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# **The Treatment of Mycotic Diseases with SANUM remedies, MORA Therapy and UBI**

**Assessment of success using Linke's optical erythrocytes  
test (OET), examination of faeces and observation of  
development and change in antibodies**

**by  
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Mycotic infections have affected about half the population through contaminated foodstuffs because of catastrophic wrong nutrition, among other things. The problem is often dismissed by conventional medicine with the words „Well, we all have fungal infections.“ With that, every single attempt to quantify and evaluate in an appropriate picture of the complaint is stigmatised from the outset. If any treatment at all is given, as a rule antimycotics are prescribed nowadays [7]. If it is left at that and nothing is done to change the conditions which were the original cause, the rate of recurrence is over 70 %, so that an attitude of resignation is common among patients and those treating them. However, in natural healing a change has begun with the possibility of using the SANUM remedies

Frequency allocation of diagnosed mycoses in 944 patients	
653	candida
326	aspergillus
79	trichophyton
52	geotrichum
32	penicillium
10	tinea pedis
3	mucor
3	saccharomyces
2	rodotorula
1	actinomyces
Total: 1161, multiple fungal infections being found in 217 patients	

Table 2

SANUM Therapy of mycosis in all chronic diseases according to F. Arnoul	
After diagnosis from the clinical picture and bodily excretions:	
Week 1:	10 drops PEFRAKEHL 5X in half a glass of water, twice daily
Week 2:	5 drops ALBICANSAN 5X, every 2 day
Week 3:	10 drops FORTAKEHL 5X, three times daily
Week 4:	10 drops NOTAKEHL 5X, twice weekly
Interval of one week	
Repeat weeks 1 to 4	
Check clinical picture and bodily excretions	
SANUM-Post 23 (1993), page 7	

Table 1: Treatment plan for candida infection according to Arnoul [1]. In our experience, the one-week interval between the two treatment cycles can also be omitted without causing harm.

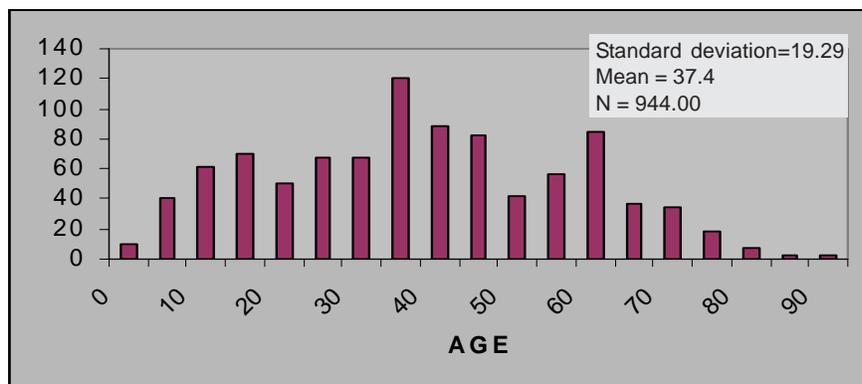
ALBICANSAN, PEFRAKEHL and EXMYKEHL, etc. Since Heine carried out his fundamental work, people have become conscious of the fact that immune stimulation can be carried out perfectly successfully with homeopathic remedies [5].

We set ourselves the target of evaluating whether this progress can be proved by statistical methods, resolutely using the plan recommended by Arnoul in SANUM Post no. 23, 1993 (Table 1) with doses of EXMYKEHL, ALBICANSAN, NIGERSAN, NOTAKEHL, SANUKEHL TRICH, etc.

### Materials and methods

944 patients (300 men and 644 women) with mycotic infections (see Table 2) with ages ranging from 1 to 94 years (see distribution by age in

Illustration 1) were involved in the study. As 217 patients were suffering from multiple fungal infections, they had to be arranged in several groups. Because of this multiple grouping, the number of fungi found rose to a total of 1161. Of these, initially 653 candidosis patients (Table 3) were treated continuously according to Arnoul's treatment plan. Afterwards the patients who had not been completely cured following this treatment or who for other reasons had been withdrawn were prescribed 1 suppository of EXMYKEHL each evening for 20 days. In the group for whom complete success could not be achieved even after this course of treatment, 5 ALBICANSAN injections were administered subcutaneously at weekly intervals. Any patients who were then not cured or who had been withdrawn were finally



treated for at least 6 sessions with UBI according to Dr. Frick.

Of 326 patients with aspergillosis, 74 were treated with MORA therapy according to Klein's procedure and 252 with MORA therapy and at the same time with a dose of 8 drops of NIGERSAN 5X each morning for a period of 4 weeks (Table 4).

*Illustration 1: Histogram to show the distribution by age of the 944 mycosis patients. Ordinate number of patients, abscissa age in years, maxima at 35 and 60 years.*

	Total number of patients	Number of patients withdrawn	Number of patients treated successfully	Success rate %
Arnoul plan only	653	44	295	45.2
Further treatment with <b>EXMYKEHL</b>	314	3	402	61.6
Further treatment with <b>ALBICANSAN-Inj.</b>	204	7	460	70.4
Further treatment with <b>UBI</b>	139	9	590	90.4

*Table 3: **Candida infection therapy in 653 patients.** The column headed 'Number of patients withdrawn' refers to patients who were withdrawn from the therapy without achieving a result. The column headed 'Total number of patients treated successfully' records the total number of patients who were successfully treated including those cured in the subsequent stages of therapy, and the 'Success rate' column shows the total frequency of the successful courses of treatment.*

**Table 4: Treatment of aspergillus and trichophyton infections**

In cases where candida and aspergillus were present together (*multiple fungal infections: Table 2*), first the candidosis was treated and then the aspergillosis.

79 trichophyton infections were treated with MORA therapy, or additionally over 5 weeks with one SANUKEHL TRICH injection per week. (*Table 4*).

In 32 cases of infestation with penicillium, the MORA therapy and MORA plus NOTAKEHL drops 5X (8 drops each morning for 4 weeks, taken on an empty stomach) were used.

1 = isolated, 2 = a few, 3 = average, 4 = plentiful, 5 = in vast numbers), by means of immuno-haemagglutination tests with erythrocytes loaded with candida antigens and titration of the anti-candida IgM, IgG and IgA using an ELISA test (Virotech). The candida serology was carried out by the immunology laboratory of Dr. Walraph, Neubrandenburg.

In addition, in every case a test using electroacupuncture according to Voll (EAV) was carried out on the ends of the paronychium of the meridians Al re, Di re or Lu re with nosodes of candida and

eruptions of a fungus + sugar was  $\geq 10\%$ . In the case of trichophyton, confirmation of the tentative clinical diagnosis was only possible this way. The assessment of the degree of severity of the mycosis and monitoring of the therapy was done using BSR [*blood sedimentation rate*], haemograms and Linke's optical erythrocytes test (OET) [3, 4, 7], which has already been explained in Volume 48 of SANUM Post.

## Results

Among the 944 mycosis patients, a clinical result could

	Negative faecal test			Pathological faeces	
	before	after		before	after
	treatment			treatment	
none	129	241	average	109	20
isolated	100	61	plentiful	90	11
a few	2	2	in vast	47	2
<b>TOTAL</b>	<b>231/477</b>	<b>304/337</b>	<b>TOTAL</b>	<b>246/477</b>	<b>33/337</b>
<b>Total in %</b>	<b>48.4</b>	<b>90.2</b>	<b>Total in %</b>	<b>51.8</b>	<b>9.8</b>

*Table 5: Faeces were examined in spot checks on 477 patients before treatment and 337 after treatment. The findings are regarded as normal up to the semiquantitative stage 'a little'; beyond that they are regarded as pathological.*

In the group of candidosis patients the diagnosis was confirmed by means of faecal examination carried out in the microbiology laboratory of Professor Menzel, Greifswald, semiquantatively (0 = negative,

aspergillus niger - in appropriate case histories also with trychophton nosodes - and saccharose. In our experience the suspicion of mycosis was justified if the total number of positive

be registered in 864 cases (89.6 %). Of these the following proportions refer to the mycoses which were investigated (*Tables 3 and 4*): 90.4 % of the candida infections were treated

successfully using a therapy combining Arnoul's treatment plan, EXMYKEHL, ALBICANSAN injections and UBI [Ultraviolet Blood Irradiation], 98.8 % of the aspergillus infections, 98.7 % of the trichophyton infections, and 96.9 % of the penicillium mycoses. The results of the examination of faeces show a change in the positive results (levels 3 to 5) from 51.8 % to 9.8 % (Table 5). According to Pearson, the clinical result correlates with the negative

positive result of 28.2 %. In aspergillus infections the corresponding titres drop from 29.4 % to 20 % (Table 6). The number of IgM candida titres falls as a result of the treatment. In contrast the number of IgG candida titres increases. The IgA are reduced in number and exhibit neutral behaviour. Likewise in aspergillois there is a decrease in the number of IgM titres as a result of the treatment, although there is seldom a clear increase in the

The mean of the OET (normal values to 3/40) in the 326 aspergillus mycoses tested, 4.8/53.9, clearly leans towards the area of allergies. As a result of the therapy the mean of the OET was improved to 3.9/47.8. Of the 1090 mycosis patients only 3.8 % show no allergies, and on average patients have 12.2+/-8.5 allergies (result from the EAV).

## Debate

With nothing more than the consistent use of Arnoul's unmodified treatment plan (1993), about one half of the active candidoses can be clinically healed. Dosing with the first-rate remedy EXMYKEHL, given for just 3 weeks (per rectum or per vagina/per rectum alternately) improves the cure rate to 61.6 %. An additional course of injections, consisting of 5 injections of ALBICANSAN 5X at exact weekly intervals improves the cure quota again to 70.4 %. Before 1989 and the reunification of Germany (the 'Wende'), when we in the former GDR were treating mycotic infections, we relied almost exclusively on the excellent effects of UBI to stimulate the immune system (2). UBI improves the cure quota again by another 20 %. In those days we used it as the remedy of second choice after nystatin and were rarely disappointed. At that time it was

Titer	Candida before therapy	Candida after therapy
0	89	43
1 : 80	13	13
	<b>102 = 56.7 %</b>	<b>56 = 71.8 %</b>
1 : 160	30	12
1 : 320	45	10
1 : 640	3	22 = 28.2 %
	<b>78 = 43.3 %</b>	
Titer	Aspergillus before therapy	Aspergillus after therapy
0	119	45
1 : 80	12	4
1 : 160	16	4
1 : 320	7	1
	<b>35 = 29.4 %</b>	<b>9 = 20 %</b>

**Table 6: Immunohaemagglutination titrations for Candida and Aspergillus before and after therapy (spot check).** The titres which should be classified as positive begin in candidosis at 1:160 and in aspergillois at 1:80. The proportion of positive titres before and after therapy is always integrated for both mycoses. The proportion of mycoses which should be classified as active always decreases by about 1/3 as a result of therapy.

findings in faeces after therapy -0.361 (p<0.01). The haemagglutination titres arguing in favour of candidosis activity move as a consequence of the therapy from 43.3 % to a

IgG. In the same way the IgA titres have a tendency almost exclusively to decrease in number.

available in the normal way through health insurance. As its prescription is now no longer covered by the insurance companies, we dare to give it to our patients only as a last resort. However, it is obvious from the Arnoul treatment plan that it should be ranked higher as it appears to be in a position similar to that of thymus therapy in carrying out TH2-TH1 conversion. The remaining 63 uncured mycosis patients present with high grade candida variations which do not respond to therapy such as candida *gabrata* and *c. tropicalis*, and are now partly being treated with Thymoject in order to attempt to bring about the TH2-TH1 conversion. However, up to now the numbers have been too small to permit adequate statistics.

At this point it should be pointed out once more that in contrast to the ideas expressed in current mycosis literature, in cases of saccharose/glucose deficiency attention should be paid to the valuable role played by uncontaminated honey. Having said that, brassica allergy must be excluded from this recommendation: MORA therapy for allergy to rape should be carried out instead. Honey contains important flower products against mycoses. Also the pentoses or five-carbon sugars from fruits containing vitamin C are not used by candida for the activation of its metabolism.

If one thinks about the fact that out of the 944 patients with tentative clinical symptoms of mycosis in the EAV, 653 responded to the candida nosode and 95 % also responded to saccharose, but of these in 477 faecal investigations only 246 (=51.8 %) turned out to be positive, then one becomes aware that the manner of diagnosis is unsatisfactory. Probably fungal infections occur more often in the upper gastro-intestinal tract, so that the faeces from the large intestine do not fully register the fact that mycosis is present. Still, even with faecal diagnosis one finds a useful correlation with the rate of clinical improvement after therapy.

In the case of candidosis, checking the serology brings about a similar improvement in diagnosis with a further 43.3 % positive identifications.

If the reduction of the haemagglutination titres against candida to 28.2 % positive titres as a result of therapy appears unsatisfactory, this could also be caused by the checks being carried out too soon after the therapy. Frequently the clinical situation is already better than the titre checks show, so that the impression is given that the titres are lagging behind.

Although the OET (4) does in fact on average show allergic

erythrocyte marginal zones in the cases of mycosis, it turned out that approximately 13 % of the erythrocyte marginal zones lie in the region of the norm and about  $\frac{1}{3}$  have very high erythrocyte marginal zones. In principle that is not changed by the therapy, but the high erythrocyte marginal zones (4) decrease to about  $\frac{1}{10}$ . The erythrocyte modifications index (4) is good for monitoring therapy as it gives clear evidence for the fact that the therapy being used brings the patient out of the 'grey zone' close to the point where the presence of a tumour might be suspected.

**In conclusion** we consider that we have suggested that isopathic therapy together with MORA therapy and UBI therapy presents a considerably more effective strategy than anti-mycotic therapy. As we are talking here only of a pilot study by the practice for the practice, we should like to encourage larger institutions to set up a controlled double-blind randomised study. Until we have this, on the basis of the evidence presented here, no patient suffering from mycosis should be denied therapy as suggested by Arnoul.

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