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Rheumatic Diseases from a Pediatric Standpoint

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Dr. Werthmann is a pediatrician practicing in Salzburg, Austria with a strong interest in pro-biotic medicine.

In this article he discusses how dietary changes, homeopathy, and neural therapy can be effectively integrated in the treatment of rheumatic disease.

In physicians' attempts made at classification and designation, diseases involving the entire complex of rheumatoid disorders are generally constrained by those systems of the various syndromes and groups, with their various symptomatic and descriptive designations, which are imposed by the particular standpoint of the medical observer. The causal factors are usually not considered, however; or the ignorance of these factors is cloaked in a symptomatic diagnosis. Fig. 1 clearly illustrates the pleonasm involved in such descriptive breakdowns.

Fig. 1: A typical breakdown of rheumatic diseases

A. Inflammatory and rheumatic processes
- Primary chronic polyarthritis (PCP)
- Bekhterev's disease / pseudo Bekhterev's disease
- Psoriasis and arthritis
- Reiter's syndrome

B. Metabolic disorders located in the synovia
- Malnutrition and hyperalimentation
- Absence or improper conduct of bodily exercise
- Excessive noxae, viruses, or bacteria
- Environmental toxins

C. Degenerative diseases of detrition
- Arthrosis and spondylosis
- Vertebral syndrome
- A combination of the above

D. Soft-tissue rheumatism

For many pediatricians, it has been a welcome boon that rheumatic disorders among patients younger than the age of 16 are further classified by the addition of the term "juvenile." This is a necessary signal to all involved — patients as well as physicians — that the onset of these rheumatic diseases — and rightly, in turn, of their causes — must be sought and found during the childhood of their victims. Still's disease, rheumatoid arthritis in children, is of course highly typical, since its development begins in the first year of life and reaches an initial culmination around the age of four.

The progress of morbidity of rheumatoid polyarthritis is highly similar in numerous points with that of allergic intestinal disorders, as I published in a study in 1985. See Fig. 2.

Fig. 2: The following factors are identical or highly similar for the following two diseases:

- Juvenile rheumatoid polyarthritis
- Polyarthritis cases with intolerance (enteric)
  - The age at the beginning of the diseases
  - Articular symptom complex:
    - Monoarthritis
    - Affliction of the same joints
  - Serology:
    - Minimal leukocytosis
    - Normal blood sedimentation rate
    - Similarly negative or positive rheumatoid factors
    - Negative antistreptolysin titer (ASR)
    - Low a and g immunoglobulins
    - Common tissue antigens (HLA = major histocompatibility complex); Dw3 /B8 / B27
    - Development of morbidity

The intestinal tract is often closely associated with disorders of immunological nature; in perhaps 80 percent of cases. The intestines with their immunological regulatory mechanisms, such as the intestinal lymph follicles, mucosae, bacteria, and appendage glands, are indeed a highly important factor with regard to the causes and therapy for allergically hyperergic developments in the human organism. This signifies, of course, that nutrition and its antigenicity also play a significant role.

In the case of prematurely and newly born children, the microvilli of the small intestine mucosa are not yet fully developed. As a result, the deficiency in immunological mucosal barriers leads to antigen reactions to a degree far greater than that observed among older children. These circumstances, in turn, lead to increased antigen absorption and penetration into the circulatory system. In case of bottle feeding of infants, i.e., nutrition from the milk of cows, greater quantities of food immunogens can be found in the peripheral blood than is the case among older children and adults.

The researchers Schäfer and Grüttner have pointed out the similarities between rheumatoid polyarthritis and colitis. They discovered that approximately 70 percent of families with one family member suffering from colitis also have one or more members afflicted by rheumatoid polyarthritis. In control groups, on the contrary, only 15 percent of families can be expected to exhibit rheumatoid polyarthritis to this degree. The researcher Panush has also recently confirmed a definite causal relationship between rheumatoid polyarthritis and immunogens contained in food. Rheumatoid polyarthritis and the colitis syndrome belong to the allergic morphological group of illnesses: a phenomenon which will be repeatedly confirmed below in the discussion of therapeutic measures.

In order to provide an overall picture of the treatment plan to be presented below, the main points will first be covered to demonstrate clinical development of a case of enteric intolerance and the articular disorders associated therewith. The colitis syndrome covers the entire range of all allergic-inflammatory disorders of the intestinal mucosa including mucous colitis, ulcerative colitis, and Crohn's disease.

Approximately 50 percent of all patients suffering from colitis are younger than 18 years old; an initial peak in these disorders is reached around the age range of 10 to 12. Among infants, enteric hypersensitivity appears through the symptoms of sniffles, relapsing respiratory difficulties, and seborrhea, depending on the length and other conditions of nursing. Among children just beginning school, on the other hand, the main symptom is a recurring cough as a consequence of sino-bronchitis or convulsive bronchitis. It is not infrequent that relapsing abdominal colic, with pain projected into the navel area, serves as the instigation for usually unnecessary appendectomies. The actual intestinal symptoms present are often masked by an immune deficiency, accompanied by recurring cough and candida infections. Older patients suffer from constipation, overly frequent bowel movements, and meteorism (tympanites).

The articular symptoms associated with these complexes of disorders become apparent in infancy. The first symptom of which a child will complain is monoarticular arthritic pain in the hip or knee. This symptom picture is frequently misinterpreted as being associated with appendicitis, or is foolishly disregarded simply as "growing pains." Even among teenagers, polyarthritis initially appears in approximately one-third of arthritis cases as monoarticular arthritis, with symptoms primarily appearing in the knee, hip, or ankle. Although simultaneous affliction of more than one joint is actually rare in this age group, it can frequently occur that arthritic symptoms will consecutively appear on an episodic basis, in one joint after the other. Symptoms can last for a variable length of time, from several days to several weeks. Among sufferers from juvenile polyarthritis, it is rare that extra-articular symptoms are encountered such as leukocyte counts over 20,000, affliction of visceral organs, subcutaneous knots, or spleen tumors, contrary to Still's disease, in which such signs do occur.

Serological evidence is not conclusive in cases of juvenile polyarthritis. The conventional tests for rheumatism, latex and C-reactive protein (CRP), as well as the antistreptolysin titer (ASR) are usually negative. The ASR is positive only if the immune system, already overloaded by enteric intolerance, is additionally afflicted by a streptococcal infection. The negative results obtained with the rheumatoid factors are probably due to the lack of essential prerequisites in the juvenile synovia. Specialists have assumed that the cause is the lack of release of lyosomal enzymes and the minimal formation of rheumatoid factors of the IgG type by the plasma cells. As a result, a physician may well be guilty of malpractice in the event that he or she rules out the possibility of juvenile rheumatoid polyarthritis merely on the basis of negative results from conventional rheumatism tests. The presence of eosinophilia points to infestation by worms; here, the sedimentation rate (after Westergreen) will amount to 20 to 40 mm in the first hour.

The immunoglobulins IgA and IgG are not pathognomonic for rheumatoid polyarthritis. It is interesting, however, that the immunoglobulin level is lower for this disorder, as it also is for patients with enteric allergies. IgA is produced in the intestinal crypts and serves as an initial defense barrier as a result of masking of the pathobionts and sealing of the intercellular spaces. IgA is significantly reduced in cases of villous atrophy, which is in turn considered as a sign of intolerance. IgG is likewise seen as a defense factor for microbial toxins in the more distant parts of the intestinal mucosal barrier, and is significantly increased only in cases of crypt abscesses in conjunction with ulcerative colitis. Evidence supplied by histocompatibility antigens (HLA) has confirmed the long-held suspicion of pediatricians and rheumatologists that a disposition to colitis and to rheumatoid polyarthritis can in many cases be inherited (see Fig. 3).

Fig. 3: Tissue antigens (histocompatibility antigens, HLA) for enteric allergies and for rheumatic disorders.

HLA B8	Is found among patients who are allergic to gluten, and patients with Sjörgensen's syndrome (deficiency in functioning of the pancreas and salivary glands). It is also found for polyarthritis.
HLA B27	Positive in cases of juvenile rheumatoid polyarthritis, Bekhterev's disease, Reiter's disease (renal hemorrhages and polyarthritis).
HLA DW3	For juvenile rheumatoid polyarthritis and allergy to gluten.
HLA DW4	According to Hartl, for over 70% of sufferers from polyarthritis.

Once rheumatoid polyarthritis is strongly suspected, a radioimmunoassay should be performed for various food antigens. In any case, tests should be conducted for cows' milk and chicken eggs. False negative findings are, however, not conclusive evidence of enteric allergic symptomatology. More details are contained in the book Enteral Allergien (Enteric Allergies), by Konrad Werthmann, through Haug Publishers.

Therapy of rheumatoid polyarthritis

Effective therapy of rheumatoid polyarthritis, especially the juvenile form, primarily consists in diminishing the magnitudes and the harmful effects of metabolic products of the intestinal antigen-antibody reactions, and of the additional more remote disturbances involved, as these act on the extracellular fluids of the body. Such therapy can effectively consist of the following:

A. Diet
- Avoidance of basic allergens: e.g., cows' milk and chicken eggs
- Avoidance of personal immunogens

B. Homeopathic therapy
- Administration of preparations determined to be most effective for a particular patient by means of the techniques of electroacupuncture
- Administration of the corresponding single-constituent and/or combination preparations

C. Neural therapy
- Administration in accordance with the methods of Huneke
- Elimination of focal disorders

And now for more detailed comments on the points outlined above:

A. Diet

The most critical and highest-priority aspect of the program of therapy sketched above can be summarized as follows: elimination of focal disorders and their pathological effects. The logical beginning here would therefore be direction of therapy to the digestive tract, since sections of this tract themselves can act as focal disturbances. Conversion to a diet free of immunogens can enable patients' organisms previously incapable of reaction to produce the reactions required for successful biological and homeopathic therapy. At the same time, functioning of the pancreas can be relieved of burdens, many of which may have afflicted the patient since earliest childhood. The pancreas is thereby once again able to exert a positive influence on the connective tissue.

B. Homeopathy / C. Neural therapy

As stated, it is critically important to ensure effective elimination of focal disorders present in the intestinal tract, composed as it is of various different intestinal sections and appendage glands which can act as foci. Elimination of these disturbances is especially important if the physician intends to administer both homeopathic preparations as well as neural therapy. This combination therapy can include injection of homeopathic medication at neural therapeutic points and tissues with particular affinity to the intestinal system. If successful, such administration can provide an immune therapeutic shock effect (after Wagner). The Regio appendikularis is one section which features a particular abundance of lymph follicles, and which plays a central role in the digestive tract. Combination injections to this section can be composed of the following mixture:

- Engystol (1 ampule)
- Hepar Suis Injeel (1 ampule)
- Procainum purum (1 ml, 0.5 to 1%).

This mixture should be injected at the alarm points of the large intestine (stomach no. 25), on both sides. In case of older children and adults, this injection should, for greatest effectiveness, also be injected at the respective point of the tonsillar ring, submucously at the forward palatal arch (palatoglossus). The respective constituents of the injection mixture have the following effects:

- Engystol activates the organism's general resistance
- Hepar Suis provides the required stimulation of liver detoxification
- Procaine relaxes lymphangiospasms which may have occurred, and repolarizes the cell membranes.

It appears significant that therapy applied by injection at the peritoneum and the tonsillar poles is longer lasting in its effects than by application subcutaneously.

The second phase of massive-dose therapy as applied here is injection of medication for detoxification of connective tissue. This step of therapy includes important detoxifying homeopathic agents and nosodes, which act on the focal disorders. For older children, this injection can also be administered in the form of progressive auto-sanguis therapy (isotherapy with a small amount of the patient's own potentized blood). The basic composition of this medication is as follows:

- Ubichinon Compositum (1 ampule)
- Echinacea Compositum (1 ampule) which contains the significant constituent Bryonia (bryony), as well as nosodes produced from streptococcus, staphylococcus, and influenza
- Magnesium-Manganum Phosphoricum Injeel (1 ampule), which features a catalytic effect for trace elements, and which acts on disorders of the paranasal sinus cavities
- Appendicitis Nosode Injeel (1 ampule), a critical constituent of this combination.

In case of suspected sinus caused influences, it is most effective to administer Sinusitis Nosode Injeel (1 ampule), instead of the Appendicitis Nosode — or, the sinusitis nosode can be given in addition to all of the above.

Any further nosodes to be used should be determined with the aid of electro-acupuncture examination according to Voll, or selected on the basis of the particular case history. In the case of children, successful therapy is critically dependent on administration of a pathogen nosode, which may include the following:

- Coxsackie A_9
- Bacterium coli
- Bacterium proteus
- Salmonellaparatyphi B (administered as Injeel)
- Worm nosodes

The heredonosodes Luesinum and Medorrhinum can also be administered, in accordance with the symptom picture.

Mycosis of the intestine plays a considerably greater role among children than among adults. Whereas Perger in his studies had determined fungus findings in one third of stool cultures obtained from the population at large, candida mycosis occurs in approximately one-half the stool cultures of children. Fungus affliction is an illness of the ill; in other words, if the primary disease is healed, the mycosis will vanish on its own. Moniliasis has only an indirect effect on articular symptomatoloy via the intestinal tract. In any case, restoration of healthy conditions in the intestine is absolutely necessary for long-term success in therapy of rheumatic disorders.

I would like to emphasize here that strict maintenance of an allergen-free diet, in conjunction with two or three repetitions of the immunotherapy injections stated above, will relieve the symptoms of any sufferer of juvenile rheumatoid polyarthritis. This therapy has also brought significant relief to adults in their suffering from articular disorders. These assertions are all based on solid research and scientific findings. Hans-Heinrich Reckeweg also had clear insights into the vicariation phenomenon of the ectoderm (epidermal tissue) and of the entoderm (mucodermal tissue), i.e., into the relationships between milk crust and pyloric spasms. The logical extrapolation here is vicariation between the mucodermal tissue of the entoderm and the cavodermal tissue of the mesenchyme, i.e., between enterocolitis and rheumatoid polyarthritis (see Fig. 4).

It is possible, as a consequence of therapy which consists of an allergen-free diet and immunomodulation and stimulation alone, to relatively quickly return the initially high serum titers for the immunoparameters back to normal ranges. Such therapy is also capable of enabling full recovery, without the necessity of intra- or paraarticular injections. And the success of this therapy is actually the best possible evidence of the interrelationships between rheumatic disorders and the colitis syndrome. In accordance with these phenomena, the common origin of both symptom pictures lies in inherited disposition and in excessive stress applied to the intestinal tract in earliest infancy through diet rich in immunogens.

I would like to conclude by describing the case of Thomas, one of my patients, who particularly well illustrates the interrelationships among the phenomena discussed above. Thomas, who was born in October of 1979, suffered from extremely painful juvenile rheumatism. As a result of administration of therapy of the kind outlined above, however, he was able to obtain relief without analgesics and without intra- or

Fig. 4

TABLE OF HOMOTOXICOSIS (abridged form)

Recovery ◄——————————————————► Lingering Illness

Tissue	Humoral phases — Diseases of the disposition: Excretion phases	Reaction phases	Deposition phases	Biological Section	Cellular phases — Diseases of the constitution: Impregnation phases	Degeneration phases	Neoplasm phases
1. Ectodermal a) Epidermal	Perspiration, cerumen, sebum, etc.	Milk crust	Atheroma, warts, keratosis, clavi, etc.		"Tattooing", pigmentation, etc.	Dermatitis, Lupus vulgaris, leprosy, etc.	Ulcus rodens, basalioma, etc.
b) Otodermal	Saliva, coryza, etc.	Stomatitis, rhinitis, aphthous stomatitis, etc.	Nasal polypus, cysts, etc.		Leukoplakia, etc.	Ozaena, atrophic rhinitis, etc.	Cancer of the nasal and oral mucosa
c) Neurodermal	Neurohormonal secretion of cells, etc.	Poliomyelitis in the pyramidal stage, herpes zoster, etc.	Benign neuromas, neuralgia, etc.		Migraine, tics, etc., veins infections (poliomyelitis)	Paresis, multiple sclerosis, spinal atrophy, syringomyelia, etc.	Neuroma, gliosarcoma, etc.
d) Sympathicodermal	Neurohormonal secretion of cells, etc.	Neuralgia, herpes zoster, etc.	Benign neuromas, neuralgia, etc.		Asthma, Ulcus ventr. et duodeni, etc.	Neuroblastomatosis, etc.	Gliosarcoma, etc.
2. Entodermal a) Mucodermal	Gastrointestinal secretions, CO_2, stercobilin, etc., toxins with faeces	Pyloric spasms/ Enterocolitis	Constipation		Bronchial asthma/ Ulcus ventriculi and duodeni	Tuberculosis of the lung and of the intestine, etc.	Ca. of the larynx, stomach, rectum, etc.
b) Organodermal	Bile, pancreatic juice, thyroid hormones, etc.	Parotitis, pneumonia, hepatitis, cholangitis, etc.	Silicosis, goitre, cholelithiasis, etc.		Toxic damage to the liver, pneumonopathy, virus infections, etc.	Cirrhosis of the liver, hyperthyroidism, myxoedema, etc.	Ca. of the liver, gall bladder, pancreas, thyroid gland, lungs
3. Mesenchymal a) Interstitiodermal	Mesenchymal interstitial substance, hyaluronic acid, etc.	Abscesses, phlegmons, carbuncles, etc.	Obesity		Forestages of elephantiasis, etc., influenza virus infections	Scleroderma, cachexia, vaginal vulvae, etc.	Sarcoma of various locations, etc.
b) Osteodermal	Haemopoiesis, etc.	Osteomyelitis, etc.	Osteophytosis, etc.		Osteomalacia etc.	Spondylitis, etc.	Osteosarcomas, etc.
c) Haemodermal	Menses, blood and antibody formation	Endocarditis, typhus, sepsis, embolism, etc.	Varicose veins, thromboses, sclerosis, etc.		Angina pectoris, myocarditis, etc.	Myocardial infarct, pernicious anaemia etc.	Myeloid leukaemia, angiosarcomas, etc.
d) Lymphodermal	Lymph, etc., antibody formation	Appendicitis	Swelling of the lymph glands, etc.		Lymphatism, etc.	Lymphogranulomatosis, etc.	Lymphatic leukaemia, lymphosarcomas, etc.
e) Cavodermal	Fluid, synovia	Rheumatoid polyarthritis	Dropsy, etc.		Hydarthroses	Coxarthritis, etc.	Chondrosarcoma, etc.
4. Mesodermal a) Nephrodermal	Urine with catabolites	Cystitis, pyelitis, nephritis, etc.	Hypertrophy of the prostate gland, nephrolithiasis, etc.		Albuminuria, hydronephrosis, etc.	Nephrosis, contracted kidney, etc.	Renal carcinomas, hypernephroma, etc.
b) Serodermal	Secretions of the serous membranes	Pleuritis, pericarditis, peritonitis, etc.	Pleural effusions, ascites, etc.		Forestages of tumours, etc.	Tbc. of the serous membranes, etc.	Ca. of the serous membranes, etc.
c) Germinodermal	Menses, semen, prostatic fluid, ovulation, etc.	Adnexitis, metritis, ovaritis, salpingitis, prostatitis, etc.	Myomas, hypertrophy of the prostate gland, hydrocele, cysts, ovarian cysts, etc.		Forestages of tumours (adnexa, uterus, testicles, etc.)	Impotentia coeundi, sterility, etc.	Ca. of the uterus, ovaries, testes, etc.
d) Musculodermal	Lactic acid, lactacidogens, etc.	Muscular rheumatism, myositis, etc.	Myogelosis, rheumatism, etc.		Myositis ossificans, etc.	Dystrophia musculorum progressiva, etc.	Myosarcoma, etc.
	Excretion principle, enzymes intact, tendency towards a spontaneous cure, favourable prognosis				Condensation principle, enzymes damaged, tendency towards deterioration, dubious prognosis		

The homotoxic phases are arranged vertically, and the tissues affected by the homotoxins are arranged horizontally. Each phase can be related to practically any other through the vicariation phenomena.

paraarticular injections. The later course of his illness included a new, moderate attack of pain in the ankle joint, accompanied by swelling, in the spring of 1987.

The cause of this relapse began with moderate disregard of his diet by eating cookies containing a minimal amount of eggs, during the Christmas season of 1986. Due to his generally satisfactory progress, however, the patient and his parents continued to disregard his diet and prolonged unwise allergen consumption considerably past the Christmas period. Thomas had a meal particularly rich in allergens only a few days before his springtime rheumatic relapse. From the case history, and especially as a result of his careful abstinence from allergens during the early period of his illness, it could be assumed that Thomas's intestinal tract was well supplied with sufficiently functioning villi. In all probability, the slow type of allergic reaction in Thomas's case allowed unnoticed the immunogen stress after the minimal consumption of Christmas cookie eggs for a limited period of time, without triggering rheumatic reactions. Strict return to a diet free of allergens, in addition to two preperitoneal injections, allowed Thomas to enjoy complete relief from his symptoms again.

Faithful maintenance of diet free of immunogens has prevented rheumatic reactions from recurring, and Thomas can now take part in physical education at school, and in skiing during vacation.

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REFERENCES

(1) May, W., Der Einfluss der Ernährung auf das Immunsystem, Naturamed Heft 2, 58-66 (1987).
(2) Kollath, W., Geiger, W., Kramer, S., Intestinale Atointoxikation, Dysbakterie und die lebenswichtige Anärobiose des Darminneren, Med. Welt 16, 207, 235.
(3) Werthmann, K., Enterale Allergien, II. Auflage, HAUG-Verlag Heidelberg.
(4) Werthmann, K., Die Störfeldkrankheit im Kindesalter, Erfahrungsheilkunde Heft 4, 234-238 (1987).
(5) Panush, R.S. et al., Arthritis and Rheumatism 29, 2, 220-226 (1986).