."

Can you believe God was kind enough to answer that so specifically? When Tom preached at our church that weekend, our pastor introduced him, saying, "For the sake of the gospel he has downsized to a 1500 square foot home!" As you can imagine, I quickly made the call to invite them. They were pleased to come. At dinner his wife said, "I love your Christmas decorations - I haven't had a chance to do anything yet."

So with that remembrance, today I'm telling the Lord, "Lord, I want to hear You like that again, but I don't promise that I won't argue with you - just ask my husband. I don't always listen to him the first time either."

*pha*

# NVIC's October 2009 Vaccine Conference: It's About Informed Choices

*by Barbara Loe Fisher*

As many parents head for the Autism One conference in Chicago next week to learn how to heal their children's vaccine-related brain and immune system dysfunction and worldwide anxiety about the swine flu lingers, the National Vaccine Information Center (NVIC) is opening registration for the Fourth International Public Conference on Vaccination. The conference will be held Oct. 2-4, 2009 at the Hyatt Regency Hotel in Reston, Virginia near Dulles International Airport and Washington, D.C. The largest and oldest non-profit vaccine safety organization in North America, founded in 1982, is sponsoring the event to provide a public forum for open discussion about vaccine issues of concern to parents and health care professionals. The conference theme "Show Us the Science & Give Us A Choice" reflects NVIC's three decade pro- education and pro-informed consent stand defending the right of citizens to make fully informed, voluntary vaccine decisions for themselves and their children.

More than 35 speakers from the U.S. and traveling from Canada, United Kingdom, Italy, Japan, and Kenya will speak about the science, policy, law and economics of vaccination; the human right to informed consent to vaccination; as well as holistic health care options for preventing illness and staying well. Pre-conference state organizing sessions start Thursday evening, Oct. 1, and Friday and Sunday advocacy training, holistic health education and vaccine injury family networking sessions precede a post-conference Monday, Oct. 5 bus trip to Capitol Hill.

Friday, Oct. 2 Highlights: Peggy O'Mara, founder & editor of Mothering Magazine and Jane Bryant, founder & editor of the UK internet news service, One Click, start the first day with a discussion about freedom of the press. The keynote address will be delivered by renowned bioethicist George Annas, JD, MPH, Chair of the Department of Health Law, Bioethics & Human Rights at Boston University School of Public Health. HPV vaccine researcher Professor Diane Harper, MD, MPH of the University of Missouri, Kansas City School of Medicine, will examine informed consent issues involving Gardasil vaccine. Evidence for influenza vaccine efficacy will be reviewed by Italian epidemiologist and physician Tom Jefferson, MD, Cochrane Vaccines Field Coordinator.

Coming all the way from Kenya is cell biologist and vaccine researcher Bonnie Dunbar, PhD, who co- founded the Africa Biomedical Center, to inform the audience about the multi-disciplinary approach to meeting unique health challenges in Africa. She is joined by Canadian pediatrician Colin Forbes, MD, who will recount his more than 40 years of experience caring for children in Kenya and how he helped reduce child mortality in some of the most impoverished child populations in the world.

Returning briefly from a health research position in Japan, MIT doctoral candidate Peter Doshi will outline the impact on democracy of U.S. and global vaccine policies. Human rights activist Shiv Chopra, B.V.Sc., M.Sc., PhD, who was former scientific advisor to Health Canada, and is author of "Rotten to the Core" will give a presentation entitled "Public Health or Corporate Interests?"

During what promises to be an historic conference, pediatrician Bob Sears, M.D. offers an alternative schedule for use of 16 U.S. government recommended vaccines and will debate pediatrician Lawrence Palevsky, M.D., who presents an alternative view of how to maintain health and prevent chronic illness. Holistic health pioneers Joe Mercola, DO and Gary Null, PhD will talk about how good nutrition and understanding how to make healthy life choices is the key to staying well, while holistic veterinarian and immunologist, Richard Pitcairn, DVM, PhD, will teach the audience about how good nutrition and homeopathy can keep pets well and Life University Professor Matthew McCoy, DC, MPH will give a chiropractic perspective on informed consent to vaccination.

"Will the Law Protect Health Freedom?" is the question that constitutional and federal law experts, along with leading medical privacy and health freedom advocates will discuss. Vaccine injury and product liability law will be the topic explored by attorneys who have won vaccine injury cases in the federal Vaccine Injury Compensation Program, and also have expertise in vaccine contamination and use of experimental vaccines in soldiers. Longtime vaccine choice lobbyists like PROVE President Dawn Richardson will join longtime autism activists M.I.N.D. Institute co-founder Rick Rollens and Unlocking Autism President Shelley Reynolds and others to help parents organize to educate legislators and protect the right to make informed vaccine choices.

During the past few years, there have been calls for elimination or severe restrictions of vaccine exemptions by doctors with ties to the vaccine industry and by government health officials seeking a 100 percent vaccination rate with all government recommended and mandated vaccines. NVIC has long taken a public stand for the basic human right to protect bodily integrity and the October conference provides a public forum not only for those who want the freedom to make voluntary choices about using pharmaceutical products and medical interventions that carry known and unknown risks, but also for scientists, doctors, journalists and health safety advocates to present information and defend their right and responsibility to investigate and speak about improving vaccine science and policies to protect individual and public health.

The conference is supported by an educational grant from the Albert and Claire Dwoskin Family Foundation, which has made it possible for NVIC to keep the registration fee for those registering by August 30 at $195 for the three day, three night conference featuring top speakers from around the world. There is a low $95 per night hotel rate, which is unheard of in the Washington, D.C. area for a fine hotel like the Hyatt Regency. Meeting and hotel room space is limited in the only hotel in the village of Reston. Conference registration and hotel room reservation is on a first come, first serve basis. For more information about speakers, sponsorship opportunities and registration,

# PHA Staff Writer Wins Women's Health Hero Award

**San Diego, CA -- (SBWIRE) -** Lisa Copen, founder of Rest Ministries, Inc., the largest Christian organization specifically for those with chronic illness or pain, won the ***Our Bodies Ourselves Award*** for Women's Health Hero: Audience Choice.

On May 11, 2009 Our Bodies Ourselves announced the 2009 Womens' Health Heroes, honoring the work of women's health advocates worldwide, marking OBOS's first annual effort to spotlight the diversity of care, education and activism in communities around the world.

See OBOS's announcement, as well as the nomination and kind comments for Lisa here:

**www.ourbodiesourblog.org /womens-health-heroes-2009**

"Every day millions of people worldwide do incredible work to improve the health and well-being of women, and we want to bring attention to their efforts," said Our Bodies Ourselves Executive Director Judy Norsigian. "Many of our

heroes accomplish so much with very few resources, particularly on the frontlines of public health, where gaps in the quality of care and healthcare access remain persistent."

The inaugural group, chosen from close to 100 nominations, represents seven countries: United States (13), Canada (2), Australia, The Netherlands, Nigeria, United Kingdom, Ukraine.

Copen, 40, who began Rest Ministries in 1997 after living four years with rheumatoid arthritis and not finding illness support that was faith-based says, "It's a great honor to win this award, but more exciting is the opportunity to have the opportunity for Rest Ministries to gain the exposure. We sponsor National Invisible Chronic Illness Awareness Week each September and have a five-day virtual conference online. I hope that this award will be a reminder of the resources that are out there to encourage people while living with illness."

To find out more about Rest Ministries visit their web site at www.restministries.org and information for *National Invisible Chronic Illness Awareness Week* is now being updated for 2009 at www.invisibleillnessweek.com.

*pha*

# "Mycoplasma" ...cont'd from pg 1

this organism was highly discouraged." In fact, until the Gulf War, the military's own medical school had been teaching about the dangers of *M. fermentans* for years.

**Background**

Just years earlier in Texas, prisons emerged in which many of the inmates and guards came down with neurodegenerative conditions at rates that were far from ordinary. In Huntsville, where three large State prisons are found, there were about 70 cases of ALS, numerous cases of Multiple Sclerosis, and highly unexpected numbers of Rheumatoid Arthritis cases. At that time, the term "Mystery Disease" was used to identify the unusual illnesses that so many seemed to have acquired.

Dr. Nicolson started testing prison guards and their family members and found that very high numbers of these people were testing positive for *Mycoplasma fermentans*. Furthermore, this appeared to be a weaponized version of the organism called *M. fermentans incognitus*, a specific strain of *Mycoplasma* that had been altered to cause more severe symptoms, to be more virulent, and to be more survivable than the naturally occurring *M. fermentans.* Dr. Nicolson believed that biological weapons experiments had been carried out on inmates in the Texas prison system for years in which humans had been used as guinea pigs.

As time progressed, these illnesses did not remain confined to the prisoners. Soon after the prisoners unknowingly became a part in these experiments, the prison guards became ill. Their illnesses gradually became those of their families. It was not long before these *Mycoplasma*-based illnesses became a broader part of the surrounding Huntsville, Texas landscape.

The Texas prisoners that came down with Amyotrophic Lateral Sclerosis (ALS) later died. In the state of Texas, at the time, the state law dictated that all prisoners that died were later to be autopsied at University of Texas at Galveston. However, that was not what was happening to the prisoners who had died as a result of this horrific experimentation, according to Dr. Nicolson. Through one of his former students who at the time was responsible for the autopsy service at UT Galveston, Dr. Nicolson learned that none of the bodies had been sent there. Dr. Nicolson had discovered that at least six private autopsies a week were being performed on deceased prisoners at a US Army base. The bodies were then sent to a private crematory at a secret location in central Texas. Additionally, prisoner records were destroyed. All of this, according to Dr. Nicolson, violated state law.

Though much of the evidence of this experimentation had been destroyed, a document was found in the basement of an Austin building that was viewed as the "smoking gun". The document indicated that the Texas Prison Board, Baylor College of Medicine, and the Department of Defense were all a part of the experiments involving the Texas prisoners - experiments that later resulted in the death of many of the inmates. According to Dr. Nicolson, some of the experiments used *Mycoplasma* while others utilized various "cocktails of microbial agents" such as *Mycoplasma, Brucella,* and DNA viruses such as *Parvovirus B19*. This project later became the topic of a book by Dr. Nicolson entitled *Project Day Lily*.

Dr. Nicolson believes that *Mycoplasma fermentans* is a naturally occurring microbe. However, some of the strains that exist today have been weaponized. Dr. Nicolson's research found unusual genes in *M. fermentans incognitus* that were consistent with a weaponized form of the organism. Weaponzing of an organism is done in an attempt to make a germ more pathogenic, immunosuppressive, resistant to heat and dryness, and to increase its survival rate such that the germ could be used in various types of weapons. Genes which were part of the *HIV-1* envelope gene were found in these *Mycoplasma*. This means that the infection may not give someone *HIV*, but that it may result in some of the debilitating symptoms of the *HIV* disease. Indicators of a weaponized organism were evident in the prison guards in Huntsville as well as in military personnel that were likely exposed to the infections both through military vaccinations as well as through weapons used in the Gulf War.

The unfortunate reality according to Dr. Nicolson is that "once these things get out, you can't put the genie back in the bottle". Once these germs have been released, they are airborne infections that slowly penetrate into the population. In the case of *Mycoplasma fermentans*, Dr. Nicolson believes that this is exactly what happened. It may be this weaponized form of *Mycoplasma* that has led to the significant increases in neurodegenerative and autoimmune diseases over the last several years. Those patients with weaponized strains of these organisms are generally very sick. They may experience 60-75 signs and symptoms and are even at risk of their diseases becoming fatal.

In looking at the source of infection in the Gulf War veterans who were contracting *Mycoplasma*, Dr. Nicolson suggests that vaccinations appear to be the most likely mechanism through which the veterans became infected. Many military personnel that later became ill were far from the battlefields or had received the vaccinations and were never deployed. However, biological weapons sprayers were known to have been deployed by the Iraqis in the Gulf War and were used to spray the sand in Iraq and Kuwait. Gerald Schumacher, a Special Forces colonel in charge of biological weapons detection, blew the whistle on this after he retired. During the Gulf War, his group was not allowed to deploy their biological weapons detectors which led to reports that no such weapons were detected or used.

The Iraqis received a great deal of assistance on biological warfare from the United States during the Iran-Iraq Conflict. Both chemical and biologic weapons were given to them from the United States. After the Gulf War, rather than taking inventory of these weapons, they were blown up. Dr. Nicolson indicates that some of his patients have taken videos standing next to crates with Hazardous Materials tags from the United States. In the same videos, the crates are opened and weapons are clearly striped as having originated from the United States and being both chemical and biological weapons.

There were clear indicators that Iraq had offensive weapons in their arsenal. In Kuwait, many people had become quite ill. It was estimated that 25% of the population after the Gulf War had signs and symptoms which matched the symptoms of those infected with weaponized *Mycoplasma*. There were also a number of other chemical exposures and thus, there was never a clear indicator as to whether or not the Iraqi illnesses were caused by biologic or chemical agents.

When asking Dr. Nicolson how much he personally has been harassed for bringing much of this information to light, he shared that it has been "a horrific time".

After Dr. Nicolson exposed the Huntsville prison experiments, the University of Texas educational system attempted to fire him from his tenured and highly respected position. Dr. Nicolson shared that a tremendous amount of pressure was put on the University of Texas system to "shut him up and close his laboratory". He was threatened on an almost daily basis with closing his lab as he continued to do his research on *Mycoplasma*. This became a major subject in the book *Project Day Lily*. Fortunately, for many of us struggling with chronic illnesses, Dr. Nicolson's experience and knowledge continue to be a benefit in that we understand so much more than we otherwise would about this formidable foe called *Mycoplasma*.

| Illness | Infections Commonly Observed |
|---|---|
| Amyotrophic Lateral Sclerosis (ALS) | *Mycoplasma fermentans* (and other species), *Borrelia burgdorferi, HHV6, Chlamydia pneumoniae* |
| Multiple Sclerosis (MS) | *Chlamydia pneumoniae, Mycoplasma* species, *Borrelia burgdorferi, HHV6* and other *Herpes* viruses |
| Alzheimer's Disease | *Chlamydia pneumoniae, Borrelia burgdorferi, HSV1* and other *Herpes* viruses |
| Parkinson's Disease | *Helicobacter pylori, coronavirus, Mycoplasma* species |
| Autism Spectrum Disorders | *Mycoplasma fermentans* (and other species), *Chlamydia pneumoniae, HHV6, Borrelia burgdorferi* |
| Chronic Fatigue Syndrome | *Mycoplasma pneumoniae* (and other species), *Chlamydia pneumoniae, Borrelia burgdorferi* |
| Lyme Disease | *Borrelia burgdorferi, Mycoplasma fermentans* (and other species), *Babesia* species, *Bartonella* species, *Ehrlichia* species |

***Chronic illnesses and infections commonly observed in each according to the work of Dr. Garth Ncolson, PhD***

**Symptoms**

The signs and symptoms of *Mycoplasma* infection are highly variable and thus it is not uncommon for a diagnosis to be entirely missed. A partial list of symptoms includes chronic fatigue, joint pain, intermittent fevers, headaches, coughing, nausea, gastrointestinal problems, diarrhea, visual disturbances, memory loss, sleep disturbances, skin rashes, joint stiffness, depression, irritability, congestion, night sweats, loss of concentration, muscle spasms, nervousness, anxiety, chest pain, breathing irregularities, balance problems, light sensitivity, hair loss, problems with urination, congestive heart failure, blood pressure abnormalities, lymph node pain, chemical sensitivities, persistent coughing, eye pain, floaters in the eyes, and many others. On Dr. Nicolson's web site at http://www.immed.org, a full list of signs and symptoms and an illness survey form can be found.

It doesn't take long to see that the symptoms of *Mycoplasma* infections are very similar to the symptoms of *Borrelia* infections in chronic Lyme disease. Dr. Nicolson has looked at some of the more common neurodegenerative diseases and the infections that are associated with each.

*Mycoplasma* is commonly found in patients with ALS, Multiple Sclerosis, Autism, Chronic Fatigue Syndrome, Rheumatoid Arthritis, Chronic Asthma, Lyme disease, and many other chronic disease conditions.

**Characteristics**

*Mycoplasma* are pleomorphic bacteria which lack a cell wall and, as a result, many antibiotics are not effective against this type of bacteria. There are over 100 known species of *Mycoplasma*, but only a half dozen or so are known to be pathogenic in humans. The pathogenic species are intracellular and must enter cells to survive. Once they are inside the cells, they are not recognized by the immune system and it is difficult to mount an effective response.

They stimulate reactive-oxygen species (ROS) which damage cell membranes. They release toxins into the body. Infected cells can be stimulated to undergo programmed cell death which may result in ALS or other severe neurological presentations. 90% of ALS patients evaluated were found to have *Mycoplasma* infections, whereas *Mycoplasma* was found in 100% of ALS patients with Gulf War Syndrome, almost all of which were weaponized *M. fermentans incognitus*.

They are thought of as "borderline anaerobes", meaning that they generally prefer low oxygen environments. Dr. Nicolson has found that airline employees are much more susceptible to these types of infections and that symptoms worsen with frequent long flights at low oxygen tension. *Mycoplasma* also have some characteristics of viruses.

Mycoplasma tend to be slow growing infections and they are usually transmitted slowly. Dr. Nicolson states that "*Mycoplasma* can be sexually transmitted, but the infection is usually passed through far less intimate contact. *Mycoplasma* can be obtained through fluid exchange, and it is easily transmitted through the air." In Gulf War veterans, the first person besides the veteran to become ill was the spouse and, later, other members of the household also became ill. Not everyone is equally susceptible to *Mycoplasma* infections, especially those with strong immune systems who can resist infection.

As already discussed,

***"Mycoplasma" ...cont'd pg 12***

# "Dental Issues" ...cont'd from pg 1

**AL:** The American Dental Association (ADA) does not yet acknowledge electrodermal screening. I am in the midst of a 10-year, FDA-approved study on the energetic relationship of teeth to degenerative disease as monitored by electrodermal screening. I have about 500 patients in the study. It is crucial to recognize that each tooth is connected via meridians to the organs of the body, and they are all connected energetically. For example, many people with heart conditions will be found to have a chronic infection at the site of their wisdom teeth - the third molars. Certain molars are connected to the heart meridian and when those teeth are stressed with chronic infection, the heart is stressed. Dr. Joseph Issels of Germany wrote that many cancer patients got well, for example, when root canals and other infections of the oral cavity were removed. I find that almost 100 percent of women with breast cancer have a chronically affected upper first molar. Likewise, reproductive organs are tied into the upper centrals, male and female. My approach is based upon the Meridian Theory from Traditional Chinese Medicine (TCM) and The Focal Theory of Infection.

Both homeopathy and Rife frequencies work energetically with Lyme; they are just different sides of the same coin. Both are effective. The difference is that for homeopathy to work optimally, you have to remove as many impediments to proper immune function as you can before using it - such as removal of dead teeth and metal fillings of all sorts, and cleaning up chronic infections in the jawbone. Rife works by generating a frequency specific to Lyme and aiming that at the body to kill the bacteria. Like homeopathy, Rife generators may or may nor produce healing crisis. That seems to depend on individual reactions. Neither one will totally eliminate the various forms of Lyme bacteria, but they help manage the disease.

**MB:** What is the Focal Theory of Infection?

**AL:** A focal infection is a local infection that expands to incorporate the whole quadrant, then the whole side of the mouth and eventually can cross the midline to incorporate the other side. Basically, the theory says the oral cavity is able to generate particularly nasty toxins that poison the body when you have had a root canal or a tooth extracted. Most dentists still do not understand the Focal Theory; it was studied more in Europe than here. Dr. Weston Price's great contribution was the discovery that focal infection bacteria are polymorphic, meaning they mutate and adapt and multiply like rabbits in the three miles of dentin tubules that emanate from every tooth. The bacteria become smaller and anaerobic - they can now live without oxygen. They also become more virulent, and their toxins more toxic. Root canals and old extractions are common focal infection sites.

When you have a root canal, a dead tooth is left in the mouth. The dead tooth lacks a blood supply to its interior. Antibiotics circulating in the bloodstream have no way to penetrate this dead tissue. Over time, the material packed inside the dead tooth shrinks a bit. Now bacteria come in and morph. The tooth has both bacteria and toxins as a result of being dead for so many years and these toxins are infiltrating into the bloodstream.

In extraction sites, the healing may not take place correctly. If the healing is incorrect, the space can fill in with fatty tissue, dead bone, improper bone, or it can fill in with infected material. All of these processes are wrong and the organ associated with that extraction site will always show this improper healing. The remedy is to clean out the socket, debride it, and remove the ligament that holds the tooth in as well as the dense bony lining of the socket. The other important factor is cleaning up the quadrant (at least) of the mouth where the extraction was performed - cleaning up all metal and any other extraction sites. This is the best way to assure proper healing from extractions.

Toxins from focal site infections are highly virulent and they tend to go to the organ associated with the meridian upon which that tooth lies. Over time, the toxins' assault will change the genetics of the organ. However, it has been found that upon proper extraction of a dead tooth and proper treatment of an extraction site, the organ will return to its normal genetics. Bob Jones, an engineer, recently did substantial genetic testing which demonstrated the ability of organs to right themselves.

**MB**: Are tonsils also focal infection sites?

**AL:** They can be. Tonsils are basically nodules of lymph tissue. Removing tonsils should be a solution of last resort. Tonsils are part of the immune system. Tonsils are a network of guard posts to infection because the body needs to protect the brain. There are valves in the veins that prevent blood from flowing backward. In the head there are no valves, so blood can flow in any direction and an infection in the brain would be disastrous. The tonsils, when functioning properly, prevent infections from entering the brain. There are four tonsils on each side of the head plus the pair we can readily see at the back of the mouth. They are prone to recurring infections because of allergies and other factors in the body. With multiple infections comes scarring of the tissue. Hence when this has occurred, the tonsils need to be dealt with as scars need to be dealt with.

**MB:** Tell us how scars interfere with the body's energy.

***Dr. Andrew Landerman, a Biological Dentist, practices in Sebastopol, California.***

**AL:** If scars are present, they act as an energetic block, much the same way a dead tooth does. And there are various ways to neutralize scars. A scar is not merely something on the outside of the skin - it is the skin. The energy flow of the meridians goes right under the surface of the skin so where there are scars, they can act as a major block to energy flow. There are various other energetic blocks, but teeth, the tonsils, and scars are the major ones. When healing energetically, all three areas are very important to deal with. The stronger the energetic system, the better you can handle outside factors like genetically modified food and environmental chemicals. Often with Lyme, it is said that you need a strong immune system to keep the Lyme under control. That is true. But you also need a strong energetic system and often that is overlooked.

**MB:** Can you tell us about one of the Lyme patients in your FDA-approved study?

**AL:** Sure, let's call her "Julie." Her history was one of a normal birth, normal delivery, normal first 6 months of development. But then she began to have pronounced joint pains, mobility problems, rashes, and her deciduous teeth - her baby teeth - showed pronounced malformation and discoloration. Julie's parents took her to a prestigious California medical facility where they were unable to make a diagnosis. She was given pain medication and anti-inflammatories. This went on for 6 or 8 months with no apparent relief of the symptoms. When I first saw Julie, she was 18 months old. Her deciduous enamel was misshapen and reddish in color. This suggested there was a deep underlying condition that probably would cause the same things to occur in her permanent teeth. I used electrodermal screening and determined she had what looked like borellia burgdorferi - the main spirochete that causes Lyme disease. She tested positive for some co-infections, but Lyme was the bigger factor. I made homeopathic remedies for this and we also used natural anti-inflammatory remedies. Within a week, the pain subsided dramatically. The swelling decreased. About one month later, the parents reported that the symptoms had disappeared. It is too early to tell, of course, but there is every reason to believe her adult teeth will erupt normally and be free of the red stains and changes in morphology that came with the baby teeth. When I saw Julie, I realized both parents had Lyme. Lyme can be transmitted through the placenta.

**MB:** How much of a role do vaccinations play with children with Lyme?

**AL:** In general, vaccines lower one's immune competency and most would impede immune function where Lyme is concerned - allow it to get an easier foothold. A vaccine does not boost immunity. It gives us a template to recognize a specific protein when it enters the body and to be able to attack that protein and render it harmless to the body. Vaccinations should not be done until about 2 ½ years of age, the point at which all the baby teeth have erupted. It is then that humans have a fully functional, competent immune system and can better handle the introduction of the complex foreign proteins introduced in the form of vaccines. That is not to say they can handle the mercury and other toxins added for stability. We have to create a culture where people realize drugs are not made to maintain healthy, happy lives. The integrity of the terrain is the major factor. Louis Pasteur, remembered for developing vaccines, reversed himself on his deathbed. He said, "The pathogen is nothing, terrain is everything." If you want a healthy terrain for children, then pre-conception health becomes critical because we are seeing more and more that degenerative changes in kids are transferred from the parents. You see teeth malformations in some children. That says something is going on with the DNA. It has been demonstrated, for example, that there are genetic changes along pathways where there are root canals. Where pathways have been interfered with, the genetic changes for worse. But when corrected, the genetic change goes back to the normal pathway. "Smart conception" means you clean up the energetics of the body first.

**MB:** What about mercury fillings?

**AL:** Mercury is about the most active of metals. The higher the temperature, the more it is released, poisoning the system. It is tough to rid the body of chronic diseases when poison constantly leeches from the mouth. Many people have crowns with an underlying layer of nickel, a very toxic metal. Unfortunately, dental schools are not much help right now. They do not teach Chinese medicine and they still consider amalgam (50% mercury filling) a usable material, when even the FDA now requires warning labels on amalgam packaging. Sometimes people tell me they got worse after they had mercury fillings taken out. I know the wrong material was used in that person's mouth. You really have to test energetically for what to use for crowns or bridges - restorations. The material I like the best is cubit zirconium, a cousin of what you find in the false diamond. It is energetically different and has been consistently good for restorations. Zirconium is a metal that looks like clear glass. When you make an oxide of it, the negative aspects of the metal disappear. It loses it crystalline aspect and becomes more acceptable to the body.

I always felt the internet would help humanity learn how to live better, naturally. As more consumers demand metal-free dentistry, this will create the change in the profession. When I started 35 years ago, I had to talk like a Dutch uncle to get people to remove mercury fillings and root canals - it was tough. Now people are getting more informed. As patients demand change, the young dentists will have to respond. The dilemma, though, is that when they get out of school, young dentists are in debt. To take on a whole new challenge, to change your profession, is a very arduous task. They need the support of the patients.

**MB:** Would you say something about your own experience with Lyme?

**AL:** Many people in my part of the country do not understand the Sierra Foothills and the coastal range in which they live is full of ticks. Many people are bitten and never know it. They don't understand that Lyme disease is sexually transmissible, and is passed through breast milk as well. I got sick because I had teeth extracted. Root canals, as well as improper extractions, weaken your immune competency. In my

***"Dental Issues" ...cont'd pg 14***

# The Power of Truth Spoken by Joseph G. Jemsek, M.D.

## Part 2

*by Tina J. Garcia*

**Tina:** Dr. Jemsek, what is your approach to patients and your method for treating Lyme Borreliosis Complex?

**Dr. Jemsek:** With regard to my approach to patients, I am unable to accept insurance, so there is a financial challenge for patients, which I regret and always appreciate. Almost all patients completely understand this situation, and we do everything we can to help with HICFA forms for insurance filing and so forth. But we all know that health insurers are terrified of the 'black box' which LBC represents, and that their business model is essentially 'anti-patient'.

There is also a travel challenge in most cases, because I see patients from all over the country and quite a few from Europe and other continents. For example, I've had patients come from Russia, Lebanon and Australia to visit the clinic in South Carolina. I've had a dozen to fifteen or more patients come from the Scandinavian countries, as well.

**Tina:** So despite all the problems forced upon you, patients still come to see you for help.

**Dr. Jemsek:** Yes, because it's a worldwide epidemic. In fact, we get emails from patients, several per week on average asking, "Can you help me?" People are desperate. It really breaks my heart. I currently only see Borreliosis patients, but I'm seeing sicker patients than I've ever seen before.

**Tina:** How does the office visit unfold when patients see you for an appointment?

**Dr. Jemsek:** A new patient intake is a two-hour visit. We ask that the patients complete a clinical medical history form, and they typically bring in an inch or two of records which we review thoroughly. I usually start the patient interview with the question, "Are you doctor referred, or are you here with your doctor's approval or understanding?' Then I ask the patient which doctors they want copied on my consultative note. Some patients say none, some want several doctors copied, and some decide later, so we're happy to do that for them and really encourage the communication.

For as long as I can remember, I have made a practice of providing a copy of the consultative note to each patient, so the patient gets our whole summary with recommendations right away, and of course, I copy any physician who referred the patient or to whom the patient wishes records be sent. Ideally, we want exhaustive but well-organized reviews up front, because if you don't get it on the first or second visit, you likely will never have a history that serves the patient well. In most cases, we set several actions in motion immediately after the visit, and it really isn't until later when laboratory tests and procedures are concluded, that we get a more complete picture. These are extensive documents that I create.

**Tina:** That's a great help to someone with cognitive dysfunction.

**Dr. Jemsek:** Exactly. Everyone's from somewhere else, so if someone's on IV therapy, for example, they have to have a collaborating physician at home, no exceptions. And if the patient is going on an oral antimicrobial regimen, we still very much encourage collaboration with a local physician, but we don't demand it.

Patients always have the discretion of taking their records and going to the next physician or finding a physician. I am currently able to interview about five new patients a week on average. That's about all I can do. On the first follow up visit or with a patient that I haven't seen in a year or two, we devote forty-five minutes. On a routine scheduled office appointment, the scheduled time is thirty minutes. So as you can see in that way, from the time allotments, I can only see ten to fourteen patients a day max. If I see more than one new patient a day, it's a really long day.

I just think that doing as much up front and doing it as thoroughly as possible pays tremendous dividends in terms of patient care, organization, and mutual understanding of what the goals are. We're booked out about four months now, but the consistent trend continues to be for this period to grow longer. We have approximately seventy-five new patients on the waiting list and the list is growing every day. However, very soon I intend to bring in two nurse practitioners, and that should significantly expand our new patient intake. As appropriate, we're going to be able to charge considerably less for the nurse practitioner visits, which will help our patients access the clinic, but I'm going to promise that I will always see the patient on the next visit.

**Tina:** What about your clinical staff and other areas of practice?

**Dr. Jemsek:** I am up to about fifteen employees now, whereas at the Jemsek Clinic in 2005 I had seventy employees serving the twin epidemics of HIV/AIDS and LBC. Some of those folks were research PhDs and we really miss them, and not that we are semi-resuscitated, but we're going to start our research again. I recently brought back some really outstanding people who worked with us before. My head clinical research RN is coming back, along with another RN whom I worked with in infection control when I was the epidemiologist at Carolina Medical Center years ago. With these outstanding individuals back on board, we're going to start doing respective chart reviews and thorough data collection. I'm also teaming up with a Ph.D. in chemical engineering who's incredibly bright and very well-connected, and has this wonderful model for database collections, among other things.

Our research efforts will follow two or three different paths. One path is basic data collection and the other paths will involve much more sophisticated research, both clinical and basic science in orientation. This will require collaboration with a number of scientists and we're confident we can make this happen. What our clinic provides, above all, is the patient population and an excellent knowledge of which questions to ask. The real trick is knowing how to prioritize what is most useful now and what can wait, since there are literally thousands of potential projects that need to be explored. I'm very anxious to turn over some of this process to people who are much smarter than me who can run with it. It's just incredible, because we're at the beginning of a new frontier. It's as though we're starting all over again. The only advantage we have is that we have the experience of HIV/AIDS, and if this research project ever gets capitalized, we can jump start this thing.

We will use the HIV/AIDS epidemic as a model, although as most recall when it first started, no one was interested in all the gays who were dying. But soon it became a national agenda, things picked up and the government did do the right thing by starting the ACTG groups. That was a really smart thing to do. They asked the clinical trial, basic science questions and did the research, the grunt work so to speak. Then pharmaceuticals and NIH became heavily involved, and of course they brought in money, and it became a multi-billion-dollar enterprise, attracting the best minds in infectious diseases.

So really, at least from a scientific point of view, once the commitment is made, the jump to understanding LBC should come from a tremendous platform built on the back of the HIV/AIDS pandemic, or at least it should work that way. On the realistic side, however, my research associate made the remark that a seasoned immunologist recently admitted to him that we know next to nothing when it comes to most chronic illnesses. And really, nothing is as easy as I have just described, so it may take decades to fully understand the epidemiology, molecular biology and nature of the disease states associated with LBC.

I expect my experience in HIV/AIDS and LBC to parallel each other, if I am around long enough. In HIV/AIDS, I came from one world where I grew up and spent the first decade or more of my experi-

ence dealing with the human aspects of a deadly disease, and so I got a crash course during part of my career getting in touch with my own mortality and who I was as a physician. Then, during the next decade, as the money rolled out and thousands more became involved in research and treatment, the science was simply incredible.

I was involved with HIV and attending and presenting data at very well-funded meetings and that sort of thing. Then I went from that world to the Lyme world, which in the beginning was pictures of raccoons and deer ticks on the wall at a meeting in some New Jersey lodge, lectures on pulling out amalgams as a cure and saying that was what was causing all your troubles and listening to lecturers who had never used a PowerPoint presentation. It freaked me out.

**Tina:** Are you aware of any research that's currently being performed or are you planning to do any research with regard to sexual transmission of Lyme disease?

**Dr. Jemsek:** No, not in the beginning. That's just too hot to handle. But I'll tell you something interesting about sexual transmission. Every married couple asks me that question. It's at the top of the list. "Can I pass this on?" So, if something is that high up in the consciousness, why is it that we've never done a study? It's obvious the CDC has an agenda to avoid this issue as long as possible. People are intimidated from even mentioning the possibility. What I tell people is that, between sex and ticks, we're all infected. And I believe that. I think the spirochete is part of our endogenous flora. Our biosphere has sort of made that transition, and I think we're all infected. So, we have this whole new paradigm in medicine, this whole new jump-shift logic.

And even though people don't smoke as much and we don't have as many smoking-related deaths, we have way, way too much chronic illness. I think that between these new infections that have emerged over the last several decades, which are relatively new in terms of penetrating the society, and what we're doing to the environment, we're in for trouble. I can't even bear it. Intuitively, we know the stuff we've done cannot be good for us, and it can only go one way -- it's got to be bad to some level. So between all the chemicals we use in our environment and the chronic illness, it's a whole new moving paradigm. Right now, all we do is just treat symptoms with very expensive drugs and shut down the immune system. What if some of these things are reversible?

Here's the ugly fact and the ugly truth: This disease is a TSUNAMI. The disease is so prevalent and it's affecting so many decision-makers and their families, that this will force the change. And I predict that in the next year or so we're going to get some big names involved. Congressmen and CEO's are being affected, and I've seen doctors and their patients for this illness, so it's bound to happen. And at some point somebody with some outrage will step up and there will be questions answered. I think the film Under Our Skin has done more than anything before it, or anything that may come, to change the consciousness of America about Lyme disease. We all get comfortably numb with what's going on, but not for long, and we can't be indifferent and ignore it anymore.

We need to change the way we approach medicine, and it's frightening that we're talking about nationalized health care. As horrible as our current health care system is, with nationalized health care, medicine would be a death knell for any hope in the revolution needed for diagnosis and treatment of LBC and other chronic illnesses.

**Tina:** Do you ever see acute Lyme disease infection?

**Dr. Jemsek:** No, I essentially only see early accelerated illness or longstanding illness. I check to see if the patient has a defined tick event, with or without a rash, and has an ill

***"Jemsek" ...cont'd pg 11***

# National Support Groups

National Multiple Sclerosis Association:
www.nmss.org

**Alabama**
3840 Ridgeway Drive
Birmingham, AL 35209
Phone: (205) 879-8881
Phone: 1-800-FIGHT-MS
Email: alc@nmss.org
www.nationalmssociety.org/alc

**Northern California**
150 Grand, Oakland, CA 94612
Phone: 510-268-0572
toll-free: 1-800-FIGHT MS
Email: info@msconnection.org
http://www.msconnection.org

**Colorado**
700 Broadway, Suite 808
Denver, CO 80203-3442
Phone: 303.831.0700
1.800.FIGHT.MS

**Georgia**
455 Abernathy Rd. NE,
Suite 210
Atlanta , GA 30328
Phone: 404-256-9700
Phone: 1-800-FIGHT-MS
mailbox@nmssga.org

**Florida**
2701 Maitland Center Pkwy,
Suite100
Maitland, FL 32751
Phone: (407) 478-8880
Email: info@flc.nmss.org
www.nationalmssociety.org/flc

**Texas**
8111 N. Stadium Drive,
Suite 100
Houston , TX 77054
Phone: 713-526-8967

**ALS Association DC / MD / VA**
http://www.alsinfo.org/
7507 Standish Place
Rockville, MD 20855
(301) 978-9855
toll free: (866) 348-3257
fax: (301) 978-9854

**Great Philadelphia ALS Chapter**
321 Norristown Road,
Suite 260
Ambler, PA 19002
Phone: 215-643-5434
Toll Free: 1-877-GEHRIG-1
(1-877-434-7441)
Fax: 215-643-9307
alsassoc@alsphiladelphia.org

**South Texas Chapter**
http://www.alsa-south-tx.org/
(210) 733-5204
toll free at (877) 257-4673

**North Texas**
http://walk.alsanorthtexas.org/site/PageServer
1231 Greenway Dr.,
Ste.385
Irving, TX 75038

s.melson@alsanorthtexas.org
972-714-0088
877-714-0088

**The ALS Association Upstate New York Chapter**
323 Route 5 West
P.O. Box 127
Elbridge, NY 13060

315-689-3380
Toll Free for PALS:
1-866-499-PALS

info@alsaupstateny.org

**Lyme Disease Support**
**Arizona**
**Southern Arizona** - Donna Hoch: nanandbo@cox.net
520-393-1452
**L.E.A.P. Arizona**
Tina J. Garcia
Lyme Education Awareness
http://www.leaparizona.com
480-219-6869 Phone
**Arkansas**
Mary Alice Beer
(501) 884-3502
abeer@artelco.com
**California**
Dorothy Leland
website: www.lymedisease.org
contact@lymedisease.org
**Colorado**
Mary Parker
303-447-1602
milehightick@yahoo.com
**Connecticut**
www.timeforlyme.org
914-738-2358
Meetings: first Thursday of every month from 7-8:30 p.m. at the Greenwich Town Hall
**National Support:**
truthaboutlymedisease.com/
Dana Floyd, director
**LDA of Iowa**
PO Box 86, Story City, IA
515-432-3628
ticktalk2@mchsi.com
**Kansas**
913-438-LYME
Lymefight@aol.com
**Montana**
bepickthorn@earthlink.com
**North Carolina**
Stephanie Tyndall
sdtyndall@yahoo.com
**South Carolina**
Contact Kathleen at
(864) 704-2522
greenvillelyme@bellsouth.net

**Lyme Disease Support**

**New Mexico**
Veronica Medina
(505)459-9858
vrmedina@comcast.net
**Oklahoma**
Janet Segraves 405-359-9401
Janet@LDSG.org
www.LDSG.org
**Portland, Oregon**
Meets 2nd Sunday of each month 2010 NW 22nd Street Second Floor from 1-3 PM.
503-590-2528

**TEXAS :**

**Greater Austin Area Lyme** Council. Teresa Jones
tmomintexas2@yahoo.com

**Dallas/Ft Worth**
John Quinn
Jquinn@dart.org
214-749-2845

**Houston**
Contact: Teresa Lucher
lucher@sbcglobal.net

**League City/ ClearLake & NASA Area**
Sandra Mannelli
smannelli@comcast.net

**Washington State**
Alexis Benkowski
WA-Lyme-owner@yahoogroups.com
**WI / IL / MNRegional areas**
Contact PJ Langhoff
(920) 349-3855
www.Sewill.org
www.LymeLeague.com (Intl)

**Western Wisconsin Lyme Action Group**
Marina Andrews
715-857-5953

**Military Lyme Disease Support**

Military Lyme Support is an online source of information and emotional support. This site is for Military Members, Veterans, and their family members who suffer from Lyme and other vector-borne diseases. Members are stationed in the United States and abroad.

**http://health.groups.yahoo.com/group/MilitaryLyme/**

**Texas Lyme Disease Association**


**www.txlda.org**

All donations are tax exempt.
Donate online with PayPal:
**donations@txlda.org**

# "Jemsek" ...cont'd from pg 9

ness compatible with an evolving, persistent, neurocognitive and musculoskeletal illness occurring within a few weeks of the recognized bite. If so, then they pretty much have a deeply embedded infection, a chronic illness, and will need to be treated like anyone else with chronic illness. Or, I'll see someone who got bitten three months ago and they're sick, going from doctor to doctor, and they manage to get an appointment because they have an awareness.

Mostly, I see chronic illness. When I get some data together, I'll be able to tell you the mean duration of illness, or give it a good try. But even more fundamentally, when you go back to determine how this disease activates, I think most of my patients are infected well ahead of the defining or recognized clinical event and sustained illness is generally associated with a tipping point from a life stressor. This may or may not be related to a tick bite or to a defined tick event. This is oftentimes related to a prolonged period of stress, another illness, physical trauma or childbirth, etc. This happens because, even though we can't measure it, there is a clear and certain immunologic frailty associated with subacute infection with Bb and co-pathogens. There's a tipping point and sometimes people stair step.

What I tell my patients to help them understand is that we're trapped by this illness in two ways. One is by the biologic nature of the illness, but we're also trapped by our health care system. So, when people get really sick, there's no way out. I see early accelerated illness, and by that time I consider the infection to be embedded. Spirochetes get in the brain within thirty minutes. By the way, IDSA has no basis for their guidelines. This illness is going to force people to 'IQ up' with regard to our approach to this disease and to medicine in general. We need to put medicine back on a cerebral and compassionate plane that works for our patients.

**Tina:** What are some of the most important clinical observations and treatment recommendations you have made with regard to Lyme Borreliosis Complex?

**Dr. Jemsek:** What I learned a few years ago is that you don't have to treat every day. And with my HIV and infectious disease background, I learned the virtues of combination therapies. When you're dealing with a complex group of infections, there's no one drug that's going to satisfactorily handle the infection unless you're not that sick. It's all about putting your immune system back in charge. And to the extent that you can eliminate the source of the immunosuppression and your immune system recovers, you've done your job.

Everyone who's trapped by this illness needs nutritional support, metabolic support, and they need antibiotics. Some people are negative about antibiotics, but you can't evaluate antibiotic therapy in a vacuum or as 'all the same'…that's patently intellectually dishonest. We are, after all, treating multiple, stubborn infections in an immunocompromised host where, by definition, the immune system cannot handle the problem. And our goal is not to see how many days of antibiotics we can administer, but to administer the fewest days needed in order to restore immunologic control. Towards that end, we need to understand the triggers to keep patients out of situations that are going to perpetuate the patient's chronic illness and/or make it unwise to attempt therapy until these destabilizing stressors are reduced, whether the stressor is as basic as a bad support system or involve psychiatric, pain or sleep issues.

In treatment models, I've learned that pulsing makes sense, and I think everyone who's really sick has multiple infections. When I treat the three major infections, which are Borrelia, Bartonella and Babesia, and do that in a certain sequence and in a certain combination, people get better. And I think it's very important for people to go off therapy on an intermittent basis for one or two weeks at a time. Those windows are very important times to see how much immunologic security they have. Patterns develop, and the better the patient is, the longer they can go off drugs. For many years now, we have learned to pulse combination antimicrobial medications in certain patterns, and I have modified our clinical approach from learning the tempo of the disease.

Often you learn more about your patient when they're off treatment than you learn when they are on active treatment. These 'holidays' provide valuable windows for observation and after a time, you learn that cycles of therapy and the way they are sequenced show reproducible patterns of response. You also learn a lot from aspects of the treatment period, whether it's being on treatment, when it's the time to take Flagyl, and certainly the time that they're off treatment is a very important window for you to see how the patient is doing immunologically. And once you learn patterns and understand them, then you know when to intervene and when to back off. One of my patients said, "You're doing a dance with this disease, aren't you?" That's not a bad analogy.

I learned a long time ago that the most common reason for people not to get better is inadequate treatment of co-infections. It's very important to address the co-infections and to do so in an overlapping way, so you're not just treating one thing and then going on to treat something else. I only treat three days a week whether it's oral or IV, and have been doing it this way for at least five years, and exclusively this way for almost three years. And on all my programs, I give a week off of therapy on average every two to four weeks. I don't do it so much at the beginning, but after we get into it, patients get immunologically revved up.

In treating patients at the clinic, we are constantly striving for a balance point in terms of clinical efficacy and manageable toxicity, the latter being an inevitable sidebar to the highly immunogenic and inflammatory lipoprotein storm we see with Borrelia lysis. When the immune system activates, a patient can actually get more toxic, so we have to balance that. It's part of the art of medicine in terms of learning how to balance the toxicity generated and the fact that the patients need to detox. And I prefer to think there's a 'back door' to this illness as regards to the detoxification issues. If the 'back door' is closed, patients may remain unwell for protracted periods. Without question, there are considerable variations in the segment of the population with this illness who are going to be very sick, in terms of the ability to detoxify. This, in fact, may be as critical to outcomes as the infectious load and immunologic/genomic factors. That's the way it was with HIV, too, in a sense.

**Tina:** Dr. Jemsek, you are a beacon of light, a hero, to many of us in the Lyme community. You are thought of in this way, because you have established yourself as a Lyme-literate physician who is able to guide patients back to health. In addition, you have faced your difficult experiences with the North Carolina Medical Board and Blue Cross/Blue Shield with a calm demeanor and resolute determination. What has helped you to remain centered and focused during the challenges you have faced with all these legal battles?

**Dr. Jemsek:** Thank you for those kind remarks, Tina. My response would be family and patients. I get boatloads of affirmations every day. The other day I got four hugs, so how can you not like doing this? I really mean this. We can help people in such a profound way just by our ability to understand. It all starts with listening. I honestly didn't always have an ear for listening, but I learned this skill in caring for the very ill with HIV/AIDS. When Lyme patients first walked through my door, they said, "I hear you treat Lyme disease." And I said, "Well, yeah. So what?" But they kept coming, and believe me, I didn't get it for a long, long time. It took me about six to eight months to really understand.

As a doctor, you have an understanding about how patients are trying to paint their picture for you, and even if you listen, you may not understand it the first or second time. But when you hear it enough, you begin to form your own belief constructs and interpretation of it. And then you get reinforced as your impressions and concepts are molded. In many ways, it's like learning a new language, a language with a new alphabet, like Chinese or Arabic. And you don't learn it overnight. But the patients learn it and we talk in this strange new way with terms not found in modern medical text. And if another doctor's in the room and is listening, they don't know what the heck we're talking about. The patients get it, but to state the obvious, a lot of the doctors become very uptight about not understanding, and the patient then becomes the problem.

So, if doctors would just let their hair down a little bit and take a big dose of humility and honesty, they'd be so much happier. It would set them free. You know, I never worry about not knowing something any more. I worry about those who feel they must always be right. AIDS taught me that, because we didn't know anything. We were up to our asses in alligators, and we were just trying to do what we could. It was a very creative period for me and a lot of other people. But some people look at you like a reckless cowboy when you do something different, because it makes them uncomfortable, even if they have no answer and even if the patients benefit.

When it comes to my patients, I always ask, "What made them better? Why did they get better?" We can grow and evolve this way, as our patients are our ultimate laboratory for progress. And so now, as complex as Lyme patients are with their 150 complaints, their symptoms and physical findings now make recognizable patterns. And I can see the patterns, and I'm very comfortable with all these complex issues. But I realize how much we still have to learn, and that's really what's fascinating. I'm having a certain amount of success, and I'm learning what questions to ask. But my constraints, of course, are time and money in trying to get answers to everything.

And I see so many neurological manifestations in LBC and I use more seizure drugs than almost anybody, because that's what I have to do. I have a whole plate of medications I use in terms of seizure, potent antidepressants and mood modifying drugs. You just have to.

But I can tell you this -- I think that this is going to be fascinating as this thing unrav

*"Jemsek" ...cont'd pg 13*

# "Mycoplasma... cont'd from pg 6

*Mycoplasma fermentans* produces numerous symptoms. Those infected are rarely found to be asymptomatic. In North America, *M. pneumoniae* is the most common *Mycoplasma* seen in various diseases. In Europe, *M. hominis* is far more prevalent and the incidence of *M. fermentans* is much lower than in North America.

The potential genetic factors involved in *Mycoplasma* illnesses are not known. Those with immune deficiencies and other illnesses, such as cancers and degenerative diseases, are at far greater risk of infection.

**Prevalence**

In one study looking at *Mycoplasma* in patients with Chronic Fatigue Syndrome, Dr. Nicolson has observed some interesting patterns in his research. Generally, the majority of CFS patients have *Mycoplasma* infections. However, CFS patients infected with *Borrelia burgdorferi*, the punitive agent in Lyme disease, had an even higher overall *Mycoplasma* infection rate. As many as 75% of Lyme disease patients appear to have *Mycoplasma* infections, and yet *Mycoplasma* is often overlooked in the diagnosis and treatment of chronic Lyme disease, neurodegenerative diseases, and many other chronic illnesses lacking clear origins.

Even more startling was the finding that of the patients infected with *Borrelia*, over 50% of the patients had the *M. fermentans* infection. Approximately 23% carried *M. pneumoniae.*

Chronic Fatigue patients that did not test positive for *Borrelia* had much more of a mixture of various species of *Mycoplasma.* Only 28% of the group not co-infected with Lyme disease had the M. fermentans infection. In normal, healthy controls, only 1.7% were found to have *M. fermentans* and at a total *Mycoplasma* infection rate of 5% compared to the 75% group mentioned earlier.

Dr. Nicolson notes that these findings are consistent with the fact that it is the *Mycoplasma fermentans* species that is more often isolated in ticks collected from the environment. The same tick that serves as the vector for *Borrelia burgdorferi* often also transmits *M. fermentans* simultaneously. Once a patient is multiply co-infected, the duration and severity of their illness both increase.

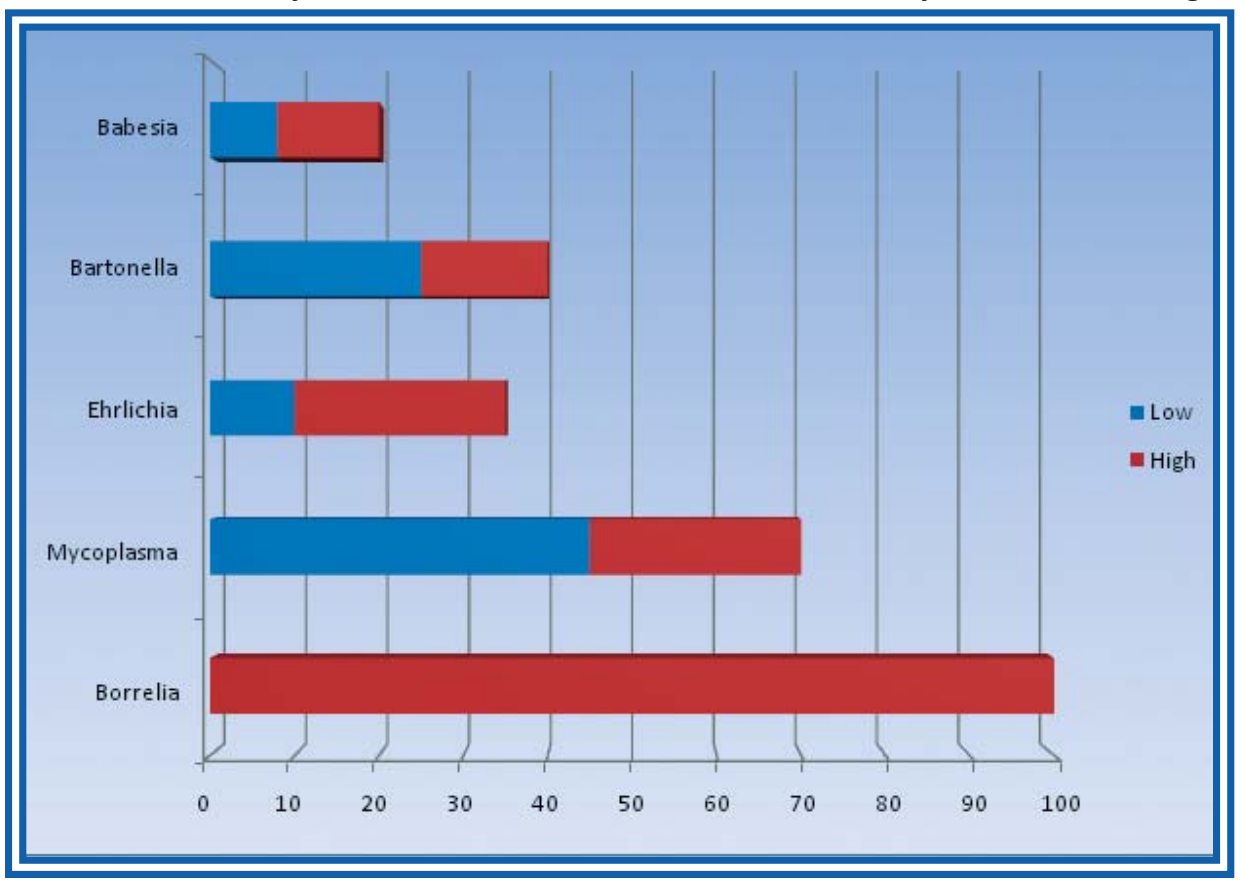
In his experience, Dr. Nicolson has found that *Mycoplasma* is the number one Lyme coinfection. The rate of infection with *Mycoplasma* in patients with Lyme disease surpasses that of *Bartonella* (25-40%) slightly and that of *Babesia* (8-20%) significantly.

According to Dr. Nicolson, a healthy immune system can generally clear *M. pneumoniae* infections though will have a harder time eradicating *M. fermentans* on its own. Healthy people can often hold these infections in check - essentially having the infection but not expressing symptoms.

**Testing**

Dr. Nicolson noted that *Mycoplasma* infections in chronic Lyme disease are often overlooked by most doctors because they simply don't test for it. He states that those that do test for it find a much higher number of infected patients. Dr. Richard Horowitz, MD in New York finds a high incidence of *M. fermentans,* according to Dr. Nicolson.

Sadly, however, even if patients are tested for *Mycoplasma,* a similar problem exists here as the one that almost all Lyme doctors and patients are aware of - namely that reliable tests do not exist. Dr. Nicolson notes that once a laboratory gets a reliable test in place, the laboratory is often shutdown. There are only a few labs left that test for *Mycoplasma* as a result.




***Incidence of Various Microbes in Patients with Lyme Disease - G. L. Ncolson***

In testing ticks for various microbial species, Dr. Nicolson has found a very high incidence of *Mycoplasma fermentans.* However, other *Mycoplasma* species have also been found such as *M. pneumoniae* and *M. hominis*. The incidence of these other species is far lower. "Far and away", it is the *M. fermentans* species that is seen in ticks, and this probably reflects the high incidence of *M. fermentans* coinfections in Lyme disease.

In terms of laboratory testing, Dr. Nicolson generally recommends Viral Immune Pathology, formerly known as RedLabs. He has found that the usefulness of any given lab in testing for *Mycoplasma* changes regularly. In the past, Dr. Nicolson used Medical Diagnostic Laboratories (MDL) for testing, but later he and other physicians found that the testing was no longer reliable. As a result, he no longer recommends MDL.

Dr. Nicolson finds that laboratories testing for *Mycoplasma* are highly scrutinized by federal agencies and that may affect the way the labs test and report this type of infection.

**Autoimmunity**

Thomas McPherson Brown, MD studied *Mycoplasma* at the Rockefeller Institute just before World War II. He was able to isolate bacteria from the joint fluid of a person with autoimmune arthritis and believed that the infection could have been the trigger for her disease. At the time, the organisms were too small to identify precisely, but it was later determined to be *Mycoplasma.*

Even then, Dr. Brown believed that *Mycoplasma* was very common and not easy to eradicate. He suggested using tetracycline drugs as an effective treatment for the disease. He later found that Doxycycline and Minocycline were effective at dealing with *Mycoplasma.* Though he garnered praise from his patients, he was generally regarded by the medical community as misguided and a trouble-maker. He died in 1989 prior to being fully vindicated. Fortunately, his work was validated through an NIH-sponsored study called MIRA or "Minocycline in Rheumatoid Arthritis".

Due to many of the characteristics of *Mycoplasma*, they may be responsible for the triggering of numerous autoimmune responses. As *Mycoplasma* replicate within cells and are eventually released, they capture antigens from the surface of the host cell and incorporate these antigens into their own membranes. This makes it almost impossible for the body to tell the difference between good and bad, between human and microbe, or between us and them. As a result, the immune system may begin to respond to these antigens now incorporated into the cell walls of the bacteria and create a condition of self-attack, or autoimmunity.

The microorganisms can produce mimicry antigens that mimic the natural host surface antigens and trigger an immune response to these antigens which may also result in autoimmune conditions through cross-reactivity. Additionally, *Mycoplasma* may cause cell death of host cells through a process known as apoptosis or programmed cell death.

**Treatment**

Though various strains of *Mycoplasma* have their own unique characteristics and drug responses, treatment tends to be quite similar. The variations in the strains do not appear to be a factor in a successful treatment response.

Dr. Nicolson suggests that in-vitro differences have been found but that it is not possible to easily extrapolate these findings to an in-vivo environment. Various factors including drug targeting, drug clearance, and the ability for the drug to cross into various body compartments are important considerations in treatment that cannot be examined in-vitro.

Dr. Nicolson believes that, like many other coinfections of Lyme disease, *Mycoplasma* cannot be fully eradicated, but that once infected, treatment becomes an ongoing "management approach". He notes that this is a commonly understood fact and that the same is true of other organisms such as *Chlamydia* and *Borrelia*. *Mycoplasma* have the ability to go into a quiescent phase in intracellular locations within the body. Once in these locations, neither antibiotics nor the immune system can effectively reach or kill the organisms.

Many people recover from *Mycoplasma* infections and are fine for years. They may later have an incident involving severe trauma or other significant life stressor and symptoms fully reappear within weeks to months.

Dr. Nicolson recommends that the physician adopt an initial 6-month course of treatment with no break followed by several 6-week on, 2-week off antibiotic cycles. Candidate antibiotics include: Doxycycline, Ciprofloxacin (Cipro), Azithromycin (Zithromax), Minocycline, or Clarithromycin (Biaxin). He notes that antibiotic combinations may be required if there is a limited response to single drug, and most patients require switching antibiotics at least once during their treatment. Some patients may find the addition of Flagyl to be a benefit to treatment.

In Gulf War patients, once effectively treated, the majority of patients recovered. For civilians, six months is the minimum recommended treatment length, and some patients require much longer treatment in order to recover.

Given that *Mycoplasma* have some characteristics of viruses, some physicians have suggested that Famvir or Ganciclovir may be added to the antibiotic therapy.

Herxheimer reactions do occur when treating *Mycoplasma* infections. To minimize this die-off effect where the patient generally feels much worse while on treatment, Dr. Nicolson advises using 50mg oral Benadryl taken 30 minutes before the antibiotics. He also finds that a strained blend of 1 whole lemon, 1 cup fruit juice, and 1 tablespoon of olive oil can be helpful.

Though Dr. Nicolson believes that antibiotics are the most effective approach to treating *Mycoplasma* infections, he has found some good natural options. In terms of natural approaches to treating *Mycoplasma*, Raintree Nutrition (http://www.rain-tree.com) has created several products that may be quite helpful for patients. These include Raintree Myco, Raintree A-F, and Raintree Immune Support.

Dr. Nicolson has seen evidence that *Mycoplasma*-specific transfer factors such as those from Chisholm Labs and others can be beneficial in some patients. He says that many natural options help in some patients, but that his experience has been that the antibiotic treatment results in the best outcomes. In many, recovery requires a push and pull between conventional and alternative treatments.

One of the hallmark signs of *Mycoplasma* infection is fatigue. The infections lead to oxidation in the body that leads to damage of the cell membranes. Oxidation accelerates the damage to the lipids in cell membranes which impacts mitochondrial function. This leads to less energy in the cell and ultimately to a fatiguing of the larger organism due to the fact that there is less energy to support necessary cellular functions.

In patients where fatigue is due to cell membrane damage, Dr. Nicolson has found NT Factor® to be highly beneficial. NT Factor® replaces the damaged lipids and helps to restore mitochondrial function. Often, fatigue then resolves or is reduced.

Dr. Nicolson has found that oxidative therapies such as ozone can be helpful in the fight against *Mycoplasma.* However, he notes that this is generally palliative and does not produce the same results as the antibiotic therapy in the long-term. He finds that the oxidative therapies "are generally more cytostatic than cytotoxic". Hyperbaric oxygen may be helpful but similarly does not appear to be a highly effective treatment in the longer-term.

In other countries, IV drips with H2O2 (hydrogen peroxide) have been used with some benefit, but Dr. Nicolson notes that these therapies, while potentially effective, are highly dangerous and not advised.

In the realm of frequency medicine and Rife therapy, Dr. Nicolson believes that the frequencies that could be used to address *Mycoplasma* are too similar to normal cellular frequencies. Thus, he is not certain that Rife therapy is an effective way to approach the problem.

In the nutritional realm, Dr. Nicolson finds that many patients with chronic infections are immunosuppressed and that proper nutrition is vital. He cautions against smoking and drinking. He suggests avoidance of sugars, trans-fats, and

**"Mycoplasma" ...cont'd pg 14**

# "Jemsek" ...cont'd from pg 11

els. And I'm telling you, people are going to discover things that I've known in my head and other doctors, like Richard Horowitz and Bernie Raxlen, have known implicitly for years. We've all known about stuff that hasn't been written down yet, all sorts of strange clinical facts. In five or ten years, they're going to say "Oh well. This happens and blah blah blah." And we're all going to say, "Well, yeeeeaaaah."

For example, I saw some case reports from Europe on ocular palsies being prominent as the presenting sign in early or advanced Lyme. And these were case reports, but on some clinic days, none of my patients can coordinate their eye movement. It's things like that that I know already from the clinical setting. The complexity of the illness has prompted many of us to learn a great deal more about neurology, endocrinology and dermatology. And while I know that the doctors in these specialties that I've mentioned are incredibly bright, they seem sort of frozen and locked into their ideology. And the more intense the ideology, the more hostile the specialist becomes when confronted with something not in their comfort zone, or something which challenges them. Doctors have lost control of their profession in a mission lost, and the prevailing attitude of false pride is part of the pathology we see contributing to the failure of today's medical system. As I stated in my speech at the Into the Light Gala, arrogance trumps reason every time. It's sad really, and doctors need to break out from this or be eternally miserable, because this epidemic is going to make fools of a lot of arrogant physicians.

You have to put yourself in a position to understand that it's okay to say that you don't know something. What's really important is that you continue to try to learn. If you do that, it all comes together. Patients really get that. Then you don't have posturing and antagonism that creates a chasm. It's just so much easier to say "I don't know, but let's learn. But here's what I do know about this." I know doctors are frustrated, but they turn their anger inward instead of looking at the real problems and getting together to try to bring the profession back where it should be. And if you don't have a passion for it, get out of medicine.

In particular, I think the infectious disease doctors have been hoodwinked, in part because their source of information has been compromised by the Lyme Cabal. The ID docs, for some reason, have a characteristic that I just don't understand. More than any other specialty in the LBC debate, they are consistently rigid. You just cannot be rigid, for we need to just admit that we only know a fraction of a percent of what we need to know about the human body and medicine. Much of what we know now is going to change anyway. So, you just try to keep learning and if you have success, you try to understand your success and understand your failures, too. And if you can do that, then you grow as a doctor and you get so much satisfaction out of seeing patients.

When you get into this ritualistic practice, like having a certain algorithm for treating this or treating that, how boring. I acknowledge that we must have some guidelines and some semi-rigidity to our beliefs and the way we practice medicine, of course, but always understand that we need to grow and learn every day when we go to work. Most doctors will view a patient based on their own experience and their empiricism rather than what's printed in a textbook, I'll tell you that. I mean the really good ones.

My message to doctors is "Get real!" Learn some humility, be honest, and it will set you free. Then you will be the kind of doctor you wanted to be when you started out from day one. But if you cover yourself up with false pride and arrogance, then you're doomed. It doesn't work, never has, never will.

pha

*Tina J. Garcia is a Lyme patient and Founder of Lyme Education Awareness Program, L.E.A.P. Arizona at: www.leaparizona.com.*

**More Information**

Joseph G. Jemsek, M.D. received his Doctor of Medicine degree from the University of Illinois, Medical Center of Chicago. He served his internship and residency at the Medical University of South Carolina In Charleston. This was followed by his postgraduate fellowship at Baylor College of Medicine at the Texas Medical Center in Houston.

Dr. Jemsek's practice, Jemsek Specialty Clinic, is located in Fort Mill, South Carolina. For more information, visit www.jemsekspecialty.com.

Please also visit www.intothelightgala.com, which covers the highly successful gathering in Charlotte, North Carolina on March 20, 2009 and which highlighted the first theatrical release of the award-winning documentary "Under Our Skin".

Also on Dr. Jemsek's website is the complete story of his medical and legal battles. I highly recommend reading this for a clear understanding of the battles taking place in the Lyme Wars.

# Into the Light Gala for Lyme Awareness

***Dr. Jemsek with Rhonda & Jack Mathieson***

***Dr. Jemsek with Ria Heslop***

***Dr. Jemsek with Jamie Israel***

*March 20, 2009 was a landmark evening in Charlotte, North Carolina! The Into the Light Gala featured the theatre debut of the Lyme disease documentary "Under Our Skin". This award-winning film was produced, directed and photographed by Andy Abrahams Wilson of Open Eye Pictures. The awareness event brought 450 people to the dual-theatre showing. The evening included awards presented to sponsors and patients. A moving presentation by Dr. Joseph Jemsek of Jemsek Specialty Cinic in South Carolina shed light upon the many issues involved in the diagnosis and treatment of Lyme Borreliosis Complex. To see photos and a DVD compilation of this wonderfully successful event, please visit www.intothelightgala.com.*

# "The Master" ...cont'd from pg 2

The legal ordeal that Dr. Jones has been enduring with his state medical board has become legendary. The protracted harassment has squandered his time, finances and energy. A Google search of his name will provide the reader with details of what appears to be a shameful political vendetta against a man whose life has been devoted to helping children whom no one else would help. He has been tolerant of the process but is growing weary of the absurdity of it all.

At the last hearing, the usually-patient Dr. Jones had to restrain himself from saying what he was really feeling, lest he be held in contempt of court. A Walt Whitman poem kept coming to his mind and he thought of the lines, over and over, written more than a hundred years before. The poem brings to mind the juxtaposition of deliberation versus action, of theory versus experiential knowledge, of ivory tower medicine versus medicine in the trenches. It provides a thoughtful ending to an article about a thoughtful man.

***When I heard the learn'd astronomer; when the proofs, the figures, were ranged in columns before me;***

***When I was shown the charts and the diagrams, to add, divide, and measure them;***

***When I, sitting, heard the astronomer, where he lectured with much applause in the lecture-room,***

***How soon, unaccountable,***
***I became tired and sick;***
***Till rising and gliding out,***
***I wander'd off by myself,***
***In the mystical moist night-air, and from time to time,***
***Look'd up in perfect silence at the stars.***

pha

*Ginger Savely is a nurse practitioner who specializes in treating tick-borne diseases in people of all ages. She practices in San Francisco.*

# FEATURE

## "Dental Issues" ...cont'd from pg 7

case, I had two front teeth and one lateral incisor killed by trauma. Subsequent root canals left me compromised.
When I was bitten by a tick, I contracted Lyme. I have every reason to believe that had these teeth been properly addressed, my immune function would have been sufficient to withstand the Lyme onslaught, because people who exhibit healthy immune function generally do not suffer from the worse aspects of Lyme.
Nobody in my family has Lyme disease - mother, father, sister, etc. I was the only one with bad teeth as well as the only one to have had my tonsils removed unnecessarily. I believe this heavily compromised my immune system.

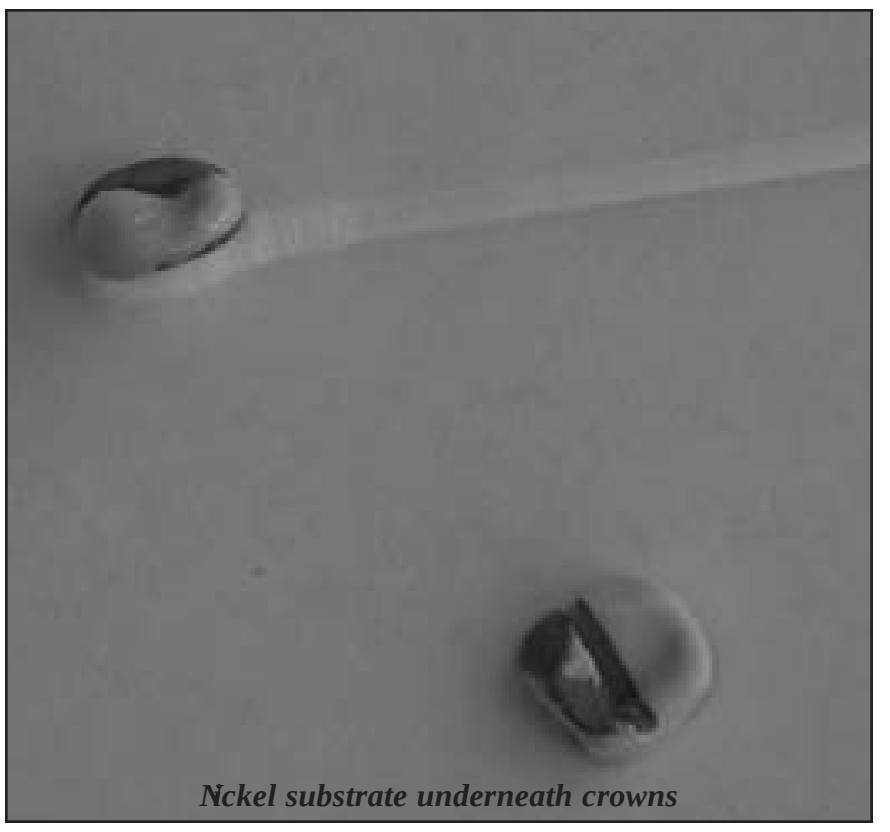
When I got bitten, I had the textbook bull's eye rash. In my opinion, those who see a rash are those who have a stronger immune system. The rash is the body's attempt to defeat the bacteria at the site. Then as the rash expands, that is a sign the body is losing the battle. Eventually, the rash dissipates and is gone. Then you can assume the Lyme has gone latent.

I still struggle with Lyme. But I don't encourage limiting anyone's life. I hunt and fish less than I used to, but that's age, not fear. I love the outdoors and it is such a valuable part of my life, I would not choose to limit that. Lyme can be treated successfully initially with antibiotics or homeopathy - if it is done immediately. But most people, like my patient Julie, don't know what they have until it is too late for conventional treatment to produce a result. *pha*

**For More Information:**

**Andrew Landerman, DDS**
**Biological Dental Center**
**707-829-0200**

*145 Pleasant Hill Ave North,*
*Suite 201*
*Sebastopol, CA 95472*



***Nckel substrate underneath crowns***

## "Mycoplasma" ...cont'd from pg 12

allergenic foods. He advises patients to increase their fruits, vegetables, and whole grains. Some dietary winners in supporting the immune system include cruciferous vegetables, soluble fiber-based foods such as prunes and bran, wheat germ, yogurt, fish, and whole grains.

Patients are often depleted in key vitamins and minerals. Supplementation with B-Complex, Vitamin C, Vitamin E, and CoQ-10 are often beneficial. Minerals are often necessary. Dr. Nicolson notes, however, that many people have poor absorption and may require sublingual or injectable forms of these nutrients. Amino acids, flax seed, and fish oils can provide additional support, but the best nutrition for cell membranes is NT Factor®.

Many patients with chronic illnesses have a toxic body burden of heavy metals such as mercury, lead, cadmium, and aluminum. Hair, stool, and urine testing is available through labs like Doctor's Data (http://www.doctorsdata.com) and Genova Diagnostics (http://www.gdx.net). Dr. Nicolson has seen reports of positive results with EDTA chelation suppositories from Detoxamin (http://www.detoxamin.com) and oral chelators from Longevity Plus (www.longevityplus.com).

For patients using antibiotics, beneficial gut flora is often depressed. Supplementation with a high quality probiotic is important, but probiotics have to be taken two hours or longer after taking antibiotics. Natural immune support can be helpful in the form of whey proteins, transfer factors, or immune-support products such as Beyond Immuni-T from Longevity Plus.

**Biolfims**

Dr. Nicolson believes that biofilms are a factor in successfully treating *Mycoplasma* infections. In cases that are refractory to antibiotics, biofilms are likely a major factor.

In men with chronic refractory prostatitis which is infection-based, one often cannot be treated effectively with antibiotics. However, when Detoxamin (EDTA) or other agents to address the biofilms are used, it then becomes possible to treat these infections with tetracyclines. Patients quickly show functional increases and decreases in pain other symptoms.

**Summary**

In chronic Lyme disease, it is often difficult to know which infections are actually responsible for the persistence of illness. However, in general terms, chronic intracellular infections that change the metabolism of cells and suppress mitochondrial and other functions will lead to patients remaining in a chronically ill state. Dr. Nicolson believes that these infections must be aggressively treated. "Similar to chronic Lyme disease, the current CDC or IDSA recommendations for short-term treatment of chronic infections are simply inadequate," he says.

Dr. Nicolson has found that there is a hierarchy of symptoms that resolve relatively quickly and those that resolve more slowly when treating *Mycoplasma*. Gut-associated phenomenon such as Irritable Bowel Syndrome (IBS) often resolve quickly. Other systemic signs and symptoms can resolve in an intermediate period of time from many weeks to many months. Symptoms associated with the central and peripheral nervous systems such as neuropathy and pain often resolve much more slowly. Skin sensitivity and burning sensations may take much longer to resolve.

*Mycoplasma* infections do invade nerves, and nerve-related symptoms are among the more difficult to resolve.

Dr. Nicolson states "We keep seeing the suppression of information on *Mycoplasma* and similar intracellular bacterial infections. The world of *Mycoplasma* parallels the world of chronic Lyme disease in terms of the politics involved. Physicians are being persecuted by their medical boards as a result of bad information. It is important for us to do everything within our power to get rid of harmful, erroneous information about these diseases. Both *Mycoplasma* and *Borrelia* have been manipulated for biological weapons purposes and as a result, both are politically incorrect to discuss, work on, or do anything about. Until this changes, we won't see any real progress." *pha*

*Scott Forsgren is the editor and founder of the website BetterHealthGuy.com where he shares his twelve year journey through a chronic illness only diagnosed as Lyme disease after eight years of searching for answers. Scott can be reached at Scott@BetterHealthGuy.com.*

*Additional information on NT Factor® can be found at www.ntfactor.com or www.researchednutritionals.com.*

**Resources**

Professor Garth L. Nicolson is the President, Chief Scientific Officer and Research Professor at the Institute for Molecular Medicine in Huntington Beach, California. Born in 1943 in Los Angeles, Dr. Nicolson received his B.S. in Chemistry from University of California at Los Angeles in 1965 and his Ph.D. in Biochemistry and Cell Biology from the University of California at San Diego in 1970. Professor Nicolson has published over 580 medical and scientific papers, edited 15 books, and served on the Editorial Boards of 30 medical and scientific journals. He is also a Colonel (Honorary) of the U. S. Army Special Forces and a U. S. Navy SEAL (Honorary) for his work on Armed Forces and veterans' illnesses. More information on Dr. Nicolson's work can be found on his web site at http://www.immed.org.

The book *Project Day Lily* is available at: http://www.projectdaylily.com/

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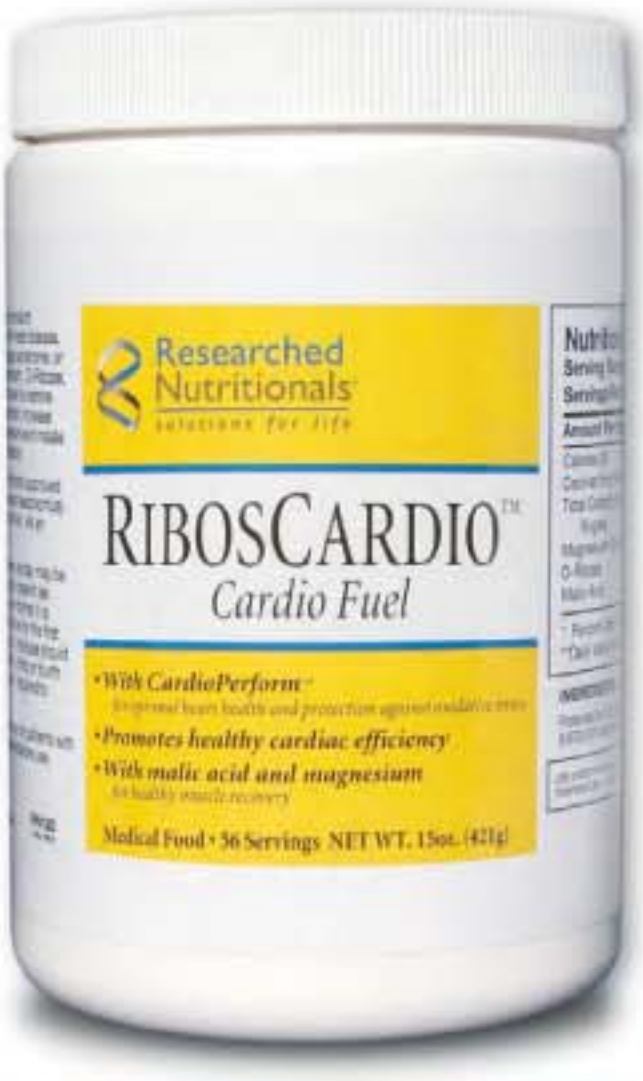


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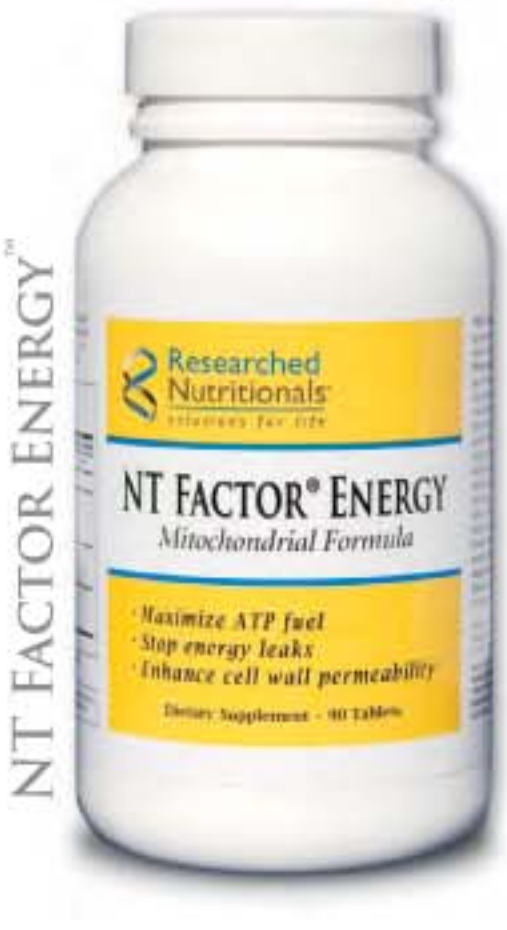
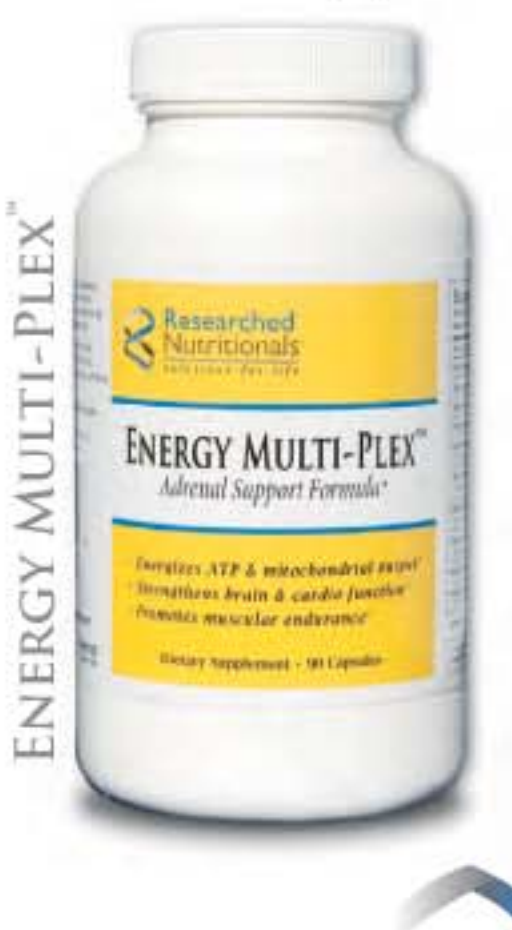



## Adrenal Support

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