ANTIHOMOTOXIC THERAPY FOR COXARTHROSIS, GONARTHROSIS, and POLYARTHROSIS OF THE FINGERS

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Ladies and Gentlemen:

Even though they affect a large number of our patients, we find ourselves repeatedly brought into a state of quandary when confronted with the illnesses coxarthrosis, gonarthrosis, and polyarthrosis of the fingers.

Numerous disorders manifest themselves at the joints. Sufficient insight into these diseases is essential for the establishment of a differential diagnosis. I

have classified these disorders for you in the following table:

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- SLIDE 1 -

CLASSIFICATION OF DISORDERS OF THE JOINTS

1. Arthritis resulting from specific infection-causing pathogens
2. Arthritis in cases of rheumatic fever
3. Rheumatoid arthritis and its variations
4. Arthritis resulting from collagen disorders
5. Ankylosing spondylarthritis
6. Reiter's syndrome
7. Arthritis in combination with psoriasis
8. Arthritis resulting from sarcoidosis
9. Arthritis resulting from intestinal disorders
10. Arthritis resulting from metabolic disorders
11. Degenerative disorders of the joint
12. Secondary joint damage
13. Neoplasms of the joint

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It was long ago when the general term "rhumatism" made its way into the language of the layman, meaning dis-

orders of the joint and of the soft tissue which surrounds it. The terms "rheumatic disorders" or "disorders belonging to the rheumatic morphological group" are generally used in this context. Regarded in a simplified manner, one can differentiate among the following three different types of rhumatism:

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- SLIDE 2 -

FORMS OF RHEUMATISM

1. Inflammatory rheumatism
2. Degenerative rheumatism
3. Extra-articular rheumatism

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The unelaborated term "rheumatism" is in itself extremely nonspecific. It is merely a collective term for what actually represents uncharacteristic symptoms and discomforts of the joint and its surrounding structures.

Although there are approximately seven hundred different rheumatic disorders in existence, each with a different symptomatology, we should nevertheless briefly

enumerate several typical symptoms of those illnesses which comprise the collective term "rheumatism."

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- SLIDE 3 -

SYMPTOMATOLOGY

1. Slow beginning
2. Stiffness in the joints with restriction of mobility
3. Pain which increases with continuous movement and abates when at rest
4. True deformity is lacking, or insignificant
5. Bulging osseous formations are frequently very prominent
6. Contractures and valgus positions are not uncommon
7. No ankylosis
8. Friction and grinding noises in many cases
9. Less prominent development of effusion or any other signs of inflammation
10. Lack of symptoms of a system disorder

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The word "rheumatism" is defined only in a symptomatic sense. It is a term which lacks clear definition, in the sense of description of a disease -- both etiolo-

gically and pathogenetically speaking. This applies even for the rheumatic illnesses in a more strict sense, which include rheumatic fever, rheumatoid arthritis with its variations, Reiter's syndrome, Bechterev's disease and collagen disease.

Because clinical symptoms of these disorders are quite nonspecific and noncharacteristic, further tests are required in addition to a local examination. These include the following:

a. Obtaining of clinical findings
b. Laboratory tests
c. X-ray examinations
d. And, in certain cases, bioptic and synovial analyses.

In my opinion, the patient's case history is also of great importance when evaluating those illnesses which make up the rheumatic morphological group. The following questions are fundamental when considering a case history:

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- SLIDE 4 -

IMPORTANT FACTORS IN ARTHROSIS CASE HISTORIES

1. External influences (infections, climate, stress, trauma, etc.)
2. Details concerning initial manifestations as well as detailed information on subsequent episodes (acute or gradual begin, fever, localization, effusions, skin manifestations)
3. Accompanying visceral symptoms (heart, eyes, lungs, urethra)
4. Degree of adverse effect on the patient's general condition
5. Reduction in the ability to move
6. Theraputic measures taken to date
7. Familial occurrence

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One can already observe differentiation here in the case history. This is important, for the physician needs such insights for finding the modalities to be used in determinining the proper medication.

During a local examination, the joints are systematically analyzed according to the following criteria:

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DISEASES OF THE JOINTS: SIGNIFICANT SIGNS TO LOOK FOR DURING EXAMINATION

1. Redness and/or excessive warmth of the skin
2. Swelling (effusion, thickening of the synovia, periarticular edema, distension of the epiphysis)
3. Crepitation (grinding and/or creaking as a sign of the damaged state of the surfaces of the joint)
4. Pain with movement and when pressure is applied
5. Reduction in the ability to move (active and passive)
6. Condition of tendons and muscles
7. Peripheroneural functioning

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Measuring tape, a protractor and a dynamometer are necessary for objective measurement. It is also important to observe the individual's movements on the whole. In order to develop a differential diagnosis and differential therapy, it is necessary to clearly analyze which characteristics noted are directly due to the diseased joint, and which are due to immobilization caused, for example, by atrophy or osteoporosis. It is also imperative that the patient's compen-

satory efforts, which can lead to secondary damage, be carefully noted.

Those organs which may have been co-affected by rheumatic disorders must also be thoroughly examined. Such organs include the skin (rheumatic nodules, nodular erythema, lupus erythematosis, efflorescence), the heart (carditis, vitiea), the eyes (ceratoconjunctivitis, iridocyclitis), the liver, the spleen, and the lymph nodes (collagen disease, rheumatic arthritis, sarcoidosis).

Numerous laboratory tests are chemically feasible, to be sure, but I would not like to treat them in detail here. My reason is that, for those forms of arthrosis which we are considering, no specific laboratory examinations have as yet been developed which could be performed in the physician's office. An important decision for us to make at this point is whether the disorder in question here is arthritis or arthrosis.

- SLIDE 6 -

DIFFERENCES BETWEEN ARTHRITIS AND ARTHROSIS

AS REVEALED UPON EXAMINATION

	Arthritis		Arthrosis
	acute	chronic	
Swelling	fluctuating / soft		resistant to touch; hard
Pain	spontaneous at rest	becoming sensitive in the morning	mechanical; becomes sensitive at night; depends on weight applied; pain upon start of movement
Abnormally high temperature	+	- (+)	-
Reddening	+	-	-
Restriction in mobility	dependent on pain	develops toward stiffness in the morning; depends on part of antatomy involved	develops toward stiffness in the evenings
Radiology	-	destruction; repair	cartilage destruction; osteophytosis; osteosclerosis

Without radiological tests, examination and differentiation are sometimes difficult.

Just what are the radiological differences between arthritis and arthrosis?

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RADIOLOGICAL CHARACTERISTICS OF ARTHRITIS

1. Various degrees of deterioration, showing:
   a. Arrosions: localized contour shrinkage
   b. Usura: deep-seated destruction of boned portions, which may be
   c. Projected in the form of pseudocysts
   e. Osteolysis: sizable areas of bone which have softened

2. Apparent narrowing of the joint spaces (an early symptom) with minimal subluxation through inflammatory loosening of the capsule.

3. Disturbance of the spongiosa structure near the joint

4. Shrinkage of the joint space (late symptom) resulting from concentric cartilage destruction

5. Subluxation, luxation, and defective positioning

6. Para-articular symptoms in the soft tissues

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The radiological characteristics of arthrosis differ from those of arthritis just described. These findings are characterized by the following:

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RADIOLOGICAL CHARACTERISTICS OF ARTHROSIS

1. Early narrowing of the joint space
2. Bony excresences or osseous outgrowths, with
   a) osteophytosis and
   b) Capsular ossification (ossicles)
3. Subchondral thickening of the bone (transformation, sclerosis)
4. Cystoid defects of the spongiosa (subchondral cysts)

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The major characteristic of arthritis, therefore, is acute or chronic inflammation; that of arthrosis, on the other hand, is various degrees of deterioration.

Various causes play a role in the development of arthrosis; these can be divided into two groups:

First we have primary arthrosis, which is found at the following locations:

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PRIMARY ARTHROSIS

1. Joints of the fingers (Heberden's nodes)
2. Metacarpophalangeals and carpometacarpal joints of the thumb
3. Hip joints (malum coxae senile)
4. Knee joints
5. Metatarsophalangeal joints of the big toe (rarely)
6. Cervical and lumbar sections of the vertebral column

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SECONDARY ARTHROSIS

1. Clinically similar to primary arthrosis, but often with more serious course of the disease
2. Susceptibility of <u>any</u> joint
3. The consequence of intra- or extra-articular trauma

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In contrast to primary arthrosis, we also have secondary arthrosis, the clinical progression of which is similar to that of primary arthrosis, but which often runs a more serious course. Secondary arthrosis can afflict all joints in the body, and may often be explained as the result of intra-articular or extra-articular trauma.

Among other causes, the development of arthrosis may be traced to a lack of proportion between the capacity of a joint and the stress to which it is subjected. With further therapy in mind, let us now examine the most important origins of secondary arthrosis:

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CAUSES OF ARTHROSIS

1. Excessive or improper subjection to stress
2. Dysplasia
3. Congenital or posttraumatic defective positioning of axes and joints
4. Excessive static stress such as caused by obesity, profession, or sports
5. Direct effects of traumatic experiences
6. Form anomalies of the boned portions of the joint such as aseptic osteonecrosis, dissecting osteochondritis, Paget's disease, and the like
7. Metabolic disorders such as gout, chondrocalcinosis and alcaptonuria
8. Inflammatory processes

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The following conditions may be detected when observing arthrosis from a pathological-anatomical point of view: a roughening and increased shrinkage of the articular cartilage, as well as the development of projections and spurs along the edge of the joint surface. The synovial membrane has thickened, and the synovial villi become hypertrophic. Complete dis-

appearance of the joint cavity never takes place, however, and the synovial membrane forms no adhesions. Inflammation plays only a minimal role.

Therapeutically speaking, arthrosis is a crux medicorum. Despite the fact that the rate of extreme physical disability is lower than that for rheumatoid arthritis, the development of arthrosis can indeed be very serious, extensively restricting physical activity. This is especially true of coxarthrosis, gonarthrosis and polyarthrosis of the fingers. We must be frank enough to accept the fact that it is not possible to completely cure arthrosis, in the true sense of the word: this is a destructive disease, and once portions of a joint are lost, this loss is practically irrecoverable.

Nevertheless, proper therapy can bring about extensive improvement in the patient's comfort as well as in the actual ability of his or her joints to function. Therapy of arthrosis should feature a variety of approaches, among which the following five measures play a major role:

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THERAPY FOR ARTHROSIS

1. Relief of the stress burden to the joint
2. Physical therapy
3. Diet
4. Medication
5. Orthopedic measures (rarely)

ANTIHOMOTOXIC THERAPY = DISCHARGE THERAPY

A THERAPY ACCOMPANIED BY REDUCED INTAKE OF HOMOTOXINS

A STATE OF HEALTH = FREEDOM FROM HOMOTOXINS

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Comments on Item 1.:

All physical activity should be kept within reasonable bounds. Extreme athletic and professional burdens of stress should be avoided. Poor posture should be corrected.

Comments on Item 2.:

Heat treatments of every kind, including mud packs, warm air, infra-red radiation, shortwaves, and microwaves; relaxation massages of the contracted-muscle area; massages of connective tissue in order to effect

enhancement in the vegetative system; lymph drainage as prescribed by Vodder; and, possibly, intermittent extension therapy.

Comments on 3.:
While there is general agreement among therapists concerning the points just mentioned, we now reach an area where differences of opinion prevail. Many consider prescribed diets to be nonsense because they consider their effects to be neither empirically proven nor scientifically adknowledged. Experience has shown, however, that a diet can indeed be exceedingly helpful in a therapeutic sense. Paracelsus himself said long ago:

> Do no harm, and let food be your medicine
> and medicine be your food.

If it is possible to fall ill through incorrect eating habits -- and we are all familiar with this phenomenon -- then it logically follows that it is possible to return to health through avoidance of certain foods and through convalescence based on the intake of appropriate nourishment. Excess weight, metabolic disorders, as well as supply of the chondral components of the joints can all be normalized through an appro-

priate diet. Above all, meat (especially pork) should be avoided, as well as sausage, cold cuts, and all types of candy and chocolate.

The effect of a healthy diet, with abstinence from such products, is promotion of an increased discharge of homotoxins. Furthermore, antihomotoxic preparations, as medicinal therapy, are extremely helpful in promoting and increasing such discharge of homotoxins, as well as in reducing homotoxin assimilation. We have a choice here among combination theraputic preparations, nosode therapy, and suis-organ preparations.

May I now add a few words on suis-organ preparations:

The most effective preparations in this area have proven to be the following:

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SUIS ORGAN PREPARATIONS FOR ARTHROSIS

1. CARTILAGO SUIS-INJEEL and FORTE
2. GLANDULA PARATHYREOIDEA SUIS-INJEEL and FORTE.

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CARTILAGO SUIS-INJEEL and FORTE has the effect of stimulating cartilage metabolism, when used alone as well as when contained as a single constituent in combination preparations such as DISCUS COMPOSITUM and ZEEL. GLANDULA PARATHYREOIDA SUIS-INJEEL and FORTE are effective in treating disturbances of calcium metabolism, and thereby positively influencing cases of chronic arthritis and arthrosis as well as other disorders associated with a disturbance of calcium metabolism.

The suis-organ preparations are primarily used during the cellular phase of the Six-Phase Table of Homotoxicosis. They may also be employed for illnesses which are situated to the left of the Biological Section: for example, in the case of rheumatic disorders which exhibit a deposition phase at the locus minoris resistentiae of a degeneration phase of the table.

Therapy using suis-organ preparations should be executed on a long-term basis, until permanent improvement is achieved.

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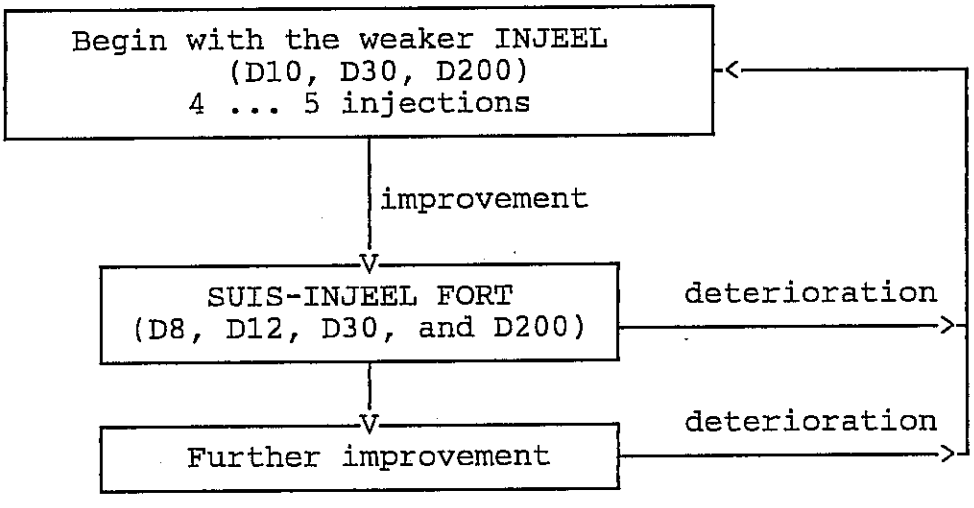
THERAPY WITH SUIS PREPARATIONS



Therapy here typically begins with approximately four to five injections of the weaker INJEEL injection solution, which is then succeded by administration of the stronger INJEEL Forte when improvement is noted. If the patient's condition should subsequently worsen, then the weaker Injeel should again be employed. If an improvement in the patient's condition is noted,

however, INJEEL Forte should be injected over an extended period of time.

The injections should be administered intramuscularly or subcutaneously, once to twice weekly at neural or at acupuncture points. In difficult cases, the integration of suis-organ preparations into auto-sanguis phase therapy, in association with COENZYM A and/or UBICHINON COMPOSITUM, should be considered. Through organ-specific stimulation, the suis-organ preparations activate the Greater Defense System, along with its five subdivisions.

For a better overview, therapy by nosode can be divided into the following groups:

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NOSODE THERAPY

1. Auto-nosode therapy: auto-vaccination using the patient's own urine or blood, and
2. Hetero-nosode therapy: hetero-vaccination using industrially-manufactured nosode preparations.

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Nosodes are homeopathic preparations which are derived from microbe cultures, viruses, or pathological secretions obtained from patients.

The basic materials used in nosode production are sterilized and homeopathically potentized. In this manner, the pathogens are therefore no longer harmful in any way. In accordance with the Arndt-Schulz Law, nosode therapy produces a slight stimulation of the body's own defense mechanism.

Natural homeopathization takes place when using autonosode therapy; in the case of hetero-nosode therapy, this same homeopathization is achieved through industrial processes.

In cases of retoxically inhibited phases in conjunction with regressive vicariation on the Table of Homotoxicosis, nosodes afford us excellent therapy in promoting the discharge of homotoxins from the body.

The two following nosode preparations have proven to be reliable in the therapy of arthrosis:

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NOSODE THERAPY FOR ARTHROSIS

1. PSORINOHEEL
2. MEDORRHINUM-INJEEL and FORTE,
   especially for treating coxarthrosis, polyarthrosis of the fingers, psychic symptoms, depression, and medication abuse.

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As a result of my experience, I can -- in cases of retoxically inhibited phases in conjunction with regressive vicariation -- most heartily recommend PSORINOHEEL, a so-called broad-spectrum nosode. This medication contains not only the three psora-nosodes Psorinum, Medorrhinum and Luesinum, but also Vaccininum and Bacillinum, and two constitutional medications sulfur and thuja, in addition to several other homeopathic constituents. Nosodes have an extensive constitutional effect, with the aid of which virtually every type of therapy can be effectively enhanced.

Dosage of nosodes must proceed on a strictly individual basis. In general, however, two injections per week are recommended for arthrosis treatment, with

progression to administration of the FORTE form among patients who exhibit no excessive reaction with the normal form. In these cases as well, injection at neural or at acupuncture points increases the medicinal effect. As often occurs when treating arthrosis cases which have persisted for years, there may be no reaction to the above-mentioned therapy. In such cases, the physician should try administering the nosodes intravenously. As a result of these measures, exceedingly strong regressive vicariation effects have often been observed.

Therapy based on simple combination preparations can indeed be limited to only a few medications:

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- SLIDE 17 -

COMBINATION THERAPEUTIC AGENTS FOR ARTHROSIS

1. ZEEL
2. TRAUMEEL
3. CAUSTICUM COMPOSITUM
4. NEURALGO-RHEUM-INJEEL
5. RHEUMA-HEEL

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In my therapy, ZEEL has proved to be one of the most important theraputic agents available for the treatment of arthrosis. For this reason, please allow me to introduce this preparation to you in somewhat more specific form:

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- SLIDE 18 -

CONSTITUENTS OF Z E E L

1. **Cartilago suis** (cartilage)
   For arthrosis deformans

2. **Funiculus umbilicalis suis** (Wharton's jelly from the umbilical cord)
   For treatment of weakness of the connective tissue

3. **Embryo suis** (embryo)
   For revitalization during the cellular phase of the Table of Homotoxicosis

4. **Placenta suis** (placenta)
   To enhance revitalization, and for circulation disturbances

5. **Rhus toxicodendron** (poison ivy)

In cases of aggravation of symptoms during cold or damp weather

6. **Arnica** (arnicca)
   For all posttraumatic conditions

7. **Dulcamara** (bittersweet)
   An agent against effects of wet weather

8. **Symphytum** (comfrey)
   For posttraumatic conditions of tendons, ligaments, and periosteum

9. **Sanguinaria** (Canadian bloodwort)
   For fast but superficial effects on rheumatic difficulties, especially on the right side; for worsening of symptoms at night

10. **Sulfur**
    Constitutional medication during cellular phases of the Table of Homotoxicosis

11. **Nadid** (nicotinamide adenin dinucleotide)
    Stimulates final oxidation in respiratory chain by acting as first link

12. **Coenzym A**

    Coenzyme in transacetylation

13. **Plus/minus-alpha lipoic acid**

    Coenzyme in decomposition of pyruvic acid

14. **Sodium alacetat**

    Active factor of the tricarboxylic acid cycle (citric acid cycle); effective for treatment of sensitivity to dampness and wind

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ZEEL represents an effective and mutually complementary combination of constituents which favorably regulates the metabolism of the synovial membrane and the cartilage of the joint, and which normalizes the disordered relationships between the catabolic and anabolic processes of metabolism. The dosage must be determined on an individual basis, according to the severity of the illness. Peri-articular infiltration (using two ampules for large joints), together with the application of dressings using ZEEL ointment, has proven to be especially reliable when administered parallel to oral therapy.

In the therapy of such cases, the preparation TRAUMEEL is employed as supplementary medication. The effects of TRAUMEEL are as follows:

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- SLIDE 19 -

THE 3 MAIN THERAPEUTIC EFFECTS OF T R A U M E E L

1. **Regenerative**, as a result of the constituents
   - Calendula
   - Symphytum (comfrey)
2. **Anti-exsudative** from the constituents
   - Mercurius (a mixture basically consisting of mercuro amido nitrate)
   - Bellis perennis (the European daisy)
   - Hypericum (St. John's Wort)
3. **Anti-inflammatory** owing to
   - Arnica
   - Hamamelis (witch hazel)
   - Millefolium (the European yarrow)
   - Belladonna
   - Aconitum (monk's hood)
   - Chamomilla
   - Echinacea (the narrow-leaved coneflower)
   - Hepar sulfuris

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In numerous cases, adding TRAUMEEL to ZEEL leads to pronounced improvement in the patient's comfort.

I am currently conducting a small study in my practice using ZEEL and TRAUMEEL for treatment of periarthritis of the shoulder and gonarthrosis. I am investigating the effects of peri-articular infiltration of two ampules of ZEEL and one ampule of TRAUMEEL as a combined injection administered three times weekly. Because I have until now treated only about sixty patients in this manner, I am unable to report exact findings at this time. Nevertheless, I do believe that I am already able to recognize the general trend. Only in very rare cases is there no definite improvement in the patient's condition. In the exceptional cases in which ZEEL and TRAUMEEL failed to provide relief, moreover, subsequent administration of radiological stimulation therapy as ultima ratio also achieved no improvement.

The great majority of my periarthritis and gonarthrosis patients, however, notice definite improvement after only one or two days of treatment with ZEEL and TRAUMEEL, with disappearance of their discomfort within approximately two weeks. Two weeks is of course too long for some of our patients to wait. Please

consider, however, that the majority of these patients had previously been extensively treated for weeks, and in some cases even for months, by my colleagues with the therapy of conventional classical medicine, and had been told that they would merely have to accept their illness as part of fate.

The tentative results of my investigation have in any case been so fascinating for me that I shall by all means publish my findings in the form of case reports.

To round out the theraputic concept, I have regularly administered the preparations CAUSTICUM, NEURALGO-RHEUM-INJEEL and RHEUMA-HEEL as accompanying medications, the choice and dosage of which will depend on each patient's individual needs. It is also vitally important to additionally provide therapy for specific organs, in order to increase homotoxin discharge. Effective medications here are, for example, REN SUIS-INJEEL for kidney insufficiency, as well as HEPAR SUIS-INJEEL for liver insufficiency. I often administer these additional theraputic agents at the proper and corresponding bladder meridian.

The following illustration shows a selection from possible accompanying therapeutic measures:

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SLIDE 20

A SELECTION OF NATUROPATHIC THERAPY

AS ACCOMPANYING MEASURES

1. Acupuncture and shiatsu
2. Neural therapy
3. Symbiosis control
4. Dietary measures*
5. Baunscheidt's air-puncture treatment*
6. Cupping and scarification
7. Employment of plaster of cantharidin
8. Venesection
9. Phytotherapy
10. Kneipp theapy
11. Cryotherapy
12. Therapy with oxygen and ozone

*Fixing of artificial reaction phases.

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Ladies and gentlemen, antihomotoxic treatment in a nutshell can be described as follows:

1. Prevention of the introduction of homotoxins into the body
2. Discharge of homotoxins already in the body.

Antihomotoxic therapy may very easily and effectively be combined with other natural medical procedures. An astounding enhancement of overall treatment is often achieved with the methods of antihomotoxicology. This, of course, should be hardly surprising when one considers that the goal of each of these therapy forms is, in essence, positive regulation of the organism -- regulation in Reckeweg's sense: "To be healthy is to be free of homotoxins."

Ladies and gentlemen, as I hope to have to shown, it is definitely possible to help our patients obtain relief from their illnesses through the use of antihomotoxic therapy -- a therapy extensively free from side effects. I hope that I have been able to provide you with helpful information of practical use to you in your practices: comments on how it is possible to provide our patients with an additional means of alleviating their discomfort.

Even if every aspect of antihomotoxic therapy has not yet been totally researched, concrete experience has shown this type of therapy to be highly effective. After all, many unresearched areas in classical medicine also exist -- which has not prevented the widespread and successful administration of medication in

that field. Since decades of experience have demonstrated that antihomotoxic therapy is also in fact highly effective, we should take heart from this evidence in a renewed effort to follow this way.

I thank you very much for your attention.