PROTOCOL FOR IV AND ORAL EDTA CHELATION

Second Draft, May 15, 2002

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Direct IV push of CALCIUM EDTA* 50 mg per Kg body weight (not to exceed 3 gms) given with no dilution through a 23-gauge butterfly infusion needle

10-15 Capsules Oral Essential Daily Defense**
(First dose can be 5 caps on arising or 2 to 4 hours before the IV
Second dose 5 capsules again immediately when the IV push is given
Third dose of 5 capsules may be taken that evening, or 4 + hours after the IV push)

**Available at Longevity Plus, Payson, AZ (800-580-7587) www.longevityplus.com

❖ One-Minute Push of Calcium EDTA ❖

The 1-minute straight IV push method of administration of **CALCIUM EDTA** has been safely used in Europe for over 30 years. Doctor Blumer near Zurich, Switzerland has given tens of thousands of these without adverse effect and followed his patients for up to 30 years afterward. He has reported an unbelievable 80-90% reduction in the incidence of heart attacks and cancer in his patients who took at least 30 of these. These pushes may be given **2-3 times a week** when the patients' need for detoxification is greater, or monthly when they are being primarily given for preventive purposes.

We have physician colleagues that have taken over 2000 IV's of 3 gram dosages, at the slow 1.5 - 3 hour rate which has been the primary method of administration of EDTA in the United States. I recommend that my patients should understand that the proven benefits and the minimum risk associated with the clinical use of EDTA suggests that if they feel the benefits from these IV pushes, they may safely plan to continue to use these IV push treatments preventatively for as long as they want, but probably less frequently once their primary health problem has been resolved. Some may even want to alternate the pushes with the standard slow infusions.

We have all seen or heard about dramatic benefits in some patients receiving the old slow IV EDTA infusions. Now I have been hearing those stories and more from physicians following the basic simple protocol I am proposing here. We are hearing about even more dramatic success stories from the physicians that I work with who are going ahead and developing more complex and specialized protocols to be used in the treatment of advanced complex diseases.

By starting with this basic approach you will be amazed at the clinical responses you will be seeing in your patients with virtually any health problem. You may become interested in

attending more conferences and sharing with your colleagues ideas that arise out of this affordable and convenient new application of IV EDTA. Since the 1-minute push is painless and takes so little time, the opportunity exists to offer other IV therapies during that same visit, depending of course on the patient's needs. This 1-minute application hopefully might even finally induce all of the health practitioners offering this wonderful heavy metal detoxification technique to REGULARLY do this for themselves as well as their families and staff. .

I assure you that based on the compliments I get everywhere I go that you will look and feel so much better that your patients will just ask to do whatever YOU are doing for YOUR health. This way there is no need to sell the benefits of effective heavy metal detoxification to your patients. They will ask for it! The provocative urine and fecal mineral tests appropriately done I assure you, will routinely find such elevated levels in virtually every patient, that they will want the treatment described in this protocol now. That documentation in your chart protects you and your medical board regarding any charges of over utilization etc.

However, your diagnosis is NOT lead poisoning EXCEPT when the report really reveals levels way above the levels you will discover in all of us. I suggest the diagnosis is that you have "evidence of increased body burden of toxic metals," that in your professional opinion, is not in the best interest of the patient in attempting to meet their stated health goal. SEE urine and fecal testing guidelines on my website.

In other words, patients with arthritis, cancer, asthma, autism etc. all deserve to receive PHYSICIAN SUPERVISED ELECTIVE HEAVY METAL DETOXIFICATION from you, but if you call this "poisoning", you will have to be prepared one day to defend that diagnosis in court. The lead industry and all other polluters have their "experts" just like the cigarette industry had. You will need to have LOTS of experience and special knowledge to warrant third party reimbursement for this treatment on your patients if you plan to use a diagnosis of either toxicity or metal poisoning, since the polluting industries can argue that most of us are "safely" enduring this level of mercury etc in our bodies, and in their eyes these toxins have nothing to do with health. Of course, I am convinced that these "average" levels are lowering the vitality and health of everyone on earth, but patients must understand this is my opinion and why.

I am concerned that although I can prove substantial benefits and only remote risks are associated with the routine ingestion of EDTA, most health professionals or the public they serve simply do not understand the facts, which is why I have placed so many abstracts on my website, so that everyone can be fully informed and decide for themselves. Calcium EDTA is about as safe and costs about the same as Vitamin C. I am convinced that I can rationally argue that EDTA should today be seriously considered to be a conditionally essential "nutrient" for those desiring optimal health while living on our seriously polluted planet. Therefore, my position is that all of us seriously underutilize EDTA. For example, not taking at least 800 mg orally every day, since it provides so many health benefits in every condition through its non- controversial and readily provable detoxification effects. See my website for 500 + PUBLISHED ABSTRACTS from mainstream literature documenting the detoxification benefits of oral EDTA.

I suggest that patients should not plan to stop the oral chelation nor the elective IV pushes, even after they have seen all their symptoms go away; this includes normalizing blood pressure levels, increasing energy, relief of vague non-specific symptoms, etc. that patients on this program routinely enjoy. EDTA based heavy metal detoxification, augmented with other oral chelators including garlic, which actually helps remove mercury from the brain, helped by malic acid and dl Methionine are a basic part of my approach to every chronic degenerative disease. The other ESSENTIAL parts of my approach are correcting the hypercoagulability and lowering the microbial load. If you learn to address all THREE of these issues concurrently, there is virtually no patient that you cannot significantly help. We have two well known 90+ year old CHELATING physicians who have personally taken over 2000 IV chelations in their lifetime. They appear 20+ years younger than their chronological age. This conclusively has convinced me that there is little possibility for most of us ever-overdoing EDTA therapy. The Intravenous CALCIUM EDTA that I

use is available from Apothecure Pharmacy in Dallas, TX. A common package size provides 30 mg vials and each cc contains 300 mg. (twice as concentrated as the old Disodium EDTA we have used in the past)

This is given through a 23-gauge butterfly infusion needle and usually we simply take an empty disposable 10 cc plastic syringe and give the CALCIUM EDTA directly in the vein with this syringe without any dilution. This is administered over 10-120 seconds. (LONGER is permissible, as you have to feel comfortable, and some still prefer to put this in some solution and infuse it over 30 minutes, but I hope, for maximum detoxification, effects it is not given any slower. Some may add other IV therapies, before or after the administration of the EDTA push, at the same visit, depending on the other therapy and the reason it is being given, particularly if giving an oxidative therapy, I believe EDTA may more advantageously be given after the other therapy.

The dose is 50 mg per Kgm body weight so a 70 Kgm person might get up to a 3.5 Gm dose but since it has been documented to provide such profound benefits at the 2-3 gm dosages, we actually rarely give over 3 Gm per person (10 cc); and for long-term maintenance dosages, excellent results are reported in Europe with just 1.5 to 2 Gm (5 - 6.66 cc) when given by this direct IV push method. I tend to try and use the higher permissible dose when doing the provocative test, which should ideally be done on either the first or second treatments. Sometimes a small dose of 1.5 Gm on the first visit allays the patient's concerns and then you can do the provocative with the highest permissible dose on the second visit. I generally use the largest permissible dose because I am training Physicians and patients on the first or second IV push to look at this new technique as a provocative test, like looking at the oil dipstick on your car to see how dirty the oil has become. The hair test is useful for screening purposes, but this IV push really uncovers substantial toxicities not seen on hair, as the exposure may have been some time ago.

Subsequently, if, as is the case with a few elderly weak or low body weight patients, they inform you that their first push where you gave the full dose, perhaps 3 Gm., made them a little weak for a few hours, there is no real need to stay at that higher level, so plan to reduce to as little as 1.5 GM. However, as they detoxify over the first 5-30 of these IV pushes, we find that generally they can easily tolerate the higher doses. This, of course, is not to exceed the dose that they are eligible to receive based on the 50 mg per Kgm dose rule, and depending on renal status. Thus, never hesitate to use the lower doses of 1.5 to 2 Gm dosages for ANY Reason, following the first provocative test. We have learned from Dr. Blumer's experience in Switzerland that most of the dramatic LONG-TERM benefits of reduced heart disease and cancer are achieved in his patients with as little as 1.5 to 2 Gm., although he felt somewhat more confident of routinely achieving the full benefits at the 2 Gm dose.

I believe however, that we have become so toxic today, that those whose weight warrants and who clearly tolerate well the dose of 3 Gm, as 98% seem to, should receive that full dose for the extra detoxification effect. I also must report that I have had dramatic success in patients who can not or will not take the IV's and instead have worked with me on higher doses of oral EDTA, such as the over 6 GM daily by mouth I have been on now for 6 + months, and over 2 Gm daily for years (as in 15 Essential Daily Defense).

The parenteral dose of EDTA must be somewhat lower in patients that have known renal insufficiency. I have long ago carefully spelled this out in what is now known as the ABCT/ ACAM protocol, that I originally wrote almost 30 years ago, and has been SAFELY used on over 1 million patients. We know that about 1-2 per 100 chelation patients may see some transient decreased renal function with parenteral EDTA chelation, although I am not aware that this has ever been reported with oral EDTA. However, it seems clear that if the lower doses outlined in the old protocol are adhered to, and adequate time between infusions (or pushes) is given, we actually have shown the reversal of renal insufficiency with EDTA so frequently that we have come to routinely expect to document evidence of improving renal function in over 90% of cases

treated as outlined in the protocol. We have even successfully administered IV EDTA to patients that were on dialysis and some of these patients no longer need dialysis.

Nonetheless, living in a litigious society, good medical practice requires some type of informed consent in treating patients in anyway that is even slightly “off label”. In other words, you are now using EDTA for its FDA approved purpose of treating increased body burden of toxic metals as revealed on laboratory tests. However, since the rapid administration was not routine in the US, you need to inform your patients that in the United States, most EDTA has been only administered by slow infusion. I suggest you can explain that this 11/2 – 3 hour treatment has been extremely useful to the over 1 million patients who have received IV Chelation therapy under the old ACAM protocol that I originally wrote, and certainly many physicians may wish to continue to offer that method that we all have become so accustomed to, but since that method was not very effectively removing mercury, alternate the old slow IV with the IV push technique.

Our deteriorating environment along with the increasing recognition of the adverse effects on our health of even the “average” levels of toxic metals that we are all routinely exposed to today, makes me convinced that we now will find even more advantages for our patients, particularly with most non cardiovascular related conditions, to also offer EDTA using the rapid 1 minute approach. This is because we can readily document vastly augmented detoxification benefits over anything ever seen with the slower 1-3 hour approach, or even with other available, often more toxic and clearly more expensive, chelators. We can prove this in almost any patient by sending a fecal and a 6-hour urine mineral test off after the old method of chelation and then repeating these two tests a few days later using my well proven oral EDTA product (EDD), combined with 1-minute IV EDTA technique. The resulting dramatic increase in toxic metals seen in urine and feces using this protocol will astound and convince you.

This new approach is documenting excretion of toxic heavy metals coming out in levels never routinely seen before with any method of administration or any other chelator currently available anywhere. It still remains to be determined if the 1-3 hour Disodium EDTA Chelation method may still have some superior anti-aging or other benefits. I believe it is possible that it may be somewhat more effective in certain conditions and but I believe that those doing well with that approach may still see additional benefits if they occasionally do the rapid IV method for its enhanced detoxification effects.

I still believe that the parathormone induction is very beneficial in some conditions, potentially in osteoporosis. This induction is only possible with the slow IV use of DISODIUM EDTA, which however, is so painful for some patients that many have unfortunately given up chelation entirely, to their own great detriment. Clearly Disodium EDTA MUST continue to be given slowly, and since many will want to continue because it has helped so many patients, we can look to the outcome of major studies currently planned for Disodium EDTA to help us determine its proper place. I always believed that this slow IV administration method provides enhanced benefits for our patients where we knew we were dealing with various aspects of metastatic and pathologic calcium accumulation. Now, however, the research about nanobacteria and pathologic calcification being treated with rectal suppositories and tetracycline may largely supplant the need for the slow IV drip of Disodium EDTA.

NOTE: I am convinced that rectal administration of CALCIUM EDTA is not better absorbed than orally administered EDTA. Therefore, unless it is artificially prevented from being excreted from the body, rectal suppositories should not be providing any benefits above those obtained with oral and rapid IV Calcium EDTA. It is claimed by some that they are seeing a higher blood level after many hours with their rectal suppositories, however, I prefer to maintain good blood levels of EDTA by taking small more frequent oral doses, so that the heavy metals EDTA attracts are not kept in the body, but are continuously being excreted. Perhaps the main indication for rectal suppositories is when the patient is unable to swallow or has an extremely sensitive stomach.

Unfortunately, since some patients failed to see reversal of their elevated coronary calcification levels as measured on E.B.T. (Electron Beam Tomography) or on coronary ultra fast cat scans with the old chelation technique as adopted by ACAM some 30 years ago, we now find a big interest in more effective approaches and certainly the work with rectal suppositories deserves careful consideration. There is always something more to learn and I prefer to use the oxidative therapies to the rectal suppositories in combination with this protocol, but there is a need to accumulate more data. The inability to reverse some coronary calcifications with the old protocol that I initially wrote, has put pressure on chelating doctors to broaden their approach to Cardiovascular disease and treat every associated risk factor vigorously, whether it is elevations of c-reactive protein, homocysteine of Lpa. This protocol is merely another step in helping to develop new protocols that can save at least some of the best and most predictable of the chelation benefits we have all seen in nearly 1 million patients, most of which I now suspect may have been due to improved NO (Nitric Oxide) induction, and not due to any roto-rooter effect or actual plaque removal.

Obviously with all of these potential considerations, we have to cover at least the relevant aspect of this for our prospective chelation patients planning to receive the rapid I minute IV push. Some of these patients may still be laboring under the belief that any form of chelation works essentially as a form of “Drano” and is cleaning their arteries. It is nice that many patients feel as though this must be happening when they can function so much better after a series of these. But as a procedure that arguably may be considered by some to be experimental, because we are not waiting for full-blown metal poisoning to develop, and therefore we are providing it as an elective procedure and we are giving it more rapidly than is commonly done in this country may well warrant your providing a full **informed consent.**

I recommend obtaining an informed consent for the protection of all involved, and I believe we must try to inform our patients as accurately as possible the benefits and potential risks. You should explain that detoxification can lead to increased NO and, therefore even though they may soon have more energy and be able to do much more physically, they may still have the 90% obstruction or more, in a major vessel than they started out with. This is confusing for patients who see their marked increase in exercise tolerance, and can not understand how they may at the same time look worse on their next arteriogram or heart scan, and some, particularly those who fail to stay on my effective natural anti-clotting therapies, which I build around oral chelation, may even sustain a heart attack or stroke. There are answers to every problem and we cannot cover all of molecular cardiology here, but for example, calcium pump in endothelial cells can not function effectively to pump calcium out of cells until fully cleared of all toxins. Furthermore, the chronic hidden infections that we all have, like chlamydia, CMV, nanobacteria etc. may require oxidative therapies and my chronic infection protocol.

Furthermore, there is a need to adequately address the subject of renal function and why monitoring is needed. After the successful safe treatment now of over 1 million patients with EDTA, is seems clear that I am not recommending these patients be required to have any creatinine clearance testing, unless there is some abnormality seen in other tests that require further evaluation. I believe in the interests of controlling medical costs, that a simple Urinanalysis provides enough information for monitoring most patients, unless there is a history of some known renal problem or previous abnormal renal function test then an occasional serum bun and creatinine.

We recognize that any renal testing related to chelation therapy, unless it is for DOCUMENTABLE metal poisoning cases, is not considered reimbursable by some insurance companies such as Medicare, since they feel the test is being done to monitor an uncovered experimental therapy. In this case, most of your patients will be choosing ELECTIVE heavy metal detoxification the same as they might choose to have plastic surgery. This logically makes any renal monitoring you order, UNLESS for other reasons, unrelated to their receiving EDTA, which reason must be documented in the chart, a non-reimbursable procedure for most patients.

We do not want to waste patient's precious economic resources on low yield extensive renal tests, but since some forms of renal abnormalities are rampant in the population, good medical practice requires your good judgment on this critical issue. This is particularly in view of the probably somewhat incorrect or slightly misleading admonition in the old protocols that administration of EDTA slowly increased the safety for the kidneys. It now seems on reconsideration of this point, that since we have successfully chelated patients who were already on dialysis, that in fact, patients with compromised renal function automatically take far longer for the EDTA to clear, and the rate of administration is minimally if at all important in safety. Total dose and FREQUENCY of administration however appear to be important factors in potential for renal toxicity.

The new concept that I advocate of NEVER giving parenteral chelation with EDTA without concurrently providing oral EDTA is because oral EDTA is only 5-18% absorbed so the remainder can remain in the intestine where it is able to chelate any toxic metals presented through the bile and through the bowel/capillary interface by the IV EDTA. This oral EDTA then can trap and hold these toxins; largely eliminating the enterohepatic reuptake of these toxins that was apparently an unrecognized aspect of all parenterally administered EDTA. This enterohepatic reuptake was markedly decreasing the detoxification efficiency of all parenterally administered EDTA, now shown by the augmented excretion levels being seen in fecal tests on patients receiving concurrent IV and oral BROAD spectrum chelating agents as found in EDD (Essential Daily Defense). Remember, we seldom have only 1 metal present in excessive amounts and no single chelator adequately binds all the toxic metals that we are routinely finding on the Doctors Data reports.

❖ Provocative Urine and Fecal Testing ❖

I urge patients to get this test done on the first or at least by the second IV push. Of course it is best to obtain those measurements early on and to have them in the doctors chart for documentation that you were treated for elevated body burden of toxic metals as established by laboratory test. Today this is easy since the values seen are generally significantly elevated on one or more of the toxic metals on almost everyone living today on planet earth. Furthermore I look at this important provocative testing as providing useful and sometimes life-saving LAB information. The provoked urine and fecal mineral test is often more informative than a treadmill ECG, which test after all carries real potential for harm and the knowledge gained is far less useful in terms of patient outcome than what you will uncover with provocative mineral testing.

The urine is collected for 6 hours after the IV push (with 10- 15 oral caps of EDD) and carefully shaken before the aliquot is poured off and sent to Doctors Data and the next day a part of the next stool specimen can be submitted. This may be 18- 36 hours after the push was given. I prefer to do these tests for both toxic and essential minerals, since low excretion of essential minerals is a good indicator of deficiency, as in copper etc.

Fortunately there is NO record of any serious renal or other damage ever occurring from a single injection of EDTA that I am aware of from the over 7000 articles on EDTA that I have reviewed over the past 30 years. Based on my extensive experience with risk to benefit ratio on medical practices particularly involving chelating agents, I do NOT require more than a comprehensive Urinanalysis by dipstick to determine general renal status before doing this initial provocative test. Subsequent plans for giving 30 or more of these IV pushes over time will require occasional renal monitoring with BUN and Creatinine and based on history and physical, possibly even more intensive testing.

I believe with the levels of toxicity we are documenting in fecal and urine tests with this protocol may provide some of our patients, at least theoretically, with documentation making them

potentially eligible for some possible legal action against various providers of these toxins, such as may exist with mercury and vaccines and or dentist exposures. Thus, our patients deserve to be shown accurately just how relatively toxic they are and I know of no way better than following this protocol and collecting URINE and FECAL material for testing to establish this information. Thus the maximal dose of EDTA for their body weight and renal status permits us to recover in the urine and fecal mineral tests the highest amount of toxic metals. This then indicates just how badly poisoned they really are, since we are all relatively toxic, and this information can help in your prognosis, as you will uncover some toxicities that until now you have not dreamed of. These toxic burdened patients are walking in and out of your offices with every form of general non-specific health complaint that may seem too non-specific to alert most of us to the contribution these heavy metals are making to our patients' symptoms. The more carefully you can document these relatively more "poisoned" patients, the better some of those patients may be able to later collect if there is found a potential source for their toxicity and liability can be established.

There is no need today for the rather excessive level of renal monitoring that I felt forced to require of physicians 30 years ago using EDTA for what even today is still considered to be experimental purposes since then we were using EDTA for treatment of heart disease. We now have over 1 million safely treated patients' data to rely on and we are NOW back to using the EDTA for FDA approved indications, i.e. treating increased lead, arsenic, mercury, cadmium and other heavy metal body burdens. Thus I believe, the frequency and type of renal monitoring should largely be left to the physician in charge of the patient, who is looking at benefit to risk issues, overall health issues, economic considerations, planned frequency of administration and even the medical condition for which treatment is being offered. For example, the literature makes it clear that chelation therapy for impaired renal functioning associated with low-level lead toxicity, particularly with elevated levels or uric acid, is almost predictably markedly improved.

❖ Oral EDTA ❖

The rapid IV EDTA treatment is leading to such dramatic outpourings of toxic metals including mercury that frankly, there is no other chelator with this degree of well-established safety and this amazing affordability available anywhere in the world that can compete with the successes we are seeing. The concurrent use of ORAL EDTA products such as **ESSENTIAL DAILY DEFENSE (10-15 caps per day)** further dramatically augments that effectiveness, as you will see for yourself in monitoring your patients urine and fecal tests, as well as the symptom improvements reported in a host of complex medical conditions. (Please see research on NO- (Nitric Oxide) and circulation, NO and Diabetes, NO and immunity, and then review old chelation literature.) This perspective will enable you to better understand the dramatic improvements in health from so many diverse conditions as are currently being reported by Physicians now utilizing this new use of an old therapy. Without understanding the importance of inducible NO and endothelial dysfunction, the reported benefits in so many seemingly diverse conditions would normally have to written off as unbelievable or at least ascribed to a powerful PLACEBO effect. Now the urine and fecal tests prove that something very basic is going on- effective heavy metal detoxification.

Please recommend 10 to 15 of the oral broad-spectrum chelator EDD, containing EDTA and other chelators such as Garlic, malic acid, dl methionine, etc. the day you give the IV push. The first dose can be 5 caps on arising or this even works if given as little as **2 to 4 hours before the IV and another 5 capsules again immediately when the IV push is given** to help prevent any enterohepatic re-absorption of toxic metals. The third dose may be taken that evening, or even just 4 + hours after the IV push. Failure to concurrently administer ORAL chelators is markedly curtailing therapeutic effectiveness when providing chelation therapy for metal detoxification. Of course, I believe that common sense suggests that since oral chelators are extremely inexpensive, yet have well documented heavy metal detoxification benefits, patients should remain on these between IV's, and possibly for life at lower maintenance levels.

ESSENTIAL DAILY DEFENSE, previously known as GARLIC PLUS, is a totally safe oral nutritional broad-spectrum detoxification and blood-thinning supplement. The FDA approved dose of the EDTA component in these capsules is 1000 mg per 35 pounds of body weight. Each EDD - Essential Daily Defense capsule contains 133 mg, thus the 10- 15 capsules daily dose recommended above with the push is conservative, and may safely be consumed continuously for years. Note: 15 capsules provide 2 GM of EDTA, which is really technically only an adequate dose for a 70-pound person, although since I plan to use this therapy long-term and we are not generally treating acute life threatening levels of toxic metals, this suffices. Technically, you could go considerably higher in the oral dose on the days the patient is not getting the IV push, I have found no need to use more aggressive oral doses as a routine. A guideline to for a **Therapeutic level of Essential Daily Defense is 1 cap per 10 pounds; maintenance dosages are 1 cap per 20 pounds of body weight.**

However, there is another case to consider, there are patients where the administration of IV 's may be impractical. For these cases, we need to try to accomplish a meaningful provocative test and offer this as an ORAL provocative challenge. In such cases we should plan to administer after calculating the full 1000 mg of EDTA dose for every 35 pound of body weight so that a 175-pound patient may now receive a full 5 gm of ORAL EDTA as a provocative test when they are not able to take the IV push. Taking that quantity of EDD is approximately 37 capsules and since that may seem to the patient to be difficult to take so many capsules we might also provide 3 gm of the dose as 1 level tsp of ORAL EDTA (pure powder in water or juice, pleasant tasting and easy to take) and the other 2 gm as 15 capsules of the EDD. This is because without the addition of EDD to the provocative test, we are not getting any of the necessary thiol groups (SH-as we now get from the organic hi potency garlic in the EDD) to broaden the spectrum of our oral provocative toxic metal challenge test and we would not see as much Mercury for example. Furthermore the malic acid component will pick up Aluminum and Iron, in some cases better than the EDTA.

For the patients receiving parenteral EDTA of any kind, the toxic heavy metals presented to the GI tract by the portion of the IV EDTA that does go through the liver and into the bile, is trapped and held in the intestine by the generally poorly absorbed oral EDTA, which in this case is an ADVANTAGE, since we want an effective chelator in the bowel at all times to catch the heavy metals presented by the liver, as well as to trap and hold any toxic metals we may be already consuming in our diet.

I tell my patients that choose to undergo elective physician supervised heavy metal detoxification that this is like plastic surgery, and is generally entirely elective, but here you do something for how you feel, not just how you look, I explain that I believe we were not intended to carry the high levels of toxic metals we are showing in virtually everyone tested as outlined above. If we do not plan to stay on some low level of oral chelation for life, these toxins will simply re-accumulate and the newly found high level of optimal health that this heavy metal detoxification program is giving, will again gradually be lost by the patient. Hopefully many will find it within their budget to also get perhaps monthly IV pushes to augment the benefits of the oral program.

◊ Latest Findings ◊

Patients whose primary focus is effective management of their cardiovascular disease are told that I have successfully prevented heart attacks and strokes with the continual use of my Binding Cellular Impurities oral formula. BCI contains 10 pills in packages that are taken twice daily. THREE of those capsules are Essential Daily Defense, thus we can count on the EDTA/sulfated polysaccharide content to significantly reduce clotting tendencies. Lester Morrison, a PhD. MD developed this concept which greatly improved when I helped him by adding the Oral EDTA to his Formula. This alone reduced heart attack rates by 91% in his $10 million study for the development of his Institute's Formula, which is the basis for my heart attack prevention program.

The benefits from using BCI are of course dose related, and therefore, it must be taken twice DAILY for full effect. In some patients where a greater heavy metal detoxification effect or heparin-like benefit is needed, I recommend extra Essential Daily Defense capsules, 1-2 with each meal. However, since we have become so aware of the important connection between Chronic Inflammation and Heart Disease, as dramatically shown in the May issue of Scientific American under the title "The Fire Within", I now feel compelled to routinely recommend an anti-inflammatory product such as Wobenzym to my heart attack prevention program. Both of these help maintain C- reactive protein levels at their lowest and safest levels, and thus effectively also help lower fibrinogen levels. With the new interest today in the coagulation panel performed by Hemex, I have found that for patients with significant molecular or anatomic risk factors, I MUST protect the patient AND myself with the use of the safe alternative natural anti-inflammatory product, Wobenzym. In some cases based on history or lab tests, Nattokinase, Boluoke, and/or Heparin are clearly necessary.

For a daily anti-inflammatory I use either Wobenzym 5 bid or for increased patient compliance. Mucos of Germany has $50 million in research supporting the efficacy of Wobenzym. This provides me with the documentation needed in recommending a product that I intend to have the patient use continuously for many years. It is clear that anti-inflammatory protection lowers not just heart attacks, but cancer and brain diseases such as Alzheimer's and Parkinson's disease, as well as providing serious protection against chronic the ravages of chronic arthritis.

I have become so confident regarding the effectiveness of this program in my patients that I have not referred any patients for any form of vascular surgery in over 20 years and I have not had a single patient that I am aware of following my program have either a heart attack or a stroke. However, I emphasize to all patients that there is no long-term protection conferred from taking these nutritional products. They must NEVER run out of these and they must at minimum take the BCI formula every 12 hours. Those, however, that have another Basic Vitamin Mineral program can choose to purchase the Essential Daily Defense separately; however, they are told they must also purchase the other critically important nutrients that are found in the 9 pills. They need Gingko Biloba and Phosphatidyl Serine, Salmon oil (EPA) and Primrose Oil; all of these that are conveniently supplied in their BC packet must be taken bid.

The infection connection to hypercoagulability is so well understood today that I further explain to all of my patients that even an entirely normal level of C-reactive protein can suddenly rise within hours when an infection activates, and that local infections on the coronary arteries will be associated with even greater increases in C-reactive levels LOCALLY, and that the usual blood test can not reveal locally elevated inflammation conditions. Yet, local infection/inflammation ALWAYS is accompanied by serious increases in blood viscosity and hypercoagulability.

We now know that every artery removed at bypass surgery will reveal evidence of some form of infection, and the more infections present in any given patient, the sooner they will have their fatal heart attack. Therefore, I explain that there is a real need for taking LOW levels of our anti-inflammatory product, Wobenzym everyday, even if their tests reveal entirely normal results on C-reactive protein testing. A safe affordable approach for someone having difficulty swallowing too many tablets will be Wobenzym 3-5 tablets bid.. Wobenzym has traditionally required 10 tablets tid when dealing with serious problems from hepatitis and trauma to cancer. Anyone that has attended a Hemex workshop would also consider using Heparin orally or by injection in addition to 1 or all of these natural anti-inflammatory products.

The other big issue in heart disease is the pro and con of using antibiotics with all of the interest today in Nattokinase. Certainly there is good rationale in patients showing elevated titers with Nattokinase testing to use an antibiotic, although some physicians and patients may want to offer a non-drug approach to their patients like the Immune Support products that I have developed in my chronic infection protocol and I strongly advocate the use of OXIDATIVE therapies for treatment as well as prevention in all patients. I am confident that we will find there is always more than one infection present in any heart disease patient and that increasingly these will be

antibiotic resistant. Thus, please consider the use of Ozone, Ultraviolet Blood irradiation, H202, or high dose (50 Gm in 50 minutes or more) IV supported with the new well tolerated BioEn'R-G'y C oral form of Vitamin C that I have helped develop that permits taking far higher doses of Vitamin C orally than was ever feasible for anyone before.

My total approach permits the effective detoxification and the control of every form of infection involving the patients arteries, whether this infection is from the mouth, and perhaps almost unidentifiable with available diagnostic tests today, or the routine chlamydia, CMV etc with which we all have been shown to be chronically infected. There are many other useful tips that I have learned that allow me to expect to routinely cancel many proposed heart transplants in children and adults. I offer one free consultation for 15 minutes by appointment for any physician to discuss any case. Call (928) 472 4263.

Sincerely

G F Gordon MD DO MD (H)