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Gluten-sensitive enteropathy / Coeliac disease – a lifelong affliction? A study of over 50 cases

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Dear bioresonance therapy enthusiasts,

I am delighted to have the opportunity this year to report once again on our work in Turkey.

Some of you may recall that last year I reported on our nationwide study involving autistic children. After the Congress we received numerous enquiries about specific treatments and the actual procedure for treating people with autism. This showed that autism is a topical subject amongst therapists. I was particularly delighted to receive calls from colleagues who informed me that my presentation had given them the courage to use bioresonance techniques to help these children. I am also grateful to Regumed's international sales department who forwarded questions to me without any hesitation.

This year I would like to report on our work in the area of gluten enteropathies. So what gave my Turkish colleagues and me the incentive to pursue this line of investigation?

1. We received a lot of enquires from mostly concerned parents who did not want their children to follow a strict diet for the rest of their lives and who were looking for alternative solutions. We received approximately 10 enquiries per week, either by mail or phone. My research into the incidence of coeliac disease in Turkey revealed an unexpectedly high figure of 1:400 – hardly surprising then that we had so many enquiries.

2. Many colleagues have asked me whether, from a therapeutic perspective, coeliac disease should be treated differently from so-called chronic central wheat allergy, from which many of our patients suffer. Apparently, colleagues are often asked similar questions and come across similar cases, hence some clarification is required.

3. The bioresonance technique is still overshadowed by so-called conventional medicine. I believe that it should exist alongside conventional medicine. Every successful treatment practised by every therapist on a routine basis is extremely valuable for the patient in question, and gives us praise and recognition. This must not be underestimated because it is the driving force behind our work. But we are not reaching the vast majority with our daily treatments. There are, of course, many excellent studies that confirm the efficacy of the bioresonance approach. However, in my opinion, these are still too few and far between. Scientific studies are tedious, time-consuming and costly. It goes without saying that investors with the necessary funding, especially the pharmaceutical companies, are not interested in giving us any support whatsoever. Nevertheless, this does not stop my Turkish colleagues and me from joining forces and presenting our studies to interested colleagues here or in Turkey. Our aim is primarily to nurture the so-called morphogenetic field and encourage people to look at so-called incurable diseases from another angle.

Based on this perspective, we came up with the idea of carrying out multi-centre studies. My Turkish colleagues and I decided to pool our results and produce a summary. Then, when we are asked whether Bicom bioresonance can be used to treat such and such a disease, we have the answer at our fingertips and can substantiate our claims

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with multi-centre studies, which carry far more weight than individual case studies. We can also take the wind out of the sails of sceptical colleagues since all of the patients discussed here were treated free of charge. Hence we cannot be accused of having a financial incentive to carry out this work.

Now before I describe our work in detail, I would like to begin by giving you a brief, general overview of certain terms and outline the pathophysiology and clinical course of various forms of coeliac disease (see also Annex 1).

Coeliac disease is a genetically predisposed condition comprising both allergic and auto-immunological components. Patients are allergic to gluten – a protein found in wheat, barley and rye. Auto-immunity is directed towards the endomysium or the tissue contained therein – transglutaminase (Endomysium = a loose layer of areolar connective tissue, enriched with blood capillaries and collagen fibres located between the skeletal muscle fibres). According to some gastroenterologists such as Professor Wirth from the Helios Clinic in Wuppertal, the symptoms of coeliac disease have become increasingly non-specific and atypical over the last 30 years. Prior to that, in the majority of cases, coeliac disease was already evident during childhood.

Nowadays, it is relatively common for cases to remain undetected until patients are in their thirties and forties. Typical symptoms such as persistently slimy, fatty stools, a distended abdomen and delayed general development in children are no longer always apparent. Contrastingly, non-specific symptoms such as joint pain, chronic fatigue, paradoxically chronic constipation, and migraine type headaches are coming increasingly to the fore. Since the clinical signs are decidedly non-specific, coeliac disease is one of the ten most frequently overlooked diseases. If sufferers avoid cereals, then the symptoms disappear. If they fail to follow dietary requirements, the symptoms will immediately reappear.

Based on my research, I would now like to give you a few explanations, which also shed some light on the actual causes of gluten intolerance.

1. The increase in the allergy potential of cereal products through the genetic manipulation of cereal. Experts in coeliac disease at Mainz University Hospital under the guidance of Professor Dr. Schuppan investigated old and new so-called high performance types of wheat from a gluten perspective over a 12-month period and made the following discovery. An additive in the form of a protein called Adenosine Triphosphate Amylase (ATI) is incorporated in the wheat, mostly through hybridisation, in order to make the cereal more resistant to pests. The overall aim is to boost yield. However, the fact that the allergy potential of the protein may have been increased through this form of genetic manipulation has either been overlooked or is evidently not seen as a priority.

2. Chronic inflammation and changes in the endomysium with an autoimmune response from the body. Irritation of the sensitive mucosa with foreign proteins such as cow's milk or eggs, for instance, triggers chronic inflammation. Industrially manufactured foodstuffs, mainly industrial sugar (industrially produced fructose, dextrose and refined sucrose / table sugar) and sugar concentrates (maple syrup, sugar beet syrup, concentrated pear juice, concentrated apple juice, Sucanat, brown sugar) upset the metabolism and trigger local irritation culminating in chronic intestinal inflammation and acidosis. Basic countermeasures are often inadequate and the inflammation persists. The epithelium of the exposed endomysium changes in terms of structure, is classified by the body as "foreign" and attacked by the formation of antibodies. **The clinical picture of coeliac disease is completed with destruction of the healthy inner layers**

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of the intestine, leaving the intestinal mucosa more vulnerable and producing a corresponding, protein-mediated response from the body. In addition, the intestine is often abnormally colonised with pathogenic micro-organisms, the main culprit being *Candida albicans*.

3. The working party led by the nutritionist, the late Dr. Max-Otto Bruker, found that in holistic terms coeliac disease is in fact a dietary-induced disease of civilisation.

Other diseases of civilisation such as type II diabetes, arteriosclerotic heart disease, obesity and chronic diseases of the musculoskeletal system mostly lie dormant for 20 – 40 years and are therefore classified as age-related as opposed to diet-related conditions. Since diet-induced diseases of civilisation take such a long time to become manifest, it is easy to understand why the sequelae of these conditions are rarely evidenced during childhood.

What about coeliac disease *per se*? In the foodstuff sector, considerable technical advances have dramatically altered the way in which foods are prepared. Thus civilisation-related changes in a child's constitution can appear as coeliac disease in childhood or lie dormant and emerge in later life in the form of non-specific symptoms.

Industrially produced foodstuffs from which vital substances are removed, and an increased consumption of foreign proteins are the perpetrators. In the case of cereals, so-called superfine flour tends to be consumed, minus the marginalised layers and the germ. We are then left with just core starch which is lacking in essential substances. Serious metabolic disorders may develop due to this lack of essential substances, especially the vitamin B complex. Yet nature has tried to make it so simple for us. The cereal grain contains carbohydrates and the vital substances needed to utilise these are found in the outer layer. If the outer layers of the cereal are removed, then vital substances will be lost and the cereal may not be used to its full potential. Fermentation processes occur in the intestine. These are also perpetuated by high sugar consumption. Cold-pressed oils and butter containing a wealth of natural, fat-soluble vitamins are often replaced by refined oils and industrial fats. However, fat-soluble vitamins are vital for ensuring healthy skin and mucosa.

A brief synopsis of the afore-mentioned points: Genetically modified foods with a low concentration of vital substances and a high sugar and foreign protein content lead to metabolic imbalance and malabsorption, culminating over the long term in chronic intestinal inflammation. The consequences are immunological responses to the protein and to modified endogenous cells, wrongly interpreted as "foreign" in genetically predisposed subjects. Meanwhile, coeliac disease is referred to as a "chameleon" amongst diseases given the considerable variation in the clinical signs and symptoms.

Further details regarding the pathophysiology of this condition are given in the references quoted at the end of my work, Unfortunately, I cannot discuss this in greater depth here due to time constraints. The material is, however, extremely interesting.

To complete the theoretical aspect, I will now give you a brief overview of the serological tests which we used as a basis for including patients in our in-house study.

The guidelines of the European Society for Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) are used to diagnose coeliac disease. The guidelines have been reviewed on several occasions in the light of highly specific, serological tests which dispense with the need for histological confirmation of the diagnosis amongst other things.

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Serological tests

Anti-endomysium (EMA)

Anti-endomysial antigen antibodies are highly specific and can be detected in over 90% of patients with coeliac disease. Anti-endomysial concentrations reflect the histological clinical picture, namely, the higher the antibody titre, the more marked the villous atrophy. Furthermore, the anti-endomysial titre substantially decreases when a gluten-free diet is maintained. Just like gliadin antibodies, they are also useful for monitoring treatment.

Anti-Tissue-Transglutaminase (tTG-A)

is a principal endomysial antigen. The detection of tTG antibodies using the ELISA method has now become the gold standard in the diagnosis of coeliac disease.

Gliadin antibodies (AGA IgA and IgG)

The detection of gliadin antibodies is highly sensitive but the assay method used is not highly specific. Gliadin antibodies are also found in allergy (atopic) sufferers or subjects presenting with other autoimmune diseases and in approximately 5% of the healthy population. Gliadin antibodies therefore play only a minor role in diagnosing coeliac disease. They are, however, extremely important in treatment monitoring: anti-gliadin concentrations decrease and symptoms disappear at the same time following strict compliance with a gluten-free diet.

Anti-deamidated gliadin peptide (DGP) IgG (EIA) antibodies

The determination of this parameter is beneficial in patients with selective IgA deficiency despite being less accurate.

IgA and IgG anti-gliadin antibodies (IgS and IgG AGA) and IgA and tTG-A endomysial antibodies (EMA) are usually assayed. With values of 87.4 – 98.2% and 86.5 – 97.2%, the latter display the highest specificity (number of healthy subjects who tested negative) and the highest sensitivity (number of affected subjects who actually tested positive), respectively. tTG antibodies are, however, always of the IgA type. Since up to 11% of patients with coeliac disease are also unable to produce sufficient IgA on genetic grounds (IgA deficiency), the total concentration of IgA must always be included so as not to overlook false-negative results. It should also be noted that EMA sensitivity is only approximately 80% in children under two years of age. Gliadin antibodies (IgA and IgG AGA) are therefore of particular diagnostic significance at this age. Antibody assays are also suitable for carrying out check-ups in subjects following a gluten-free diet since concentrations fall below the limit of detection the longer treatment continues.

Molecular genetic HLA diagnosis

The following can be said of molecular genetic HLA diagnosis
(HLA = histocompatibility antigen):

Familial clustering evidenced in close relatives and research conducted on twins is a key factor in the development of coeliac disease. Virtually all coeliac disease patients are carriers of HLA DQ2 or DQ8. Subjects who do not carry these parallel risks are highly unlikely to suffer from coeliac disease (“diagnosis of exclusion”). However, since approximately 30% of all healthy subjects also carry this feature, HLA typing alone is not suitable for confirming suspected cases of coeliac disease.

The latest guidelines drawn up by the European Society for Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) make a diagnostic distinction between symptomatic and asymptomatic coeliac disease with an increased risk of the latter. The essential biopsy performed to date is now no longer required under specific conditions.

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Three of the four criteria should be met.					
	No need to perform biopsy	"Seronegative" coeliac disease (very rare)	"HLA-neg." coeliac disease (very rare)	"Silent" coeliac disease (relatively frequent)	Coeliac disease
Symptoms (gluten-sensitive)	+	+	+	–	+/–
HLA-DQ 2/8	+	+	–	+	+
Symptoms (gluten-sensitive)	+	–	+	+	+
Histology	(+)	+	+	+	– (Marsh 1)

European Society for Paediatric Gastroenterology, Hepatology and Nutrition
Source: 107th Annual Conference of the DGKJ (German Society of Paediatric and Adolescent Medicine), 2011, Bielefeld

Histo-pathological evaluation

If a histo-pathological evaluation is required, the so-called **Marsh Classification** (see Annex 2) should be used to assess mucosa in the upper small intestine. All changes typical of coeliac disease can also be detected with other diseases. The response to a gluten-free diet continues to play a vital role and is one of the two diagnostic criteria. A type 2 change in the mucosa must at least be evident in order to confirm a diagnosis of coeliac disease/sprue.

Patient selection, implementation and results

Patients were initially asked to complete a questionnaire (see Annex 3) in order to record their personal data, serology results to date, histological findings and symptoms. On completion of bioresonance therapy the treating practice added details of the duration and number of treatment sessions together with serological and histological test results following the therapy and the gluten-free diet. The patient's condition after treatment and when not on a diet was also recorded.

All patients who received bioresonance therapy underwent both serological and histopathological tests beforehand and had been given an unambiguous written diagnosis of "classical coeliac disease" by a hospital clinician. Patients who did not satisfy both criteria received treatment but are not included in the findings presented here.

Similarly, all patients presented with symptoms indicative of coeliac disease before their condition was diagnosed. No cases of "silent coeliac disease", which were discovered by chance, were included in the rigorous patient selection process.

Number of cases: 55
(37 further cases could not be assessed due to a lack of findings and are unfortunately not taken into account in this study).

Age range: 3 – 57 years

Age	No. of patients	Time needed for diagnosis (average number of years)
Up to 5	1	1
6 – 12	10	4
13 – 17	11	6
18 – 40	28	12
Over 40	5	12

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A bioenergetic examination of blood samples using the Biotensor gave the following results:

	No. of patients	%
Cereals (wheat, rye, barley, gluten, gliadin)	55	100
Cow's milk	41	75
Hen's eggs	7	13
Candida	55	100
Yeast	34	61
Parasites (Oxyura, Taenia, Helminthes)	41	75
Bacteria (Streptococci, Staphylococci, Helicobacter pylori, E. coli, Salmonella)	34	61
Viruses (Epstein-Barr, Cytomegaly, Coxsackie, Hepatitis A, Herpes simplex)	18	33
Heavy metals (aluminium, lead, mercury, cadmium)	34	61

The patients described the following symptoms:

Symptoms	Before diagnosis		After diagnosis, following a gluten-free diet	
	Number	%	Number	%
Diarrhoea	55	100	2	4
Constipation	9	16		
Meteorism / distended abdomen	33	60	4	7
Weight loss / loss of appetite	26	47	5	9
Anaemia	30	54	6	11
Unsatisfactory weight gain/underweight	23	42	5	
Delayed overall development	20	36	7	13
Stomatitis aphtosa	5	9		
Chronic fatigue	26	47	6	11
Apathy / depressive moods	12	22	3	5
Fatty/slimy stools	28	50	1	2
Skin rash/redness/eczema	4	7	1	2
Bone development not consistent with the subject's age/osteoporosis/osteopenia	11	20	6	11
Other:				
Abdominal pain	33	60	1	2
Amenorrhoea	1	2	1	2
Narcolepsy	2	4	1	2
Joint pain	1	2		
Gastro-oesophageal reflux	6	11		
Recurrent urogenital tract infections	2	4		

Number of cases with at least one family case of coeliac disease, expressed as a percentage: **17**
No. of Bicom therapy sessions (on average): **22**
Observation period on completion of Bicom treatments (average number of months):
9 (not more than 15)

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Treatment concept and procedure

Bioresonance therapy for coeliac disease is based on 4 pillars:

1. Since it involves chronic intestinal inflammation, it is important to treat the latter first of all. In most cases, the condition had been diagnosed years earlier. A gluten-free diet alleviates symptoms and the intestinal villi recover but chronic mucosal irritation lies dormant in the majority of cases. This is presumably for the following reasons:

a) "Gluten-free" means in fact "not completely gluten-free". According to EU Regulation 41/2009, which came into force on 1.1.2012, gluten-free foodstuffs can and may contain up to 20 mg/kg gluten. Foodstuffs containing 100 mg/kg gluten must be labelled "very low gluten". This means that even when subjects are following a strict diet of what they believe to be gluten-free products, it is possible they may still be consuming small quantities of gluten.

b) According to the literature, patients with coeliac disease are intolerant to animal proteins. Since dietary recommendations focus essentially on gluten, cow's milk is still consumed. Latent inflammation will develop when the inflamed intestinal mucosa comes into contact with unfamiliar proteins, even in subjects following a gluten-free diet.

c) A sugar-free diet is generally overlooked. The damaged intestinal epithelium provides the ideal culture medium primarily for the fungus, *Candida albicans*, which feeds on sugar. Other pathogens, especially anaerobic bacteria, also have the opportunity to colonise the intestine due to the weakened immune system.

2. Coeliac patients suffer from malabsorption. The absorption of essential vital substances (vitamins, minerals and trace elements) is no longer guaranteed because of the local inflammation of the intestinal epithelium. This is a chronic situation. Many metabolic processes cannot be completed to sufficient extent due to a lack of these vital substances. Nutrition is not adequately processed. Carbohydrates, proteins and fats are not properly metabolised. We have found that vitamin B1 in particular has to be substituted in almost all patients. Before oral substitution can take place, the application of Bicom therapy to the nutrition points using the Sizzi Karz method has proved beneficial. Programs to support protein, fat and carbohydrate metabolism based on the Sissi Karz technique have also been used.
I recommend this approach to all therapists and not only for treating coeliac disease. In my opinion, all chronically sick patients should be tested and treated in this way.

3. As mentioned earlier, patients with coeliac disease are allergic to gluten. This can be treated effectively with bioresonance. To this end, we used a "cereal cocktail" containing various types of cereals (wheat, rye, barley and oats). Industrially produced wheat and rye meal together with various wheat and rye breadcrumbs and oat flakes were also mixed in with the cocktail. To this blend of allergens we also added to the Bicom input cup the various ampoules (wheat, gliadin, gluten, rye, oats, cereal flour, basic nutritional ampoules) from the CTT basic test sets and allergy test sets.

4. We adopted the same strategy for other principal allergens such as cow's milk and hen's eggs. This means that ampoules from the test sets were added to the native allergens in the input cup and processed using the procedures and Bicom programs as outlined below.

5. Any heavy metal contamination was likewise eliminated using a suitable Ai program followed by general toxin elimination.

Treatment for *Candida albicans* and other intestinal pathogens was carried out at the

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same time as toxin elimination, support for the eliminating organs and stabilisation of the organs and organ systems using the 5 elements test set.

Priority was obviously given to the **elimination of so-called treatment blocks** (geopathic stresses, temporomandibular joint block, scar block, etc.) prior to each treatment phase for coeliac patients (as with other diseases treated with Bicom bioresonance therapy).

In addition to bioresonance, so-called probiotics were prescribed in most cases to stabilise the intestinal milieu and strengthen the intestinal defence mechanisms. The oral substitution of vitamin and mineral preparations was carried out after assessing individual requirements and calculating the dose using a bioenergetic test method (biotensor, kinesiology or electro acupuncture).

Once treatment had been completed, the gluten-free diet followed up until this point was replaced with increasing quantities of wholegrain products. Patients were advised to avoid superfine flour as much as possible and to consume industrially manufactured sugar only in exceptional cases. Natural sources of sugar (e.g. fruit) were recommended instead. The benefits of fresh fruit were explained and all patients were advised to avoid industrially manufactured foods that often contain additives.

The following Bicom programs were used:

Treatment time and the amplification setting needed for each program were assessed for each individual patient using a bioenergetic test method.

Re. point 1: Objective: Elimination of epithelial inflammation, mucosal regeneration, strengthening of digestive organs and digestive support

Program description	**BICOM 2000**	**BICOM optima**
Tissue process, chronic	923	923.0
Small intestine acute / chronic	290, 291	290.1, 291.1
Large intestine acute / chronic	220, 221	220.1, 221.1
Stomach acute / chronic	330, 331	330.1, 331.1
Liver acute / chronic	310, 311	310.1, 311.1
Gallbladder acute/ chronic	370, 371	370.1, 371.1
Pancreas acute / chronic	300, 301	300.1, 301.1
Lymph acute / chronic	200, 201	200.1, 201.1
Metabolism acute / chronic	260, 261	260.1, 261.1
Improve intestinal flora, regulate intestinal activity	561, 562, 565, 460	561.0, 562.0, 565.0, 460.5 10038, 10040
Skin/mucosa acute/chronic	350, 351	350.1, 351.1
Acid-base balance	812	812.1

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Re. point 2: Objective: Support of fat, carbohydrate and protein metabolism, improved absorption of vital substances

Program description	**BICOM 2000**	**BICOM optima**
Lipometabolism	460, 520, 250	10051, 10049, 3064
Protein metabolism	910, 518, 530	3107, 910.1, 518.2, 530.6, 3106
Carbohydrate metabolism disorder	819, 992	10082, 3107, 3064
Vitamin B1	805	805.0
Vitamin B5	809	809.0
Vitamin B6	808	808.1
Vitamin B12	826	826.0
Vitamin B13	814	814.0
Vitamin B15	815	815.0
Vitamin B complex	240	240.2
Vitamin C	360	360.3
Vitamin D	211	211.4
Vitamin E	251	251.2
Vitamin A	900	900.3
Vitamin K	823, 549	823.0, 549.9
Zinc	600	600.2
Folic acid	810	810.0
Calcium	580	580.5
Iron	800	800.1
Magnesium	570	570.5
Mercury	813	813.0

Re. point 3: Objective: Allergen tolerance

Program description	**BICOM 2000**	**BICOM optima**
Allergy therapy (standard therapy)	963, 944, 998, 977	11310, 12310, 13310
Intolerance to vital substances and foodstuffs	977	977.3
Elimination / heavy metals allergy, especially mercury (in amalgam fillings)	998/999	998.5, 999.2
General toxin elimination	970	970.5
Abnormal reaction to food	991	991.4

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Re. point 4: Objective: Treatment of *Candida albicans* and other pathogens, general elimination and elimination of so-called endotoxins and heavy metals

Program description	**BICOM 2000**	**BICOM optima**	**BICOM optima channel 2**
Infection therapy	978 1078 (978, Di instead of Ai) 192 (anti-parasite, anti-virus, bacterial killer)	978.1 1078 (978, Di instead of Ai)	Anti-parasite Anti-virus Bacterial killer Endotoxin elimination General toxin elimination propolis Fungostatin (Biofanal) Tea tree oil Ascorbic acid
Ai program CTT test sets	191	191.0	
A program CTT test sets	192	192.0	
Special Candida program according to Dr. Sabine Rauch		1002 (Ai 15, sym. sweep 50 sec, band pass 17.8 Hz) 1003 (Ai 10, sym. sweep 50 sec, band pass 17.8 Hz)	
Detoxication of mucous membranes	999	999.2	
Toxin elimination	970	970.5	
Toxin elimination according to Dr. Sabine Rauch	1007 (H 2.4 Di 3.0; band pass 13 Hz, const. Amplification)	1007 (identical)	
Heavy metal elimination	979, 998, 999	979.2, 998.5, 999.2	

Following completion of bioresonance therapy, subsequent testing and negative blood test results, patients were advised not to follow a gluten-free diet any longer. They were asked to avoid superfine flour and sugar as far as possible and follow a healthy diet with wholemeal products plus a daily intake of fruit and vegetables.

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After abstaining from a gluten-free diet for at least three months and completing bioresonance therapy, patients were once again asked about their symptoms:

Symptoms	Before diagnosis		After diagnosis, on gluten-free diet		**After completing BICOM bioresonance therapy, no gluten-free diet for at least 3 months**	
	Number	%	Number	%	**Number**	**%**
Diarrhoea	55	100	2	4		
Constipation	9	16				
Meteorism / distended abdomen	33	60	4	7		
Weight loss / loss of appetite	26	47	5	9	**1**	**2**
Anaemia	30	54	6	11	**3**	**5**
Unsatisfactory weight gain/underweight	23	42	5		**2**	**2**
Delayed overall development	20	36	7	13		
Stomatitis aphtosa	5	9				
Chronic fatigue	26	47	6	11	**1**	**2**
Apathy / depressive moods	12	22	3	5		
Fatty/slimy stools	28	50	1	2		
Skin rash/redness/ eczema	4	7	1	2	**1**	**2**
Bone development not consistent with the subject's age / osteoporosis/osteopenia	11	20	6	11	**4**	**7**
Other:						
Abdominal pain	33	60	1	2		
Amenorrhoea	1	2	1	2		
Narcolepsy	2	4	1	2		
Joint pain	1	2				
Gastro-oesophageal reflux	6	11				
Recurrent urogenital tract infections	2	4				

Based on this result, we can conclude that even with gluten exposure hardly any symptoms were observed after 3 months. Digestive tract symptoms were no longer apparent. Only a few non-specific symptoms were mentioned. These presumably take longer to disappear completely or have a different aetiology.

With regard to published data in which gastroenterologists stress the importance of a life-long diet in order to remain symptom-free, the fact that patients who

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underwent bioresonance therapy without a gluten-free diet no longer experienced any symptoms must challenge the competence of conventional medicine in this domain. Both experts and patients alike report that meteorism and diarrhoea in particular usually reappear within days to weeks in the absence of a gluten-free diet. So what (continue at upper right) were the results from the serology and histology controls?

Serological and histological tests were carried out not earlier than three months after giving up the gluten-free diet. Compliance with this time limit should guarantee maximum and therefore intensive exposure of the intestinal mucosa to the allergen.

Number of patients	**Anti-endomysium (EMA)**	**Anti-Tissue-Transglut-aminase (tTG-A)**	**Gliadin antibodies (AGA IgG)**	**Biopsy Marsh 2-3-4**	**Gastro-intestinal symptoms**
25	**Neg.**	**Neg.**	**Neg.**	**No**	**No**
8	**Not tested**	**Neg.**	**Neg.**	**No**	**No**
4	Not tested	Neg.	Pos.	No	No
7	Not tested	Pos.	Pos.	Marsh 2 – 3	No
2	Not tested	Not tested	Neg.	Not carried out	No
5	Not tested	Not tested	Not tested	Not carried out	No

The following conclusions can be drawn from this table:

33 (25+8) of the 55 patients (60%) no longer experienced any digestive tract symptoms following bioresonance therapy. Similarly, serological and histological tests confirmed that they were no longer gluten-sensitive.

Despite being asked on several occasions, five patients refused all serological and histological controls.

Seven patients refused an endoscopic follow-up.

Four patients with a positive AGA IgG test result were advised to undergo a tTG-A test. A biopsy was to be performed in the event of a positive result (latent/silent coeliac disease? See also Annex 1).

Although symptom-free, seven patients were seropositive and presented with inflammatory intestinal mucosa according to the Marsh classification. Coeliac disease was confirmed based on ESPGHAN criteria. In such cases, a gluten-free diet should initially be reinstated. Repeat bioresonance intestinal treatment is recommended after a long rest period and intestinal cleansing. Surprisingly, these patients were found to have no gluten sensitivity during the tensor blood tests.

And now I would like to tell you about an interesting case treated by a colleague. This could in fact help many patients with coeliac disease.

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CASE STUDY

Faruk E., a 48 year-old male patient living in Ankara

Occupation: Lecturer working in a teaching institute at a University Hospital in Ankara.

Coeliac disease was diagnosed in 2001 by the Hacettepe University Hospital on the basis of serological tests and confirmed histologically through small intestine biopsies. There was no other family history of coeliac disease.

Results of bioenergetic tests:

Allergens: Wheat, rye, oats, barley, hen's eggs and cow's milk

Pathogens: *Candida albicans*, Gamma Herpes Virus, Coxsackie Virus, Streptococci, Staphylococci, Helminthes

Therapy time: 1 Feb. 2011 – 10 May 2011

No. of Bicom treatments: 14

The patient remembered the long drawn-out saga prior to diagnosis. Up to 2001, he experienced the following symptoms which, in his own words, "made life difficult":

chronic, slimy, bloody stools, meteorism, unexplained weight loss despite a healthy diet, chronic anaemia despite iron replacement therapy, Stomatitis aphtosa, chronic fatigue, depressive moods and gastro-reflux symptoms. An endoscopic surgical procedure was carried out to treat the reflux but, unfortunately, symptoms still did not improve.

Once coeliac disease had been diagnosed and the patient followed an appropriate diet, the symptoms improved. The diarrhoea stopped, anaemia was no longer evident, the oral mucosa became ulcerated less frequently and the patient gained weight. However, chronic fatigue, depressive moods and occasional slimy stools persisted. The patient's main problem was meteorism which he attempted to treat with medication and home remedies, etc. To no avail. On occasions the patient's resolve would weaken and he would give up the strict gluten-free diet. His condition would then deteriorate almost immediately, so the patient would take action and reinstate the diet. His condition fluctuated in this way for around a decade.

Mr. Faruk E. came to the bioresonance clinic on the recommendation of a successfully treated coeliac patient. Because of the extent of his suffering to date, patient compliance was excellent throughout the entire treatment period. After completing Bicom treatments, switching to a normal diet and eating essentially wholemeal products, all of the afore-mentioned symptoms disappeared completely. Even after the occasional slice of white bread, the patient no longer experienced any symptoms.

The serological tests
(first test on 26 May 2011 and repeated twice at 3-month intervals):

Anti-Gliadin IgA neg., anti-Gliadin IgG neg., anti-Endomysium neg.

The histological test on 16 October 2011:

No villous atrophy, no evidence of coeliac disease, intact small intestinal mucosa from various biopsy test sites.

In view of the clear histological findings, the treating physician praised the patient with the following words: "The results are remarkable. You really have stuck to the gluten-free diet!" When the patient explained that he had not followed a gluten-free diet for months but had undergone Bicom therapy instead, the doctor berated him.

Mr. Faruk E. works in a hospital and has a number of friends in the medical profession. When he discussed his situation with one such friend, a professor of pathology, this friend had the marvellous idea of having the histological study repeated in another hospital. When this result too confirmed the absence of coeliac disease, the treating physician was prepared to listen to a talk on Bicom bioresonance methods by the patient, who was by now familiar with this form of therapy.

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The upshot was that the university professors invited Bicom therapists from Ankara to the hospital in order to find out more about bioresonance.

Dear colleagues,

please document successful studies even if you are not working collectively. Summon up the courage to present your findings here. Whether on a national or international level, we all benefit from solidarity, shared practice and the support of one another.

Thank you for your attention.

I look forward to seeing you again next year and wish you all a safe journey home.

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- Website of the Deutsche Zöliakie-Gesellschaft (German Coeliac Society), u. a. Zöliakie-Empfehlungen für Diagnostik und Betreuung
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- Website of Labor Dr. von Froreich, 02.03.2011 (Dr. Von Froreich's Laboratory), Dr. Eckart Mummert, Phadia GmbH, Freiburg
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Annex 3 (continued)

Annex 1

Criteria for various forms of coeliac disease (according to Professor Dr. Stefan Wirth)

Form of coeliac disease	Transglutaminase AK	Duodenal histology	Procedure
Classic coeliac disease	Very positive	Villous atrophy	Gluten-free diet
Mono-/oligo-symptomatic coeliac disease (e.g. only abdominal or joint pain)	Positive	Villous atrophy	Gluten-free diet
Silent coeliac disease	Positive	Villous atrophy	Gluten-free diet
Atypical coeliac disease	Positive	Villous atrophy	Gluten-free diet
Latent coeliac disease	(slightly) positive	Minor changes or normal	Depending on symptoms
Potential coeliac disease	(slightly) positive	Normal	Monitoring
Transient coeliac disease	Only positive in children $\leq$ 2 years old	Normal later after stress	Monitoring
Refractory coeliac disease	Positive	Persistent villous atrophy	Gluten-free diet, risk of malignoma

Annex 2

Immunopathology of the mucosa in the upper small intestine

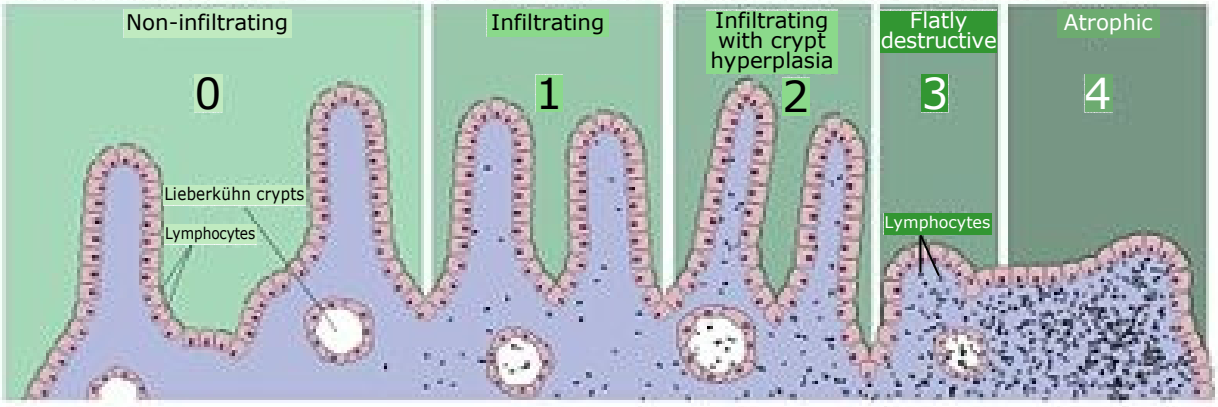

Diagram illustrating changes in the intestinal mucosa according to the Marsh classification (Source: Wikipedia)

Type 0: IEL < 40, normal crypts, normal villi
Type 1: IEL > 40, normal crypts, normal villi
Type 2: IEL > 40, hyperplastic crypts, normal villi
Type 3a: IEL > 40, hyperplastic crypts, slightly shortened villi
Type 3b: IEL > 40, hyperplastic crypts, markedly shortened villi
Type 3c: IEL > 40, hyperplastic crypts, villi completely missing

Explanations:

IEL:	White blood cells in the upper most covering layer of the mucosa
Crypts:	mucosal deepening
Villi:	musosal folds
Hyperplastic:	extended

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Annex 3

"Gluten enteropathy" Multi-centre Study

Patient's details:

Name and first name (patient's initials): …… Age: ……..

Date of diagnosis: …… Institution making the diagnosis: ……

Is there a family history of gluten enteropathy? ……yes ……no

Serological tests carried out?

(e.g. anti-gliadin IgA-IgG, anti-endomysium, anti-t-transglutaminase) ……yes ……no

Biopsy carried out?: ……yes ……no

Symptoms described by patient (mark with a X):

Symptoms	Before diagnosis	After diagnosis following a **gluten-free** diet	After completing BICOM bioresonance, **no** gluten-free diet
Diarrhoea			
Constipation			
Meteorism / distended abdomen			
Weight loss / loss of appetite			
Anaemia			
Unsatisfactory weight gain / underweight			
Delayed overall development			
Stomatitis aphtosa			
Chronic fatigue			
Apathy / depressive moods			
Fatty/slimy stools			
Skin rash/redness/eczema			
Bone development not consistent with the subject's age / osteoporosis/ osteopenia			
Other: …… …… ……			

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Annex 3 (continued)

How many BICOM sessions? …… 1st treatment on: …… Last treatment on: ……

Apart from wheat, were the following principal allergens also tested using a bioenergetic test procedure (please circle): Cow's milk, Hen's eggs, Refined sugar

Was there any evidence of Candida-related stress? ……yes ……no

Other pathogens/stresses confirmed using a bioenergetic test procedure:

……

……

Serological tests performed after completing BICOM treatment. Please specify: ……..

Test date: …… Result: ……

Was a histological test performed after BICOM therapy had been completed?

Date: …… Result: ……..

Comments from the BICOM Therapist:

……

……

……

Medical director of the BICOM practice:

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