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### Thank You!!!

I would like to take the time to publicly thank the PHA staff and writers for the amazing job they do in writing their articles for nothing more than a "thank you" as labor of love to the Lyme Disease community. You are an amazing group of people who are selfless in your work and advocacy for the cause of those suffering with chronic illness and Lyme Disease. You inspire me so much!

I am so proud to be a part of your outreach and advocacy efforts. You truly do make a difference!  
~Dawn

## Impressive Clinical Research and Expert Care

### An Interview with Dr. Kenneth B. Liegner

by Tina J. Garcia

Medical history was made on July 30, 2009, when sixteen scientists and physicians and two Lyme disease patient advocates testified in Washington, D.C. Testimony for and against the 2006 Lyme Disease Practice Guidelines issued by the Infectious Diseases Society of America (IDSA) was presented to a Review Panel comprised of nine independent, unbiased physicians. The Hearing was the result of an antitrust investigation of the IDSA's method for developing Practice Guidelines for the treatment of *Borrelia burgdorferi* infection, commonly known as Lyme disease.

The antitrust investigation conducted by Connecticut Attorney General Richard Blumenthal began in late 2006 and resulted in a legal Agreement signed on April 30, 2008. The Agreement called for the Review Panel to review research submitted by the public, listen to testimony presented by selected individuals and determine whether the IDSA's 2006 Lyme Disease Practice Guidelines should be revised in part, in their entirety or not at all.

I am grateful to have been selected as one of the patient advocates who presented testimony to the Review Panel on that historical day. It was a wonderful and humbling experience for me to provide a voice for the worldwide Lyme patient community. The physicians and scientists who also testified in favor of extensive revision of the Guidelines provided fantastic and riveting presentations.

Among those testifying on behalf of persistent infection post treatment, the most moving testimony was given by Dr. Kenneth Liegner of Armonk, New York. Dr. Liegner began with his impressive medical experience and training and then related the tragic stories of two adults and one child who succumbed due to chronic Lyme infection. He included deeply affecting photographs and a video in his presentation. It was evident that the suffering and eventual loss of these individuals could have been avoided had there not been so much unwarranted opposition to diagnosis and

treatment of Lyme disease for the past thirty years.

**Tina:** Thank you very much for the opportunity to speak with you, Dr. Liegner. It really was a pleasure meeting you at the IDSA Review Panel Hearing in Washington, DC on July 30th last year. I was so impressed with your presentation. It was an emotional experience for me, especially as a patient who has suffered so many difficult symptoms from Lyme infection, and it brought tears to my eyes as I watched it. I imagine that was a terribly difficult experience with Vicki Logan.

**Dr. Liegner:** Well, you know, before I came down to give the talk, I had to preview the presentation with some of my staff. One of my staff, Debbie, burst into tears when she saw the video, because we all knew Vicki. Vicki wasn't expecting to die, but she did.

It's important to get the message out there about the science, but it's also important to put a human face on the disease, as you and Lorraine Johnson did with your presentations, too.

**Tina:** It was one of the best experiences in my life and I'm very grateful that I had the opportunity to participate. I will cherish the memory always.

May I begin by asking you to describe your current practice and your approach to patients?

**Dr. Liegner:** Well, I'm a dinosaur. I have a home office at present and have done it this way since 1985. That has its pluses and minuses. It's worked out well in some ways; it's very good for home life with my family. For instance, when my son was growing up, he was upstairs while I was downstairs working. The downside is that you never get away from your work.

But the upside has, in a certain way, enabled me to be more productive than I might have been, had I had an office somewhere else and left each evening and not thought about it until the next day. There's so much responsibility that goes along with running a private practice. There's so much detail that you have to stay on

top of.

**Tina:** Has running your office out of your home allowed you to retain the valued characteristic of being a "home visit" type of physician?

**Dr. Liegner:** Well, when I first went into the practice of general medicine, I did general internal medicine and a wide range of things, including critical care at the hospital. At that point, I provided home visits to some people who required that, but I only did that to a point. It's not a very efficient way to practice. Although I have done that in rare exceptions, right now I generally don't make home visits. For example, I visited Mr. Eisenhardt, whose case I presented at the Hearing. His wife was very dedicated to him, and I would occasionally visit him in his home in the Catskills.

**Tina:** I'm thinking that you have been able to retain more of a personal approach with your patients due to the way in which you have your practice set up.

**Dr. Liegner:** Well, I would say that we practice the old fashioned way in a certain sense, which I think is the right way. What I mean by this is giving the patient whatever time is required for a new visit. It's rarely ever less than two hours, commonly three hours and occasionally, it's four, five or six hours.

**Tina:** So, you definitely have a higher level of involvement with your patients.

**Dr. Liegner:** Each of us personally takes our own history the old fashioned way, just like we did when we were in medical school. We learned to do the whole history, the past history, the family history, the review of systems, allergies to drugs and all that stuff. We do all of that ourselves. We could pawn that off on a question-



naire or a nurse, but to me, that elicitation of history is very important because one question may lead to another. It's also the interaction between the patient and the physician that occurs that is important. However, it is time consuming and certainly doesn't lend itself to a managed-care minute.

**Tina:** I have to say, thank goodness for that.

**Dr. Liegner:** Yes, but it's hard to do that. You can't really do that if you have a contractual relationship with an insurance company or even a government program. You just can't; it's not possible. Most managed care visits are necessarily abbreviated. So much emphasis is placed on the electronic medical record (EMR), as though that in itself is going to save cost and lead to better care.

Personally, I don't believe it does. Many of my patients tell me their doctors are more interested in key-boarding than in having eye contact with them. A lot of the EMRs I see are garbage boiler-plate and computerized regurgitation of previously-garnered history. Yeah, it looks great and it fits the insurance company "reimbursement templates", but it's not very beneficial to patients.

**Tina:** I'm assuming, because of the location of your practice, that you see patients with acute Lyme disease.

"Liegner"... cont'd pg 3

Download Dr. Burrascano's Lyme Protocol FREE at:  
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# Dr. Warren Levin Addresses President Obama in an Open Letter



President Barack Obama



Dr. Warren Levin

Dear Mr. President:

As a Fellow of the American Academy of Environmental Medicine, I was overjoyed by your campaign promises for a change in the USA's environmental stance. I am even more delighted by the actual changes already underway. Please, Stay the Course. What gives me the temerity to address a letter to the President is my standing in the community of Complementary Alternative Medicine [CAM]. I opened the first Holistic Health Center in NYC in 1974, and successfully fought against the suppression of my specialty by the NY State Office of Professional Misconduct. During that 14 year battle, I had great support from Berkley Bedell, Orrin Hatch, Dan Burton and others on the Hill. I am on a first-name basis with most of the experts at your recent hearings on CAM, and I recently accepted the position of Chairman of Biomedical Education for a newly formed Northern Virginia chapter of the National Autism Association, a 501(C)(3) Foundation.

I am writing today because, in my fiftieth year of practice, I find myself at the center of 3 major "Controversies" in American Medicine. The federal government is right there with me and it seems that neither of us has been able to effect the changes necessary. I certainly don't have the power, although my desire and intent are strong; while the government appears to lack the cohesiveness needed between different offices to

exert their combined influence on:

1. Mercury and Fluorides in Dentistry
2. The alarming rise in Autism
3. Endemic Lyme disease

Furthermore, they are entwined with one another, causally and therapeutically, and more importantly, *they suffer from the same underlying obstruction to change in their respective paradigms for diagnosis and treatment.* That blockage is the true subject of my letter. Truly, all progress in medical paradigms stems from Heresy!

Like it or not, we are today a litigious society, and the threat of lawsuits against the standard-bearers of the status quo makes it almost impossible to expect a change to take place voluntarily, viz:

1. The FDA has ignored rulings from the courts and instructions from the legislatures, with regard to publishing the scientific proof of the toxicity of Mercury and Fluoride. If they were to appropriately protect the public, and announce the elimination of both of these substances from Dental Offices and Public Water supplies, the legal eagles who specialize in post facto actions would have a field day, because *the science is compelling, it has been known for a long time, and the effects are actionable.*

2. The status quo in autism holds that this problem

is incurable, and can only be dealt with by "rehabilitating" the various external expressions of the problem: speech, hearing, vision and musculoskeletal issues. What is totally ignored is the biochemistry of the brain, which must be diagnosed and individually addressed before full rehab can be accomplished. I am enclosing two DVDs showing recoveries based on such an approach, yet the Centers for Pediatric Neurology continue to ignore them for over a decade. Parents of these kids have spent a fortune trying to create a home environment to help them cope with their limitations, whereas proper treatment allows the vast majority of them to rejoin the world. Many will also attempt to exact retribution from the Authorities, because *the science is compelling, it has been known for a long time, and the effects are actionable.*

3. With regard to Lyme disease, the Infectious Disease Society of America, creators of the "official" Guidelines to Diagnosis and Treatment of Lyme Disease, as posted on the website [www.guidelines.gov](http://www.guidelines.gov), have recently been sued for conflict of interest in the creation of that document by the Attorney General of the state of CT. The panel has been disbanded, a new panel appointed, and Hearings are underway with the new panelists sworn to freedom from conflict of interest and to the obligation to scientifically review all evidence that has heretofore been arbitrarily rejected. All of this is under the watchful eye of a Professor of Medical Ethics.

Nevertheless, a serious question remains as to whether the new panel's guidelines will leave the previous panel at risk for retaliation, because *the science is compelling, it has been known for a long time, and the effects are actionable.* In the meantime, as examples of the impact of the errors on quality of life, I have had two cases of ALS and one MS, all of whom tested positive for Lyme by special testing and all of whom made good to spectacular progress while on IV antibiotics. All of them were denied continuation of therapy by their [different] insurance companies because they "did not fit the guidelines", and all of them regressed when treatment was discontinued. *The common denominator that impedes the progress of science in our society is the certainty that lawsuits will follow any meaningful change in medical practice that does not represent a new technology, but merely a change in opinion.* I believe that the Federal Government should pass a broad amnesty bill, covering practitioners from lawsuits over changes in guidelines for diagnosis and treatment. Freed from that onerous burden, new committees will be free to create, and re-create, guidelines that can more truly represent current "Evidence-Based Medicine."

Sincerely,

Warren M. Levin, MD

FAAFP [ret], FAAEM, FACN

## 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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“Liegner” ... cont'd from pg 1

**Dr. Liegner:** Well, I do, but realize that a lot of people don't come to see me for acute Lyme disease, because everybody knows how to take care of that. You know what I mean? You have the rash and it's kind of a knee-jerk response to get your six weeks of Doxy or whatever. I'm not saying that they might not benefit from coming to see me, but as a practical matter, a lot of those people are seen by their primary care physician, the ER or a walk-in clinic, where they get the standard treatment, and of course for some people that's fine. They're not troubled with anything further.

Then there are a lot of people who often, later on, have problems, and that's when it becomes more difficult because it's not obvious at that point just what's going on and the tests aren't always reliable. The kinds of symptoms that people report are so varied and complex; they can be hard to make sense of.

**Tina:** I was really impressed when you relayed in your testimony your history of working with the CDC on Lyme disease. I wasn't aware that you have such an extensive history with them. You provided the CDC with many samples of cerebrospinal fluid (CSF) for study way back in the 1990s, in which one significant spinal fluid culture revealed *Borrelia burgdorferi*.

**Dr. Liegner:** Yes, that Bb positive spinal culture was from Vicki Logan's CSF, and significantly, she was seronegative and culture positive post antibiotic treatment. I mostly and frequently communicated with David Dennis at the CDC. We were co-authors on that first report on Vicki Logan. He was excited about it and that was their own finding.

**Tina:** I'm surprised that the current CDC position on chronic Lyme infection is not based upon those findings.

**Dr. Liegner:** I don't know why that is the case. It could be a very deeply-held belief system in which one has certain assumptions that are very dearly held. If you work within that framework, everything seems very internally consistent, very coherent and very intellectually satisfying. The only thing wrong with that is that it may not match biologic reality; it may only match one's mental constructs.

**Tina:** Well, the Lyme community cannot help but wonder about the answer to that question. Getting back to your practice, what are the clinical observations and treatment recommendations you have made regarding Bb infection?

**Dr. Liegner:** As a clinician, it seemed pretty obvious to me early on that Lyme doesn't behave the way the book says it should behave. You don't even have to be a great observer. It's just so obvious. It's so amazing to me that it's not more obvious to more people, if you're at all a good observer, right?

**Tina:** Well, I think it's obvious and I'm not a doctor.

**Dr. Liegner:** So, it's incredible to me that something that is so clinically obvious is so opaque to people who don't see it that way. It's hard for me to imagine that people could be so dense.

**Tina:** I've had a lot of patients tell me that their erythema migrans rash was diagnosed as a spider bite, a blood clot or eczema. I agree with you that it's hard to believe that with all the information out there, more diagnoses are not being made.

Are you seeing patients from your immediate area, or do you see patients who live in other parts of the country as well?

**Dr. Liegner:** We get patients from all over. Some are local and some are from various regions in the country. Occasionally, we get patients from overseas and other areas of the Americas.

**Tina:** Do you notice particular co-infections endemic to certain areas?

**Dr. Liegner:** We certainly see a fair amount of Babesiosis and Bartonella. I'm not sure about Mycoplasma. There was a time when we were getting an awful lot of positive PCR's from MDL (Medical Diagnostic Laboratories) for Mycoplasma fermentans. However, they changed their methods a couple of years ago and now we hardly get any. So, I don't know whether the results before were false positives and the test results now are false negatives. We have the same patient population, so I really don't know what to think.

**Tina:** Can you give us a general idea of how you approach a patient who does not show improvement despite treatment?

**Dr. Liegner:** Well, of course, you need to reassess the diagnosis. Do you have the right diagnosis? If you do have the right diagnosis, then you might wonder if there is an occult co-infection that you're not addressing. But again, the problem is that the tests are not always reliable. So sometimes, if you have a strong clinical suspicion, even though the tests are negative, it might be appropriate to give an empirical trial of treatment for whatever it is that you're not covering and then see if that makes a difference.

Or, if there is some identifiable immune-mediated pathology that may have evolved out of tick-borne disease, the patient may not be responsive just to antibiotics alone. It might be possible that patients who really did start out with Lyme and/or Babesiosis may be experiencing a scenario where it kind of morphed into a dermatomyositis-type picture. Those patients have required joint care with a physician having expertise in dealing with autoimmune disorders.

Sometimes, one doctor can't do it all or know it all, and you have to work as a team, on

behalf of patients, with doctors who have other expertise.

I'm fortunate that I have a really super rheumatologist who is very open to and understanding of the interplay between infection and autoimmunity. He is Mark Eberle at NYU, and we work together very well.

I've also worked quite a bit with Andrew Franks, a dermatologist, who is also very mindful about the interaction between infection and immune-mediated processes. It is very helpful working with these folks. I work sometimes with a very top-drawer immunologist

...the way things typically work in medicine is that physicians look to the authorities as experts, listen to what the authorities preach or teach, and then model themselves after those authorities. Now, that's fine if the authorities are on track. However, it's not fine if the authorities are misguided or mistaken, and it's my belief that the so-called Lyme "authorities" have been mistaken.

at Albert Einstein, Arye Rubinstein, to take care of the immune angle.

You see, we have some patients who have tick-borne disease, but they also have impairments of one kind or another. So, it sometimes requires working as a team with some of the more complicated patients and those who don't respond. There are some patients who do respond beautifully to antimicrobial therapy, either singly or antibiotics in combination with anti-parasitics if they have Babesiosis. It's very, very clear that when you treat them, they get better, and when you stop treating them, they get worse. As long as you keep them on a maintenance approach, they're fine. They can go on with their lives, and they don't really have to give that much thought to their illness.

If we can get the chronically-ill patients to a point of being "boringly stable", that's our goal. This occurs when their illness is so well-controlled that it's not the focus of their lives.

**Tina:** Yes, that's something which I have gone through myself. As patients, we may focus only on the illness with the illness defining the patient's identity. It's very nice when a person can break out of that.

**Dr. Liegner:** That's one of my goals when helping my patients

-- to get it under such good control that they become stable and can pursue other interests. Of course, they can still have an interest in Lyme if they want to, because it is an area that needs a lot of help and attention, but the goal is to get them to a point where they can have a life.

**Tina:** I've talked with several physicians -- some do a lot of IV treatments and I know one doctor who doesn't do IV treatment at all. I'm curious as to whether you do both and how you determine whether a patient needs IV treatment versus oral therapy?

**Dr. Liegner:** Unless it's a desperate situation, we try lesser intensive approaches, just because many people respond effectively to that. It's simpler, safer and less expensive. However, there is a subset that does require IV but I'm not too quick to put people on IV. Then again, if I decide they do need IV, it could be for a long time. I think it can be done safely, but it has to be done with great care.

**Tina:** When you gave your presentation at the Hearing, one thing I was so impressed with was that you spoke about differential diagnosis and ruling out everything else. I think you were able to drive that point home with the Panel, which is not a characteristic of Lyme docs that is portrayed by the other side. The other side doesn't give Lyme-experienced doctors the credit they deserve in looking at a differential diagnosis.

They often say that Lyme-treating physicians diagnose everything as Lyme disease and do so in a careless fashion.

**Dr. Liegner:** Well, it's partly a political statement on their part. Yet, on the other hand, you could throw the same thing back at them. Their field is to diagnose ABL - ANYTHING BUT LYME. The contortions that some of the people on the other side go to avoid making a diagnosis of Lyme, even when Lyme is correct, amazes me.

**Tina:** Do you have any thoughts you'd like to share on the Hearing process or the Review Panel?

**Dr. Liegner:** The task that they were set to by the settlement is not an easy one. It's a complex series of arrangements that they agreed to undertake. Personally, I thought Jennifer Padberg of the IDSA did a terrific job of what was not an easy thing to arrange. There were a lot of pieces to the puzzle in order to satisfy all of that. It was difficult and I thought that was admirable. I also found the way Carol Baker conducted herself as the Chairwoman and the way the Panelists conducted themselves to be fair.

The Panel seemed to comport themselves respectfully toward everyone involved in the presentations, and I did make a point of introducing

myself to each of the Panelists thanking them for taking on the task, because it's a heavy duty that they took upon themselves.

Notably, most of them seemed to be pretty open and seemed to want to understand the issues and try to do the right thing. That was my sense. How it will all play out in the end remains to be seen.

**Tina:** Thank you for sharing that. I also have faith that the Panel members will vote fairly. I believe that they're taking everything into consideration - the science and the patient situation.

**Dr. Liegner:** All I can tell you is that I continue to encounter infectious disease folks who are just rabid. I thought that one of my patients, who lived quite a distance from my office in another part of the state, should get IV for Lyme. I don't undertake trying to give IV therapy to someone who lives hundreds of miles away. So, she heard some good things about an ID specialist in her area. I referred her to him with a nice referral letter and sent all of her records. The records were pretty thorough with a lot of data that showed that Lyme certainly could very plausibly be an important part of her problem. I was shocked at the rabid, disrespectful, knee-jerk response from this ID physician.

The attitudes expressed and the behaviors engaged in by people like that very much resemble a "bias crime." That is to say, those folks spit out all of their pent-up rage, anger, frustration and hatred at Lyme patients and the Lyme physicians who care for them. It seems to be socially acceptable within the "old boys network". This has got to change. It should be recognized for what it is -- hateful behavior.

Hateful behavior should not be socially acceptable. Those who engage in it should be "called out" on such behavior, because it's similar to what was done to James Byrd, Jr. and Matthew Shepard. Hateful behavior towards persons with Lyme disease should be equally recognized as socially unacceptable, and those who engage in it should be strongly socially ostracized.

Therefore, it really makes me wonder what it's going to take to turn such people around. Even if the IDSA Panel modifies the Guidelines, are the ID physicians going to follow suit or are they going to stick with the old IDSA Guidelines?

**Tina:** That's an excellent question to consider.

**Dr. Liegner:** How much influence will this Panel's decision have on this ingrained group-think that exists? Will the practicing physicians be dismissive of it and say, "Oh, their decision was only made because of political pressures. It's not really the truth." I just see so much resistance in the rank-and-file infectious disease doctors who have been influenced thus far by the existing Guidelines.

**Tina:** From a physician's perspective, do you think it would

**Tired of Living with Me**

**Maintaining Your Marriage in the Midst of Suffering, Part Three**



by *Linnette R Mullin*

There are days I'm so tired of myself I could scream. I despise the person I've become and if I could climb out of my body I'd run away and leave me far behind.

I endure enough types of pain from head to toe to drive a person insane. Fatigue and depression come and go on a whim all their own and leave me flailing through life. At times my resolve weakens and I want nothing more than to dissolve into a puddle of tears, yet I refuse (well, most of the time) knowing it won't change a thing.

Those who know my pain can understand why I might want to be rid of my body, but it isn't the only reason I'd love to escape. I weary of the constant battle to figure out what is most vital for me to do with my day's limited energy. Living in constant upheaval because I can never accomplish all that a mom should frustrates me. And then, there is the complaining. Nobody likes a whiner! I often clamp my mouth shut to refrain from complaining to my husband and children, but I still wage the battle in my mind and soul, and my introspection disgusts me. I strive to shut out the voices that beckon me to give up - the voices that tell me the pain is too much to bear. What keeps me from becoming a lunatic or committing self-murder?

A friend asked me one night about my Lyme disease and that of my boys. He had a couple dozen questions for me only to ask me what keeps me from shooting everyone including myself. Though he said it in jest and we both laughed, we also recognized it as a viable question. He couldn't believe

the things we have to endure on a daily basis. This was an eye opener coming from someone who suffers from diabetes. I had reached the point to where I sympathized with all types of chronic illness, diabetes included. But here was a diabetic who couldn't fathom enduring the kind of life my family and I live.

So, what does keep me sane? What keeps me from going off the deep end on any given day?

Remember John 15 about the vine and the branches? Jesus wants intimacy with us. He doesn't want to be an impersonal God who cannot empathize with our plight. If that were the case, He would have never come to earth as a baby only to be persecuted and die for us. But, He didn't stop there. He conquered death and returned to heaven where He prays for all those that will believe in Him (John 17).

But, how do we develop an intimate relationship with a God who is in heaven? There are three key tools to developing an intimate relationship with Christ: prayer, mind renewal, and honest self-talk.

**Prayer**

Prayer plays a vital role in our relationship with God. It's how we communicate with Him. He wants us to talk to Him. He doesn't ask us to pray, but He tells us to pray and to pray without ceasing (1 Thessalonians 5:17). It's something every one who seeks a relationship with Him must do.

Does this mean we spend every moment of every day bowed down and on our knees? That would be ludicrous. What it does mean is that He wants to be so much a part of our lives that we keep in constant communion with Him. Like texting or emailing your favorite people, you share tidbits of your life with Him all throughout the day. And by sharing the ins and outs of your daily life with God, you form an amazing bond with Him that is unrivaled.

**Mind Renewal**

In writing to the church in Rome, Paul encourages the believers to purposely live in order to please God rather than themselves. He says, "Do not be conformed to this world, but be transformed by the renewal of your mind, that by testing you may discern what is the will of God, what is good and acceptable and perfect." (Romans 12:2, ESV)

But, how do we do this? What does Paul mean by renewing our minds? God tells Joshua that "this Book of the Law shall not depart from your

mouth, but you shall meditate on it day and night, so that you may be careful to do according to all that is written in it." (Joshua 1:8a, ESV) It's not enough to just read the Word. Just like we are to pray without ceasing, we are to meditate on God's Word, think on it throughout the day. As different circumstances arise in our lives, we are to think about how God's Word applies to the situation. Never are we to define the scriptures by our experiences! We must guard ourselves

**Honest Self-Talk**

As a kid, I always heard people say that talking to yourself was a sure sign of becoming senile. I assure you that I don't advocate going about muttering to yourself about every little thing all day long. But, there is a sense in which we need to talk to ourselves. We need to constantly remind ourselves what God's Word says. We need to remember who we are and what our relationship with God is or should be. We need to focus our minds on truth rather than our feelings and sometimes even what appears to be the reality of the moment.

Each time my husband was laid off or a contract ended, I reminded myself of God's promise to provide us with what we need. He may not always give us what we want, but He certainly provides what we need. God knows about our chronic illness. He knows we need insurance. He knows that we can only go for a brief period of time without insurance in order to stay insurable. Many times I agonized over these things and fought off fear. Even when I couldn't see when or how, I told myself again and again to trust that He would provide because He said He would. I often reminded myself that faith is "the assurance of things hoped for, the conviction of things not seen" (Hebrews 11:1, ESV) in order to ward off the fear that threatened to consume me. I assure you, God has never let us down.

Honest self-talk is how we remind our hearts about the truth. We tend to follow our hearts when we should be telling our hearts what to feel. If you make a conscience effort, you will observe that the tendency of the heart is to follow your thoughts. For example, thinking about the way

your spouse ignores you when you're in pain and need to be understood and comforted can send you into a frenzy of anger or send roots of bitterness deep into your heart. But, if you remind yourself that the pain will subside in time and to be patient with yourself and your spouse, bitterness is thwarted and your strength is reserved for coping. In another instance, thinking about the enormity of things left undone at work or around the house might cause you to despair and give up before you even start. On the other hand, telling yourself to take things one step at a time helps you to focus your energy and accomplish at least a portion of your tasks. So, speak truth to your heart and your heart will typically follow.

This is why God states clearly the kinds of things we are to think about. In fact, He stresses it by naming them one by one, "...whatever is true, whatever is honorable, whatever is just, whatever is pure, whatever is lovely, whatever is commendable, if there is any excellence, if there is anything worthy of praise, think about these things." (Phillipians 4:8, ESV)

So, make yourself think right thoughts - thoughts that reflect the word and will of God. Remind yourself to trust Him in every situation. We don't always like what God says or chooses to do, but we must remind ourselves that He knows best even when we don't understand.

**Your Reward**

In those moments when you're tired of living with yourself and you wish you could climb out of your own skin and leave yourself far behind, remember the basic three: pray, renew your mind, and practice honest self-talk. Isaiah said of God, "You keep him in perfect peace whose mind is stayed on You, because he trusts in You." He then tells us to "trust in the LORD forever, for the LORD God is an everlasting rock." (Isaiah 26:3-4, ESV).

Linnette R Mullin is a freelance writer and author. You may visit her at [www.LinnetteMullin.com](http://www.LinnetteMullin.com) or contact her at [Linnette\\_PHA@yahoo.com](mailto:Linnette_PHA@yahoo.com).

**"...thinking about the enormity of things left undone at work or around the house might cause you to despair and give up before you even start. On the other hand, telling yourself to take things one step at a time helps you to focus your energy and accomplish at least a portion of your tasks. So, speak truth to your heart and your heart will typically follow."**

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## “Liegner” ...cont'd from pg 3

be worthwhile for Lyme-treating doctors to host training lectures at hospitals?

**Dr. Liegner:** Well, it might be helpful if doctors who treat chronic Lyme disease were acknowledged as having expertise in the field. You see, the way things typically work in medicine is that physicians look to the authorities as experts, listen to what the authorities preach or teach, and then model themselves after those authorities. Now, that's fine if the authorities are on track. However, it's not fine if the authorities are misguided or mistaken, and it's my belief that the so-called Lyme "authorities" have been mistaken.

**Tina:** What other words of wisdom would you share with the medical community concerning Lyme and other vector-borne infections?

**Dr. Liegner:** When faced with Lyme, go back to the lessons of syphilis, learn the lessons of syphilis and realize that there is a lot of applicability of those lessons. Unfortunately, a lot of modern-day physicians have forgotten the lessons of syphilis. Or, perhaps they never learned the lessons of syphilis, period.

**Tina:** Is that because they were never taught those lessons?

**Dr. Liegner:** I believe that many in the modern era have very little experience with syphilis. Unless you're familiar with HIV patients or those with other sexually-transmitted diseases, I think any sort of run-of-the-mill ID physicians and internists don't see a lot of syphilis anymore. There are a lot of things about syphilis that are taken for granted that are not true, also, such as the notion that syphilis is easily cured with penicillin. Whereas, those who really know syphilis, know that isn't true and know that it was never true. It's treatable, but people still need to be followed, even if they have been treated.

In my submission to the IDSA Review Panel, I spoke to the lack of biologic plausibility that Gary Wormser put forth, that it's unprecedented and impossible. It's not unprecedented; it's precedented! In fact, Gary Wormser even published a paper on that, in which he showed spirochetes in a patient who had failed their treatment. If anything, the Lyme spirochete has a more complex genome than the syphilis spirochete. As I said in my talk, when you have a patient that is infected with two, three or four of these tick-borne diseases, it really gets complicated and confusing when trying to treat and help them.

Here is an excerpt from my submission paper to the IDSA Panel regarding the similarity between Lyme and syphilis infections:

"It is also crucial to realize that treatment failure after application of intensive antibiotic therapy has been reported for syphilis, another spirochetal infection, in persons with impaired immune status as well as in immunocompetent

individuals (40-50). The well-accepted practice of following persons who have been treated for syphilis for surveillance purposes reflects the wide recognition within the medical profession that this illness has the potential to relapse despite prior treatment. Furthermore, if neurologic symptoms occur in such persons and if no other plausible cause of the symptoms is evident after careful evaluation, the dictum is to treat further with antibiotics (51-53). Whereas the authors of the 2006 IDSA Lyme disease guidelines maintain it is "biologically implausible" for Lyme spirochetes to survive despite prior treatment with antibiotics, actually there is ample precedent for this phenomenon in syphilis."

**Tina:** Once again, it really is so obvious. However, there appears to be a concerted effort to disregard these obvious correlations. What do you think needs to be done by researchers and physicians to bring forth positive change?

**Dr. Liegner:** We need better methods of treatment, and we could have that. Also, a definitive test is of utmost importance. As I said in my presentation, better tests have already been developed and mothballed for reasons unknown. That's extremely frustrating. It seems that the mainstream has done everything in its power to sabotage, marginalize or mothball any tests that really do have promise of being superior.

**Tina:** What is your opinion of the C6 Peptide test?

**Dr. Liegner:** To my mind, it's just another antibody test, and in my experience, it's not that great. If it's negative, it doesn't rule out Lyme. If it's positive, it's bullet-proof evidence of Lyme. I think that people had hoped that it would be some kind of marker or indicator of disease activity and that didn't pan out. Unfortunately, right now, with the current state of the art and with what is available out there, the Western blot still remains the most useful, clinically available test.

**Tina:** And do you find the CD57 helpful?

**Dr. Liegner:** I don't use it, and I don't know what to make of it. We need a test for Lyme that is highly sensitive, highly specific, and desirably, not only qualitative but quantitative. That way you can track the disease by having something that is the equivalent to a viral load for HIV. I call it the Borrelial load. It could give us an idea of what kind of numbers of spirochetes we're dealing with. I think that could be developed.

Again, I emphasize, what we need is the Rocky Mountain Lab's capture assay that Barbara Johnson attempted to be dismissive or disparaging of at the Hearing. I think her dismissiveness was completely inappropriate, uncalled for and

unjustified. She just kind of dismissed the assay as though nothing had panned out, and that's not true. It was an inaccurate and inappropriate response to the Panel's question about the usefulness of the RML capture assay. However, she had to say that in order to maintain her beautiful little world of antibody testing.

This is what I wrote about the capture assay in my submission paper to the Panel:

"In the early 1990s, colleagues at the Centers for Disease Control asked me to forward to them samples of urine and serum from patients

**"Science demands that all available information be evaluated in trying to approximate the truth, not just evidence that supports one point of view. Failure to consider all of the relevant evidence concerning chronic Lyme disease violates fundamental principles of inductive reasoning central to dispassionate and objective scientific inquiry and impedes scientific progress."**

who were under evaluation for possible Lyme disease.

Unbeknownst to me, CDC forwarded these specimens on to the Rocky Mountain Laboratory of the National Institute for Allergy and Infectious Diseases for study by Dr. Claude Garon, Ph.D., then Chief of the Microscopy section, and his colleague David Dorward, Ph.D. They had done fundamental work on the biology of *B. burgdorferi* which they published in the journal *Scanning Microscopy* (16). They devised a method using electron microscopy for detecting blebs shed by the outer membrane of Lyme spirochetes by immunogold staining (17). Drs. Garon and Dorward prepared a chart comparing the results of the RML urine antigen test versus standard ELISA methods in serum (18) and the results of testing on my patients was also reported at the V International Conference on Lyme Borreliosis (19). Their work demonstrated that many patients testing negative on standard serologic methods tested positive on direct antigen detection using their method in urine. These patients had an impressive diversity of clinical presentations. One, who gave a history of an eruption historically compatible with erythema migrans, died of pulmonary hypertension. Unfortunately, an autopsy was not performed.

The test method of Garon and Dorward was her-

alded in an article in the Health Section of the New York Times (20). Unfortunately, their method has languished and has never been used further on

either a research basis or commercially for clinical diagnostic purposes. Their work does reveal that there is a deep complexity to Lyme disease such that presently available methods do not begin to scratch the surface of the biologic reality of the disease."

**Tina:** In my opinion, the failure to utilize existing testing methods such as this one has resulted in rampant, unnecessary and avoidable suffering.

Such inhumane disregard is inexcusable.

Is there anything else that you'd like to share with the readers, Dr. Liegner?

**Dr. Liegner:** Well, practice prevention if you can. I think that there are things you can do to protect yourself if you're in Lyme endemic areas, but you have to be a bit of a fanatic about it. I believe you have to regard yourself as going into a battle zone if you live in a Lyme endemic area and you're active out of doors. Wear proper clothing sprayed with Permethrin and recognize that tick habitat is a threat -- a serious danger -- and comport yourself in that fashion.

This is a little bit different attitude toward nature than we all grew up with. Nature is wonderful, but there are risks out there, too. The problem was always out there to some degree, causing disease that nobody had a clue about. So, in a way, it's

pretty exciting to have an agent that possibly can be linked to so many disease states that right now may be treatable or preventable.

However, I think we have a long way to go. I think a lot could be accomplished if the denial stopped, if there was funding commensurate with the threat and if people worked on the same page cooperating instead of fighting. Then I think a lot could be achieved. In the meantime, everyone has to keep chugging along doing the best they can and try to assure that the proper priorities are being addressed in the biomedical research establishment. That, ultimately, does become political. How do you allocate resources? Who's in charge of dispensing those resources that are allocated? It's a political dogfight.

**Tina:** Dr. Liegner, I'd like to thank you very much for all that you are doing in helping your patients and for testifying at the Hearing.

**Dr. Liegner:** You're quite welcome, and thank you for coming forward and testifying also. I think it's important for the patient voice to be heard, so that the patients are not viewed as statistics only.

**Tina:** I'd like to leave the readers with a quote from Dr. Liegner's submission paper to the IDSA Review Panel, in

which you so adequately and eloquently described thirty-plus years of disregard for the plight of patients suffering from chronic Lyme infection.

"Science demands that all available information be evaluated in trying to approximate the truth, not just evidence that supports one point of view. Failure to consider all of the relevant evidence concerning chronic Lyme disease violates fundamental principles of inductive reasoning central to dispassionate and objective scientific inquiry (56) and impedes scientific progress."

*pha*

### About Dr. Liegner:

While in college, Kenneth B. Liegner, M.D. worked as an orderly at the Neurologic Institute of New York. Between college and medical school, Dr. Liegner worked as a research assistant to Dr. Malcolm Carpenter, author of the renowned text *Truex and Carpenter's Human Neuroanatomy* and preceptored Columbia P&S Med students in their Neuroanatomy Lab.

Dr. Liegner graduated second in his class at New York Medical College and completed one year in post-graduate Anatomic Pathology that included twenty to thirty complete autopsies. He completed his residency in Internal Medicine and went on to train in Critical Care Medicine within the Department of Surgery at Westchester County Medical Center, which also included three months in the Burn Unit.

Additionally, Dr. Liegner worked as an attending physician on the Surgical Critical Care Service at the Washington Hospital Center, in Washington, D.C.. Dr. Liegner is in private practice in Armonk, New York. His office number is 914-273-2121.

Read Dr. Liegner's complete IDSA submission paper at <http://www.leaparizona.com/drliegneridsasubmission.htm>

### About Tina J. Garcia:

Tina J. Garcia is a freelance writer, Lyme disease patient and patient advocate who founded Lyme Education Awareness Program, L.E.A.P. Arizona, a non-profit that provides education about Lyme disease and co-infections. Visit her website at [www.leaparizona.com](http://www.leaparizona.com).

Through July 2010, read the statements and watch the video testimonies from the IDSA Review Panel Hearing at this link: <https://www.idso-society.org/Content.aspx?id=15026>

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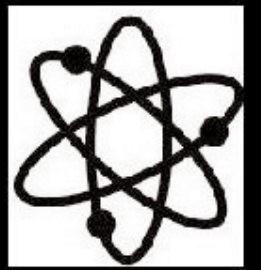


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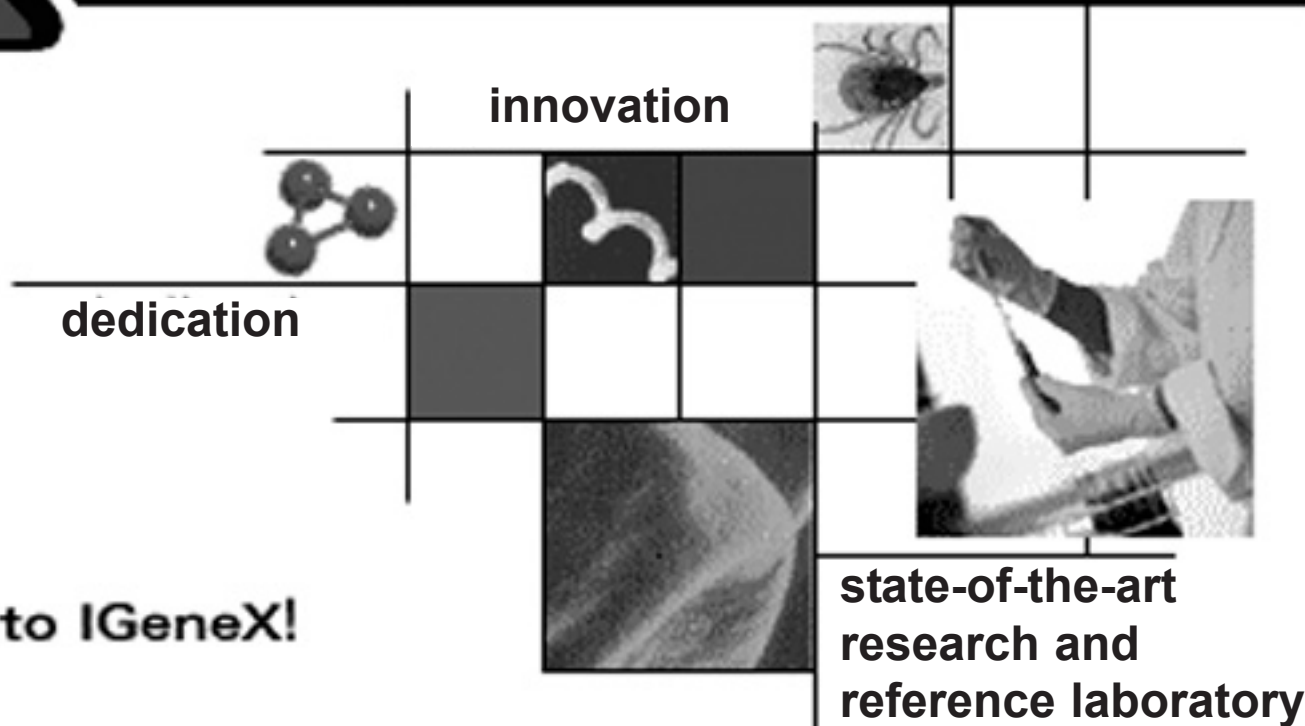
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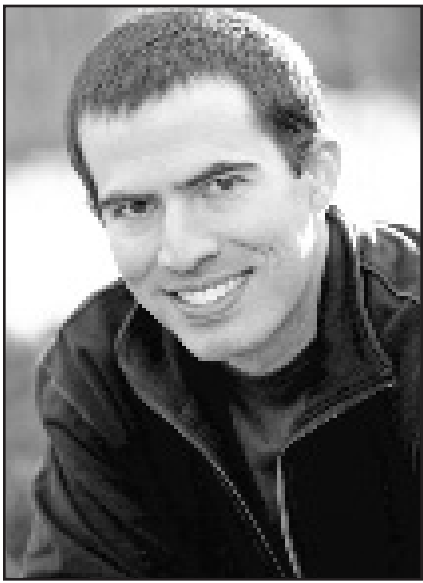
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# What's the Buzz About this So-Called Marshall Protocol?

## Part 2 of 3 in a series



by Bryan Rosner  
www.LymeBook.com

### About this Series

This is a 3-part series on the Marshall Protocol. Currently you are reading Part 1. In 2007 I published a book called "The Top 10 Lyme Disease Treatments" (available from <http://www.lymebook.com>). This article series will be based on direct excerpts taken from that book. The Marshall Protocol remains a very controversial treatment. It has helped me personally, and I know of many others who it has also helped, including one highly visible businessman / politician. Other people find that it is unhelpful or even harmful to them, although my suspicion is that some types of "adverse reactions" to the protocol may in fact be herxheimer (or die-off) reactions. Looking back now, 2 years after the book was published, I will say that I am still a believer in the Marshall Protocol but I do believe that it should only be administered under the careful supervision of a licensed physician who is versed in the protocol. The purpose of this article series is to introduce you to the protocol, not to serve as medical advice. Please consult a licensed health care practitioner before beginning any new treatments.

### Disclaimer

The author of this series is a layperson journalist, not a medical practitioner. Also, the opinions represented in this article are those of the author alone; this article has not been reviewed or endorsed by Trevor Marshall, Ph.D., the inventor of the protocol.

### Marshall Protocol principles

#### Vitamin D dysregulation

Also known as calciferol, Vitamin D was misnamed as a vitamin after its discovery in 1922. A vitamin is a type of organic substance that is required in the diet and essential to nutrition and metabolism. Vitamin D is unique because it is not required in the diet; instead, it is manufactured by the body via exposure to sunlight or artificial lights. Although we do consume Vitamin D in our diets, it is not technically a vitamin since it is not required in the diet.

For the purpose of explaining the Marshall Protocol, we are less concerned

about the technical definition of Vitamin D and more concerned about how it affects chronic disease. Whether a true vitamin or not, Vitamin D plays a critical role in the pathogenesis of Lyme Disease and other illnesses involving infection with cell-wall-deficient bacteria. At the center of the Marshall Protocol is the breakthrough discovery that Vitamin D is not handled correctly in the bodies of people infected with cell-wall-deficient bacteria. Let's look at how this dysregulated handling of Vitamin D occurs.

As we mentioned, Vitamin D can enter the body in two ways: it is either synthesized in the skin after exposure to sunlight or artificial lights, or it is consumed in the diet. Once Vitamin D is inside the body, not all of it remains in static form. A small portion of Vitamin D is converted to a type of secosteroid known as 1,25 dihydroxyvitamin-D (abbreviated "1,25-D"). A hormone required for regular body function, 1,25-D is manufactured by the kidneys as a metabolite (or product) of Vitamin D. In healthy people, the body tightly regulates how much 1,25-D is made in the kidneys; although critical to health, too much 1,25-D can be very harmful. If present in excessive quantities, 1,25-D can be immunosuppressive and cause a plethora of physical and psychological symptoms.

In people infected with cell-wall-deficient bacteria, the production of 1,25-D can spiral out of control and rapidly reach damaging levels. This happens because, as an evolved survival mechanism, cell-wall-deficient bacteria are capable of catalyzing the process by which Vitamin D is converted to 1,25-D. Instead of a slow, controlled conversion which occurs only in the kidneys, 1,25-D production becomes uncontrolled, occurring throughout the body inside cells infected with cell-wall-deficient bacteria. Specifically, immune system cells harboring cell-wall-deficient bacteria can turn into tiny, unrestrained factories producing excessive amounts of 1,25-D. Bacteria catalyze the 1,25-D conversion process intentionally to cause immune system suppression and create a more favorable living environment in the body.

The result of catalyzed 1,25-D production is a subclinical yet devastating immunosuppression syndrome that allows Lyme Disease (and other types of cell-wall-deficient) bacteria to persist chronically in the body. When present in appropriately controlled quantities, 1,25-D is a critical nutrient and is important to health, as we have said. However, when present in excessive quantities, 1,25-D is immunosuppressive and inhibits the immune system from fighting infections. This process is one of the core survival mechanisms of *Borrelia burgdorferi*. The excessive levels of 1,25-D often present in people harboring chronic infections leads to a greatly inhibited host defense system.

By accelerating conversion of Vitamin D to 1,25-D, these tiny bacteria are basically able to neutralize the human immune system.

Additionally, as we have alluded to, elevated levels of 1,25-D itself (even without infections on board) can cause a plethora of disease symptoms. So, an elevated level of 1,25-D has a two-fold impact: it suppresses the immune system and also creates numerous other symptoms of malaise. This is why it is so important to address elevated 1,25-D levels when treating Lyme Disease.

The aforementioned principles are at the core of the Marshall Protocol. One of the primary objectives of the Marshall Protocol is to reduce the excessive levels of 1,25-D in the body. Since 1,25-D is a metabolite of (or product of) Vitamin D, the process of reducing 1,25-D levels in the body requires that a person suffering from infection with cell-wall-deficient bacteria decrease their consumption of Vitamin D foods and supplements, and also reduce their exposure to sunlight and bright lights. Both of these actions are primary components of the Marshall Protocol that will be examined in a few pages. By curtailing the amount of Vitamin D that enters the body, 1,25-D production is also reduced, bringing the immune system back into balance. While Vitamin D consumption (and exposure to sunlight and other artificial lights) may be neutral or even beneficial to healthy people, it can be poison to people infected with cell-wall-deficient bacteria because of this pathogenic process.

In addition to Dr. Marshall, Dr. James Schaller has also found that 1,25-D is involved in other inflammatory processes. Specifically, 1,25-D levels have been found to be higher in inflamed, damaged, and arthritic joints in comparison with healthy joints. This observation further confirms the principles on which the Marshall Protocol is based.

Now that you have some background in the nuances of Vitamin D, we'll turn our attention back to the role Vitamin D plays in the Marshall Protocol. In the Marshall Protocol, the goal is to reduce excessive 1,25-D levels (which are almost always present in Lyme Disease sufferers). This is accomplished by intentionally avoiding exposure to sunlight and bright lights and by decreasing consumption of Vitamin D-containing foods and supplements. We will further discuss these topics in a later section of this chapter. First, though, before moving on, I am sure some of my readers will be scratching their heads and wondering if they should actually consider Vitamin D reduction as a valid Lyme Disease therapy. Let's take a small detour with some additional discussion of that issue.

It is natural to be skeptical that intentional reduction of Vitamin D in the body could be



Dr. Trevor Marshall, Ph.D.

healthy. Vitamin D supplements line the walls of your favorite health food store. Vitamin D may be a part of your daily supplement routine. New research is available almost daily detailing the benefits of Vitamin D. However, you need to shift the platform from which you view Vitamin D. Any good thing can become a bad thing under certain circumstances. Water, for example, is essential to sustaining life, but it can also cause death. No one would tell a drowning person not to worry because water is our friend. Vitamin D is no different. People infected with cell-wall-deficient bacteria will find that Vitamin D can and does become toxic. The effects of elevated levels of the Vitamin D metabolite known as 1,25-D are, quite frankly, responsible in part for the word "chronic" in "chronic Lyme Disease."

There is no one-size-fits-all formula for Vitamin D. Some health conditions may benefit from its supplementation, while others are harmed. Consider, for example, the analogous nutrient, iron. Too much iron makes you very sick (my father has this condition, called hemochromatosis, and has to give blood every couple weeks to lower his iron levels). Conversely, we all know that too little iron leads to anemia. In the case of iron it would be misguided to argue about whether iron is good or bad. The right amount is good, and the wrong amount is bad. The same is true of Vitamin D?in some cases it may be too low, and, in other cases, too high.

If you need objective verification that your 1,25-D levels are in fact abnormal, several laboratory tests are available. These tests look at levels of 1,25 dihydroxyvitamin-D, 25 hydroxyvitamin-D and angiotensin-converting enzyme. The codes for these tests are LabCorp #081091, #081950, and #010116, respectively. A physician trained in applying the Marshall Protocol can help you understand, order, and interpret these tests. You can get a referral to such a physician and learn more about these tests at [marshallprotocol.com](http://marshallprotocol.com).

If you do not have access to a Marshall Protocol-

trained physician, the tests are still worth doing because they can help you convince your current physician that your Vitamin D levels are indeed problematic and that the medications and lifestyle modifications advocated by the Marshall Protocol are indicated. Test results are also helpful for patients themselves to see, as they can objectively identify Vitamin D dysregulation and establish that the protocol may be helpful. Seeing objective test results can dispel doubt in the protocol and establish a scientific basis for its use.

In the case of Lyme Disease, laboratory tests, while helpful, are not a necessary prerequisite to proceeding with the protocol. The tests can be quite expensive and are often not covered by health insurance. I personally never had Vitamin D tests done. The results of these tests are not always a perfect indicator of the treatment's potential usefulness and should not in any case be relied on too heavily. In lieu of or in addition to the tests, a therapeutic trial of the protocol can potentially determine whether or not a specific patient will find benefit.

Because the goal of reducing Vitamin D in the body is so unusual, many of you may be wondering why you should even consider it at all. After learning the basic principles of this protocol, I was asking the same question. However, after using the protocol, the answer became clear: I used the protocol because it works. It provided enormous, sustained improvement even after many other therapies failed. This improvement did not occur overnight, and there were some counterintuitive experiences along the way. We have already seen some of the counterintuitive principles involved in the Marshall Protocol, but let's take a closer look to ensure that these important concepts are fully covered.

As we have said in the Spotlight on Vitamin D SideBox, people infected with cell-wall-deficient bacteria may actually feel better with higher levels of Vitamin D on board, but this leads ultimately to increased severity of their disease. As Vitamin D is convert

"Marshall Protocol" ... pg 10

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## 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 & IASA Area

Sandra Mannelli  
smannelli@comcast.net

## Washington State

Alexis Benkowski  
WA-Lyme-owner@yahoo.com

## WI / IL / MI Regional areas

Contact PJ Langhoff  
(920) 349-3855  
www.Sewill.org  
www.LymeLeague.com (Intl)

## Western Wisconsin Lyme Action Group

Marina Andrews  
715-857-5953

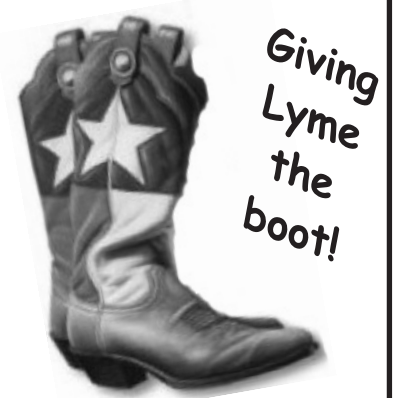


## Military Lyme Disease Support

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](http://www.txlda.org)

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2nd Saturday each month 2-4 p.m.

**Harris Methodist Hospital- HEB**  
1600 Hospital Parkway  
Bedford, TX 76022-6913

We meet in the left wing when facing the front of the building.

Contact our group leaders for more information:

Rick Houle, email: [Pedler3710@aol.com](mailto:Pedler3710@aol.com)  
Home: 972.263.6158 or Cell: 214.957.7107

John Quinn  
[jquinn@dart.org](mailto:jquinn@dart.org)

## Southern California Lyme Support

*Serving Los Angeles & Orange Country areas*

Contact: **Earis Corman**  
13904 F Rio Hondo Circle  
La Miranda, CA 90638-3224

**562. 947. 6123**

**[eariscorman@aol.com](mailto:eariscorman@aol.com)**

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OPEN EYE PICTURES

## “Marshall Protocol” ...cont'd from pg 7

ed into 1,25-D by cell-wall-deficient bacteria, immune system activities (inflammation) are diminished. This results in a symptom-reducing effect. The superficial improvement experienced may even lead Lyme patients to seek out Vitamin D sources. The appropriate course of action, in actuality, is to reduce levels of Vitamin D in the body.

When Vitamin D levels are lowered to the point that bacteria are no longer able to stimulate production of 1,25-D, the immune system can again begin to perform properly. Herx reactions will accompany the reviving immune system as it begins to attack the infection and kill bacteria. If you have read Lyme Disease and Rife Machines, recall that herx reactions are a necessary, albeit uncomfortable, part of the recovery process. Be aware that it is easy to misinterpret what is actually going on. Herx reactions that occur as Vitamin D levels are lowered may seem like worsening of the disease. These herx-related symptoms may even be misinterpreted as Vitamin D deficiency. In reality, such symptoms are not indications of disease worsening, nor are they signs of Vitamin D deficiency, but instead, they are indications of true healing.

In the short term it is easy to conclude that the Marshall Protocol's Vitamin D reduction is harmful-it seems to increase symptoms. It is also natural to conclude that Vitamin D supplementation is beneficial-symptoms are alleviated. Because of this confusion and the counterintuitive nature of Vitamin D's effects in someone infected with cell-wall-deficient Lyme bacteria, it is important to study thoroughly and understand fully the Marshall Protocol. Vitamin D avoidance can be confidently relied on only if you feel comfortable in your understanding of its mechanism of action.

Please remember that the information in this chapter about Vitamin D is experimental and investigational. There may be negative side effects to Vitamin D reduction. Consult your physician.

### Amplified Effects of Antibiotics

The second foundational

principle on which the Marshall Protocol is based is intimately connected with restoration of proper Vitamin D regulation: upon restoring healthy 1,25-D levels, not only is the immune system revived, but another related, and very significant, benefit is seen. Also at the core of the Marshall Protocol is the breakthrough discovery that standard pharmaceutical antibiotics have greatly enhanced effect when Vitamin D levels are properly balanced. This was first discovered by Dr. Marshall in relation to treating his own case of sarcoidosis.

In the past, sarcoidosis patients have received only minimal benefit from antibiotic therapy. But Dr. Marshall discovered that, upon reduction of 1,25-D levels, sarcoidosis patients can actually be cured with antibiotic therapy. Eventually, dozens of people with other chronic illnesses (including Lyme Disease) discovered the same to be true: having given up on antibiotic therapy due to disappointing results, they found relief and even remission when taking antibiotics after reducing 1,25-D levels. These discoveries launched the Marshall Protocol: a program that eradicates cell-wall-deficient bacteria by utilizing a coordinated schedule of particular antibiotics in combination with various methods of Vitamin D control.

When Vitamin D levels are appropriately reduced (which leads to decreased production of 1,25-D), antibiotics not only work better, they can become hyper-effective. So effective, in fact, that only a minuscule dose is needed to elicit powerful antibacterial action. This outcome is seen even in patients who have previously failed to respond to high-dose antibiotic therapy. For example, someone who previously experienced only mild benefits when taking 300mg/day of minocycline will experience dramatic benefits during use of the Marshall Protocol even though doses as low as 10mg/day may be used. Incredible, isn't it?

The amplified effect of antibiotics has a twofold benefit. First, it means that antibiotics will actually start to work for people who had not previously responded to them; and

second, it means that antibiotic side effects are kept to a minimum during use of the protocol because doses can be kept low. This is great news! The Marshall Protocol solves two of the primary problems facing Lyme Disease sufferers: the marginal effectiveness of antibiotics and the toxic side effects associated with their use. Of course, increased effectiveness of antibiotics also means that herx reactions can be much more severe, thus, special care and caution is necessary.

Spotlight on Vitamin D: Is Vitamin D a Health Restorer or Destroyer?

In recent times, Vitamin D has been highly touted by modern researchers and health-care practitioners across the world as a beneficial nutrient for both healing disease and health maintenance. Studies show that it reduces symptoms of numerous chronic afflictions and that it contributes to health and vitality. In reality, however, the subject of whether or not Vitamin D is a beneficial nutrient to consume is actually quite controversial.

Controversy arises because there is more than meets the eye when it comes to Vitamin D. In some instances, its intake can actually be toxic and counterproductive to healing, even while it can trigger perceived symptom improvement. There is a very large cross section of sick people who can actually be harmed by the nutrient, despite the fact that it initially makes them feel better.

What separates people who benefit from Vitamin D from people who do not? The presence of pathogenic cell-wall-deficient bacteria in the body. Infection by cell-wall-deficient bacteria contributes to excessive production and disturbed handling of one of the metabolites of Vitamin D, known as 1,25-D. While often leading quickly to symptom improvement, excessive levels of 1,25-D ultimately slow healing and prolong illness.

How does excess 1,25-D lead to symptom improvement? Since 1,25-D is a similar substance to steroid anti-inflammatory drugs, it can have a similar effect as those drugs. Consider what happens when

Lyme Disease is treated with steroidal anti-inflammatory drugs: immediate improvement in symptoms is experienced as the inflammatory response of the immune system (the primary cause of symptoms) is reduced. Yet, behind the scenes, steroids actually cause the Lyme Disease infection to worsen, considerably. With the immune system shut down and inflammation eliminated, the bacterial infection is free to proliferate and spread. Joseph Burrascano, M.D., one of the nation's leading Lyme doctors, has repeatedly said that steroids can cause severe aggravation of Lyme Disease-leading, in some cases, to permanent damage-despite the fact that steroid drugs make you feel better.

Steroid anti-inflammatory drugs typically result in dramatic symptom reduction in Lyme sufferers?but at an unacceptable cost. Similarly, people suffering from infection with cell-wall-deficient bacteria may feel better when supplementing Vitamin D (which is a precursor to 1,25-D), or when exposed to sunlight or bright lights, but in reality these things worsen their disease. Like steroid drugs, excess levels of 1,25-D can make you feel better but actually be bad for you.

This counterintuitive principle can lead patients, physicians, and researchers to mistakenly conclude that Vitamin D is beneficial in the treatment of chronic infections and other diseases such as multiple sclerosis and fibromyalgia (which may actually be caused by chronic infections). In the same way that doctors sometimes erroneously prescribe steroid drugs to the detriment of their Lyme patients, some Lyme sufferers may intentionally increase their Vitamin D consumption and exposure to sunlight only to their own detriment.

It is easy to conclude that feeling better indicates true healing. After all, in most sicknesses (such as colds and flu) improvement in symptoms does indicate healing. In actuality, however, Vitamin D?which is a precursor to 1,25-D?can be a poison to Lyme sufferers. Instead of eradicating the infection, it masks symptoms and provides a false sense of relief.

The situation gets even

more confusing because the opposite scenario can occur: Vitamin D avoidance can feel bad but actually be good for you. When the Marshall Protocol is used to reduce Vitamin D consumption and thus 1,25-D synthesis, the immune system is freed up to function properly. As a result, inflammation and herx reactions occur as the body engages in the battle with the bacterial infection. This phenomenon is often experienced subjectively as an increase in symptoms, so it can be erroneously identified as an exacerbation of the disease. Although symptoms are increasing, healing is in fact occurring.

In my first book, Lyme Disease and Rife Machines, it was noted that though herx reactions are extremely unpleasant and feel like backsliding, they are a necessary part of the healing process. The same is true of Vitamin D avoidance. Vitamin D reduction leads ultimately to true and permanent healing even though it can feel like backsliding.

The Marshall Protocol is based on an entirely new paradigm, unaccepted by and directly opposed to much traditional medical thinking. We are in the midst of the birth pains of an entirely new way to think about Vitamin D and its relationship to infectious disease. For many people, the breakthrough discoveries of Trevor Marshall, Ph.D., mean restored health and an end to the chronic infections caused by cell-wall-deficient bacteria. The challenge at this point in time is providing accurate information and education about this new paradigm, not only to patients but also to health care practitioners and researchers. You are encouraged to frequently check the official Marshall Protocol web site ([www.marshallprotocol.com](http://www.marshallprotocol.com)) to stay up to date with the latest information.

Stay tuned for part 3 of this article series! More information about the Marshall Protocol next month! (You are currently reading part 2; to view part 1, which was published last month, visit [www.publichealthalert.org](http://www.publichealthalert.org) or [www.defeatlyme.com](http://www.defeatlyme.com).)

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(1) Journal of the American Nutraceutical Association 2003; 6(1); 23-28.

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