

Treating the causes of ulcerative colitis and Crohn's disease

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International nomenclature:
Chronic Inflammatory Bowel Diseases

Back in 1996 here in Fulda, and in 1998 and 2000 at the Medizinische Woche in Baden-Baden, I reported on the use of Bicom therapy to successfully treat chronic inflammatory bowel disease (IBD) and diseases of civilisation arising from food allergies.

If I am lecturing about this subject again it is because **chronic inflammatory bowel disease**, especially the atopic diseases **ulcerative colitis** and **Crohn's disease**, as well as neurodermatitis and allergic asthma are occurring with increasing frequency and the gastro-intestinal tract has become one of the organ systems most under attack.

These disorders with their symptoms such as frequent diarrhoea (in the worst cases, up to 20 to 30 bowel movements per day), mucous discharge and haemuresis, severe weight loss, vitality deficiency, long-term inability to work, to name just the most important, represent a huge burden both for the individual affected and also for their families. These patients very often are forced by their symptoms to live on the margins of society. The number of people affected is estimated today at 320,000 in Germany alone.

You all also know that in your day-to-day work more and more patients are complaining of vague and often varied complaints of the gastro-intestinal tract. The usual diagnostic methods offered by conventional medicine do not generally get us very far and so it should not surprise us

that increasingly vague "**symptom syndromes**" are being used for diagnosis because the exact causes are not or not yet known, as is the case with what is known as **irritable bowel syndrome**, for example.

Despite increasing scientific knowledge, the explanation of the **aetiopathogenesis** of IBD remains almost as unsatisfactory today from a medical and scientific viewpoint as at the time of my 1996 lecture. Experts are still agreed that, based on the interpretation of epidemiological, molecular biological, immunological and human genetic studies, there is a **multifactorial genetic disposition** as supported by familial clusters and also the high concordance rate among identical twins. One gene, NOD2, has already been discovered which apparently triggers pathogenesis in many patients. This gene belongs to a larger protein group which is responsible for resisting bacterial invasion of the body.

Consequently it is not surprising that the idea of the intestinal flora as the trigger for IBD pathogenesis is coming to the fore again in scientific studies, with the cause increasingly being assumed to be impairment of the intestinal mucosal barrier in genetically predisposed patients. According to Prof. Marteau of Paris, the bacteria affect mucosal structure, epithelial turnover, development of immune responses and intestinal function. Apparently the number of pathogens in and on the mucosa of IBD patients is much higher than in healthy individuals and the intestinal flora is unstable with, at the same time, a high number of bacterial strains

which are normally also found in healthy intestinal flora. With the mucosal barrier impaired, bacteria, **toxins and allergens** could therefore penetrate through the mucous membrane and activate the immune system accordingly. So-called **defensins** (small peptides 30 to 40 amino acids long) are apparently responsible for this antimicrobial resistance. They have an enormous antibiotic range and just a very low concentration in the micromolar range is sufficient to display their effectiveness. Today this mucosa-based intestinal immune system is regarded as the largest immune organ which is responsible for the immunity of the entire body.

Conventional medical treatment of IBD consists initially of administering Mesalazin (e.g. Salofalk) and also possibly the locally active steroid Budesonid (e.g. Budenofalk) for ulcerative colitis as well as antibiotics, if necessary, for Crohn's disease. If this is not sufficiently effective, then stronger drugs, yet which also carry side effects, are used such as systemic corticoids, Azathioprine and even sometimes Methotrexate. Recently the tumour necrosis alpha blocker Infliximab has also been used. There are numerous regimes for this which I do not want to go into here. Moreover, there is an American study of 54 patients with ulcerative colitis who were treated with helminthes in the form of worm eggs (*Trichuris suis ova*).

The complications associated with ulcerative colitis and Crohn's disease are stenoses with sub-ileus syndrome (incomplete intestinal obstruction), especially in the terminal ileum. These occur at least once during the course of the disease in approximately 20-30% of patients. Fistulisation is a classic complication of Crohn's disease. It arises between various sections of the intestine, mostly in the area of the lower small intestine but also from the intestine to the bladder, to the vagina or to the skin. Accordingly surgical intervention is frequently necessary. With Crohn's disease

alone, 30% of patients have to be operated within the first twelve months following diagnosis. According to a Danish study conducted in the Copenhagen area, out of a total of 185 patients with Crohn's disease, 55% were operated on at least once within 10 years, with 85% requiring surgery within 20 years.

Although ulcerative colitis is primarily treated conservatively, 31% of the 783 patients recorded in the Danish study still required surgery within 18 years. A colectomy (i.e. removal of the entire colon and rectum preserving the anal tissue) was also performed in some cases of ulcerative colitis which resisted all therapy.

The following statement is still true of the medical treatment of IBD today:

"Treatment of IBD should **relieve the symptoms of the disease** to improve and maintain the patient's quality of life. A **cure is not possible** with the current state of knowledge as it is."

As regards dietetic treatment the situation is the same as in 1996, namely there is not currently sufficient reliable data available to demonstrate the effectiveness of a special diet or dietetic treatment to hold Crohn's disease and ulcerative colitis in remission.

However the same authors admit that in practice the diarrhoea symptoms have been shown to improve in one third of patients with Crohn's disease and one quarter of those with ulcerative colitis if foods containing milk are eliminated from the patient's diet. This could also be connected with the fact that more specific antibodies against milk proteins are detected in the blood of IBD patients, whereby the inflammatory activity correlates with the antibody titre.

Back in 1996 I reported here in Fulda in my lecture on IBD on the results of the 1989 study conducted by Lebenthal et al. in Buffalo Hospital where an increased concentration of serum antibodies against

cows' milk proteins was observed in 80 children with Crohn's disease and ulcerative colitis, with the highest titre being recorded in the active stage of the disease.

These observations now bring us right to our Bicom diagnosis and therapy of IBD.

Bicom therapy (BRT) of inflammatory bowel disease

This followed from the findings of our instructor and colleague from Innsbruck, Dr Schumacher, who in his scientific study, published in 1991, of over 200 cases of allergy over a twelve-month period established food as the cause in around 64% of cases and was able to cure these individuals with specific BRT. Of these 64% food allergies, around 34% were triggered by wheat allergy and around 16% by allergy to cows' milk.

Based on these findings, as a gastroenterologist, I was able to find the same connections for IBD and report here for the first time in 1996.

In the light of the results of our own studies and therapy we Bicom therapists can assume that IBD, like neurodermatitis, can also be regarded as a hyperergic reaction by the body to a cows' milk or wheat protein allergy based on genetic disposition. For I was **always** able to detect either a cows' milk or a wheat allergy or both with both ulcerative colitis and also Crohn's disease. Obviously other factors such as toxins, heavy metals and, here especially, amalgam contamination also aggravate the situation further and I will talk about these when I come to the actual treatment.

Back then I could already report over 35 cases of IBD in the period from late 1988 to August 1995, 25 of these with ulcerative colitis and 10 cases of Crohn's disease. 68% of these had cows' milk allergy and 32% wheat allergy.

These statistics had not essentially altered by October 2000:

Of 43 cases of IBD, 28 had ulcerative colitis and 15 Crohn's disease.

Once again around 70% had cows' milk and 30% wheat allergy, with cows' milk allergy predominating in ulcerative colitis.

These cases were obviously all confirmed by endoscopic examination and, in most instances, by histological testing.

Unfortunately due to software problems I was unable to continue my statistics from the end of 2000 to the present day. Yet there must now be around 70 to 80 cases with ulcerative colitis and Crohn's disease, with roughly the same ratio of cows' milk to wheat allergy. In addition I have an ever increasing number of cases of chronic diarrhoea without the typical changes found in ulcerative colitis and Crohn's disease.

My strategy for examining and treating patients with IBD

Diagnosis naturally always starts by **examining the patient's case history in detail**, even if patients with IBD generally come to the surgery with a confirmed diagnosis and results. For thorough questioning can provide many valuable tips for subsequent therapy.

This is all the more important with patients who have been complaining for some time of frequent diarrhoea yet where endoscopic examination has not yielded the typical image of ulcerative colitis or Crohn's disease. Often the diagnosis is "colitis mucosa" or endoscopic examination reveals no pathological finding at all so that the talk is of irritable bowel syndrome.

As IBD is what is known as an atopic disease, we Bicom therapists know from our own experience and results that close links exist with allergic asthma and neurodermatitis. Prof. Weiss in Mannheim

was able to demonstrate through his own studies of 119 patients with IBD that almost one third of Crohn's disease patients also had atopic skin disease.

The following factors are consequently important:

- Symptoms, first occurrence, location
- In the **family history**: questions about neurodermatitis, allergic asthma and IBD in parents, siblings, any children and obviously in the patient himself.
- Normal birth or caesarian: in my experience patients born by caesarean section more often have allergies than patients born normally. Were drugs prescribed to suppress or induce uterine contractions?
- Did the patient bring up its food or cry a lot as a baby: bringing up food and intestinal cramps indicate food intolerance, generally cows' milk.
- Pronounced cradle cap
- Particular post-vaccinal reactions
- Particular childhood diseases
- Susceptibility to infection, frequent paranasal sinus conditions or bronchitis
- Operations, fractures, concussion, whiplash injury to the cervical spine, disorders affecting the spine and intervertebral disks, other infections due to possible energy blocks
- Usual case history of other bodily functions, etc.

I consider it particularly important to ask the patient about any medication taken and to monitor these for side-effects. I should like to present a particular example of this.

CASE STUDY

Case 1: Female, 74-year-old

Patient from Hamburg with daily frequent watery diarrhoea, approx. 4-6 bowel movements per day, no added blood or mucus, for about 9 months. Examined several times as an in-patient, including at

the university hospital, without any identifiable cause.

When asked if she was taking any medication, the patient mentioned the platelet aggregation inhibitor Plavix amongst others. I already knew that diarrhoea was a side-effect of Plavix. As my tests for food allergies were negative, I recommended the patient stopped taking Plavix immediately.

3 days later the patient called me from Hamburg and reported that her bowel movements had returned to normal. Even the hospitals hadn't thought of this!

Extensive physical examinations and laboratory tests, if the patient has not brought the results with them, are definitely recommended in order not to overlook any other essential previously unknown findings.

I perform **biophysical testing** on the patient with the biotensor and REGUMED's test sets.

I always begin my testing with the main foodstuffs cows' milk, wheat and egg albumin where I **always also** test the cows' milk and wheat with the natural product. If I suspect food allergy, I always use the actual natural products as well as the test ampoules where possible.

As mentioned earlier, cows' milk or wheat allergy is always present with IBD if medications are not responsible for triggering the disease. These must be searched for especially if there is no evidence of food allergy where a patient has diarrhoea. I should like to add here that, personally, I very rarely find egg albumin allergy. Schumacher also commented on this, which is the reverse of conventional medicine.

With wheat allergy which is becoming increasingly common, I perform the following test on the patient: I test a test

tube with **wheat cultivated** – today we say **biodynamically** – from really old seed which always tests negative even on individuals with the most severe wheat allergy, unlike standard commercial wheat. I mentioned this phenomenon here briefly years ago. The patient is then naturally surprised. I give him my explanation: standard commercial wheat is pumped full of insecticides, pesticides and intensive chemical fertilisers so that it produces as high a yield as possible.

In addition, after all the testing I conduct a kinesiology test on the extended arm with the normal wheat test tube which then gives positive, i.e. pathological, results. Then the patient is given a single grain of wheat hidden in their closed hand. You can hardly imagine the subsequent surprise of the patient when their arm then gives way, especially in men whose overall condition is strong. This is intended not so much for show but more to point out to the patient how important it is to pay particular care when subsequently abstaining from eating wheat. The intention here is to perform this test again at the end of all the treatments to demonstrate to the patient by a negative test how successful the treatment has been.

I should like to add that, in my experience, so-called food additives such as preservatives, colourings, etc. do not generally play a part in treatment of IBD. In very rare cases there may perhaps be an additional glutamate intolerance.

Next I test for **toxic stresses**:

- in the maxillo-dental region
- tonsils
- through viral diseases, especially following infection with herpes simplex, herpes zoster and genital herpes
- through childhood illnesses where I frequently test otitis media
- as well as through all the vaccinations.

I should like to make the following comment as regards vaccinations: the 5- and 6-fold vaccinations in infancy and

early childhood very often lead to a manifestation, i.e. to the outbreak or even to an exacerbation of a latent atopic condition, especially neurodermatitis. Consequently these vaccinations very often give positive results in the test and must be included in the treatment. Today we can no longer advise mothers against vaccination as they then allow the vaccinations to be given under pressure from the paediatrician – “so do you want your child to die as a result of a childhood illness” - ,this time however without our generous help and support from our Bicom therapy. So, following successful treatment, most of my mothers come to me one or two days after the next vaccination, preferably with the empty vaccine bottle (due to the charge) for the vaccinated child to receive Bicom therapy.

An important requirement for the actual allergy treatment is to explain carefully to the patient or mother, in the case of a child, the need to abstain from eating the allergen, i.e. cows' milk or wheat, for at least four weeks.

Then there are Regumed's comprehensive dietary regimens which really must be gone through and explained in detail, supplemented by personal experience in cooking. Always stress the need to avoid citrus fruit and their juices as firstly the high proportion of fruit acids and secondly the particularly high insecticide and pesticide residues are toxic for the skin and mucosa. Consequently organic food and organic fruit should be eaten in preference.

Think too of the heavy contamination in bananas which mothers are so keen to give their children.

Certain important rules should be observed when going out to a pub or restaurant:

Don't go to a cafe or, in the case of wheat allergy, to an Italian restaurant because the air is “impregnated” with oscillations from cows' milk or wheat. Meat and fish should only be eaten grilled, boiled or steamed as,

in fried dishes, the cook always turns the meat and fish briefly in flour beforehand so that the product remains crispy and juicy. The patient doesn't think of the effect this has!

All in all: Don't simply hand out the nutritional regimen because then the patient will not take adhering to it so seriously. You must go through it in detail point by point.

Bicom therapy of IBD and of causal food allergy

I perform Bicom therapy of IBD and of the causal food allergy according to the tried and tested rules of our bioresonance therapy. It is obviously not the task of this lecture to examine the principles and technical requirements of Bicom therapy. This is the task of the individual Regumed seminars.

My therapy program proceeds according to the following stages:

- **Basic therapy** following testing. Personally however I often prefer program 135.
- **Releasing energy blocks** according to the patient's case history, e.g. program 581 for spinal disorders and head injuries, also often generally prog. 915 assuming that in most cases some kind of energy block is present with no indication from the case history.

This includes elimination of scar interference where I basically treat larger scars or previous secondary healing, especially following perforated appendicitis, without previously testing this out.

Obviously geopathic stresses are considered as well.

- **Supporting the eliminating organs**, especially the liver as the main detoxifying organ.
- **Toxin elimination:** e.g. amalgam, vaccines. In addition, toxic stresses

tested from previous illnesses, viral diseases, etc. where I prefer programs 999, 978 or 979 depending on the trigger.

- I have stored the following program for **treating cows' milk or wheat food allergies:**
 - Ai
 - 52 kHz manual frequency with wobble
 - constant amplification with Ai 8-fold
 - continuous operation
 - therapy time 7 minutes

With babies and young children I generally prefer program 999 with attenuated amplification and reduced therapy time as well as the remaining programs.

Apart from when eliminating scar interference, I always place a large flexible electrode on the navel area as input with IBD. The modulation mat is placed on the patient's back.

Of course you can make therapy for cows' milk and wheat allergy more effective with the Bicom chip in the output cup. In this case the chip is applied to the "sea of energy" acupuncture point (about 2 fingerbreadths below the navel).

In this context I should in particular like to mention that I always place the natural cows' milk or wheat product in the input cup together with the test tube.

Further options exist to influence intestinal activity or to treat Candida infection with the appropriate programs.

In addition, parallel to dietetic treatment, the intestinal flora can be regenerated and cleansed. Mutaflor, the E. coli strain Nissle 1917, is preferable for this. I recommend starting with a low dose as otherwise severe flatulence may often occur and the patient will then reject this therapy.

As a rule I find 3 sessions with these programs at 8 day intervals is effective provided there is no Candida infection or other complications. The retests are negative. However I allow the patient to keep roughly to the so-called diet for the following 10-14 days and slowly introduce normal food. Often patients are even willing to adhere to the healthy spelt diet they have learnt.

Finally I should like to mention a phenomenon which I reported on back in 1998. In the course of my many years' of Bicom therapy and specifically of treating the central food allergies, I noticed that overweight patients with a wheat allergy already reported a dramatic weight loss of several kilos and oedema disappearing during the period they abstained from eating wheat without them following a special weight-reducing diet or even a slimming cure. The most was once 21 kg. Effects such as this, of wheat intolerance on body weight, cannot be explained simply by metabolic processes and electrolyte metabolism, especially as in most cases these parameters are normal. In my opinion, the possibility should be discussed of abnormally high water retention in the interstitial tissue as a result of increased permeability of the capillaries in terms of allergic oedema.

Patients must be alerted to this possibility so that they are not alarmed by the sudden weight loss.

Finally I should like to report briefly on three typical cases.

CASE STUDIES

Case 2: Crohn's disease

Female patient, d.o.b. 28.06.1959

Family history:

1 sister with neurodermatitis since childhood.

Diagnosis of Crohn's disease established in 1984 following endoscopic examination and histological tests.

1990 right hemicolectomy.

1995 anastomosis stenosis dilated.

Since 1984 perianal fistula opening into the left anorectum.

Treated as in-patient from 16.07-29.07.97 for: terminal ileitis with stenosis over a 30 cm stretch. Inflammatory stenosis in area of anastomosis – no passage into neoterminal ileum.

Planned: fistula surgery and cleansing with creation of stoma as well as removal of affected ileum.

Bicom diagnosis on 05.08.97:

- ▶ Cows' milk allergy
- ▶ Chronic amalgam contamination.

After keeping off lactalbumin for just 4 weeks, fistula secretion had ceased!

Bicom therapy from 23.09.97:

Continuing improvement, no longer any blood in stool, continuous abdominal pain disappeared.

28.10.97: State of health good, only 1 bowel movement per day, stool almost formed, otherwise thick pasty, no pain.

1.4.-17.11.97 Monitoring as in-patient:

Sonography: Abdominal organs including ileum and colon normal. No longer evidence of internal fistulous opening.

Coloscopy: possible to advance 20 cm into terminal ileum. Mucosa slightly oedematous, relief resembles paving stones, individual aphthoid lesions.

Histology: Mucosa of large intestine normal in all biopsies. Obvious chronic focal erosive ileitis in neoterminal ileum. Doctors presumed records had been mixed up!

Case 3: Chronic colitis

Female patient, d.o.b. 19.02.1955

1st Consultation and examination on 25.01.2007:

Strong tendency for diarrhoea since 1980s, up to 30-40 bowel movements on worst days.

Family history: father had baker's asthma and was sensitive to certain foods.

Own history: difficult birth! As a baby tended to bring up her food! "Could not tolerate cows' milk!"

Previously often had purulent tonsils.

1986 major laparotomy: "appendix removed, purulent ovaries and inflamed uterus removed." Poor wound healing. Adhesions.

Teeth had virtually all been extracted due to suppuration. Frequent purulent inflammation of the paranasal sinuses – consequently lots of antibiotics. Frequent headaches.

Epstein-Barr infection 2 years ago. Had also had Candida infection.

Patient was totally exhausted and depressed because of intestines.

Main Bicom finding:

- ▶ Wheat allergy!

Bicom therapy:

Initially only wheat-free diet and detailed counselling on nutrition.

When patient came on 6.02.07 (12 days later) for so-called relieving therapy, she was overjoyed.

She no longer suffered from diarrhoea and her stools were formed! After checking up on the phone, this lasted until the end of February. The actual Bicom therapy was scheduled to start at the end of March due to my holiday.

Case 4: Chronic colitis

Male patient, aged 73.

1st consultation September 2006:

Constant diarrhoea with 6-8 bowel movements per day for the last 9 months.

Constant cold with chronic impeded nasal breathing.

Previous medical history relatively normal.

Several thorough examinations with endoscopy as an in-patient, including in university hospital. No cause could apparently be found. The result was classified as so-called "irritable bowel syndrome".

Main Bicom finding:

- ▶ Wheat allergy

Bicom therapy:

First a wheat-free diet was introduced.

Just 8 days later the patient called of his own accord and reported happily he now had completely normally formed stool with one bowel movement each day.

The patient's health was restored once Bicom therapy was performed.