



The Arthritis Trust

Dedicated To Eradicating Rheumatoid Disease From The Earth

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Thomas McPherson Brown, M.D. Approach to Solving Arthritis

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The following article by Dr. Brown in 1968 summarizes his successful approach in determining one of the primary causes of rheumatoid disease. As was the case with Roger Wyburn-Mason, M.D., Ph.D., a single source-cause of the disease was often envisioned. Now we know -- and Dr. Brown also knew -- of course, that rheumatoid disease is a multi-factored disease, and that several avenues of approach are necessary to reduce the stress vectors that contribute to rheumatoid diseases. And, as with the Wyburn-Mason treatment, successful results of any kind are to be commended and broadcast, especially to those who suffer from the disease.

Arthritis has been known to exist since prehistoric times, and for more than 2000 years it has been recognized as a clinical entity following the original clear description of the disease by Hippocrates. Over 4000 remedies have been

devised and despite the magnitude of the therapeutic efforts and basic research, arthritis still remains a progressive, destructive disease of unknown cause.

Behind the scenes are indications of real progress at last, and among the most encouraging aspects are those related to a new approach to treatment based on a concept of the disease mechanism developed primarily at The George Washington University. An account of this endeavor as it has evolved over the past 20 years may be useful in helping to clarify some of the mysteries of this great medical enigma.

Since the days we first selected an investigative direction in the uncharted sea of arthritis research, three decades have passed. During this time we have always aimed our efforts at the cause of the disease. We have believed this direction would provide the greatest likelihood of reaching our objective; namely, sustained therapeutic effectiveness through induced remission of arthritis inflammatory activity. The course we chose was not without risk. It is well known that those who attempt to discover the cause of disease face a lonely, troubled voyage with the strong probability

of arriving at a destination where new findings are ignored through fixed opinions and disbelief. Parenthetically, after these many years of persistent effort, a safe harbor seems near at hand and friendly natives are coming out to greet us. Great new worlds for exploration lie ahead.

When we began our comprehensive approach to the problem at the University Hospital in April 1948, the outlook was generally dismal except for two sustaining assets: 1) a new mechanistic concept of the nature of rheumatoid disease we had developed during the 10 years prior to coming to George Washington; 2) a realization of a need to project our work over a long period of time for meaningful results. In the beginning, there were many obstacles to overcome. No arthritis clinic for the essential long term observation and measurements of results of the treatment existed. There was no laboratory for continuation of our basic investigative studies, and there were no supporting Research funds. Perhaps the greatest problem of all was the lack of interest in the field of arthritis as well as in many other areas of chronic disease.

A major reason for apathy stemmed from the accepted opinions at that time on the nature of arthritis. These views were generally discouraging and provided little appeal to students and young physicians in the process of choosing the direction for their future work. Four standard concepts of the cause of arthritis

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IN MEMORIAM

Jack M. Blount, M.D.

August 28, 1921 - September 11, 2003

BY PERRY A. CHAPDELAIN, SR., EX. DIR./SEC.

Jack M. Blount, M.D. was born in Hickory, MS, August 28, 1921. He received his undergraduate degree at "Ole Miss" (University of Mississippi) and his M.D. degree at George Washington University, Washington, D.C.

Even prior to entry in medical school, Dr. Blount had the misfortune to be afflicted with crippling rheumatoid arthritis, the systemic disease visibly affecting his hands, feet and hips more than other portions of his body.

As there was no known way to halt the disease by conventional treatments, Jack later on had to have his hip joint replaced twice. He also suffered a great deal from pain day and night, as most of those afflicted with this terrible disease know. To halt the mind-numbing pain, Jack took a large variety of traditional treatment drugs and alcohol,



Jack Blount, M.D.

until finally, like many arthritics, he despaired of life itself.

Jack was a strong church member and had always been an active contributor to charity and community needs, even to the extent of having purchased and contributed a school bus for the school system in his hometown of Philadelphia, MS.

Unless one has been thru the terrible affliction of rheumatoid disease, it is almost impossible to describe the daily pain and emotional travail that stems from it as well as from traditional treatments. Perhaps only the common mistreatment of cancer can be understood as more severe.

Little by little Jack watched his toes, feet, fingers, arms and hips become twisted and virtually useless.

In what follows, we reproduce his own words describing his long-time suffering as a very fitting tribute to his faith in God and his long-standing hellish pain and disfigurement.

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Autoimmune Diseases Caused by Mycoplasmas

BY HAROLD W. CLARK, PHD

Mycoplasma Research Institute, Florida
<http://homepage.hiit.net/hwcmri>
From the book *Why Arthritis?*

Searching for the Cause and the Cure of Rheumatoid Disease, (c) 1997 by Harold Clark, Ph.D.

The primary function of the immune system is to distinguish foreign invaders, such as microbes, from the components of host tissues and facilitate in their elimination. Even though there are experimental animal models of autoimmunity, reacting against their own tissues, there is no general unifying theory to explain how the autoimmune processes like rheumatoid arthritis (RA) and Lupus (SLE) get started in humans and progresses in chronic and cyclic patterns. It would seem that autoimmunity and autoimmune diseases have multiple origins including environmental factors such as microbial infections and genetics. Current investigations of autoimmune diseases have focused on the concept of molecular mimicry by viral, bacterial, mycoplasma or other microbial antigens having antigenic epitopes or structure similar to and reactive with both the host proteins and the foreign proteins. In the laboratory mycoplasmas have been found to mimic their culture media contributing to their variable physical and chemical properties. They also can detach membrane components from erythrocytes and leukocytes resulting in autoantibody production and disease.

Now for the first time a natural mechanism that could apply to multiple Autoimmune (AI) Diseases has been demonstrated in mycoplasma infected rabbits. Mycoplasma are ubiquitous with unique properties, making them widely suspected as a potential cause of hypersensitivity in the multifaceted AI diseases. Being the smallest free-living microorganisms limits their metabolic action. Mycoplasmas are highly pleomorphic with

a lipoprotein membrane controlling their permeability and adherence to vascular and neural tissue membranes. Mycoplasma's fastidious growth requirements are provided by their saprophytic activity and available pre-formed macro molecules in a cell-free tissue digest broth. These include basic peptides, cholesterol and fatty acids (lipoglobulins), nucleotides (basic). Mycoplasma affinity for mucoproteins is indicated by their frequent colonization of the nasopharyngeal (NP) and the urogenital (UG) tracts. Finding mycoplasma and ureaplasma strains in the central nervous system would indicate their potential role in the neurologic disorders. Of special consideration is finding the greatest mycoplasma infectivity in females (4:1) reflecting their prevalence in most autoimmune (AI) diseases and thus the basis for the Gender Gap. Also the organ and tissue preference of the several human mycoplasma strains could contribute to a variety of AI diseases.

Mycoplasmas cultured in serum enriched broth specifically incorporate basic proteins such as IgG gamma globulin from the serum. The molecular attachment alters the basic protein structure making them foreign and autoantigenic to the host. When attached to the mycoplasma lipoprotein membrane the cells act as both carrier and adjuvant for the altered basic tissue proteins now autoantigenic to the host. The altered IgG causes the production of autoantibodies characteristic of the so-called rheumatoid factor (RF) and other autoantibodies. Rheumatoid arthritis developing after *M. pneumoniae* infection is host dependent producing immune complex (IC) with IgG autoantibodies.

To test this autoimmune mechanism, in the absence of human tissue, *M. pneumoniae* was cultured in a rabbit digest broth enriched with rabbit serum. The cultured and washed mycoplasma cells were used to immunize rabbits. The resulting rabbit antisera was positive to both *M. pneumoniae* and IgG a rabbit autoantibody to its altered self.

Although not required for growth the mycoplasma incorporated various amounts of the basic IgG protein from the serum enriched culture. Injections of rabbits with their own native serum does not elicit autoantibodies to the native IgG unless conformed and/or given with an adjuvant carrier such as with the available mycoplasma lipoprotein membrane. The production of an experimental autoimmune disease requires the host antigen, such as basic myelin protein, to be given with some adjuvant.

Rheumatoid Arthritis (RA), one of the more prevalent autoimmune disease, has long-been suspected of being caused by some microbial agent and immune complex. Investigators have directed their research towards typical microbial infections and not the host's hypersensitivity response mechanism of immune complex (IC) diseases as currently suspected. The microbial antigens in the immune complex should be identified to determine and eliminate their allergic cause. The function of immune complex (Antigen+Antibody) diseases as currently suspected are those in which the deposition of circulating IC's initiate injury and inflammation in multiple tissues from the activation of the proteolytic complement system. Many of the AI diseases are associated with an immune complex and diffuse connective tissue disease symptoms.

Answers to autoimmunity will come from conclusive tests when mycoplasmas are cultured in human tissues: erythrocytes, leucocytes, myelin, pancreas, brain and other tissues associated with specific AI diseases. The AI diseases result when the host's immune system, meant to defend against bacteria, viruses, and other foreign substances, produces autoantibodies against specific basic proteins in normal host tissues, cells and organs. Mycoplasmas are now recognized as a cause of rheumatoid arthritis. Not all people with mycoplasma infections develop rheumatoid arthritis indicating genetics and other cofactors are involved.

As with most autoimmune disorders and allergic hypersensitivity dietary changes and detoxification are usually helpful especially under experienced medical supervision. Mycoplasma hypersensitivity as a cause of arthritis has been demonstrated in rabbits previously immunized against a strain of mycoplasma and then challenged with the autologous strain. The safe and effective antibiotic treatment of RA, one of the more prevalent autoimmune diseases, should also be tested in the other AI diseases. The tetracyclines multiple action; antioxidant, antiinflammatory, immunosuppressant, chelation in suitable dosage could provide less toxic and effective therapy for the complex IC diseases.

Next edition will start the more detailed description of the Thomas McPherson Brown, M.D. Rheumatoid Arthritis treatment as described by his long-time, immediate co-worker, Harold Clark, Ph.D.



Harold Clark, Ph.D.

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Thomas McPherson Brown, M.D.

BY HENRY SCAMMELL

According to the book *The Road Back* by Thomas McPherson Brown, M.D. and Henry Scammell, Thomas McPherson Brown, M.D. was a distinguished physician who has dedicated his professional life to finding the cause and cure for rheumatoid arthritis. He graduated from Swarthmore College and Johns Hopkins Medical school, and then spent two years at Rockefeller Institute in New York and was for many years Chairman of the Department of Medicine at George Washington University School of Medicine in Washington, D.C., later becoming the Director of the Arthritis Institute of the National Hospital in Arlington, Virginia.

Thomas McPherson Brown, M.D., Eugene Meyer Professor of Medicine, has seen his pioneer research on the cause of rheumatoid arthritis and other rheumatic diseases come of age last year.

Thirty years ago he published his first article on the recognition of obscure minute organisms, called PPLO or mycoplasma in rheumatic exudates and tissues. His report to the readers [summarized] the evolution of a concept of arthritis mechanism based on this original work. During the past 22-year period he and his coworkers have consistently added illumination to unknown elements in the cause and treatment of arthritis.

As Chairman of the Department of Medicine at the University Medical School and Chief of Medicine at the University Hospital, he has also been Director of the University's Arthritis Research Unit, Consultant in Arthritis and Infectious Diseases for the Veterans Administration Hospital in Washington and Co-Director of the Rehabilitation Research and Training Center at the University. His services are requested also in the capacity of Consultant at the Clinical Center of the National Institutes of Health, D. C. General Hospital, and Washington Hospital Center, and as Member of the Board of the Arthritis and Rheumatism Association of Metropolitan Washington. He serves broadly the work of such enterprises as the Eugene and Agnes Meyer Foundation, the Board of Directors of Sidwell Friends School, the Dean's Council of the University School of Medicine and the Executive Committee of the University Hospital.

A Washington native, Dr. Brown won honors at Sidwell Friends School here in Washington and at Swarthmore College before he entered Johns Hopkins University Medical School as Henry Strong Dennison Fellow. During World War II he reached the rank of Lieutenant Colonel in the Army Medical Corps. His research on tropical diseases while posted in Australia, New Guinea, and the Island of Leyte in the Philippines won commendations. He became Chief of Medicine

and Director of Arthritis Research at Mt. Alto Veterans Administration Hospital before being named Professor of Medicine and Executive Officer of the Department at the University in 1948. While at Mt. Alto he established the first arthritis clinic in the District of Columbia. It was designed to investigate the cause of the disease and also to rehabilitate and treat patients suffering from it.

His interests in medicine have always been broad, while his research has been directed mainly toward arthritis. He has used the team approach in the arthritis program at George Washington to care for patients through the specialties of medicine, orthopedic surgery, physical medicine and vocational rehabilitation. Recognition for his achievements include such honors as membership in the American Medical Association's Council of Pharmacy and Chemistry, and being named Physician of the Year for the District of Columbia. He has served in varied capacities related to education and the medical profession as a whole



Thoms McPherson Brown, M.D.

and his memberships have included The Washington Academy of Sciences, The Washington Academy of Medicine, the Board of Managers of Swarthmore College and the Vocational Rehabilitation Administration's Research Study Section, as well as George Washington's Committee of Eighteen, The University Senate and other faculty groups. As an undergraduate he was elected to both Phi Beta Kappa and Sigma Chi. He was listed in the *American Men of Science*, *Who's Who in America*, and the *Encyclopedia Britannica*.

Dr. Brown foresaw a future when "rheumatic diseases may be potentially completely controlled, if not eliminated." He had lent his assistance in raising "funds for fellowships, research facilities and of greatest importance support of medical beds for the management and rehabilitation" of arthritic patients and those with other chronic diseases. He espoused the full training of medical students and graduates to spare patients "the tragic consequences of neglect." He believed that ours is an "era of anticipatory medicine" when many can and will be spared both chronic illness and the threat of disability, so long as we always "add the advantages of new scientific knowledge to the setting of individualization in the care of patients."

Henry Scammell - Henry Scammell is a freelance writer chiefly in the fields of medicine and business. He graduated from Harvard where he won the Bell Prize for literature. Henry Scammell co-wrote with Thomas McPherson Brown, M.D. the book *The Road Back: Rheumatoid Arthritis - Its Cause and Its Treatment*.

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were usually considered. Some thought the condition was a genetic or hereditary weakness. Others were convinced it represented an unknown basic defect in metabolism (extensive research in this direction had been unrewarding). Psychologic or physical imbalance promoted by stress seemed likely to many investigators. An unexplained acceleration of the natural aging process appeared most logical to some. As we visualize the arthritis mechanism at the present time, elements of all these concepts are important, but in an interrelated fashion and at a secondary level. By definition, these earlier viewpoints provided little hope for achieving basic improvement with treatment.

There was one important stimulus to pursue arthritis research. It was the magnitude of the problem which literally cried out for better understanding and sustained interest. More than 12 million arthritics in the United States faced an uncertain future with a likelihood of progressive disability and the eventual loss of independence in living.

Our starting point was the organization of a teaching program with a shift of emphasis from the joints in rheumatoid arthritis and the connective tissue diseases to a systemic approach where the joints are only one of the many targets of involvement. We found that few realized the extent to which other areas were affected. Rheumatoid disease affects the skin, the eyes, the ears, the blood forming system, the blood vessels (usually the smaller ones), the muscles, the skeletal structure, the heart, the lungs, the gastrointestinal tract, the liver, the pancreas, the kidneys, the central nervous system (and mental functioning), the autonomic and peripheral nerves as well as the

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joints. In fact, no connective tissue area is immune to attack. This total approach to the rheumatic and arthritic problem led naturally to the need for greater understanding of the strange behavior patterns of the disease. Without this knowledge basic advances in treatment methods would continue to be as incomplete as they had been in the past. It was also clear that if the causative factors could be controlled the reversal of many systemic symptoms would be expected.

Infection as a cause of arthritis had been contemplated intermittently for many years and was finally discarded with the discovery of the cortisone effect in 1949. The dramatic action of steroid drugs seemed to place arthritis in the metabolic or endocrine area once and for all. During the previous 10-year period we had been developing a basic concept where infection of a new type was primary in the process. We viewed arthritis as a cellular hypersensitivity state created by long exposure to foreign protein derived from a hidden or invisible microbial source. Cortisone was believed to produce a blockade at a secondary level, the site of the antigen-antibody reaction, while the primary causative factor, the antigen itself, was not suppressed. Thus, steroids would be incapable of sustained benefit to the patient. In fact, the dramatic initial symptomatic relief associated with the steroid blockade could promote false security while subclinical worsening was occurring through the known steroid effect in the reduction of immunity. This contention published by us as early as 1950 proved in time to be correct in so far as the failure of steroids was concerned, and thereby gave strong indirect support to the validity of the total concept.

An obscure microbial source of a sensitizing substance responsible for the reactive state had been known to us as a likely antigen since 1939. At that time we had reported the isolation of a virus-like agent from rheumatic tissues known as PPLO, now classified as Mycoplasma. Since then many reports of the isolation of mycoplasma from rheumatic sources have appeared. The inconsistent aspect of such isolations seems to be due to the elusive nature of these agents which are invisible in tissues by staining techniques, and most difficult to isolate with uniformity from human sources or to cultivate in the laboratory. It should not be surprising that the delicate mycoplasma would have escaped identification through routine cultural detection. In situations where microbes produce their pathogenic effect by sensitizing the host, the identification of the responsible agents by the usual techniques is often not possible. Classical examples of this are the paucity or absence of organisms in tuberculous pleurisy with effusion, syphilis past the early phase and chronic brucellosis. Even in rheumatic fever the streptococci usually disappear from the surface of the throat at the

onset of the illness, and in allergic states such as asthma, the sputum is generally free of micro-organisms. In other words hyper-reactive states may be as hostile to the causative agents as to the involved host, suggesting the usefulness of the reaction as an aspect of the immune mechanism. Of particular interest were the number of similar microbes more easily isolated from animal tissue and known to produce arthritis in a number of species. Spontaneous cellular hypersensitivity does not occur in animals as it does in man, thus cultures would be expected to be more productive from animal sources. The infectious tie-in became progressively more tenable when bacterial variants as L-Forms of organisms derived from focal infections were found similar in appearance and structure to mycoplasma. Focal infections were known to activate arthritis. It was possible that tissue invisible L-Forms (or mycoplasma) left in the wake of an infection, could perpetuate the inflammatory reaction through continued antigen releases rather than microbial invasion. Thus was born a recognition of the rheumatic complex in a total sense and with it the need for an entirely new approach to medical management where control of antigen production would be a necessary component of any balanced treatment program. If this concept could be further supported through exacting therapeutic experience, this evidence would indicate that arthritis is an acquired illness and thereby potentially curable.

With the availability of a laboratory, a basic research team was formed to continue investigating mycoplasma, L-Variants of bacteria, antigen production, antibody inter-relationships, host reacting factors and cellular hypersensitivity measurements. The key personnel, Dr. Harold Clark, biochemist, Jack Bailey, Ph. D. candidate, and Rachel Miller and Irene Iden, both medical technologists, brought together special skills and techniques in biochemistry, immunology and microbiology needed for this unique and difficult research area. This laboratory was one of the first of its kind in the country. Within the past few years many programs have been developed at other universities for similar studies of mycoplasma and their relationship to human disease.

Many important findings have emerged from the continued research in our laboratory. Antibodies against various strains of mycoplasma have been found in the blood of arthritic patients and also those with other connective tissue diseases giving further support to an etiologic relationship. Certain drugs known to affect arthritis in a similar manner, such as gold salts, antimalarials, and tetracyclines, were found in our previous laboratory experience to affect mycoplasma specifically. A continuation of this area of exploration has had great practical value in meeting the needs of suppressing antigen and

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satisfying individual differences in drug acceptability. Anti-microbial substances such as sulfonamides and penicillin have no effect on mycoplasma and have not been known to modify the course of rheumatoid disease in the long term sense. Another attack through current studies is being directed toward the sensitized host cell from the arthritic patient and factors which influence cellular reactivity. It is of particular interest that a special technique developed by Dr. Clark and used by Dr. Chanock at the National Institute of Health was instrumental in the discovery that a certain species of mycoplasma was the cause of virus pneumonia. Also a new type of antibody was discovered in our laboratory which inhibits the growth of mycoplasma, a unique finding in microbiology. The future possibility of usefulness of vaccination against mycoplasma for the control of arthritis could be dependent upon the development and measurement of this antibody. The growth inhibiting effect could account for the rare unexplained spontaneous remissions of rheumatoid arthritis.

Over the years, our clinical program has paralleled our progress in basic research both in strength and momentum. We will always be indebted to those private donors who kept our investigation alive until enough work was done to attract the interest of various granting agencies. Research support for both clinical and basic investigation did finally come from the National Institutes of Health, the Vocational Rehabilitation Administration and the Hartford Foundation in a total amount in excess of half a million dollars. Through this support all our projects in recent years began moving ahead at a much more rapid pace, with the personnel necessary to handle the many interrelated facets of this complex basic and clinical program.

Our clinical team was organized with great care. Unique attributes were needed to manage complex treatment in the long term, immensely difficult cases of arthritis. Drs. Stewart Bush, William Felts, Richard Fowler and Cap Oliver represent the clinical team with broad responsibilities in clinical investigation, teaching and patient care. Dr. Fowler's primary interests are in engineering methodologies as they may be applied to diagnosis, measurement and rehabilitation. Additional members of our rheumatology staff who are active in our

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teaching program on a part time basis are Drs. Joseph Ney (O.P.D. Arthritis Clinic Director), Alfred Baer, Israel Kessler, and Myer Stolar. Others in the community who have served under our training program, Drs. C. David Cooper and George Economos, are also contributing at a high level in this field. Eleanor Flores is a young and able trainee in Rheumatology.

One of the primary problems in the arthritis and rheumatic disease area has been the lack of a satisfactory standard method of measurement of either the natural course of the disease or the effects of different types of treatment. An accurate means of therapeutic appraisal is needed for comparison of results between clinics. The evaluation of treatment by the usual double blind control method is not applicable to arthritis problems where there is a continuous need for evaluation for a period of five years or longer. Also in hypersensitivity states a great many individual patterns of the disease are expressed and variations in the types and amount of acceptable medication occur. It is not possible to match these many variables for comparison, thus negating the value of the double blind control method under these circumstances.

A new approach to the problem of measurement is now being undertaken by our group through the aid of a large sustaining grant from the Vocational Rehabilitation Administration. The preliminary data shows promise of achieving for the first time the type of complete, comprehensive measurement we have been seeking. The program devised by the entire clinical team under the pleasant and exacting statistical direction of Prof. Harold Bright and Senior Statistician Ruth Mellon. This undertaking is a monumental task, and the attempt is being made to capture the major points for measurement of all types of arthritis and connective tissue disorders. One of the eight parameters being investigated -- namely, that dealing with mental functioning -- is being programmed and analyzed by Drs. Jesse Rubin and Frederick Nothman, and Audrey Shuler, covering in a highly precise manner the fields of psychiatry, psychology and psychiatric social work as they relate to the individual patient with arthritis. Master's degree candidates in psychology and medical students are also helping in this research.

At the present time, more than 100 patients with 8,000 check points each have been programmed for the computer and are being re-examined at six-month intervals. It is hoped that in addition to appraising the results of therapy, this program will provide many other advantages in capturing useful data heretofore lost by less accurate methods. An example would be the conversion of precise subjective clinical patterns into objective values customarily used in measurement. Certain subjective patterns are used constantly in

medicine and never questioned, such as migraine headaches and angina pectoris for which no objective measurements exist. Equally valuable but neglected patterns exist in rheumatology.

The principles of treatment must be guided by the very nature of the hypersensitivity reaction. Antigen must be suppressed, reactive substances neutralized and symptoms relieved in the manner of titration and balance. We have learned that

Thus, we come to the greatest need of all, a new recognition of the primary role of the physician. We must look to his education and preserve his freedom.

medications should be selected with low allergenic potential. The dosage must be kept at the lowest possible level for the establishment of therapeutic control without aggravation of the reactive state. Large amounts of medication are gradually rejected by the hypersensitive host in a delayed manner as with any foreign substance, and they reflect this change by becoming ineffective and shifting the usual pattern of symptoms. Unlike the rejection of tissue transplants, medication can be decreased in amount, spaced in administration or replaced by another substance with similar action and the clinical balance can be repetitively re-established with control of this tendency for delayed drug sensitivity until remission is achieved. These many clinical aspects require both knowledge and experience through continuity of observations of the patient by the same physician over long periods of time. By adhering to these many principles which have become more clear with time, we have improved our ability to handle these delicately balanced problems. The essential guiding beacon is the concept of mechanism of the disease.

Within our own institution this program has assisted in physical therapy. Rehabilitation accomplishments have been noticeably more effective when the arthritis inflammatory reaction has been controlled at a basic level. The same has been true when the orthopedic surgeon has had the advantage of medically established control of the disease prior to the operation.

After 20 years of this program, The George Washington University Hospital has gained an international reputation for a unique continuity of interest, and the most effective long term plan of management available for arthritis and the various types of connective tissue disease. Many of the patients treated have now reached a stage of apparent remission, requiring little or no medication to maintain clinical balance. Of particular interest has been the repetitive pattern of improved general health consistent with the decrease of rheumatic activity. Patients have been referred from nearly every state in the Union, and from Europe, Africa, Canada, Central and South America. This indirect evidence of effectiveness combined with the ongoing appraisal of results through computer analysis should spark new interest in this approach and promote far more

rapid progress than at any time in the past.

An account of this short chapter in the long and complex Story of Arthritis has brought to mind many satisfying aspects of this period. The growth of interest and support in recent times stands in strong relief to our stark beginnings. Perhaps the greatest satisfaction comes from the realization that for the first time we have the apparent capability of reaching arthritis at the causative level.

As we visualize the future, we recognize a great

need for new thinking. We must begin to look beyond the materials at hand to the methods and reasons for their use. The cure will not rest with the drug alone but with a complete knowledge of the limiting host reactions as well. Future success in the field of arthritis will depend upon the understanding, the ability and the wisdom of the physician to a far greater degree than to the tools he uses. Just as a beautiful painting is conceived through the artist's vision far more than with his brush, so it is well to remember that philosophy and logic remain cornerstones of the scientific method. They become essential in gaining an appreciation and providing measurement for cellular behavior patterns not reached by humoral tests.

Thus, we come to the greatest need of all, a new recognition of the primary role of the physician. We must look to his education and preserve his freedom.

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Once Jack had found a way to halt the progress of the disease (through application of the English Professor Roger Wyburn-Mason, M.D., Ph.D. treatment recommendations) Dr. Blount re-opened his medical clinic and began treating all who requested it, whether they could afford the price or not.

Dr. Blount treated more than 17,000 people by the Roger Wyburn-Mason, Ph.D., M.D. method described on our website, <http://www.arthritis-trust.org> in our article "Arthritis' Primary Treatment Protocol."

Gus J. Prosch, Jr., M.D. — who later treated tens of thousands of arthritics using the same protocol — was himself cured of a seven-year-standing backpain by Dr. Blount.

This writer, also suffering from what his family doctor described as "galloping rheumatoid arthritis," was one of those cured in six weeks by Dr. Blount.

Many years of traditional drug treatments as well as alcohol used to numb present-time pain had taken a severe toll on Dr. Blount's liver and other organs. One day some years ago Dr. Blount became comatose. His wife, Carole, a trained nurse, called in a physician who mis-diagnosed some form of mental problem, and therefore Jack was brought to a psychiatric clinic in Meridian, MS.

This concerned writer visited Jack during his stay there, finding that he was kept under deep narcotics and being given electric shocks three times weekly. Jack was virtually unaware of what occurred in his room from minute to minute.

When this irrational and damaging treatment was terminated (for whatever reason), Jack was again diagnosed by a different physician, who pointed to a failing liver problem.

Placed on a regimen which permitted his liver to recover to some extent, Jack regained some semblance of his conscious identity.

When this writer asked Jack why he'd permitted electric shock treatment, he said, "Perry, had I been conscious I wouldn't have permitted electric shock!"

When his wife was asked why she permitted electric shock, her answer was "Well, it was the doctor's advice, and one must do what the doctor says."

Carole was and is a lovely, loving person, and her response certainly reflects that of the dutiful well-trained nurse embedded in our customary medical practices.

Jack's severe pseudo-medical treatment left him mentally impaired, but still able to function to a limited extent, whence he became a physician for the care of aged people in a home for the elderly. This did not last long, as Jack seemed to deteriorate mentally and physically.

At one trip to the hospital for non-arthritic reasons, his stay so weakened his muscles that once again he was unable to move about without assistance. And, once again Carole became the full-time home-nurse with a bed-ridden husband.

The changes in Jack's mental acuity, drive, and physical activity after electric-shock treatment were obvious. Although severely crippled, Jack's entire outlook had been to help folks with similar arthritic disease. After damaging pseudo-treatment by psychiatrists, Jack's life was virtually terminated, with little ambition and a steady downward spiral.

Of course, one can excuse the psychiatrist, and rationalize and ascribe Jack's final condition to that of his many years of alcoholism, drug abuse, and other pain-relievers which damaged his liver and other organs. But even with all those negative factors, prior to electric shock treatment, he was up daily working to help other folks conquer their insidious and misunderstood disease process.

After the electric shock, not only rational integration was increasingly lessened, but also drive -- within himself and for the plight of others.

Please note that Jack Blount, along with Wyburn-Mason, were honored for their work in helping others toward wellness by naming this foundation after them, it's official name being "The Roger Wyburn-Mason and Jack M. Blount Foundation for the Eradication of Rheumatoid Disease," also for short called either "The Rheumatoid Disease Foundation" or "The Arthritis Trust of America."

His story is an emotionally gripping account of a man who has been to the very depths of hell and has come back to tell us how he escaped the fires. He told his story simply, without any attempt to embellish, and it was

told with a genuineness that makes you believe in his continued concern for your health and welfare. Keep in mind that he was cured of the ravages of rheumatoid arthritis, that he had since treated better than 17,000 patients successfully, and that he freely gave of his knowledge to any who asked. He was a man who was active physically in his youth although his symptoms began as a systemic illness in his teens with muscle pain, metatarsalgia (pain in the foot), lumbago (pain in the back), intercostal (between ribs) pains, iridocyclitis (inflammation of eye), psoriasis (skin lesions) and that eventually he got pains in the joints, generalized arthritis with effusions (fluids into joints), carpal tunnel syndrome (compression of nerve in wrist), paresthesia (loss of feeling or perverted sensation), ulcerative colitis (sore or inflammation of colon), aseptic necrosis (death) of a femoral head for which a prosthesis (steel and plastic joint) was inserted, etc. He was reduced to total invalidism and took to alcohol, morphine-containing drugs, barbiturates and was a terminal case. He had to give up his medical practice in March 1974 and had taken steroids for more than twenty years.

Now read Dr. Blount's own joy at, when, at last, achieving freedom from the ravages of rheumatoid disease!

Dr. Jack M. Blount's "Miracle" & His Gift to Mankind

Dr. Blount's Story:

Rheumatoid Disease is of the Entire Body

I cured myself and more than 17,000 others of an incurable illness. "Rheumatoid Arthritis." I call it a MIRACLE.

I had rheumatoid disease. Rheumatoid Arthritis is a disease of the entire body, not of just the joints although most of the pain and destruction seems to be in and around the joints. I was hopelessly ill.

In the Spring of 1974 I had developed aseptic necrosis (complete destruction) of my right hip socket and femoral head. I had to quit work (private medical practice) and take to the bed. The only thing that would help was a hip replacement with a prosthesis. The orthopedic surgeon that I went to said at first he would do the operation but then changed his mind giving the excuse that because I was only fifty-two years old at the time I was ineligible. They didn't know, yet, how much dependence to put on the procedure.

Despair

Despair set in, I could only lie in bed and stare at the ceiling. The cure of my illness was hopeless. No one knew the cause. No one know anything useful to do for it. The usual advice was to take a lot of aspirin and learn to live with it. Pharmaceutical companies tried to improve on aspirin and gave us Butazolidin[®], Indocin[®], Motrin[®], Tolectin[®], Nalfon[®], Naprosyn[®], Clinoril[®], Meclomen[®], etc. They called these "nonsteroidal anti-inflammatory" agents [NSAIDS]; all were useless except for some analgesic effect.

"Cortisone" was introduced in 1949 and was hailed for a while as the long awaited answer. It was, and still is, the quickest relief of arthritis symptoms, but it causes devastation worse than the disease. These adverse effects included hyperadrenalism (Cushing's Disease), diabetes, ulcers, weakened bone, (decalcification) etc. I took a form of this for about twenty years.

While lying in bed my arthritis became complicated by colitis, with diarrhea of sometimes up to twenty times a day, kidney stones, alcohol, and drugs. I was in and out of hospitals repeatedly. I thought I would surely die. Friends kept sending word that they were praying for me. I often thought of committing suicide. The pain and agony were unbearable. One morning after I had accumulated about forty Seconal[®] capsules (sleeping pills) I swallowed them all. Four have been known to kill. I didn't want to kill myself, but I couldn't endure such perpetual agony. After some hours my wife found me unconscious and on finding the empty bottle, she knew what I had done. I awoke very groggy and tied to a hospital bed. After regaining enough sense to know anything at all, I wanted to know if I had been apneic. (Had I been deprived of oxygen long enough to cause permanent

brain damage?) I was assured the answer was "no". Despite such an overwhelming dose of sleeping pills I had continued to breathe adequately without supplemental oxygen or assisted breathing. This was a miracle in itself. "Somebody up There" was not ready for me.

Why Was I Saved?

Back home I kept breathing but hardly living. Why was I still here at all? I had been waiting for some earthly savior and none came. Was there some "learned University professor or researcher" somewhere who knew something to do?

The Miracle of Professor Roger Wyburn-Mason

One day in the spring of 1976 I came across an article in *Modern Medicine* entitled "Rheumatoid Disease: Has One Man Found the Cause and Cure of Rheumatoid Disease? Arthritis," written by Robert Bingham, M.D., practicing in California. Dr. Bingham, orthopedic surgeon, had heard of work done by Professor Roger Wyburn-Mason, England, and had gone to there to interview the Professor. His article told about how the English researcher, practitioner, microbiologist, had determined that the etiological agent (cause) of rheumatoid disease is actually a germ, a protozoan, an amoeba, similar to the "lettuce bug" amoeba that causes dysentery. He also reported that a chemical (in fact, several chemicals) had been found that would kill the "bug" in patients without killing the patient. [There are most likely more than one microorganism and causation to Rheumatoid Disease, we now know. Ed.]

He was curing people who had the disease that was killing me. The chemical (medicine) that the Professor was using successfully was called clotrimazole.

That's wonderful, but how could I get some for myself? It was not on the market anywhere in the world for systemic use. [For a source, contact a compounding pharmacist. Ed.]

Finally, in the Spring of 1976, my orthopedic surgeon decided to operate. They removed the upper part of the right femur with the femoral head and reamed out the acetabulum (socket). The socket was filled in with plastic to make a new one and the bone was replaced with a "comma-shaped" steel rod with the pointed end inserted down into the marrow, distally, of the remaining femur.

Now, I thought I would recover. But recovery was terrible. I still needed my pain medicine and booze. My brother became disgusted with me and had me sent to an alcoholic ward and "detox" center at the State Hospital. After a month there I was off everything addicting except my daily early morning "Cortisone." I still had my rheumatoid disease -- my germs, the amoeba. I still had to rid my body of them. The operation seemed to give them new life.

Somehow, I remembered that clotrimazole is the active ingredient in a preparation used to treat yeast and fungus infections of the skin but it was

A MIRACLE! God had put the answer to my illness that close to me.



Jack M. Blount, M.D. hip x-rays for joint replacement

just one part clotrimazole plus ninety-nine parts propylene glycol, car antifreeze -- Prestone[®]. This is poisonous to man if taken internally.

I decided to telephone Delbay, the company that puts the mixture together, and see if I could get clotrimazole that hadn't been mixed. The answer was "no". They were afraid of the U.S. Food and Drug Administration.

Failing with that endeavor I started wondering if there might be something else almost the same that would work. I looked at the word 'clotrimazole' and focused on the 'azole'. I looked that up in the medical dictionary and found that the parent of this is 'imidazole'. Somehow I remembered that I had heard that word somewhere before. I kept repeating it. Then I remembered that this is the chemical name of the medicine metronidazole, or Flagyl[®]. I compared the formulas of the two and they looked close enough alike that I thought it was worth a trial. We [Americans] had had Flagyl[®] since 1962 and used it to cure amebiasis (intestinal) and vaginal trichomonas infections. It was known to be able to kill both of these protozoa. I decided to try it. Later I pulled out a drawer in my bath room and there was a bottle of one hundred Flagyl[®] tablets. A MIRACLE! God had put the answer to my illness that close to me.

How should I take it? I realized that the small dosages that were recommended for trichomonas and intestinal amebiasis would not do any good. If it would have, someone would have discovered it accidentally. I checked the medical text books and saw that it had been given in doses as high as three tablets, 250 mgm, three times daily. That is the amount I started to take.

I Experiment On Myself

I didn't know how long to continue taking it. I didn't know if it would kill me. I realized I didn't have much to lose; therefore I took all I had which lasted eleven days. On the morning of the eleventh day, I got nauseated while brushing my teeth -- and emptied my stomach. Then I knew I couldn't take anymore even if I had had more readily available, so I stopped. [This early experimental dosage is not recommended. See <http://www.arthritis-trust.org> "The Roger Wyburn-Mason, M.D., Ph.D. Treatment for Rheumatoid Disease" for correct dosages by body weight. Ed.]

But during these eleven days a miracle had begun to happen. My arthritis started getting better. I awoke in the middle of the night and realized that the soreness, stiffness, and swelling had started subsiding. I looked at my hands which had been so bad and now were so much better. I couldn't hold back the tears. I started praying and thanking God.

After that I didn't know how much was enough. I knew that I was still sick. I still had sweats and felt cold. I was bound to still have the infection. After two weeks I decided that I needed more. I restarted taking three 250 mgm tablets three times a day. I took it for eleven days more and on the eleventh day I got nauseated again. But, I was

surely improving by the day. I decided to continue this pattern.

More Successful Patients

I decided to find out if some of my former arthritis patients were brave enough to try it.

I telephoned them and invited several of them to my home, one at a time. To each I explained what it was all about. Every single one was eager to try it, nothing else had ever helped. Why not? During the Summer of 1977 about thirty of them were treated and most of them had the same good experience that I had. Some got nauseated from the start and decided to quit.

Among the thirty was a Reverend Ethel Beall. Brother Beall not only had arthritis, but had lost a leg due to an automobile accident. The bone in the stump of the leg had gotten infected and drained constantly and was always painful. During this treatment period with Flagyl[®] his arthritis got better and his leg got well and stopped hurting. (Several months later he died suddenly of embolus [blood clot] while recovering from a prostate operation).

Well Again!

After 8 months I was able to return to my private medical practice on a limited basis. I had been out three and one-half years. On September 1st 1977, I was back in the office seeing patients by appointments.

I decided to write Professor Roger Wyburn-Mason in England and tell him of my experiences. I owed him my life. He answered immediately and said that he had decided to include my case in a book he was writing, *The Causation of Rheumatoid Disease and Many Human Cancers - A new Concept in Medicine.*² My story appears on page 205 in the book.

We continued to correspond and I visited with him during the Summer of 1978. He told me that he tried metronidazole at one time and it didn't work. His dosage was not adequate; he had tried giving only 250 mgm three times daily. However, later he gave 750 mgm three times daily and it did work about equally as well as clotrimazole. He found other nitroimidazoles that would do the job, also. [This early experimental dosage is not recommended. See <http://www.arthritis-trust.org> "The Roger Wyburn-Mason, M.D., Ph.D. Treatment for Rheumatoid Disease" for correct dosages by body weight. Ed.]

Later he found three commonly used medications that are ameobicidal when used in high doses: furazolidone, allopurinol and rifampicin. [There are also others. Ed.]

His experiments proved that Flagyl[®] and the other nitroimidazoles are excreted slowly from the body and it is not necessary to give them on a daily basis. After giving a loading dose for two days there is an effective blood level (for killing the amoebae) for several days more. During the

past six years I have treated more than 17,000 arthritic people with very gratifying results. Some are cured of the disease while in others it has been arrested. People are now coming from all over to share in the miracle.

Professor Roger Wyburn-Mason should be nominated for the Nobel Prize in medicine.

Prayer for the Entire World

I pray that the entire world will soon know and people every where can receive the same relief that I have. What a joy I know now!

I thank God!

This information is free to whomever will take and use it. I need no wealth and seek no fame.

References

1. *Modern Medicine*, "Rheumatoid Disease: Has One Investigator Found Its Cause and Its Cure?" Robert Bingham, M.D., Feb. 15, 1976, pp. 38-47.

2. *The Causation of Rheumatoid Disease and Many Human Cancers*, Roger Wyburn-Mason, M.D., Ph.D., Iji Publishing Co, Ltd., Japan.. Out of print. Limited number have been donated to medical libraries (USA) by Jack M. Blount, Jr., M.D. An *Addenda* (precis' and summary) is available from The Arthritis Trust of America/The Rheumatoid Disease Foundation; 7376 Walker Road, Fairview, TN 37062-8141 requested donation \$8.50).

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