Multiple Sclerosis and Heavy Metals
(A Case History)
by Byron S. Braid, MD, PhD

History
CB, a 32-year-old woman, was diagnosed with Multiple Sclerosis in January 2004, initially presenting with optical manifestations. Her symptoms began as a central smudging effect, which evolved into complete loss of vision in the right eye and severely compromised vision in the left. Consultation with a neurologist resulted in treatment with steroids and Interferon, resulting in her vision “clearing a bit.” Following this episode, her sight remained cloudy. In the autumn of 2005, she experienced several acute attacks manifesting as visual symptoms as well as tingling in the legs, which later led to difficulty with walking. She also developed abdominal spasms. She was treated with a 12-day course of steroids, which brought a slight improvement, followed by worsening after Christmas. During December, she also developed spasm in her hands with a sensation of sandpaper. Treatment with intravenous steroids brought about a minimal improvement.

Initial Presentation
At the time of initial presentation at Paracelsus Klinik in January 2006, her vision remained compromised enough to prevent reading. Right-eye vision was restricted to the perception of dim light, and in the left eye, vision was restricted to extremely large objects. She also complained of pain in the left arm and shoulder accompanied by paresthesias following an ulnar nerve distribution. In addition to the visual findings, physical examination revealed acute tenderness in the left stellate ganglion, left submandibular gland, left vagus and mastoid area, as well as left optic ganglion. Examination of the shoulder was consistent with a brachial plexus syndrome instigated by weakness in the shoulder musculature and pressure on the ulnar branch of the brachial nerve.

Lab Findings
Pertinent laboratory findings include a DMPS provocation test for heavy metals, which revealed a mercury level of 106.98 mcg/g (asymptomatic less than 20 mcg/g typically), tin 58.1 mcg/g (normal < 15), and Palladium 186.1 mcg/g (normal < 5). This patient had only a few small fillings and no easily identifiable origin for the massive Palladium level. She lived for several years in the vicinity of a mine and metal-smelting plant in Canada, and thus far this remains the most logical origin of the Palladium burden. Bacterial antibody testing revealed abnormally elevated IgM levels of Hafnia alvei, Pseudomonas aeruginosa, Morganella morganii, Pseudomonas putida, and Citrobacter koseri. Pseudomonas putida also had an elevated IgA. The IgM for Klebsiella pneumoniae was borderline elevated.

Stool analysis revealed deficient flora and diminished digestive capacity. Fatty acid metabolism was slightly deficient for Omega 6 EFAs, and Omega 3 EFAs were within the normal range.

The Darkfield Blood Examination showed moderate rouleaux formation, endobiont infestation of the erythrocytes, and significant filiform formation. There were no high valence symbionts seen. The Dried Layer Test emphasized digestive system problems, confirming dysbiosis, heavy metal burdens, and hyperacidity.

Treatment
Treatment was conducted at Paracelsus Klinik Lustmühle over a four-week period in January 2006 and consisted of milieu regulation with alkaline infusions, local hyperthermia using the Indiba device, matrix regeneration therapy, colon hydrotherapy, and neural therapy, among the various treatment modalities.

Terrain management was guided with the use of the Biological Terrain Management (BTM)* system. The initial test of urine and saliva revealed a deficiency of urine NO3, indicative of a bacterial/parasitic burden. She was in Zone 9, indicating a triple warmer meridian theme. This was specifically treated with Pefrakehl, Fortakehl, Probiotics, and Ornithine given as oral supplementation, as well as neural therapy with Berberis / Urtica
Heavy metal detoxification was treated with Nanocolloidal Detox Factors (NDF), starting with ten drops twice daily and increasing as per tolerance to two pipettes daily. Sanum remedies including Mucokel, eye drops, Pefrakehl, Recaracin, and Utilin were administered, as well as Conjunctisan A eye drops. I have also prescribed Regeneresen RN13, Regeneresen Linse, and Regeneresen Bindegewebe (Dyckerhoff Pharma) on a rotating basis. Neural therapy was performed on a weekly basis, as were the alkaline infusions. Gradually, vision in the right eye began to return. Plans were made for a return visit to the clinic.

Second Visit
The patient returned in June 2006 with vastly improved vision in the left eye, with only brief periods of “cloudy” vision. Sight in the right eye had improved enough that she was able to read large print formats. Almost all the sensation of paresthesia in the arms was gone, accompanied by an increase in strength and endurance. There were no complaints of spasm, fasciculations, weakness, or pain in the legs.

Once again a DMPS heavy metal challenge test was performed with a rather dramatic outcome. The patient had only utilized NDF as the detoxification agent. The test revealed a mercury level of 26.32 mcg/g, Tin at less than 1.0 mcg/g, and Palladium at less than 2.0 mcg/g. The elapsed period of time between the two tests is slightly less than six months (Table 1).

At this point in time, there continues to be gradual improvement in muscle strength, endurance, and visual acuity. The left eye has only short periods of diminished visual acuity that have continued to resolve. The right eye remains more compromised, but is clearly recovering visual capacity.

Summation
This case of Multiple Sclerosis appears to have surfaced from a multi-causal milieu disturbance with both elevated heavy metal findings as well as an ongoing bacterial disturbance supported by the finding of elevated IgM levels. It is our clinical experience to find that these results are often seen together and represent an overburdened and decompensated immune system. NDF was utilized exclusively as an agent for heavy metal detoxification. It not only provoked no side effects, but also provoked a rapid detoxification effect documented by follow-up laboratory testing. BTM testing was used throughout to efficiently guide terrain management on a corrective course. It is the author’s experience that the BTM test was of inestimable assistance in defining the meridian theme in a dynamic and immediate manner, repeatedly guiding the therapy on a corrective course. The BTM can be used in an extremely flexible manner, adaptable to the therapy style of the practitioner. We have been able, as a consequence, to understand intriguing and highly individualized treatment models that are easily re-directed with the use of the BTM as a guiding force. This case illustrates a particularly rapid capacity to re-compensate from a catastrophic symptom pattern, guided by this unique terrain-based metabolic approach.

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The NDF Line of Remedies
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Table 1:

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