MS12

THE TREATMENT OF MULTIPLE SCLEROSIS

by

DR. HANS A. NIEPER

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Now it is true that percentage-wise, MS is not as serious a problem as cancer, heart problems and circulatory problems. There are, as a rule, somewhere between 240 and 360 severe MS cases per million in central and northern Europe. However, it does require special attention because of the long-term suffering that it causes, because of its typical appearance, and the problems with which the victims and their family have to contend.

MS was not my original medical specialty. My original specialty was oriented toward cancer therapy and the metabolic aspects of the heart, vascular tissue and the skeletal structure. I owe my involvement with MS to be a result of my previous scientific experience, although I am an internist not a neurologist.

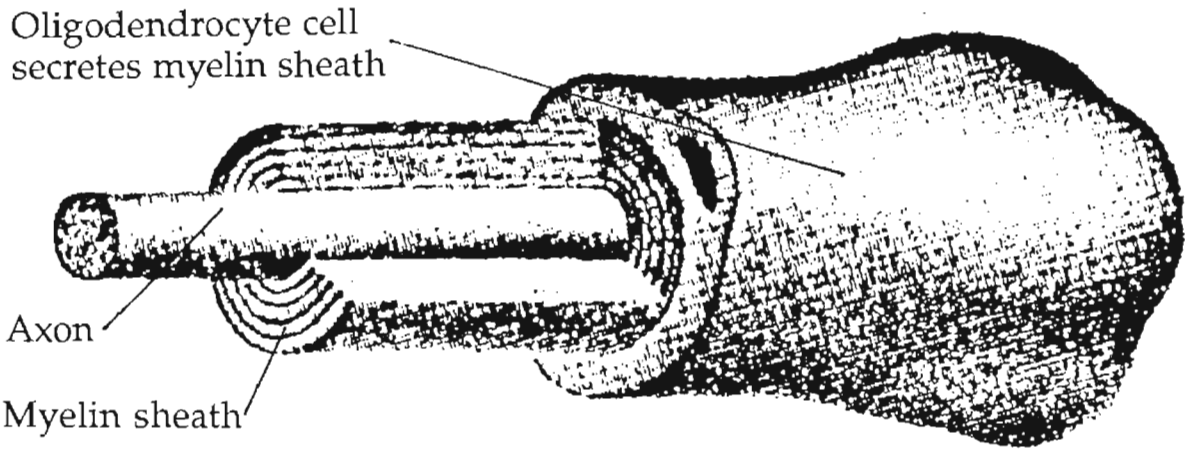
I have an enormous MS practice—I have treated over 1,300 patients for this disease, both ambulatory and non-ambulatory from all over the world—but unfortunately, I have no competition at all. An enormous task for one physician. I have been treating MS for over 20 years now.

80% of my MS patients come from North America. The rest from Northern and Central Europe, and some from Italy, South Africa, Australia, Tasmania, and New Zealand. The results are basically far better than any other therapy that has been carried out up to now. The enormous flood of MS patients—especially from North America—can only be explained as mouth to mouth repetition started by enthusiastic patients.

Thanks to American research, our knowledge about MS has been considerably enlarged in a few essential points in the last two years. So now it is possible for me to relate the origin and the fundamentals of this disease for the layman.

We call the nerve fiber, which carries the impulses from the nerve body to control the muscles or other functions, the central axon. (See illustration next page.) This fiber is surrounded with a multi-layered sheath with, from about five, to more than thirty layers. It resembles a large tobacco leaf, coiled around a central trunk, and is produced by a special cell—the oligodendrocyte. The entire group of cells is called the oligodendroglia.

The individual layer of the laminated leaf which makes up the myelin sheath is structurally identical with the membrane of a cell. That means they now have the capability of holding an electric charge of opposite polarity, thereby fulfilling the function of an electric condensor. We have only understood the function of the myelin sheath in the insulation of the central fiber for about a year. It was brought out by an article that first appeared in the magazine, SCIENCE. Indeed, one can measure the insulating ability of the myelin. When they did this however, they discovered that the many-layered condensor system which was constructed in the myelin sheets, acted as an electrical shunt to the central axon.



Just like insulation covering an electric wire, the nerve fibers are surrounded by the myelin sheath. The myelin sheath in turn is surrounded by the medullary sheath or oligodendroglia which is composed of oligodendrocyte cells which secrete myelin (a lipid or fatty substance which serves to insulate the nerve fibers or axons). During MS exacerbations (attacks), the sheath is partially destroyed (demyelinated) by so-called "killer T cells", leaving patches of scar tissue in the myelin sheath. This scar tissue interrupts communication from the brain to nerve terminals resulting in various disturbances of the nervous system—poor coordination, weakness, etc.

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In plain language, this means that we have here a classic Tesla technique which in all probability converts gravity field energy to the electrical energy necessary for the function of the central axon. We are talking about the same technique as was described previously in this magazine in reference to the Plasma Ignition that is being put on the market in Germany. Through this technique, the ignition energy of the spark can be strengthened 100 to 250 times. From observing the considerable amount of wrappings in the myelin, it might possibly be that the strengthening is much greater in the human body.

There are certain chemical compounds necessary for the correct bonding of the electrical charge to the cell membrane. One that is especially necessary is the compound colamine phosphate (2-aminoethanol phosphate) which we call EAP for short. This substance was first described as a component of the cell membrane by the famous American biochemist CHARGAFF in the '50's. Credit must be given to the FERRARI husband and wife team for outstanding research on colamine phosphate (EAP).

If there is an insufficient amount of EAP in the cell membranes, the binding of the electrical charge and the condensor function will be subnormal. We have now discovered in the patient who is subject to immune disorders, apparently the body is not producing enough EAP, and also does not have enough in the blood and the urine. This not only holds true for the MS victim, but also for other immune disorders—for example, it may affect the lungs, the kidneys, and other organs. We have found that in the MS patient, all cell membranes are affected, not just those in the myelin sheath. Their porosity is defective—even the membranes of the red blood cells.

As the electrostatic charge of the urinary tract cells is insufficient, there is a constant danger of urinary tract infection flaring up since the electrostatic defense filter, which is responsible for keeping the urinary tract clean, is not functioning sufficiently. Special credit must be given to the American biochemist GALLAND, who conducted extensive research on this. Moreover, this loss of charge capacity, can be measured by the insertion of a R.C. gauge.

The voltage of the condensor, which normally runs up to 70mV, drops when the binding of the electric charge between the two layers of the cell membrane is insufficient. This is also a part of the Tesla function—that is, the supply of the necessary energy to the central nerve fiber (axon) will be greatly diminished. It is not very often that this is properly described in the MS patient.

As this Tesla function (sometimes called the Orgone box function) drops off in all the cells, the patient becomes cold and chills constantly. Likewise, as the electrostatic barrier fails, the patient is more subject to spreading urinary infections.

There are many other side effects to be observed—for example, the small vascular capillaries become brittle, with an assortment of bluish spots appearing and also joint problems, etc. When such patients are given EAP compounds, they chill less, brittleness of the capillaries diminishes and the blue spots also become fewer.

Now, it appears that there is some hereditary disposition in this inability of the body to supply enough EAP to the membrane to bond the necessary charge. Especially in our American patients, we have noticed this in families—mother, child, or with siblings. Also, familial MS has been observed in identical twins.

There is yet another result of the inadequate discharge of the membrane system, these membranes are no longer able to defend themselves against immune body aggression. Such membranes and cell systems fall victim to immune diseases much easier, as has already been described—not only for MS, but also for other immune diseases. Roughly speaking, the analogy is much the same as using a storage battery which is not being recharged constantly. It may very suddenly go kaputt. So we must further appraise the origin of MS by contemplating the problems of faulty cell membranes and immune aggression. The combination of functional membrane inferiority, possibly caused by EAP insufficiency, plus the resulting harm done by lymph cells and antibodies, leads to more or less total destruction of the myelin through demyelinization disease.

In addition, in MS we can observe an inflammatory process in the so-called "blood-brain-barrier" (BBB) a segment in the brain venules which is responsible for fluid and pressure exchange between the blood and the brain serum.

When the inflammation of the BBB predominates, an MS-like picture arises, which yet is somewhat atypical. It is accompanied by a migraine-like headache (not found in typical MS) and after an exacerbation, the recovery is nearly back to normal. Also, we find less degeneration of the optic nerve in the back of the eye.

The German neurologist and brain specialist, who works for the Max Planck Institute, KUWERT, was the first to draw our attention to the two types of MS, and since then we have referred to them as Kuwert I and Kuwert II.

Actually, the credit for differentiating these two belongs to the Swedish pathologist BROMAN in Goeteborg. I had a long discussion with PROFESSOR BROMAN in 1968, during the course of a long automobile trip, in which he explained the pathological picture of MS. It was very enlightening for me.

Very often, the diagnosis of MS is accompanied by a lumbar spinal tap so that the cerebrospinal fluid can be examined for evidence of inflammatory change. By all means, as little as possible of the fluid should be removed, and furthermore, once the diagnosis is secured, it should never be repeated. The pressure stress created by the fluid removal can be most harmful to the BBB, may produce long-lasting headaches, and may also result in an exacerbation of the illness. The same is true of the X ray or CAT scan of the brain or any spinal cord. By no means, whatsoever, should the patient be subjected to repeated taps, or any so-called "invasive" diagnostic treatment. This is a very important fundamental rule, which as you well know, is frequently violated.

We still have no idea why the loss of EAP in the cell membrane is accompanied by an obvious diminishing of the membrane polarization. There is such a thing as an extremely high membrane polarization due to a very strong electrical charge bonding, mainly due to calcium. This causes a raised Tesla or Orgone activity leading to hyperthermia (high body heat). This is just the opposite of MS, where the Tesla or Orgone activity is too low.

We know of several other diseases where there is a reduction of the amount of EAP in the cell membrane. One of these is "Leukodystrophy". (A demyelinating disease, hereditary, commonly appearing in early childhood.) In this case, the damage can be repaired very well by the use of EAP salts, and an artificial restoration of the myelin is produced. There is no doubt that heredity or familial factors play an important part in increasing the inability of the membrane EAP to function properly.

But yet there are other factors involved here besides heredity. One that is highly suspicious in damage to the membranes and the nerve system is "aluminum". A study of ALS in Guam showed that it was frequent in aluminum welders. We have found evidence of aluminum exposure in our ALS patients also. We have now treated about 60 patients for ALS, and they have been considerably improved. As the brains of people with Alzheimer's have 10 to 30 times as much aluminum as normal brains, it is certainly not out of this world to be suspicious. Not all bodies collect aluminum which means that there must be some predisposing factor. We are exposed to it constantly—pots, pans, and in the US, soda pop is most commonly distributed in uniform "aluminum cans". In Alzheimer's, a degeneration of the forepart of the brain, there seems to be a strong suspicion of aluminum hydroxide, a component of deodorants.

There is another factor which will harm the proper electrostatic recharging of the membrane. That is the effect of "Geopathogenic zones". As we interpret it today, this is obviously an effect of frequencies which are primarily imparted by the tachyon field.

The primary cause of harm however, is of neither electric or magnetic influence. Between 75 and 80% of MS patients show a correlation to geopathogenic zone exposure. With cancer, it is even higher—about 93%; this

was reported in the magazine, SCIENCE. The frequency of cancer is very high with persons who work in transformer stations, on power lines or who live in close proximity to power lines. The EPA is now conducting a research program on this phenomena.

Toward the end of 1984, I had an MS patient from the vicinity of Eureka in Northern California. Her husband reported that they lived in a region of continual earthquake activity and not far from a place where a man must stand at an angle and not perpendicular to the earth, to keep from falling down. (See my book, Revolution on the conversion of gravity field energy—DR. HANS NIEPER.) In that region, the frequency of MS is over 4,000 per million. This would be more than ten times higher than in an average cross section of the country. It should be obvious, that MS patients, and everyone else for that matter, should by all means avoid contact with electric blankets, heating pads and the like.

The other component which we need in setting up the MS picture, is the development of immune aggression against the myelin. There is no doubt that the autoimmune process is initiated by a viral infection. This is initially a healing action, (destroying bacteria and other foreign protein invaders) but somehow develops properties of its own and after a latency period it not only is programmed to destroy the initial virus, but it also attacks the myelin membrane structure and occasionally the BBB, and even sometimes the oligodendroglia.

The most important starter virus appears to be measles. This was indicated 20 years ago, by the Hamburg neurologist. (note—DR. HAROLD MANNER says, "Everyone, and I am talking about 100%; every patient with MS has had a severe bout with measles, or has recently received the measles inoculation.") Another equally important starter virus is canine distemper (a very similar virus to measles). We have been aware of this for about 15 years. Also suspect are mumps, chicken pox and possibly small virus components.

The body throughout, as we know, is known to be provided with the means to eliminate the undesirable programs that cause harmful immunological derailments which result eventually in more harm than good. Thanks to modern cancer research, we now have been given a glimpse into the function of these repair programs. The Belgian scientist FISSER lectured on this to the Royal Society in London. This repair material comes from the adrenal cortex steroids. Steroid precursors are also definitely in the picture. These steroids are completely ineffective as repair materials unless they produce a high degree of electrical excitement.

Without this electrical stimulation, they are completely ineffective, no matter how concentrated they are. The analogy would be a car without gasoline. This necessary electrical stimulus is apparently supplied and renewed by tachyon energy conversion and so it is dependent upon the Tesla (or Orgone) activity of the cell membrane. As already mentioned, the cell membrane activity of MS patients is not up to par.

In addition to the harmful effects of the geopathogenic zones, there are also certain elements which are known to harm and inactivate steroids. Some of the known ones are fluorine, platinum, nickel, mercury, silver (amalgam fillings in the teeth) chromium and other heavy metals. Aluminum and chlorine are in

some cases harmful. All of these substances are poisonous and by nature harmful to the electrical function of the cell membrane.

There is one point that cannot be ignored however, the frequency of MS is especially large downwind of industries that work with chromium, nickel and other heavy metals, in Ohio, for example. Another factor to be considered is that much of the drinking water in that region is fluoridated. This is also definitely the cause of harmful aggravation of the surveillance system, both for autoimmune disease and for cancer.

The highest concentration of MS is in the North although there are some pockets in the South. One explanation is that there is a greater exposure to sunlight in the South. There is a good chance that light can activate the surveillance system against cancer and autoimmune disease. For example, maybe we can lessen the frequency of colon cancer with increased exposure to sunlight. From my own observations however, this holds little weight for MS. MS is for the most part, widespread in the dairy regions where milk products are predominate on the market. Wisconsin, a dairy state with a very high MS percentage, is quite typical.

On the North side of the Rio Grande, in Texas, we find that the frequency of MS is at least 10 times higher than on the other side in Mexico. In Texas, the usual diet is Anglo-American, with a heavy emphasis on dairy products. In Mexico, the usual fare is of the Spanish-Mediterranean milk poor diet. (Olive oil instead of butter.)

In South Africa, MS is concentrated in the province of Natal, even though they have plenty of sunlight there. Here again, this is the dairy region. In Australia there seems to be a decided difference in the frequency of MS in different provinces. Here again the pattern fits—it is one of milk production and dairy consumption, which closely follow the same pattern.

There are two theories to explain the close relationship between the dairy industry (or dairy consumption) and MS frequency. One assumes that there are viral particles in the milk, which bring about the sickness in the sense of a "starter virus". In favor of this theory, is the fact that the groundwork of susceptibility to MS, is quite obviously laid in early youth. That is, if someone from Arizona, for example, comes down with MS, the chances are that he spent his early youth in an MS pocket such as Ohio or Wisconsin.

There is another theory, almost 20 years old, which originated and was researched in England. This involves "glutens" (an immune active sugar-albumen complex) from milk (and possibly also those from cereals) which can activate the condition, so that it becomes clinically evident. The theory is, that if the person had not ingested the glutens, the disease would not have broken out.

According to an article from the British Medical Journal, about 63% of the cases where there was a suspicion of MS became clinically evident within 8 or 10 years. Certainly, what we know now about the origin and advance of MS is only the tip of the iceberg.

Possibly, there are conditions where subliminally repeated MS-like injuries are occurring, but they never reach the point of being an apparent illness. There are possibly many other activation procedures (boosters) which may bring out the

illness. For instance, there was a considerable amount of American MS patients who became sick in 1978. Of these, a very high percentage had had swine flu immunization in 1977. (Some think that MS increased after the introduction of Small Pox immunization.)

The ability of substances like EAP to bind an electrical charge on the membrane is a special physiological quality. We call the substances that have this ability, of which EAP is a classic example, "neurotransmitters". This quality of EAP has been known for some time, as can be concluded from the brilliant lecture of DR. PRESSMAN in New York. Recently, we have found other substances which are taken up by the cell membrane and qualify as neurotransmitters. The aspartates (salts of aspartic acid) for example, which go to the inside of the outer cell membrane. Hopefully I have given you a part in the origin and development of MS.

You will find that this information is vastly different from that disseminated by the German DMSC and the American MS Society. It would be advisable to compare these. At the very least, this knowledge presented here should bring about a diversion in therapeutical concepts and preventive measures. In my opinion, the knowledge entailed here is very significant and promising for the therapeutic treatment of MS.

In light of the above, we have evolved the following program for the treatment of MS:

First, it must be determined whether the patient 1.) sleeps in 2.) lives in or 3.) spends much of his time in (at his desk, for example) a geopathogenic zone. This can be determined by a Geo-Magnetometer such as the Mersmann Gerät, but we think that a good, well-qualified dowser is still the best for this determination.

Second, we must stress the extreme importance of a good diet. Besides the fundamentals previously mentioned, we recommend avoiding milk and milk products as far as possible. An exception is guaranteed French cheese in which gluten is broken down by the fermentation process. Actually, I am not so sure of the real significance of using milk and milk products once the disease has already become established. A few patients. out of well over a thousand, did report that their MS definitely worsened when they used milk products.

In 1928, DR. EVERS (Hachen Klinik in Germany) was able to show how the MS picture would definitely improve on his regimen: controlled exercise, plenty of rest, and a strict diet of raw, organically grown foods.

In 1935 (or '36), PROFESSOR NONNE of Hamburg, who was the president of the German Neurological Society at the time, called a meeting to discuss this unmistakably demonstrable phenomenon. My father, who was a neurologist, attended this meeting. I still remember him talking about it. I was 8 years old at the time.

It is very difficult to follow the complicated EVER'S diet. Also the basics, (cause and effect) of the EVER'S diet were never precisely explained. Based upon what we know today, I would surmise that this phenomenon is caused by Kirlian activity, which brings about the ability to convert field energy into photon energy, the stimulation energy mentioned earlier, for the surveillance substances are assembled through the Kirlian positivity of the raw foods. Further investigation

has indicated that the electrically active beta carotene capsules (Carotaben—electrically active beta carotene used for cancer therapy) has no beneficial effect upon MS. Nevertheless, we recommend a liberal raw food diet, especially olive oil, for the beneficial results mentioned.

Both active and passive smoking are strictly forbidden. (Even breathing smoke from someone else may be harmful.) The so-called "nicotine effect" is mainly brought about by an impairment of the neurotransmission. Just a few cigarettes (1-3 a day) will bring about a lasting impairment of the sickness condition. Credit for the discovery of the nicotine effect upon the electrical conducting properties of the cell membrane should be given to my friend for many years, the French scientist, LABORIT. Any exposure whatsoever to the poisonous smoke should be avoided.

It is also essential to avoid fluoridated water, fluoridated tooth paste, or fluoridated mouth wash. Chlorinated water may also be harmful. Another important assignment is removal of amalgam fillings from the teeth. Lately, there has been a series of articles in the American press relating to the possible relation between mercury amalgam fillings and the activation of MS. Only after considering these fundamental precautions is one in a position to attempt to slow or stop further deterioration of the defective immune process.

Several decades ago a so-called "smear cure" was recommended in an attempt to inhibit the immune process. A mercury salve was smeared on the skin repeatedly. There were some positive clinical results it is true, but the side effects, on the kidneys for example, were extensive. We have a series of medicaments recommended for their immune inhibiting ability, today. One of these is azathioprine (Imuran, Imurek). We occasionally run across patients who have been treated with these substances. Before administering this, I think that it is essential to fully warn the patient that azathioprine will cause liver damage if used for any length of time. In addition, there is an increased susceptibility to viral infection and possibly even cancer. There have been repeated warnings in the newspapers, especially in the US, of the carcinogenic activity of immune inhibiting drugs.

And then there is cyclophosphamide (Endoxan, Cytoxan). Occasionally, American doctors will prescribe this in highly toxic doses. We often get these patients with their hair falling out, and with severe damage to the blood building bone marrow. For this reason, it is not advisable to use Endoxan. There is a much better alternative, the chemically related Trophosphamide (Ixoten). This is just as effective as an immunodepressive substance and is tolerated far better over a period of time. We have used Ixoten for about twelve years now—generally, 50mg daily, (100mg at the most) for about 10 to 12 weeks. In certain cases, the treatment is continued (50mg daily) for about 1,000 days. The indication for Ixoten is a special immunological test for the depletion of the lymph cells, of which I cannot go into detail here. It involves personal communication with the patient on the basis of his long time experience. One thing is sure, in every case, Ixoten therapy is only for a limited time.

The most important part of the treatment of MS must be an attempt to correct the chemical and electrical defects of the cell membrane which we

mentioned previously. The remedies of choice are the colamine phosphate salts, calcium EAP, and also phosetamin (magnesium potassium EAP). The salts of colamine phosphate were synthesized by the world famous chemist DR. FRANZ KOEHLER (unfortunately now deceased) in Alsbach, at my request. This project was carried out with the intent of finding a highly effective sealing substance, on the membrane level, against the penetration of virus and toxic antibodies. We were very successful with colamine phosphate.

In 1972 MOENNINGHOFF announced some very interesting research with the electron microscope, which showed almost complete sealing of the cell membrane against the penetration of peroxidase granules with colamine phosphate. He also found, at the same time, that the salts of l-aspartic acid also had a similar sealing effect. For that reason, we added calcium-l-dl-aspartate (Calciretard) to our program as an anti-immunological sealing substance. Some of our patients have been treated solely on this basis with Calciretard for nearly 20 years.

It was discovered later that both colamine phosphate and aspartate function as the so-called neurotransmitters, and so are needed for the binding and flow of the electrical charge on the cell membrane. Since colamine phosphate can be given in other forms besides the calcium salt, we must also consider the potassium and magnesium salts for definite membrane-physiological reasons. So, we give the MS patients about 8 dragees daily of phosetamin which contains magnesium and potassium EAP. Part of the calcium EAP must be given by injection (I.V.) as this is the only way to build a sufficient concentration of colamine phosphate on the cell membrane. Generally, two or three injections per week are given, each containing 400mg of calcium EAP.

An interruption of the colamine phosphate therapy almost always will result in a severe exacerbation of the disease, as then a large number of so far repelled lymph cells are turned loose to attack at once. We also observed that there was a defect in the construction of the phosetamin pill which could be quickly corrected. We have ample documentation that a premature discontinuing of the I.V.'s (roughly within the first four years of therapy), results in a definite worsening of the condition. The therapy (especially the CaEAP I.V. injections) should be continued for an unlimited time—at least for seven years. In selected cases the I.V.'s can be replaced by a higher oral intake and CaEAP suppositories.

In addition, we give the patient calcium orotate (from orotic acid, also known as vitamin B_{13}. This produces a sealing effect on the surface of the inner cell membrane, but not on the outer cell membrane. Both the aforementioned inflammation of the BBB (blood-brain-barrier) and the inner structure of the oligodendroglia cells are favorably influenced. The calcium orotate is increased in the case of the MS form Kuwert II and then the tendency toward migraine-like headaches completely disappears.

Furthermore, we try to improve the function of the surveillance system previously referred to, which obviously is part of the MS defect. One possibility lies in the administration of prednisone (no other cortisones). Only prednisone affects the so-called thymosterin circulation pathway, under the prerequisite of

furnishing additional stimulation energy. Vitamin D_2 (not D_3), also called ergo-calciferol, has the same function.

The use of any other cortisones, i.e. ones that are not natural and so not partners of the vascular system, are only good for intercepting an active exacerbation, nothing else. For an acute progressing inflammation of the optical nerve, Triamcinolon (Volon) should be given.

We have found the habit quite widespread—maybe we should say the "bad habit"—of prescribing ACTH (adrenocorticotropic hormone) to MS patients. While there is a temporary improvement, the long run picture is of steady deterioration. This is the only way that it can be, because the already exhausted adrenal cortex system is just being squeezed harder. If one should be given ACTH for a short time, it is absolutely necessary to supply the required foods for the adrenal cortex systems—raw foods, vitamin D_2, vitamin C (in large doses), beta carotene (electrically active), and especially selenium (about 50 to 200mcg daily). We would like to emphasize that we have never used ACTH at all for the past ten years.

There is yet another aspect which has appeared recently and which is of special interest—"squalene". Five years ago there was a report from the Smithsonian Institute stating that sharks are cancer free (one tumor in about 25,000 sharks). Looking for a substance which can be held responsible for the phenomena, our finger points to squalene. Basically, it is a so-called "tripertenoid"—a very old biogenetically mother substance for steroid—and also other substances which apparently perform as surveillance substances in the human organism. "Iridodial" belongs to this group. One of the peculiarities of squalene is that it is extremely Kirlian positive, and converts field energy into photon energy. This means that the shark obtains a large share of its energy from the universe, and a rather small part from its food. The same is true for insects, they get 90% of their energy from universal energy, rather than from their food. One of the productions of the insects is "royal jelly", which is extremely resistant against virus and cancer development, yet they have no protein immune system. We have used squalene for the treatment of cancer for about $2\ ^1/_2$ years now, with considerable success.

Squalene is easy to dispense, but we have to get the pure form from Japan and prepare it for prescription in a special way. It apparently is not only the mother substance for the desired surveillance material, but it also makes available the necessary stimulation energy for the aforementioned Tesla function to operate. Some suggest that the polarization of the cell membrane is considerably raised by squalene and that the Orgone function is activated along with it. Accordingly, the patient who receives one to two teaspoons of squalene daily, feels (and actually is) especially warm. So it should be obvious that the MS patient should receive squalene. The results, so far, are very promising—essentially improved warmth of the extremities and the patient doesn't chill anymore—a distinct improvement of the MS picture. Olive oil too, contains squalene (about 2%) and we recommend its use in the diet. The amount however, is not enough to replace the prescribed squalene.

We must now give special consideration to the propensity of the MS patient to develop infections of the urinary passages. A stubborn inclination toward such infections is, as we mentioned, caused by the defective functioning of the defense filters in the urinary passages. For long-term protection, we use the sulfonamide, Harnesal. It is not so much the bactericidal effect of the sulfonamide, as the electrostatic activity which the excreted Harnesal restores to the urinary passages. About two tablets per day suffice.

The rate of success following our treatment varies. As a rule, the shorter the term of illness, the greater the response. There is a succession of criteria tied up with that response—whether for better or worse. I cannot go into all the details here. There is one thing that is very noteworthy however, and that is that there is a distinctly better response with the American patients compared to that of those from Germany or South Africa. We have given much consideration to this, and there again, we cannot go into all the details here. Our therapy, as a rule, results in a fairly reliable improvement, at least partly back to normal—the bladder function, the intestinal sphincter muscles, voluntary control of the big toe—even with badly crippled patients. These observations suggest that the injury is more in the electrofunction of the lower spinal cord, rather than destructive.

In addition, the upper body functions are also improved—vertigo, slurring of speech, facial expression, motor function of the arm and hand, and especially the so-called medulla oblongata deficiency symptoms. Those which are potentially very dangerous are: ability to swallow, breathing functions, and regulation of circulation. These life-sustaining functions also are deficient in ALS, which I already referred to, and likewise, there the colamine phosphate salts will supply continuous protection.

Unfortunately, the disturbed motor function of the upper thigh muscles, (which is an essential part of walking) is quite resistant to this therapy, or at least, improvement in this field is restricted to a certain few. We can avoid this, however, if therapy is started early. In an observation of about 100 patients who started their treatment while still ambulatory, in the course of more than five years, only two have had to submit to a wheelchair. Unfortunately, out of more than 1,300 patients who have received our therapy, there have been only 60 who elected to come in right after their definitive diagnosis and so in the early stage of the established disease. There is a certain group of these patients who have been treated since 1968. In every case, with these patients the MS-related conditions are not a bit worse than they were in 1968.

After just a short time of clinical application, some of the MS-related disturbances, especially those cerebellum-related such as vertigo and ataxia, show considerable improvement. Proof of this was first reported in an article published by the Hachen MS Klinik in 1968. (The largest MS Sanitorium in the world.) On the basis of this research report, the German, "Bundesgesundheitamt" (the German equivalent of the American FDA) which had officially declared calcium EAP to be an official MS medication, now revised that declaration to "for cerebellar ataxia form of MS". (It had been declared two years earlier as applicable for MS and several other disorders. (See the "Gebrauchsinformation" slip that

accompanies the medicine.) Strictly speaking, this is incorrect. Observations over a longer period of time, as we mentioned previously, show that the other MS-related symptoms respond, as well as those which are cerebellar-related. We should however, mention that another phase of cerebellar-related sickness, the so-called familial "Cerebello-Atrophy", is not influenced by colamine phosphate salts. It has been printed this way on the information slip from that time on. I have never applied for a correction for this indication declaration. In fact, the available results from a long-term study, over 20 years, of this therapy, are really remarkable. In every case, they are better than any other clinical alternative currently used.

Here are a few reports from patient groups in America: Toledo, Ohio—out of 35, 34 permanently improved; from southeast US, out of 22, 20 permanently improved; Bozeman, Montana 4 out of 5 improved, 1 the same; Milwaukee, Wisconsin, 10 out of 10 improved.

Another important point to be considered is reasons for therapy failure:

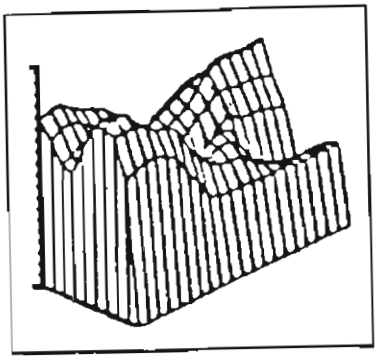
One is a lack of pepsin in the stomach and small intestine. This results in a lack of absorption of the enteric-coated pills, especially the phosetamin. This will cause a failure of the therapy.

There have been a number of therapeutic programs introduced in the last 10 years. One of these involves the introduction of certain nonbiodegradeable fatty acids (Efamol and Naudicelle) into the system. Although it was recommended by the DMSG, we failed in finding any positive effect that would allow us to come to any supportive conclusion, but we did find out that it worked against the EAP therapy.

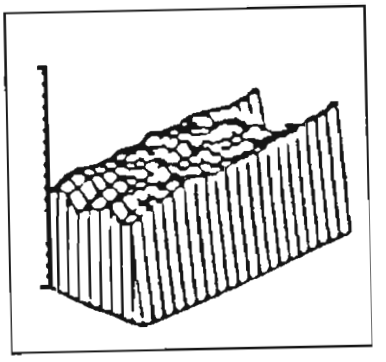
DR. JONAS E. SALK, the developer of the Salk vaccine for infantile paralysis (polio) in La Jolla, California, has been experimenting with so-called "basic mucoids". In principle, he created a decoy, which theoretically was able to lure away the immune reaction from the myelin membrane. It was indeed a classical immunological absorption procedure. However, we have received several patients from the the JONAS SALK research group, who still had active MS, and we found that a very high lymph cell concentration had built up in the blood as a result of the application of this material, which was decidedly unwanted. DR. SALK'S program is no longer available.

The vaccination of swine brain tissue under the skin—as was practiced by DR. JELESIC—is similar in principle to the Salk program. Although the program has not been very successful—a few qualified physicians have reported some positive results—the program is well-founded in theory, and no charlatanism, as the communications from the DMSG would try to convince the people.

I reported the use of colamine phosphate in the treatment of MS in the '60's in several professional medical journals. These were in English with one exception.



old sleeping place
very disturbed



new sleeping place
disturbance free

3-D graphic printouts representing geopathogenic disturbances in sleeping quarters as shown on a "3-D-Grafik-Computer" from information obtained with a "Geo-magnetometer".

September 1985

UPDATES:

*MS and fats: Carnitine plus Thiamine (300-500 mgs p.d.) plus Membrane Complex 7 p. day is the best procedure to build more lipid poles in MS-damaged myelin. This procedure very much improves our results in the MS treatment over the treatment with the colamine phosphates alone. It takes about 2-6 weeks to see the improvements over AEP alone. The proposal for this program came from Prof. Neunhoeffer, a world renowned German biochemist.
If the Carnitine has to be stopped, it should be reduced slowly.

Some insurance companies cover this therapy. About insurance forms: All patients are given forms from North American Health Insurance Coordinators, Inc. in Houston, Texas. They help with insurance claims. It is important that patients keep their receipts with the exchange rates from the bank to prove the correct exchange rates.

*We have started this program in August 91.

Update 1-26-94

In Germany the application of the so-called Colamine Phosphates (AEP,EAP-Ca, Mg, K-salts) is officially declared as an MS Therapy by the German Fed. Health Authority in Berlin, since 1967.

In this institute some 3500 MS patients, were treated on this basis since 1964. The profit (positive response rate) is about 82% which is in agreement with the outcome of the Morrissette study conducted in the US in 1986-87 (on 284 patients entering into this retrospective study). Since about 3 years we have introduced a more active form of this therapeutic concept. The patient receives 2 - 3 vials (10 ml/400 mg) of Ca-AEP in a carrier solution like Ringer, combined with K-Mg-aspartate and Ouabain in order to enhance the retaining of the Ca-EAP on membranes. With this a further progress has been achieved. In the early stages of MS this therapy is unproportionally more effective than in advanced stages. This therapy also prevents osteoporosis, otherwise frequent in MS pts.

A new decision expressed by the Supreme Court of the Fed. Rep. of Germany says that prospective and retrospective studies be considered equal, legally and insurance-related.

The expenses for this MS-therapy are, therefore, refunded by the European insurances. There is no alternative for this kind of MS-therapy in sight. If this therapy be started within the first months of the onset of the disease the disease will apparently be wiped out for a forseeable future.

(signed)

Dr. Hans A. Nieper

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