Biological Regulation Therapy in Cases of Intestinal Disease

Focusing an Diverticulitis and Recurrent Colitis

by Dr. med. Thomas Rau

Semmelweis-Institut GmbH
Verlag für Naturheilkunde · 27316 Hoya · Germany

The intestine, in particular the colon, with the enormous surface of its mucous membrane measuring up to 1200 m^2, is a centre for the body's regulatory processes. The intestine also has enormous vitality as a result of its ability to renew and reconstruct itself very quickly in only a few days, and this vitality can express itself very intensely in Symptoms. These Symptoms, whether (for example) diarrhoea, flatulence or even painful inflammatory reactions, bring the patient to the doctor's door.

However, these symptoms are not a disease in themselves, but the expression of intense regulatory processes, and their message regarding the whole of the body must be recognised and supported. Merely suppressing the symptoms through the use of medications - that is, without removing the cause of the regulatory processes causing the symptoms - will lead to an actual disease of the intestine or immune system: for example, as the result of long-term antiexudative or anti-inflammatory therapy. In such cases, the intestine and the Peyer's patches which are found in it can be permanently damaged by the deposition of toxic substanees or excessive, long-term strain an the immune system when there is intolerance towards certain foodstuffs; enterohepatic toxicity may also occur.

Thus, it is understandable that in what follows, the treatment of diverticulitis is very similar to that of ulcerative colitis or Crohn's disease. These therapies are primarily the support and stimulation of excretion, the avoidance of all allergenic substances in food and the stimulation of the regulatory functions of the intestine. The intestine often blocks allopathic therapy in many different ways, because of its extremely high level of vitality, an the other hand it is very open to regulatory biological therapy.

Experiences of therapy from the practice

In our general medical practice and in healing medicine, over a period of more than two years we observed and treated over 30 patients with clinically typical diverticulitis and recurrent colitis. These patients were given a course of empiric regulatory therapy, including a special diet and detoxification therapy. The following criteria were used as the basis of this therapy:

- The patient had suffered at least one relapse
- There were pains in the abdomen which were strong, constant or cramp-like in a particular region, lasting at least one day
- There was localised peritonism
- There were disorders of the stool regulation mechanism, which were acute and/or were recorded in the patient's medical history.
- A limit of approx. 12,000/mm^3 had been reached for the number of leukocytes.

According to most patients' medical history, shortly before the relapse being treated there had been a period of less attention to diet (as around holiday periods) with increased consumption of protein - especially in the form of pork -, frequently combined with an increase in the consumption of foods containing sugar and long periods of sitting. In most patients, the episode being treated was already the n^{th} relapse. When asked, all patients complained of troublesome stinking flatulence over a long period which showed decomposition of the intestinal flora and/or dysbiosis. More than half the patients had already suffered from episodes of haemorrhoids, and all the patients had already had yellowish paste-like deposits an the back of the tongue for a long period, thus already showing signs of intestinal hepatic overload. The average age of all the patients was only 54 years, and the number of people of each sex was almost exactly equal.

Ten patients had already undergone a coloscopy an one occasion, and all the patients had previously been treated with antibiotics or even as hospital in-patients because of diverticulitis or episodes of colitis. Almost all the patients had already been given a source of laxatives. It appeared that none of the patients that we observed had previously been informed about the connections between foodstuffs which cause decomposition, foods which contain sugar and therefore promote the growth of fungi, and the dysbiosis, which is the root cause of diverticulitis, i.e. insufficiency of the intestinal flora. Again and again in our healing centre, we saw post-operative patients who had undergone sigmoid resections, who before their attack and afterwards had never been treated consistently with a special diet and/or by building up the the symbiotic flora.

Results of examinations showed chronic conditions

The results of examinations always showed strong pain in the region subjected to pressure, localised peritonism, in the majority of cases an the left side. The patients were slightly to moderately adipose, with a flabby abdorren and weak stomach muscles, and generally did not practise abdominal breathing. Several patients were already showing signs of a big reduction in intestinal sounds in certain regions: this was a bad sign and showed that there had been a transition from the reaction and excretion phase into a deposition phase according to Reckeweg. Two patients had already got a hard diverticular tumour, and one had even got an inflamed stenosis through which it was hardly possible to pass the Single use catheter. However, after approximately 2 weeks' treatment this could no longer be detected in control colonoscopy.

Laboratory investigations are not generally very productive and hardly help the medical practitioner to make good decisions about txeatment. Even during episodes of strong pain, the BSR values could be normal; these are probably more strongly linked to hepatic reaction, the protein situation and enterohepatic autointoxication. The IC values were sometimes raised, sometimes normal, did not correlate with the strength of the clinical picture and in individual cases could be used in neither diagnosis nor therapy.

The stool tests for occult blood were only partially positive and also could hardly be used for decisions on therapy; however, they were important for the diagnostic strategy in that all the patients with a positive haemoccult result had a colonoscopy after the acute phase. One cancerous adenoma of the intestinal villi was found, and we were able to operate and remove this. After the pain had subsided and following treatment, in almost all patients the haemoccult tests were again for the most part negative.

In cases of diverticulitis/colitis, the stool bacteriologies show an increase in candida levels, which is a very important indication of dysbiosis. This is also described by *Kolb* (with candida levels of up to 80% in cases of colitis) and *Werthmann/Hartmann* in SANUM Post no. 19. Candida infection is always pathological, but it cannot easily be tested for, and unfortunately, it is usually not tested for in stool bacteriologies and is even normally interpreted only as a „superinfection". To prove its presence a fresh stool is required: it may not be more than one day old at the time of the test. Infection with candida always requires treatment and is usually a long-term condition. In 80% of tests on diverticulitis patients we have been able to prove the growth of candida, whilst other authors found it occurring in only 5% of people with healthy intestines.

The CEA titres in serum cannot be used as aids to decisions in diagnosis or therapy, as they showed unstable results scattered over a large area. However, we consider that CEA values in serum of above 5 ng/ml should be rechecked, also where haemoccult results are found to be positive at the same time, indicating the need for colonoscopy - which, however, is only carried out when the acute diverticulitis episode has subsided as a result of the course of treatment which I am about to explain.

Before therapy commenced, the results of the stool tests were almost without exception an the acid side, probably as a sign of acid fermentation or an „emergency outlet" for intestinal elimination of acid. The pH value of the stools of people with healthy intestines and those whose acid-base metabolism is balanced is alkaline. In a similar manner to the findings of previous antibiotic therapies, the acid milieu also favours candida life-cycles and thus provides ideal conditions for enteral fungal infections.

Important aspects of the therapy

The holistic treatment of diverticulitis, which is also very similar to that for other forms of colitis, even Crohn's disease and ulcerative colitis, always has to be carried out very closely and an a very individual basis because of the acuteness and gravity of the illness. Essentially it achieves:

- Cleansing of the intestine and excretion of toxic products
- Building up of the intestinal flora
- Regulation of the pH value
- Building up of the immune system

To this end, the therapy consists of an adjustment to the diet, enemas, control of symbiosis with SANUM remedies, an extra supply of alkalis, replacement of minerals and sti-

mulation of the immunobiological system with SANUM remedies.

DETAILS OF THE TREATMENT

The medicinal diet

There are many publications an diet in cases of colitis, e.g. by *Waerland, Schaub, Rauch (according to F.X. Meyer)*, which are highly recommended as reading matter. To these results, I should essentially only like to add the criterion of hypoallergenicity, taking into consideration the enormous increase in food allergies and other forms of reaction against food, particularly to animal protein. This does not only include meat but also cow's milk and hens' eggs. This is described fully in the book „*Enterale Allergien*" [Enteral allergies by *Werthmann*.

Our diet for the course of treatment consists of the following:

1. Restriction of food intake for 2 to 3 days to relieve pressure an the intestine and to clear it of protein. If the haematocrit values are above 40%, the patient can fast for a longer period. During this phase, the patient takes only herb teas, 1 to 2 litres per day, in the form of very weak camomile, peppermint or fennel tea, together with approximately 0.5 litres of Breuss Juices.

2. Then follows a slow building up with a basic soup made up as follows: celery/celeriac, green beans, instead of beans possibly lentils or potatoes and courgettes. Chop everything up quite finely into even-sized pieces and cook gently for 10 to 20 minutes. Then strain off the vegetables and serve only the vegetable broth: 300 - 500 mls each morning, to be drunk one sip at a time.

3. According to how the pain is continuing or reducing, after 3 to 6 days the patient is given mashed potato, carrot soup, possibly hard rolls, which should be chewed until they are well mixed with saliva, or - with care - sour milk products, also gruel, etc.

4. After this, the food intake is slowly built up again, always with the emphasis on alkaline foods and with a complete ban on meat (at least in the beginning), and to accompany this, mostly ALKALAN is given.

5. After about one week, raw food is added, which is retained for longer, particularly very finely grated carrots which as a result of their high beta-carotene content have an anti-inflammatory and anti-oxidative effect which prevents against carcinomas.

6. There is a permanent ban an all pork products in view of the allergens contained therein, the histamine and because of the adrenalin-type substances in meat; the ban also helps to reduce the decomposition of the flora.

7. There is a complete and permanent ban on industrially-produced sugar and all foods containing sugar, in order to achieve a reduction in the candida flora, which is always pathological, and which in cases of diverticulitis is for the most part chronic.

8. In the long term, we recommend a hypoallergenic diet (according to *Werthmann*, slightly modified) which does not include any cow's milk and milk products, no hen's eggs and egg products, no pork, no sardines or anchovies, no rabbit meat, no citrus fruits or kiwis and no food or drinks which contain sugar. This diet is continued in the long term because colitis, like diverticulitis, is mostly the expression of a disorder of the body's ability to regulate itself, which happened a long time in the past, resulting in strain on and depletion of the intestinal immune system. During the period of rebuilding the intestinal flora and the villi of the mucous membrane, these should be confronted as little as possible with substances known to be most frequently allergenic, and so, this particular diet is to be recommended in the majority of chronic diseases where the immune system is under strain and where there is inflammation. In the regulation therapy which we carry out, we very frequently find allergies to foodstuffs in all types of regulation disorders and diseases, and this justifies this diet over and over again.

9. In the long term, we recommend a high proportion of raw

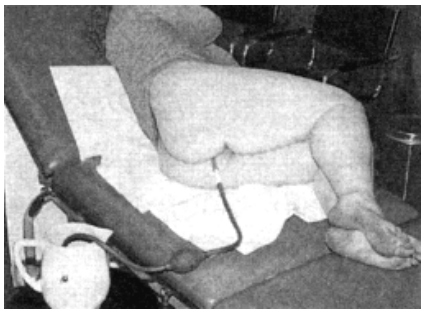

Fig. 1: A patient is given a therapeutic enema

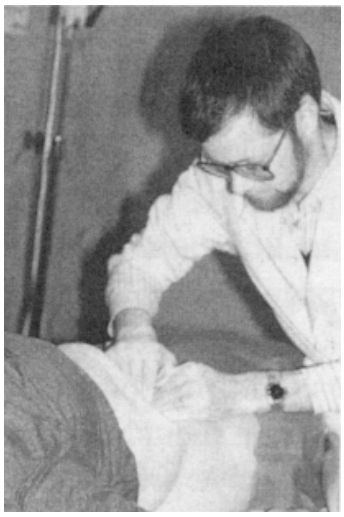

Fig. 2 and 3: A doctor gives a special massage to a patient with intestinal disease

foods in the diet with finely grated vegetables, but a slow and careful increase in the amount of raw food is indicated. In order to avoid unrest at night right from the beginning, the patient should avoid eating raw foods in the evening. The action of the beta-carotene in raw food, which protects the mucous membrane, is important. Here, we can also assume that it will prevent carcinomas, which is particularly important in cases of diverticulitis with its enormously increased incidence of colon cancer. The high proportion of plant fibres in raw foods also helps to prevent the formation of toxic products which lead to decomposition - such as carcinogenic nitrosamine, in particular.

10. The very common lack of magnesium, particularly in colitis patients, makes the colitis worse with bowel spasms and more diarrhoea. Care should therefore be taken to supplement the diet with sufficient magnesium, particularly as magnesium works as an alkali and bonds with acids from the metabolism of protein. As a medication, magnesium is best used in the form of magnesium orotate, 100 to 200 mg per day. The patient should also aim to eat magnesium-rich food: bananas, cashew nuts, soya products, wheat bran, oatflakes, etc.

Therapeutic enemas

At the beginning, enemas are given daily, increasing in volume; in our centre colonic irrigation is also carried out as an alternative. On the first day, the enema consists of approximately 300 ml of weak, lukewarm camomile tea, usually with approximately l2 a measuring spoonful of ALKALA N. After this, the volume of the enema is gradually increased each day up to maximum of one litre, at which point two enemas are administered each day. According to the localisation of the main pain, the enema must be instilled higher, then slower, or less high and instead several times. 20 to 30 drops of NOTAKEHL 5X are generally added at each instillation. The instillation is carried out with the simple 'Klysopumpe' and a size 18 single-use catheter for men.

Camomile tea is given as an enema only for one or two days, because it dries out the mucous membrane and is low in acid. Afterwards, the enemas which are given are of a special tea mixture made up to Dr. Karsch's recipe: this is a mixture of crushed fennel (2 parts), juniper (2 parts), aloe powder (1 part) and foenum gracum (fenugreek - 1 part). This mixture is left to stand for about 10 minutes over gentle hegt. After it has cooled, NOTAKEHL 5X drops and ALKALA N are added to the extract. Enemas using this liquid have a particularly stimulating effect an the liver and detoxicating effect. In some enema prescriptions, approximately 20 ml of linseed oil is added at the end of the final enema.

Therapeutic acid-alkaline balance

In the majority of chronic inflammatory diseases there is overacidification of the tissues, which gives rise to an increase in the acid secretion of the mucous membranes. These in turn irritate the surface of the mucous membrane, which is why we suffer the enteral excretion of acid with the help of the enemas and so restrict the reabsorption of the acid. At the same

time, ALKALA N is mostly given orally as a effective alkaline. The problems of disorders in the acid-base metabolism cannot be dealt with more fully here. I recommend the book „Praxis des Säure-Basen-Haushalts“ (The practice of the acid-base metabolism) by Worlitschek which is full of insights.

Treatment with medication

The building up of symbiosis by means of medication is carried out an two fronts. It is begun with NOTAKEHL, 1 tablet twice daily. In addition, NOTAKEHL can also be prescribed with 5 to 10 drops in the enema liquid. After 3 or 4 days, we combine this wich FORTAKEHL, 1 tablet twice daily. Only Afer the acute symptoms have subsided do we turn to ALBICANSAN, 1 capsule daily, and/or PEFRAKEHL, 1 capsule daily - over a period of about another 10 days.

Only after this do we proceed to long-term treatment with SANKOMBI, 10 drops twice daily, or alternatively MUCOKEHL and NIGERSAN tablets, preferable in adults. Here, the MUCOKEHL tablets are best given in the mornings as a yin medication and the NIGERSAN tablets are best taken in the late evening or at night as a yang medication.

In a series of stool investigations Dr. Werthmann has been able to show that the course of therapy described above leads to an increase in the number of physiological intestinal flora and to a reduction in the candida population, and in its effect can be compared with control of the symbiosis. In individual cases, this can also be supported at the start by a 2- or 3-week course of treatment with Symbioflor l, 20 drops twice daily or Bioflorin, 1 tablet twice daily.

In cases of chronic colitis (Ulcerative Colitis or Crohn’s disease), we mostly give an additional course of enzyme therapy, e.g. with Wobenzym, 1/2 tsp. 3 times daily, or with Kombucha tea. If at the start, there are strong indications of inflammation, we additionally prescribe Traumeel in the form of tablets, injections, or added to the enema. In individual cases and as an addition, neural therapy (segment therapy) has also proved its worth, with administration of NOTAKEHL and/or Traumeel.

As for the necessary immunological therapy, we start from the assumption that with colitis, and also with chronic recurrent diverticulitis, there is an accompanying disorder of the intestinal mucous membrane, which again puts a strain an the intestinal defences. This shows up as a disorder of the intestinal lymph node system, including the important Peyer’s patches. This makes the disturbance field of the intestinal mucous membrane into a focus, putting strain on the whole organism and with consequent weakening of the immune system and an increase in the general tendency towards disease and recurrent infections, etc. Intestinal allergies are also becoming more common as the cause of chronic inflammatory diseases. This is shown in work by *Professor A. Rost* and from our own observations using contact regulation thermography.

For these reasons, we always combine the treatment of colitis and recurrent diverticulitis with an immunological stimulation therapy with SANUM remedies. At the beginning REBAS 4X is injected i.m. daily, but possibly also combined with neural therapy and the use of NOTAKEHL, as already explained. This treatment continues for 1 or 2 weeks. Then follows improvement of peroral stimulation using RECARCIN and UTILIN in capsule form, with one capsule of each being given per week in the early morning an different, preferably non-consecutive days (e.g. an Sundays and Wednesdays). From the third to fourth week onwards, the triple combination of UTILIN, RECARCIN and LATENSIN is given, 1 capsule of each per week.

If there are allergic factors, e.g. a food allergy, atopy, an allergic lymphatic diathesis in iris diagnosis or problems with the joints, each month from about the fourth week we give one i.m. injection of UTILIN „S“ weak or one capsule of UTILIN „S“ strong orally: UTILIN, RECARCIN and LATENSIN are then not given that week.

With the complex therapy described here we have been able to treat successfully all the named cases of diverticulitis, and also individual cases of serious colitis (Crohn’s disease) in our outpatients’ clinic. There were recurrences, mostly connected with a faulty diet and generally in situations where there was an excess of acid. In one case, it was possible to determine by means of colonoscopy that a

previously impassable inflammatory sigma stenosis had disappeared. Antibiotics were only prescribed once and for a very short period; because of the need to travel during an acute recurrence of the condition, 100 mg of Doxycyclin was given as an exception.

First published in the German language in the SANUM-Post magazine (23/ 1993)