The Detoxification Supplementation Therapy: A Shortcut to the Recovery of the Mental and Degenerative Diseases

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INTRODUCTION

In the field of Orthomolecular medicine, nutrition plays a most crucial and significant role. The Orthomolecular approach of recovering the body from physical illness and then providing supportive treatment for the affective (emotional) and cognitive (mental) states, points to the vital contribution in the treatment of degenerative diseases.

This study is presented in two parts: Part I contains the theoretical aspects of the detoxification supplementation therapy, and Part II presents its applications through case studies. The Appendices present the statistical tables and selected sample cases.

The thesis of this paper is: If the body is so intoxicated with endogenous or exogenous toxins from whatever source, it is but rational to detoxify the body.

The objective of this paper, therefore, is twofold:

1. to highlight the contribution of orthomolecular medicine and nutrition in the detoxification supplementation therapy; and

2. to present practical application of the detoxification supplementation therapy through case studies describing in detail the treatment processes in the recovery of degenerative diseases.

Toward this end, the focus of this paper centers on my clinical experience and medical research as a student and pioneering practitioner of Orthomolecular medicine in the Philippines for the last five years.

The bulk of data/information presented herein is derived from my compilation of cases treated using the Orthomolecular approach. Cases treated in my clinic were documented to show the effectiveness of the therapy.

PART ONE: THE THEORY OF THE DETOXIFICATION SUPPLEMENTATION THERAPY

I.Rationale for the Detoxification Supplementation Therapy

From the standpoint of nutrition, we know that the body must be nourished properly. We must breathe healthy air, drink good potable water, and consume food which is free from chemical-industrial pollution. Additives, preservatives, antibiotics, and

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steroids fed to our livestock and poultry and which we indirectly imbibe into our system, diminish our resistance to disease. Diseases, on the other hand, are caused by environmental or ecological toxins; improper or toxic food; bacteria; viruses and even fungi. We are surrounded by gasoline fumes, exhausts from machines, inhalants, insecticides. Our foods are highly preserved, flavored, colored, salted, or sugared so that the nutritive value is next to zero.

Therefore, if the body has been so intoxicated with endogenous or exogenous toxins from wherever these toxins come from, it is but rational to detoxify the body. Cleansing the body is the essence of the detoxification supplementation therapy. The process involves the administration of massive doses of ascorbic acid, the B complexes, minerals, together with Dextrose and the necessary fluids. This process is similar to the practice of kidney dialysis when a kidney does not function or fails to function efficiently.

In cleansing a patient from excess anesthesia, I would advise a surgeon, particularly during post surgery, not only to cleanse the patient with plain dextrose but also to add massive doses of ascorbic acid, the B complexes, and minerals. The result of this treatment is that the patient will wake up and recover faster. The same is true with all degenerative diseases. This modality of treatment has been proven to hasten the disappearance of the symptoms of malperception and simple paranoid delusions resulting in the total recovery of the patient. Depression or thought disorder often disappears completely if the patient has not been ill for a long time. After the treatment, the patient often says, "I feel new."

The advantage of Orthomolecular medicine is that vitamins and minerals are non-toxic. If ever there are mild side effects, these disappear upon withdrawal of the supplements. On the other hand, I have encountered a number of patients with foul-smelling breath, the effect of drugs which caused hyperacidity of the stomach and other ailments. I have also noticed many side effects on overdrugged patients; dyskinesias which are now reversible by cleansing the system with manganese (Kunin, 1978).

Fasting is another form of cleansing the body (Cott, 1974). It is a Christian tradition in the Philippines to fast on Friday during the Holy Week. I recall that, as a young girl, my family and I were obliged to fast and we did not feel any weaker from not eating the whole day. This tradition should be revived, since fasting is beneficial to both our body and our budget. Ideally, fasting should be for a period of four days. Moderate fasting, however, can also be adopted by taking fresh fruits and vegetable juices even for just one whole day.

II. Indicators for the Application of the Detoxification Supplementation Therapy

I consider acute those patients who have been suffering from symptoms of malper-ception from a few weeks to one year; subacute those who have been ill from over one year to three years; and chronic from three years up. When a patient is on the chronic stage, especially drug addicts and alcoholics, treatment is more complicated and takes longer. Another delaying factor in a patient's recovery is when he has been under tranquilizers for some time. In this case, the toxicity of the drugs causing the tardive dyskinesias must be controlled. However, those cases who do not use tranquilizers and are natural-food conscious are sure candidates for recovery, although they may be acutely ill.

Although it has been speculated that 30 percent of mentally affected people will recover spontaneously, it is nonetheless a great gamble not to subject a patient to Orthomolecular therapy.

1. Physical Examination

Some important points to consider in physical examination are the patient's general appearance, weight, skin, the buccal cavity, deformities, and blood pressure. For example:

- Is he emaciated or obese?
- Are his eyes dull, sharp, or just staring blankly, apathetic, or with no affect?
- What is the color of the skin: china-doll, ashen, sallow, pale?
- Is the skin dry, pigmented, especially at

the exposed areas of the arms and legs, back of neck? (There are pellagra lesions one has to look for.)

- Are the hands and feet wet/dripping with perspiration?
- Are there white spots in the nails (indication of zinc deficiency)?
- Are there stretch marks or striae at the hips or back of the thighs (indication of Vitamin B6 deficiency)? (Pfeiffer, 1975).

In addition, the buccal cavity should not be neglected. One discovers bad teeth, bleeding gums, canker sores, cracked lips, black or swollen tongue (glossitis). The skin is very important to note because the color and skin lesions are indicators of Vitamin A deficiency and because many hypoglycemics are also eczematous. However, these lesions and ailments disappear with megadoses of vitamins and minerals.

2. Behavior of the Patient

It is important to observe the behavior of the patients: the movements, the manner of talking (sometimes superfluous, nonsensible), walking back and forth, rocking the body, or stationary in the catatonic cases. Parents complain that the patient washes the hands continuously, or takes a bath as many as five times a day. Patients go from one place to another without direction. Others do not take baths, do not change their clothing, or move their bowels for as long as a week or more. All these types have to be considered, as the treatment and recovery of a patient will depend on his return from pathological to normal behavior which is acceptable at home and in society. Most of the abnormal behavior disappears after the detoxification supplementation therapy.

III. Instruments in the Diagnosis of the Illness

1. Dr. Tavel's Health Score Symptometer (Susser, 1976).

The International Academy of Preventive Medicine, of which I am a member, gives me permission to use Dr. Tavel's Symptometer. The questionnaire consists of 48 questions which a patient answers according to the degree of severity of his ailment or symptoms or degree of metabolic impairment. These questions were formulated to determine the possibility of hypoglycemia. A score of 26-35 indicates a 70 percent chance of hypoglycemia: 36-45, a 90 percent chance; and over 45 virtually indicates incidence of hypoglycemia.

2. Hoffer-Osmond Diagnostic Test (HOD) (Kelm, Hoffer and Osmond, 1967).

This test consists of 145 cards containing statements which the patient answers true or false according to how he feels. The "true" answers are marked in a score sheet and later evaluated with the aid of score keys.

There are six score keys. Two are for the total score; then there are also the perceptual, the paranoid, and the depression score keys. The last score key is the short form, a verification of the other scores; if a patient cannot finish all the 145 cards, he can just go over the short form cards.

From the results of the test, one can monitor a patient's degree of malperception as to sight, hearing, smell, taste, touch, time, etc. A very high score shows metabolic imbalance and probability of schizophrenia or schizoid syndrome. In my experience, a paranoid score indicates that the patient had been chronically ill and has been much affected by his environment. The depression score shows how much affected or sick the patient is. Most depressive patients cannot sleep, eat, or are generally so uncomfortable they have a tendency to suicide.

3. **Experiential World Inventory (EWI) (El Meligi and Osmond, 1970).**

More sophisticated than the HOD test, the EWI consists of Part I and Part II. Each part comprises 200 questions to be answered true or false. Again, there are score sheets and six score keys. The score keys are for sensory, time, and body perception, perception of others, dysphoria, and impulse.

The EWI is given to patients of relatively high academic achievements, since it is a rather complicated test. It is a very effective test for executives and college students who may be permitted to go back to work or to school when their scores return to normal.

4. Laboratory Examinations

These include the following:

a) Complete blood examination; high eosinophile and high basophile counts are particularly noted. High basophile may indicate that the patient is histadelic or high in histamine. High eosinophile may show that the patient is either highly allergic, in which case further workup on allergy is necessary, or that he is worm-infested. If there is blood discretia, then proper medication to correct this is indicated.

b) Urinalysis-to eliminate the possibility or suspicion of diabetes. Very often, however, I omit this test since diabetes can be fully diagnosed with the six-hour glucose tolerance test.

c) Lithium level of the blood. Lithium works for the very depressed or manic depressive patients. An initial dose of 300 mg lithium carbonate is given three times a day prior to the extraction of blood for the lithium level. Usually, this level must be maintained as much as possible. Since we do not know for sure how toxic lithium is, we should be watchful for signs of toxicity.

d) The glucose tolerance test. Orthomolecular psychiatrists insist on the five to six hour glucose tolerance test, since the post-prandial or the three hour extraction of blood is not sufficient for the diagnosis of low blood sugar. Also, in five to six hours, the patient starts to feel the inconvenience and marked symptoms. Taking the glucose tolerance test also helps the patient to monitor the time of his meals and how frequently he ingests food. I usually forego the half hour extraction to save the patient from fear of too much blood extraction.

I use a glucose tolerance graph with symptoms of the syndrome written above the graph. To convince the patient that the sixth hour glucose tolerance test is needed. I make him underline the symptoms he feels on the Dr. Tavel's Symptometer. When he agrees to take the test, then I initiate the treatment. The different curves in the graph are explained to the patient, including the probable curve his test will show.

PART TWO: THE APPLICATION OF THE DETOXIFICATION SUPPLEMENTATION THERAPY -SAMPLE CASE STUDIES

I. Profile of the Cases

Most patients who come to my clinic have been treated by orthodox therapists and, quite often, they do not know how to relate their problems. Some say that their psychiatrists told them that their illness is incurable, and that they have to take tranquilizers for the rest of their lives; otherwise their sickness will recur.

The Orthomolecular approach consists of recovering the body from physical illness and then providing supportive treatment for the mind and emotions. Specified support in the form of counselling may also be given to the patient.

The following are selected cases which demonstrate the detoxification supplementation therapy:

1. Catatonic schizophrenics.
2. Restless or hyperactive schizophrenics.
3. Drug addicts who are willing to withdraw and accept the therapy.
4. Alcoholics who want to cooperate with the therapy.
5. Hypoglycemic executives who can hardly function or are not functioning efficiently and want to get well soon.
6. Some cases of acute asthma and very debilitated patients who desire to feel well and energetic.

These selected individual cases were treated and documented by my clinic from June 1978 to July 1979, a period of one year. The total number of patients studied is 120, of which *77* are male and 43 are female. It is interesting to note that more than 50 percent belong to the 20 to 29 age group. The oldest patient is 79 years old. The youngest is 15 years old. The Summary Table for these cases is given in Appendix A.

Below are the profiles of the first four cases.

1. Catatonic Schizophrenics

It is easy to start the detoxification supple mentation therapy on the catatonic patient. Fasting is one of the preliminary procedures in the therapy, and so I ask the family not to be alarmed if the patient is required to fast.

In my experience, catatonics wake up from their withdrawn spell after the fifth or sixth bottle of fluid. Not all catatonics sleep.

Some are wide awake but appear to be sleeping. A sedative is needed, like Valium or Thorazine, to be infused through the I.V. tubing for the duration that the patient is not sleeping. I usually sedate a patient for 48 hours. After that time, life is seen to emerge.

I had a catatonic girl, a teacher, who could not even walk anymore, was not eating for a week, and was urinating in bed. After the sixth bottle of fluid, she changed; when she awoke, the first thing she did was to eat a heavy meal. I continued the fluids up to the ninth bottle. She was able to go home after eight days in the hospital, very much improved and aware of her environment. She went back to teaching after taking megavitamins orally for six months. She continues taking maintenance doses of supplements up to now. This patient had earlier been confined at the Medical Center in Manila for two months prior to her detoxification therapy.

2. Hyperactive Schizophrenics

Then, we have the very restless, hyperactive schizophrenics, violent, uncontrollable. These patients cannot relate to their families and are much more difficult to handle than the catatonic. These restless patients have to be sedated for at least 24 to 48 hours. Thereafter, the detoxification supplementation therapy is applied.

3. Drug Addicts

There are two types of drug-users. The first group includes those who are using morphine and its derivatives; they take these drugs by injection or sniff the codeine powder. The second group comprise those who take cough syrups thinking that the codeine in the syrups will give them a high or low feeling. They smoke marijuana and take pills to put them up or down. Some of these pills are: Mandrax, Librax, Valium, etc. Among the common cough syrups drug addicts take are: Tussionex, Mercodol, Endo-tussin, Deltatussin, etc. Lower-income drug-users inhale Rugby, a chemical used for gluing shoes and slippers. Others sniff turpentine which makes them "high."

A priest once asked me about the composition of toothpaste mixed with Lemolime
which some children drink. Cocacolics drink one family size of cola soft drink in one sitting and cannot take their meals unless with these drinks. I suggest that more research be done to see what contents of cola drinks make our children addicted to them. Another drink is the Lipovitan; if one examines the contents, its stimulating ingredient is caffeine. One recent innovation of drug addicts is mixing marijuana with brownies (chocolate cookies).

Most of these drug habits started with coffee and smoking. Marijuana smoking is rampant throughout the world. Although it has been said that marijuana is not a dependent drug, one of its many evil effects is that when a person gets used to it and is not satisfied with its effect anymore, he tends to look for stronger drugs like Mescaline or LSD. Later on, the drug user may fall victim to the morphine derivatives.

4. Alcoholics

We also have several degrees and kinds of alcoholism. Some alcoholics take off only in the evening after work, and sit down with glasses upon glasses of beer. There are those that go only for hard drinks. The chronic alcoholics start drinking upon waking up in the morning, take booze every two hours, and become violent and noisy. These patients, who are difficult to convince, are the ones who need more help.

II. The Detoxification Supplementation Therapy

If the patient is very restless and unmanageable, I usually have him injected initially from 50 to 100 mg of Thorazine I.M. and 50 mg of Benadryl I.M. If, after two hours, the patient is still not yet sedated, another 50 mg of Thorazine and Benadryl is injected I.M. After this, the patient usually falls asleep, and the fluid is started.

I normally give five percent dextrose, one liter, and incorporate three sets of I.V. Parentrovite or its equivalent in other brands. The fluid has to run 35 to 40 drops per minute. It is always safe to do a sensitivity test for the supplements before incorporating them with the fluid.

Sometimes, in very severe cases, I put four

sets of Parentrovite. I usually give from four to ten bottles of fluid. After the dextrose, I usually give Normosol 5 percent dextrose in saline. The rationale is that since fluid washes the body, the minerals in the body will somehow be washed out too. Therefore, it is also necessary to replace the minerals.

Sometimes the needle is dislodged. When this happens, the venuclysis is stopped to give time for the patient to relax and have a shower in between. The average that I have used is four bottles of dextrose and two liters of Normosol; the Normosol is given after two bottles of dextrose.

Fasting for the first two days has a better effect than allowing the patient to eat enormously. While the fluid is being infused, the patient is encouraged to get up if able (when he is no longer catatonic or restless). This is done specially in the case of drug-users. When the patient is allowed to eat, the hypoglycemic diet is followed. **1. Oral Medication**

If the patient is able to eat, the megavita-min and mineral therapy is given. I usually give B1, B2, B3, B6, B12. Pantothenic Acid, Ascorbic Acid, Vitamin A and D, Vitamin E are also given depending on the case. Each patient has an individualized mixture of these supplements. I also give some enzymes or amino acids such as Glutamic Acid or Tryptophane as needed. Hormones, if needed, are given after the hospitalization.

The duration of the hospitalization for this modality ranges from three days to one week. For drug-users who cannot be controlled at home, I encourage the relatives to keep him in the hospital for three weeks to one month, with a companion to watch him so that no agents can give him drugs in the hospital.

Most patients are insomniacs. It is therefore preferable to have them sedated at night. I usually give Valium five to ten mg through the tube, I.V. push to the fluid. Sometimes, the patient prefers Thorazine and I usually give 50 mg of this with 50 mg Benadryl through I.V. push. In my experience, the patients wake up in the morning without any hangover.and I attribute this to the action of dextrose and vitamins, meaning the fluid sedates the patient and washes off the excess tranquilizers.

2. Post-Detoxification Supplementation

From the hospital, the patient is instructed to take the oral medication. By this time, the patient must have already lost most of his malperceptions, anxieties and depression, and can go out and help himself.

a) The patient is encouraged to exercise. No matter how he feels in the morning (and this condition has been a pattern for most patients) he has to get up. To help the patient become lively and stimulate him, he is given Anafranil 25 mg or Tofranil 25 mg or Navane 5 mg upon rising. Usually, at the beginning, a relative or companion has to accompany the patient to walk, jog, swim, or play tennis, depending on the patient's choice.

b) Exercise is followed by a warm bath and a wholesome breakfast. The hypoglycemic diet has to be followed with the oral medication. The patient is asked to report every week or every other week as a follow-up of the oral and parentheral medication and a check-up on his recovery. The HOD test is given with the Dr. Tavel's test.

3. Added Regimen for Drug Addicts

Following the literature of Drs. Libby and Stone, I give massive doses of Sodium Ascorbate or Ascorbic Acid parentherally or by mouth to patients, especially those who have been under Codeine or Heroin. I give as much as 50 to 60 grams per day. One side effect I noticed is that on the third day the patient complains of painless diarrhea. I attribute this to the fact that ascorbate is a laxative and it is good for cleansing the bowel.

III. Results of the Medication

1. I have never encountered anyone having any allergic reaction to this modality of treatment.

2. After the third bottle, I notice the color of the patient turn from china-doll, ashen or waxen complexion to pink, and he is able to smile. Some patients may insist on discontinuing the fluids at this time, but I always

encourage them to continue the therapy.

3. In many cases visual, auditory, and touch malperceptions disappear even before the sixth bottle.

4. Majority of my catatonic patients recovered after six to ten liters of fluid.

5. In the case of drug-users and alcoholics, although they may say the urge to drink has disappeared, I cannot take their word until after three months of therapy. One can see, however, that they feel strong and alert; and they do not talk the language they are used to—repetitive, demanding, sneaky.

6. The general well-being of the hypoglycemic after therapy is well appreciated by the patients themselves. A number of them wanted to repeat the regimen after three months, since they claim that fluid therapy helps them a lot.

APPENDIX A

SUMMARY TABLE

	No.
Total Number of Patients	120

Classification by Sex

Male	*77*
Female	43

Classification by Age

15-19 years	16
20-29 years	62
30-49 years	31
50 and above	11

Classification by Disease or Symptom

Schizophrenias: acute, subacute, catatonic, hyperactive	32
Drug Users *	27
Heroin and Codeine (7) Cough Syrup and Pill (20)	
Hypoglycemia with Schizo affective symptoms *	39
Manic Depressive	7
Hypoglycemic with Phobias*	4
Epileptics*	2
Bronchial Asthma *	4
Allergy *	3
Senility with Arthritis and General Debility	2

Diagnosed by the six-hour glucose tolerance test.

Rate of Recovery Based on this Treatment

	No.
Well up to the present	55
Much improved; still under Orthomolecular treatment	31
Much improved with ortho-molecular treatment and minimal tranquilizers	*27*
Did not return after the detox ification supplementation treat ment; very much improved after discharge from the hospital (most of these cases are acute patients): possible complete recovery	7

Average Confinement in Private Hospital

Three days to one week

Duration of Treatment in Relation to Recovery

1 week - 4 weeks	26
4 weeks - 3 months	34
3 months - 6 months	22
6 months - present	38

Criteria for Recovery

- Normal HOD test.
- Normal Dr. Tavel's Symptometer.
- Testimony of family and patient; patient has returned to a normal social life; has gone back to work or school; verbalizes normally; sleeps well; no longer nervous and irritable; can sleep without any sleep pills or minimal tranquilizers (e.g., Melleril 25 mg or Valium 2 mg).

Duration of Study: June 1978 to July 1979.

Place of Study: Orthomolecular Medical Clinic. Dr. Purificacion L. Verzosa, Metropolitan Manila, Philippines.

APPENDIX B SELECTED SAMPLE CASE HISTORIES

Case I: Hypoglycemia, Drug Abuse

1. Identifying Information: V.J., male, 19 years old, single, first year college.

2. Date of Admission: September 26, 1978.

3. Physical Examination: Height - 5' 8"; Weight - 167 lbs.; Color - normal; Others - White spots on fingernails, straie at hips, buccal cavity normal, no signs of skin lesions.

4. Chief Complaint: From mother - For the last five years, he has been smoking marijuana; drinks cough syrups such as Corex, Mercodol; takes pills such as Mogadon and Valium, Theracon; smells Rugby, a paste for gluing shoes. Observation - Nothing unusual.

5. Tests Given and Results: a) Dr. Tavel's Symptometer - 70; b) HOD tests - Sept. 26, 1978 - 65 - 7 - 6 -15 - 26 - 5; Oct. 7,1978 - 37 - 4-4-3-11)4-1; Oct. 15, 1979 - 26 - 3 - 7 -1-26-1. The ratio score is consistently high, shows the patient is ill (26 -11 - 26; normal is ***VA).***

6. Medication: a) Fluid detoxification supplementation. Six liters of fluid was given in a period of three days. D 5 percent water and two liters of Normosol M incorporating three-four sets of I.V. Parentrovite per liter. (18 sets in all), b) Oral Medication: (1) When the patient was awake, he was given ten grams of Sodium Ascorbate in one-half glass of plain water during meals and snacks, five times a day. (2) Other oral medications: Niacin, 750 mg; Niacinamide, 1500 mg; Vaneular (consists of Thiamine), 250 mg; Pyrodoxine Hc1, 250 mg; B12, 250 mg; Clusivol, a Vitamin A & D Complex, once a day. (Clusivol has 25,000 I.U. of Vitamin A and 800 of Vitamin D.); Ascorbic Acid, 3000 mg after discharge from hospital. Tranquilizers: Equipax at bedtime, only one capsule.

7. Sustaining Dose: Oral Medication increased daily doses: Niacin, 1500 (increased); Niacinamide, 1500 mg; Ascorbic Acid, 3000 mg; Vaneular, 1 tablet; Clusivol, 1 capsule. Parentheral Medications: Parentrovite by I.V. every week and later every two weeks.

When the mother went to the South for two weeks, V.J. took care of the house, since all the brothers and sisters were at work or at school. He accepted responsibility. By the end of May, he decided to go back to school. He enrolled last June and is still doing fine. He feels well and strong, and would not go back to drugs. He says he still continues with his hypoglycemic diet.

Present Supplements:

A capsule combined Niacin Pyridoxine and Ascorbic Acid, one capsule three times a day. (1) Niacin, 333 mg; Pyridoxine Hc1,100 mg; Ascorbic Acid, 333 mg; (2) Clusivol, once a day; (3) Vaneular, once a day.

Case II: Hypoglycemia, Reactive

1. Identifying Information: L.J., mother of Case I, 48 years old, female, married with children. Weight - 158 lbs; Height - 5' $^{1}/_{2}$", quite obese.

2. Chief Complaints: For five years on and off, she was feeling nervous, with morning headaches, palpitation, leg pains and cramps, constriction of the aesophagus, chest pain, cold hands and feet, plugged nose especially in the morning, blurred vision, difficulty of sleeping, compulsive eating of sweets, and many more. She has been to many doctors she can think of, including a brother-in-law.

3. Tests Given: a) Dr. Tavel's Symptometer - 86 (100 percent Hypoglycemic); b) HOD test - taken August 3,1978.105 - 32 - 2 -12 -$8^{3}A$ - *7.* **Note:** The absence of paranoia—her perceptual score is very high, meaning she is metabolically imbalanced; her depression score is high.

She was not agreeable to going to the hospital for the Glucose Tolerance Test. She had a great fear about having a heart problem and said will not be able to take the test. Oral medication was given during two visits to the clinic, and by the end of September she finally consented to undergo the GTT.

Results: Fasting B.S., 74 percent; 1st hour, 118; 2nd hour, 118; 3rd hour, 101; 4th hour, 60; 5th hour, 70. **Note:** Patient refused the sixth hour. She said she was feeling weak, like dying. She went to a hospital not used to the modality of my treatment. The moment she went to the hospital, dextrose was inserted. One and one-half liters of dextrose was given to the patient prior to the day when the GTT was done. In spite of the dextrose in her system, the patient's blood sugar went down to 60, and during the test

she had marked symptoms of hypoglycemia. After the test, six liters of fluid with B Complex and Ascorbic Acid in the form of Parentrovite I.V. was infused.

4. Oral Medication: Daily Dose: Niacinamide, 1500 mg; Ascorbic, Acid, 1500 mg; Vitamin E, 4001.U.; Vitamin A & D (Clusivol), 5000 I.U. Vit. A, 800 I.U. Vit. D; B Complex pill consisting of: B1, 250; B6, 100; B12, 250 mcg; Lecithin granules, one tablespoonful after each meal.

The following vitamins were added to the oral medication on January 13, 1979: Calcium Pantothenate, 300 mg; Vitamin E increased to 600 I.U. daily.

On July 12 I added: enzymes and selenium tablets.

Before the Christmas holidays, she was able to travel alone to the South by plane, something she has not done before. Then she travelled again in March 1979. She said her symptoms occur on and off, especially when she eats a lot of cakes and ice cream. From date of admission, August 30,1978, to June 2, 1979, she lost 15 pounds. In the last part of July and in August she came for her Parentrovite I.V. injection. She said she feels strong and sleeps soundly after the injection. On August 14, 1979, she came to bid goodbye. She was accompanying her husband to Texas, U.S.A., for heart surgery. She got a two-month supply of vitamins and intravenous parentrovite injections before she left.

She has arrived from the U.S.A., still well.

Case III: Schizophrenia

1. Identifying Information: E.I., female, 26 years old, single BSE graduate, unemployed.

2. Date of Admission: May 15,1979.

3. Duration of Illness: Three years ago, she had been an out-patient at the PGH. She was given many kinds of tranquilizers, according to an elder sister with whom she lives in Metro Manila. Their parents stay in Bicol.

4. Patient's History (from sister): In 1976, she was withdrawn for so long and had to be confined at the PCH for two months; later she became an out-patient. She improved but relapsed in 1977 and during the summer months she gets worse. She does not sleep but is always lying down. She is very irritable and destructive and tears clothes that do not belong to her, especially the clothes of those she hates at home. She speaks bad words, is often violent, and refuses to take a bath. Her menstruation is normal. In the clinic she refused to talk. Her gaze is far and blank; her complexion, sallow.

5. Physical Examination: Hands dripping with perspiration. Behavior - She just sat down, refusing to do anything and did not like to answer the HOD test or the Dr. Tavel's Symptometer. The sister decided that she be confined in the hospital. Thorazine 50 mg was injected I.M. When she felt sleepy, she was brought to the hospital. No laboratory test was done. I felt it was unnecessary.

Upon admission, the detoxification supplementation therapy was started. She was completely sedated because she refused to have the needle inserted. We had to restrain her since the needle was always out. After the third bottle, she became cooperative. Nothing was given by mouth, except fruit juices. She could not swallow the supplements. She stayed in the hospital for five days, consuming eight bottles of fluid. On the third day, she was able to get oral supplements, as follows: Niacinamide, 1500 mg; Ascorbic Acid, 1500 mg; B6, 400; Theragran M, once a day. I did not give the Niacin as she might dislike the resultant flushing.

On May 25, 1979 she was able to do the HOD test with a score of 65 - 7 - 4 - 8 - 7 3/8 - 7. The Dr. Tavel's Symptometer score was 47. It could have been higher before the therapy.

6. Increased Supplements: Niacinamide and Ascorbic Acid, 3000 mg each daily.

Her sister wrote that the patient

- is able to respond in conversation, can interact within the family circle;
- remembers to take her medicine on time, unlike before when she refused to take any;
- is conscious of her diet now; before she did not even eat on time;
- sleeps regularly;
- complains of backaches;
- hated her father very much;

- desires to work already;
- is now willing to consult the doctor,

unlike before when mere mention of con sultation made her irritable and excited.

On June 11,1979, she was given the HOD test, with a score of: 21 - 2 - 1 - 3 - 7 - 1. I could not consider this a normal score yet, since the ratio score is high. Same medication was given to the patient.

The sister wrote: "I am very sure she is getting better although at times when I ask her for some favors, like handing me the basin, she seems to ignore me; but maybe because at that time she was watching TV. This happened not just once though. Is it because of lack of interest? Or laziness? I am working, so I am away from home most of the time. I ask her to do some things for me, like giving my children their milk and food at the right time, and they have been properly accomplished. At other times, however, she thinks that I have a wrong attitude about giving my baby boy his food."

She is now anticipating landing a job or enrolling in school. I explained to her that she needs to rest at least six months. She is agreeable, but mentions once in a while that she is not growing any younger.

On July 31, 1979, her sister reported that she is very well now and that they have no more problems with her. "I won't know what to do without her as she takes care of my children very well. Since she came out of the hospital, she tried to tear up a dress once but she was able to control herself."

Advice: Same medication. It was to be taken for the next six months until withdrawn or the patient is given some maintenance dose. About working, will tackle this issue next October; but she must work, study part time, or take some vocational courses to bring about her complete recovery.

Case IV: Schizoid Syndrome

1. Identifying Information: E.P.I., male, married, 53 years old, six children (all girls), businessman, and general manager of a big project of a big construction.company.

2. Observations: From the office-mates: In almost a month, his personality changed. He *is* overly talkative, restless even at the table, hardly eats. He functions in the field (construction) but he is irrationally angry at his superiors, accusing them of impartiality. From his wife: He advises the children a lot; walks around the house; hardly eats or sleeps.

I saw him two weeks prior to the medication. His eyes were sharp, his complexion sallow, and he has lost weight. There were visitors in the staff house and he talked a lot. He denounced many people, recited poetry, said he is good and that he took up the Dale Carnegie Course on "How to Win Friends and Influence People." He liked-Nap-oleon and all the heroes.

He was getting worse, and I convinced him to rest as he looked tired. I explained the procedure and we did the detoxification on the job site, with the field nurses monitoring him. We started the therapy at night after supper so it would not interfere with his work. After insertion of the needle to infuse the fluid, I put him to sleep with Thorazine 50 mg and Benadryl 50 mg taken through the I.V. tube. He fell asleep instantly.

He woke up the next day feeling drowsy, the effect of the tranquilizers. He worked in his room, signing papers and giving instructions. We continued the detoxification process to the fourth bottle until the next day. The following night, I again sedated him with the same dose of Thorazine and Benadryl. He woke up late the next day, complaining of stiff neck. This is understandable since he was not moving in his sleep. After two nights of good sedation and fluid therapy of four bottles, he said he felt much better and asked that the I.V. fluids be stopped already.

I observed tnat he had already quieted down and was not given to superfluous talking anymore, so I stopped the fluid when the fourth liter was consumed. He was given oral supplementation after the fluid therapy, a minimal dose of which he takes up to now. All his emotional talks and behavior stopped.

Case V: Schizophrenia, Drug Use

1. Identifying Information: R.T., male, single, 19 years old, weight - 110 pounds, height - 5' 8", third year B.S. Fisheries, U.P. (but dropped out).

2. Date of Admission: January 15,1979.

3. History: His mother claims that the pat ient admitted being on drugs for five years already. She did not notice any symptom until R.T. starting to withdraw from the drugs, could not cope with the withdrawal pains anymore, and finally confided to his widowed mother. The mother noticed that R.T. always looked tired and refused to go to school. At first, the mother thought that her son was just insecure and that is why he was absent-minded and irrational. He was brought to a physician who gave him tran quilizers.

At my clinic, the patient claimed he feels insecure and his muscles feel numb. Later, he hallucinated and heard voices and saw visions. He used to be one of the top ten students in his class. He took marijuana, Mogadon and Valium when he cannot sleep. He refused to take the HOD test and the Dr. Tavel's Symptometer. He was restless and indifferent. The mother was very much worried and kept on asking if he will get well.

4. Physical Examination: Except that he looked emaciated, had sharp eyes, and reacted negatively to what we say, nothing was particularly wrong with him.

5. Oral Medication was started as follows: Niacin, 750 mg; Ascorbic Acid, 3000 mg; B1, 250 mg; B6, 200 mg; B12, 250 meg; Clusivol, one capsule.

After one visit to the clinic, there were no visible improvements when he returned two weeks later. The mother said that he cannot be convinced to follow the hypoglycemic diet.

On January 30,1 was able to persuade him to go to the hospital for the Glucose Tolerance Test and, later on, the detoxification supplementation therapy if he is proved to be hypoglycemic.

Results of the GTT:

		Urine
Fasting	76	Negative
1st Hour	144	Negative
2nd hour	112	Negative
3rd hour	101	Negative
4th hour	60	Negative
5th hour	68	Negative
6th hour	70	Negative

On this basis, we can again conclude that a three-hour extraction is not sufficient from the results of the fourth to sixth hour; the fourth hour showed only 60 percent. The patient agreed to have the fluids started after I explained the mechanism of his carbohydrate metabolism.

He improved after the third bottle, became cooperative, and his complexion changed to a clean pink hue. In the hospital, he was given only Melleril 50 mg orally at night.

February 15, 1979: I added to his supplements yeast for his constipation and calcium tablets for-his muscle cramps. His mother said he is already improving and manageable. He also eats properly. He was only given Melleril 25 mg at daytime and Melleril 50 mg at bedtime.

March 14, 1979: The mother asked if we could still accelerate the recovery. I gave the patient a parentheral injection of Hydroxocobalamin and B complex, intramuscularly injected every week, one cc. each. Oral medication was Niacin 3000 mg, Ascorbic Acid 4500 mg, and B6 200 mg.

March 17, 1979: Oral medication was increased as follows—Niacin 4500 mg; B6 400 mg; the following were added—a B complex with mineral, BID, Ascorbic Acid 4500 mg, Dolomite three tablets daily, Clusivol once a day. The parentheral medication be continued.

When the mother complained that the patient is very troublesome, would like to go out of the house, and cannot be controlled, Haldol 2 mg BID was given.

After some time, the mother came to replenish her son's vitamin supply. She said R.T. was doing fine and does not like to take tranquilizers anymore. Last June, he re-enrolled at the U.P. to continue his studies. I met his mathematics teacher and she said that he is okay, no signs of illness at all. He still takes the vitamins but the injections were stopped.

He recovered in six months.

Case VI: Hypoglycemia, Reactive

1. Identifying Information: R.A.T., 42 years old, male, married, lawyer, writer, executive, looked tired, ashen and weak. He complained that he is losing his mind and was

afraid he might become crazy. He went to a Jesuit psychologist for consultation to clear his mind. While in New Guinea, he read about my work in mental Nines through a magazine. He came to my clinic believing that his illness could be biological and not • just psychological as he read. He knows two of my children and this, he said, gave him an insight and confidence in my work.

Before he came to me, he saw a psychiatrist who prescribed Tofranil 25 mg and Dalmane 30 mg at bedtime. He was also given Mutabon, Phosellite, Valium 2, Neuro-bion, Becedin, Fundamine E (only 30 I.U. of Vitamin E). He was presently on Ativan.

2. Date of Admission: July 7,1978.

3. Chief Complaints: Marked depression, insomnia, general weakness, no appetite, palpitation, backache, leg cramps, no concentration, mental deterioration, loss of libido, dizziness, etc. He had seen an endocrinologist who said he had thyroid insufficiency and gave him Tapasol, Inderal and Rauverid.

4. Physical Examination: Weight - 158 pounds; blood pressure - 120/90; color -ashen; wobbling gait; cannot talk freely; inhibited; no affect.

5. HOD Test Results: 105 -13 - 3 -16 - 6 -8. The test result shows more or less that he is not psychotic, as indicated by the low paranoid score. The high perceptual score points to his metabolic imbalance. His score on the Dr. Tavel's Symptometer is 96, an absolute hypoglycemic score. I put him first on the oral dose (since he said he is not yet ready for the six-hour glucose tolerance test and the detoxification supplementation), as follows: Niacinamide, 1500 mg daily; Ascorbic Acid, 1500 mg daily; Todobe (Ascorbic Acid with B complex), three times a day; Pyridoxine Hc1, 400 mg daily. To induce sleep, I gave him Serenace 1.5 mg before bedtime.

After one week, he came back saying he slept and felt much better and is in a hurry to get well. He was confined in the hospital; the six-hour glucose tolerance test was taken with the following results after two weeks of Orthomolecular therapy:

Urine	Negative	
Fasting B.S	73	for sugar
1st hour	140	Negative for sugar
2nd hour	95	Positive (+)
3rd hour	93	Positive (++)
4th hour	76	trace
5th hour	70	Negative
5th hour	74	Negative
6th hour	70	Negative

Although one may diagnose this an a normal hypoglycemic curve, the presence of traces and positive sugar in the urine is an abnormality and could indicate a predia-betic state. Also, at the fourth hour, the blood sugar, instead of maintaining the level of 93, went down to 76, and 70 on the sixth hour. A dip of 20 mg shows hypoglycemia and this is confirmed by the patient's complaints during the test.

Immediately after the sixth hour extraction, fluid therapy was given: six liters of fluid consisting of four bottles of D5 percent water and two Normosol with three sets of I.V. Parentrovite, were incorporated in each bottle.

R.A.T. was put on mild sedation so that he will not crave for food as he fasts in the first 24 hours. The nurses were instructed not to take the vital signs and help him only when he goes to the bathroom. After the third bottle, within 25 hours, his face started to light up and he said he was feeling better. He was on a fruit diet the next day. Suppository was inserted to stimulate bowel movement as he said he was constipated. It is very important that the patient be encouraged to eliminate his bowels daily, or even twice a day.

On the third day, he was encouraged to ambulate in the hospital, carrying his bottle on one hand. One problem is that, in the hospital, my patients cannot follow a strict hypoglycemic diet, as the nutritionists either do not want to cooperate or do not understand my therapy. The family, therefore, is obliged to bring the correct food to the patient.

Oral medication was augmented by giving Dolomite and bigger doses of the multi-vitamins, kelp, a natural seaweed with Iodine.

R.A.T. came to the clinic every two weeks, and each time, he asked for Parentrovite I.V. He continued to recover.

On January, 1979, he went to Europe on an official business. He was an international driver's license holder and drove all the way through Europe alone. He is still very well, has gone to Korea lately, and says he is cheerful and more efficient than before he got sick.

ADDENDUM

This method will confirm the article of Dr. Vasant G. Joshi and Dr. S. Eswaran (1980), on vitamins B1, B6, and B12 in the adjunct treatment of schizophrenia.

Based on my reading of different literature on the uses and functions of the B vitamins, I added these vitamins to my regimen of treatment. One will notice the rapid recovery of my patients. Some are of the severe catatonic or excessive hyperactivity. During the three-day hospitalization, I incorporate the following in the fluid:

1. Parentrovite. It comes in the intra venous and intramuscular form. The intra muscular form is given after the hospitaliza tion if the patient prefers it to the intra venous route.

a) Intravenous Parentrovite by Beecham (ampule No. 1) contains: Thiamine Hc1 - 50 mg; Riboflavin - 4 mg; Pyridoxine Hc1 - 50 mg.

b) Ampule No. 2 (intravenous) contains: Nicotinamide - 160 mg; Ascorbic Acid (as sodium ascorbate) - 500 mg; Anhydrous dextrose, B.P. -1000 mg; Sodium Pantothenate - 5mg.

Note: The intramuscular set is the same regarding the vitamin content with the intravenous, except that it is based on benzyl alcohol, B.P. instead of dextrose. These two ampules are mixed prior to injection.

2. Benutrex by Organon Pharma. I set each of the Benutrex C and the Benutrex B12, then mix the two ampules together; but usually I use one set of Benutrex 12 to 3-4 sets of Benutrex C. The contents per ampule:

a) Benutrex B12 has B1 - 200 mg; B2 - 50 mg; B6 -10 mg; Nicotinamide - 80 mg; Dexapnathenol - 50 mg.

b) Benutrex C has B1 - 40 mg; B2 -10 mg; B6 -10 mg; Nicotinamide - 80 mg; Panthenol -10 mg; Vitamin B12 - 6 mg; and Vitamin C - 500 mg.

Mixing these two ampules will give a high potency of the vitamins needed.

3. Betasymplex by Winthrop-Stearns carries the same vitamins and specify the ampule with Vitamin C, but the contents are not strong enough.

Oral B1, B6, and B12 which I use are available in my country as:

1. Neurobion - B1 -100 mg; B6 - 200 mg; B12-200 mcg.
2. Supraneuron - B1 250 mg; B6 - 250 mg; B12-500mcg.
3. Terneurine - B1 - 250 mg; B6 - 250 mg; B12-250mcg.
4. Neurovitan - B1 - 300 mg; B2 - 30 mg; B6 -100 mg; B12 - 250 mcg.
5. Vaneular - B1 - 300 mg; B2 - 30 mg; B6 - 100 mg; B12 - 250 meg; B3 - 25 mg.

As I said earlier in my article, the improvement appears after the patient has been infused with three liters of the fluid with the vitamins. In order to replace the minerals that may be drained during the infusion, I usually give fluid with Minerals like Normosol M which contains some minerals or lonosol MB with dextrose or Isolyte E with dextrose.

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