



Plasmocytoma and its naturopathic therapy

by Dr. Konrad Werthmann



Many serious, even carcinomatous diseases are concealed behind quite commonplace complaints. The first things one thinks of are the obvious causes and it is only when symptoms are the subject of repeated complaints that further examinations are instigated. Every therapist experiences this at least once in his lifetime. Plasmocytoma and M. Waldenström are among such diseases.

Plasmocytoma (multiple myeloma, M. Kahler) is a neoplastic disease, originating in the plasmacellular reticular cells of the bone marrow and becoming generalised, above all in the skeleton but also in all the internal organs. Solitary, medullar and extramedullar plasmocytomas are variants or different stages of development of plasmocytoma, in a similar way to plasma cell leukemia which rarely becomes generalised as leukemia. In plasmocytoma an excess of monoclonal, immunoglobulins (paraproteins) is formed (Scheurlen). In Central Europe, more than 10 people per 100,000 die of this disease, primarily in the 40-60 year-old age group. Women are affected somewhat more frequently than men.

Pathology

The common origin of the haematopoietic and osteopoietic systems explain why bone marrow diseases affect not only haematopoiesis but also osteopoiesis, and can break down bones containing active marrow. Not all blood diseases do this, only plasmocytoma and M. Waldenström. Plasma cell tumours develop primarily in bone marrow. The

commonest locations are the skull, the spinal column, the pelvis, the trunk, the ribs and the bones of extremities close to the trunk. The microscope reveals plasma-cellular reticular cells with varying degrees of differentiation. In rare cases extramedullar tumours also develop in the liver, spleen, the lymph nodes and the kidneys.

Symptoms

The disease presents without fever and starts with uncharacteristic complaints such as loss of performance and mild weight loss. The first indications may be complaints which might be interpreted as rheumatism – pulling pains located in the back, legs and shoulders. The X-ray image shows up such foci as osteoporotic zones. Thus, persistent sciatic neuralgia or deformations of the spinal column, spontaneous fractures of the ribs or extremities, even paraplegia are the first indications of plasmocytoma, before the diagnosis is then made on the basis of chemical blood tests and X-ray examination. Large osteolytic tumours may sometimes be palpated from the outside as painless knots. Owing to the high level of paraprotein formation, blood viscosity may be raised and there may also be hearing and eye disorders and disruption of the blood supply to the CNS, plus a tendency to thrombosis.

Diagnostic indications

X-ray: bones of the skull, the skeleton, the spinal column: gibbus formation, diffuse osteoporosis, osteolytic foci of various sizes.

Serology: high sedimentation (100 and more), particularly strongly

accelerated (high initial sedimentation within 10-20 min.).

Electrophoresis: differentiated capture of paraprotein peaks. In small-molecule paraproteins higher levels of albumin are eliminated via the renal filter (Bence-Jones) and the ESR is normal; serum iron concentration raised (raised production of monoclonal immunoglobulin).

Haematology: anaemia (expansion of the processes in bone marrow, gastro-intestinal blood losses, coagulopathy), hyperchromaemia and rouleaux formation, leucocyte and thrombocyte levels drop.

Urinary findings: with every osteolysis, osteoporosis, check urine for albumen (positive to highly positive), 50% of patients develop renal insufficiency.

Bone marrow puncture: proliferation of plasma cells or plasmocytoma cells above 15-20%, atypical cells.

Rectal biopsy: evidence of amyloidosis.

Lymph nodes and spleen: occasionally enlarged.

Vegetative problems: feeling of thirst, constipation, lowered urinary excretion, vomiting and anorexia (caused by hypercalcaemia), excruciation.

Naturopathic concepts of therapy for plasmocytoma

Therapy is restricted from the start owing to the inevitably unfavourable prognosis. The interval bet-



ween the first emergence of symptoms and death is an average of 18 – 30 months, in the best cases 3 to 4 years. This means that one can only improve the quality of life and render the symptoms less distressing for the patient. On the basis of the following points, the narrow scope for isopathic therapy, but also other therapies, can be more clearly defined.

- 1) The amyloidosis observed with plasmocytoma and M. Waldenström differs from secondary amyloidosis in its characteristic pericollagenic location. In terms of therapy they are both treated the same way. It is primarily the nervous system and vessels, the tongue and submucous sections of the intestinal tract which are affected. Difficulties in eating (thickened tongue) and alterations to the mucous lining of the intestine lead to dyspepsia and malabsorption syndrome.
- 2) Owing to a regulatory mechanism, the synthesis of normal immunoglobulin is reduced. This results in an antibody deficiency and consequently disruption of the defence against infections. An aggravating factor is that the monoclonal immunoglobulins impede the physiological phagocytosis function of the granulocytes. There is some discussion as to whether increased substitution of gamma globulins inhibits physiological gamma globulin synthesis.

- 3) Therapy with Mephalan, Cyclophosphamide and Prednison, including stem cell transplants, is currently standard practice. Most patients ask for an alternative treatment or alternative support after just one series. It is worth mentioning that „chemotherapy“ usually only achieves a short remission and above all a clear reduction in bone pain.
- 4) Every leucosis comprises a proliferation of blood cells, which is why, with this disease, no therapeutics should be used which are characterised by a proliferation of white defence cells, like SANUKEHL Pseu. The same is to be expected of individual immunobiological agents. Therapeutic agents containing *Bacillus subtilis* or *Propionibacterium avidum*, are to be avoided. They heighten the body's awareness of foreign substances and the production of white blood cells begins.
- 5) In contrast, therapeutic agents deriving from the tuberculin series, or which have a positive effect on tuberculous weakness, are to be preferred. The bones and the intestinal area are subject to *Aspergillus niger* and consequently tuberculosis bacteria.
- 6) The so-called **Cell Wall Deficient Forms** („CWD“) are bacteria without cell walls, so they scarcely induce immunity. They can trigger the same problems as bacteria with cell

walls, from which to some extent they derive. In plasmocytoma, paraproteins are formed, some of which represent fragments of immunoglobulins but do not exercise the same sort of function as immunoglobulins. One suspects that such fragments of immunoglobulins trigger other problems in the sense of paratuberculosis, or contribute to initiating the complaint. That is why one would use SANUKEHLs Myc or Coli and Strep.

- 7) Additional administration of anabolics (25-50g Deca-Duranolin-Nandrolodecanoate weekly) has also proven useful. Probably this has a positive effect on the retention of urophanic substances and anaemia.
- 8) In any case one would thoroughly purge the areas liable to disruption – around the teeth (root treatments, granulomas, heavy metals) and the tonsils.

Therapy proposal

Points 1 and 2 in particular encourage to try a therapy, because by improving the intestinal symptoms (constipation, diarrhoea), appetite and deficient amyloid storage, and through better absorption, an improvement in the underlying initial vegetative symptoms can be achieved.

In addition to the microbiology, the Mucosa enteralis needs to be stabilised with a hypo-antigenic diet (Werthmann).



Naturally, the disturbance fields around the teeth should be cleansed as quickly as possible. Nonetheless, one has to wait until a remission phase, or a clear improvement in the vegetative symptoms, is observed, because even cleansing a tooth is stressful.

Point 5 demands isopathic therapy, which one should not deny a patient.

Microbiological therapy:

- EXMYKEHL 3X suppositories 2x 1 daily for 10-20 days, then switch to basic therapy: MUCCOKEHL 5X tablets 1x 1 every morning and NIGERSAN 5X tablets 1x 1 every evening, always from Monday to Friday, and at the weekend EXMYKEHL 3X suppositories 1x 1 every evening before bed.
- From the 3rd week of therapy onwards, the NIGERSAN component may be enhanced, for example NIGERSAN 4X capsules 1x 1 every evening and after a while, NIGERSAN 3X suppositories 1x 1 every evening.
- For infirm patients or for the sake of simplicity, one could also prescribe SANKOMBI 5X drops 2x 10 daily, but here too only from Monday to Friday, with EXMYKEHL 3X suppositories at the weekend, 1x 1 every evening before bed.

Additional therapy:

- LATENSIN 6X drops, at first 1x 5 rubbed in daily, after 2-3 weeks taken orally and UTILIN „S“ 6X drops 1x 10 orally each week.

- Possibly SANUKEHL Myc 6X drops, SANUKEHL Strep 6X drops and SANUKEHL Coli 6X drops alternating daily, each 1x 5 drops rubbed in, subsequently orally.
- With bronchitis or infection, RELIVORA Complex drops 3x 20-25 daily or CERIVKEHL drops 1-3x 5-10 daily.
- Tonsils can be treated with a neural therapy injection (NOTAKEHL 1.0 ml and Lidocaine 1% 0.5 ml).
- Where the ratio is poor (ratio of T3:T4 cells), REBAS 4X capsules are indicated.
- In order to reduce the evident proliferation of paraproteins, prescribe Wobenzym or Phlogenzym capsules and activate the hepatic metabolism with a combination of Hepar compositum/Ubichinon compositum/Co-enzyme compositum amp. (Heel).

Dietary measures:

Nutrition should be low in protein from the start, absolutely free from cows milk and hens eggs (Werthmann), rich in minerals and unsaturated fatty acids (LIPISCOR 2x 1 capsules daily); the minerals magnesium and zinc should not be overlooked (MAPURIT capsules 2x 1 daily and ZINKOKEHL 3X drops 1x 10 every evening).

Generally speaking, as a therapist, one's treatment strategies can only try to keep pace with this severely degenerative disease. Therefore, it is really a matter of chance whether

one can achieve a total cure or not. At present there is believed to be no possibility of curing plasmocytoma. However, this does not mean that one should give up – it should be taken as a challenge. Any improvement in the prognosis, any relief of the symptoms, indicates that the therapy is the right one.

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First published in the German language in the SANUM-Post magazine (53/2000)

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