Best Cases In Biological Medicine
Series #17

K.Z. was a 53 year old single female with a 15 year history of progressively increasing pain and stiffening in her hips, fingers, elbows, and wrists. This has been accompanied by severe fatigue and generalized muscle aches. She was mildly obese. She denied smoking, drugs, or alcohol use. Her early age dental mercury had been removed 5 years before. She had no root canal teeth. She worked in a high stress environment as a bookkeeper. She had no prior surgery or significant accidents or medical conditions. She had tried various solutions for the pain including a raw diet and various nutritional remedies without improvement. She had seen multiple alternative practitioners without significant progress.

In desperation she sought a Rheumatologist who did the following labs:

ANA pos 1/160 homogeneous pattern
RA Factor neg
ESR 42
Hip Xray: Significant joint calcifications
CBC and non fasting Chem 25 were normal
Gluten /Gliaden negative

She was diagnosed as having "mixed connective tissue disease" and given a prescription for Plaquenil. The Plaquenil gave her headaches and she was worried about possible retinopathy and discontinued it.

She came into Lifeworks Wellness Center for evaluation.

Physical exam showed BP 96/55, HR 88, with mild obesity. She had limited motion and pain in her hips, wrists and fingers. Skin was dry, without rashes or palpable calcifications or nodules. Heart, lungs, abdomen and neuro exam were normal. ART testing was positive for autoimmune. She opened on mercury and localized to adrenals.

An Adrenal Stess Index was ordered from DiagnosTechs. A Metal Free challenge (3 days of treatment followed by stool for heavy metals) showed very high stool levels of Mercury. Serum fatty acids showed low Omega 3's and very high arachadonic acid. Amino acids were normal. Fasting blood sugar was 58.

She was given four treatments of autosanguinous injections with Pleo Lat, procaine, and Traumeel. She developed fever to 102F and severe fatigue for three days after the first injection. Subsequent reactions were mild. She was placed on an alkaline diet with frequent meals of organic foods and Zone type calorie distribution. Omega 3 fish oil, 15 cc twice daily was given. Extra salt was permitted to taste. She was given Vascuzyme (Ortho Labs) 6 tablets TID on an empty stomach. She began a series of 10 colonics and had daily infra red sauna treatments. DMSO IV was suggested and refused.

Three times weekly Meyers cocktails were given with Coenzyme Compositum, Traumeel, Wala Tendon, and Wala Adrenal Cortex.

On recheck in two weeks she was marginally better. Review of her ASI test showed a severely depressed am salivary cortisol of 8 (13-24), noon 4 (5-10) and 4 pm 1 (1-4). Total cortisol 14 (23-42). 17 OH progesterone was 18 (22-100) DHEA 4 (3-10)

She was given Hydrocortisone 7.5 mg am, 5 mg noon and 5 mg 4 pm along with Prenenolone25 mg BID and Biotin 2000 mcg BID. (Biotin is an important cofactor in the enzymatic production of cortisol from Prenenolone. It also helps to stabilize blood sugar through optimization of glucose phosphatase activity.)

Within five days after beginning the Hydrocortisone, Pregnenolone and Biotin treatments she called to say

that she was much better. She described it as being in the present and out of a fog. She had much improved energy. She could actually plan a day. Her joint pain was very much diminished and she felt like walking. She said, "you've hit a home run with me!"

The diagnosis of adrenal insufficiency is one of the most rewarding that a physician can make. I first learned about this from Pharmacist Wally Simmons at Women's International Pharmacy, and we find his compounding of Hydrocortisone to be the best we've used. When he first spoke about this, he handed me a copy of Dr. Wm McK. Jefferies book, ***Safe Uses of Cortisol*** *(http://members.aol.com/jefferiesw/safeuses/safecor1.html)* and what I learned from this text has allowed me to help many patients.

With the addition of exogenous, physiologic doses of cortisone, we were able to allow her adrenals to recover, reduce the inflammation, and with other supplements, detoxify her mercury burden. Her future was bright.

This diagnosis of "mixed connective tissue disease" is a complete wastebasket. Here we have a patient with an autoimmune condition (probably mercury induced), with adrenal exhaustion (probably mercury), Omega 3 deficiency, high arachadonic acid and hypoglycemia issues. These factors, along with her high level of job stress led to an elevated ACTH. Eventually the adrenals became exhausted from trying to keep up with the demand. When they failed, their low levels of cortisol could no longer mediate the inflammatory cascade and her symptoms became worse. Tissue calcification was the consequence of the chronic inflammation.

I know that because of the dangers of prednisone and its devastating effects, many physicians are fearful of using cortisone replacement therapy for adrenal exhaustion. But one must remember that this is bio-identical hormone replacement at physiologic levels and not drug therapy. Just as Premarin is not bio-identical estrogen, so Prednisone, is not cortisol.

In our experience, adrenal glandulars can have their place in therapy for support, but when the cortisol level is too low, and the systemic reaction too severe, the real hormone is often needed until the glands can recover. When the ASI shows salivary cortisol straight line across the bottom of the graph, I can lick my chops, and look the patient in the eye, and confidently say, "I've got something that will really help you." And in most cases the prediction comes true. We always give the patient a few precautions:

1. If you feel hyper the dose is too high and we cut it back.
2. If you feel no change the dose should be increased.
3. The highest dose should be in the morning upon rising.
4. It may increase your appetite- so watch your portions.
5. Urinary frequency and thirst may increase.
6. Watch the BP and for water retention if the dose is too high.
7. Some people cannot take the third afternoon dose because they cannot sleep, so we may skip it.
8. An occasional person who can't sleep may need a small dose before bed (1mg-2.5 mg)
9. We usually have the capsules made up in 2.5 mg doses so we can adjust it more easily.
10. Patients ALWAYS have concerned friends and family tell them they should not be on cortisone, so we always prep them on this and explain why we are using it and its record of safety and let them read Dr. Jefferies' book if they are interested.
11. Patients must be followed closely. Most need to stay on for 1-2 years and are able to be weaned off if they follow our program to handle what caused it in the first place and maintain a sensible lifestyle. Those that burn the candle at both ends must learn to listen to their body and rest when they are tired instead of pushing the limits and overdoing it with caffeine and/or other stimulants.

Biological Medicine is the science of working with the laws of nature and life to heal the body. When these principles are followed, and the patient is compliant, and providing we are not too late, we can be successful.

The purpose of this series is to present illustrative cases from different practitioners in order to demonstrate the highly effective principles and practice of Biologic Medicine. If you have cases that have educational value for others using Biological Medicine in practice, please email them in Word format to Dr. David I. Minkoff M.D. at ***drminkoff@bodyhealth.com****. They will be presented each month as part of the* ***Best Cases in Biological Medicine*** *series.*