Chapter Three

The Catalytic Agent as an Antidote to Surgery in Thyroid Toxicosis

Mr. Chairman,
Members of the Local Medical Society,

We are pleased to have the opportunity to bring to your attention and to discuss with you a very interesting subject, frequently in practice and well understood among physicians. I speak of the "thyroid glandular disorders," and our methods of treatment, which differ from the surgical technique.

Years ago I was training in a specialized unit working on the "surgical treatment" of thyroid disorders. My knowledge was acquired by practical training and attending lectures in Dr. Crile's Clinic at Cleveland, Ohio. At that time, Dr. Crile's father was highly recognized among outstanding surgeons in the treatment of thyroid disorders. His skill and technique in goiter resections have been accepted by surgical textbooks and medical journals in this country, and are acknowledged as a classical procedure.

So years ago, I was very proud to begin establishing a surgical approach to the solution of thyroid toxic manifestations. The surgical technique is usually made under local anesthesia: within forty-eight hours after, the stitches were removed, and very insignificant scar tissue appeared. The majority of these patients were able to walk in a short time. We believe it was the first time in the history of surgery that "early ambulation" was established. Today since we are in contact with the use of the Catalytic Agents, our ideas on the treatment and correction of thyroid disorders have changed considerably. This means that for the past four years I have not treated a single patient afflicted with thyroid enlargement with surgical operation!

As a surgeon, I understand that this approach to recovery without surgical operation or surgical mutilation is not advantageous from a remunerative standpoint. However, from the standpoint of results, we save many patients from the necessity of surgery, a scar, and in some occasions from complications that follow. As you know, the thyroid gland is a very essential vascular organ, which is located in the anterior region of the neck, and has profuse circulation and intimate nerve connections.

Years ago in my practice, I found that the most interesting study of the thyroid problems concerns the development of thyroid disorders during the adolescent period, from thirteen to fifteen years of age. Dr. Crile considers this the "school girl" period, during which perhaps the changes of adolescence determine the underlying factors in the development of a goiter in the adult age.

To any clinical man, thyroid disorders seem to be more frequent in the female sex. This is explained by the relationship of functions between the thyroid glands and the ovarian functions. This relationship is so pronounced that in the opinion of some investigators, I quote, "The thyroid gland in the woman represents the womb of the neck." We know that normally the relationship between the thyroid and the ovaries is often noticeable during pregnancy, as well as during the menstrual cycle, at which times the thyroid gland is frequently enlarged.

In the male sex, this glandular relationship is different from the female. The relationship, in fact, is much less pronounced in the male. Very seldom in my practice have I seen thyroid tumors in males. It seems that in the male the thyroid secretion has more tendency to attribute to physical development rather than to influence the sexual glands. Consequently, the thyroid gland in females is a weak point of the glandular system, particularly the ovarian and pituitary systems.

The importance of focal infection was described years ago by Professors Gray and Womack of the Department of Surgery at the University of Washington. From the autopsies of forty-one patients whose deaths were caused by diseases like pneumonia, heart conditions, and pleurisy; the post-mortem examinations of the thyroid glands showed that 26 percent were considered a normal tissue while the remaining 74 percent were affected with degeneration. The same doctors, experimenting on guinea pigs that had been injected with toxins of different kinds and with animals in which they provoked artificial intestinal obstructions (lock bowel), discovered that the thyroid examinations showed systematic glandular alterations. In our opinion and estimation, the focal infection is a secondary factor in the production of thyroid toxicosis.

The deficiency of iodine, which is lacking in different degrees in relationship to the enlargement of the glands, has been also considered an etiological factor in thyroid toxicosis. In my interpretation, the iodine production of the thyroid gland is a physiological function, which could be increased or decreased, in excess of defect, depending on the relationship with the pituitary and sexual glands.

I would like to mention a recent interpretation of the etiological factor in thyroid disease: the bacteriological problem.

Careful pathological examination of thyroid specimens from patients afflicted with goiter, has shown the German bacteriologist, Prof. Von Bremmer, the existence of spore strains of different shapes and arrangements which, he believes, is the living organism producing thyroid growth.

These spora have been designated with the name: siphospora polymorpha. According to Prof. Von Bremmer's interpretation then, the "spora in cyclos 8," is the organism producing malignant tumor (cancer'). For many years, Dr. Koch has called attention to the theory that thyroid tumors are pre-cancer growth structures. (He has done this in his *book "Chemistry of Natural Immunity.")* Long-standing cases of thyroid growth usually ultimately develop or transform into the malignant stage.

The importance of the bacteriological factor (siphospora polymorpha) in the production of thyroid disorders cannot be overemphasized. It shows once more that the Koch Therapy can deal with this condition and is the logical treatment in the attempt to correct it by eliminating the toxins of the producing organism through the intense oxidation created by the administration of the carbon Catalysts.

Classification:

To a practical physician thyroid toxicosis will occur in two forms: thyroid toxicosis with enlarging glands, which is the so-called tumor or goiter, and thyroid toxicosis without the enlargement of glands. In both cases, the patients referred to the physician had typical manifestations: loss of weight, nervousness palpitations, and menstrual disorders. On occasions gastro intestinal manifestations were also present in the form of diarrhea and abdominal complaints. These patients develop a very strained, peculiar facial expression.

When the tumor is present, the diagnosis is not difficult to be established. The case of diagnosis is quite different, however, in the case where the tumor is not present and yet the gland is functioning in excess. There is thyroid toxicosis without tumor manifestations, which occurs frequently during adolescence. To a confident, capable surgeon the first group of patients is a sure target for his work. However, for the second group of patients without tumor, the surgical approach is usually considered more carefully, even perhaps as an improper remedial measure.

In my estimation, we have in our hands today a wonderful "antidote" for the "hungry surgeons" who would perform surgical mutilations of thyroid toxicosis patients. This "antidote" is the Catalytic Agent.

Female disorders are prominent among the symptoms of thyroid toxicosis. Patients refer to irregularity in the menstrual period and occasionally to a profuse menstrual flow that requires rest in bed. The second manifestations of importance are palpitations and irregular heartbeats with a change in blood pressure. On many occasions, these circulatory disturbances are mistaken for heart disease.

Among the other manifestations of thyroid toxicosis are shortness of breath, difficulty in swallowing, and sensations of strangulation or spasms in the throat or chest region. Nervous manifestations are frequently observed in the forms of insomnia, melancholia and other manifestations, which occasionally place these patients under the treatment of a nerve specialist.

Functional Tests:

Among the functional tests in thyroid toxicosis, the first one was described in 1915 when the Mayo Clinic established the first Basal Metabolism test unit in this country. The Basal Metabolism tests, in the opinion of Dr. Crile of the Cleveland Clinic, are tests of importance in the establishment of the diagnosis, but are not to be considered as absolute proof of the disease. Dr. Plummer and Dr. Rankin are of similar opinions. In other words, it is a frequent occurrence that a patient afflicted with functional manifestations of thyroid toxicosis, reacts normally to the metabolism test. Failures of the test are explained by the fact that there is no reason to believe that the disease is confined to one particular organ, and because there is a relationship among the glands affected by pathological disorders.

Treatment:

For many years the treatment of thyroid toxicosis has been considered a surgical approach, particularly in those cases where the glands are afflicted with a tumor. Symptomatic treatment has been employed, however; for which the iodine solution, Lugol's solution, and Buehan's solution were introduced by Dr. Plummer. Dr. Mason and Dr. Star of the Royal Victoria Hospital of Montreal corroborated the iodine solution in thyroid toxicosis.

Today we know that the Lugol solution, which has been discriminated against, does not solve thyroid toxicosis problems, but only gives a temporary relief over the clinical manifestations. This solution is used only as a preliminary medication to the surgical technique. Bromides, Phenobarbital, and similar symptomatic medications are also administered to give temporary relief from clinical symptoms.

Hormone therapy (anterior pituitary and ovarian substance) has been tried for the remedy of thyroid disorders, but does not seem to improve or control the clinical symptoms except in a temporary way. Insulin has also been used experimentally in thyroid toxicosis, particularly on patients who have lost large quantities of weight.

Within the last two years, the medical Staff of Lahey Clinic in Boston has extensively used Thiourocil and its two derivatives, Propyl-thiourocil and Methyl-Thiourocil in the treatment of thyroid disorders. At the Lahey Clinic around thirteen hundred patients afflicted with thyroid disorders were treated with the Thiourocil medications. In a review, Dr. E. C. Bartels, of the Department of Internal Medicine of the Lahey Clinic, estimated that this medication is the "choice" of the treatments of toxic goiters. Furthermore, failures, if they take place, are the result of either improper dosage of the drug or an improper diagnosis of the case.

The daily doses of Thiourocil used at the Lahey Clinic is between six hundred mgm. for Propyl-Thiourocil, and two hundred to three hundred mgm. for the Methyl-Thiourocil.

Today we know that this medication's failure to overcome certain definite complications is due to the toxicity of the drug. This is true particularly in blood disturbances like Leukopenia and Agranulocytosis. In case of emergency complications, blood transfusions are required to overcome the complications caused by the drug toxicity. Minor side reactions from these drugs include nausea, sensations of numbness, severe pains in the joints, and arthritis.

Dr. Crile believes that the beneficial result with the drug necessitates doses as high as four hundred mgm. daily. There were prompt remissions of symptoms and elevation of the Basal Metabolism test rate when the doses were reduced to two hundred mgms. daily.

In my estimation, the practice of medical treatment of goiter with this preparation is a precarious one because of the dangers of complications developing, of the necessity of prolonging the treatment, and above all, danger from the toxicity of the drugs. The inability of "medical treatment" in thyroid toxicosis was a reason for opening the doors to the "surgical approach" in the same way; an attempt at remedying pulmonary tuberculosis has been approached through surgical resection. Surgical interventions in thyroid toxicosis have been shifted from the ligature of the thyroid arteries up to the subtotal resection of the glands.

Unfortunately, on many occasions, surgical resections of thyroid glands, as a treatment for thyroid toxicosis, are also a total failure, no matter how skilled the surgeon may be. Some patients, upon whom we have operated, continue to show different clinical manifestations plus complications, arising from the surgical operation. Occasionally the development of hypothyroid symptoms takes place with skin dryness, lack of respiration, drowsiness, coolness, and fatigue and swelling of extremities and eyes. These manifestations are very closely related to a myxedema so-called hypothyroid deficiency. At times I have seen severe

complications occur right on the operating table, during the process of thyroid resection. The patient developed cyanotic coloration, irregular respiration, and coma persistent for seventy-two hours after the thyroid resection. This patient was revived by a single administration of two c.c.'s of Glyoxylide solution, which re-established the internal oxidation mechanism. Therefore, in my experience, the use of the Catalytic Agent in thyroid toxicosis should be divided into two groups: (1) Patients on which surgical operation has been performed, and (2) Patients on which the surgical approach has not been established.

In the first group, you will find serious complications that occur during the operation and complications that develop months after the surgical operation. This is when the patient still shows all the clinical manifestations of the thyroid toxicosis despite surgical skill. In these two particular cases, the Catalytic Agents have been proven to us to be wonderful in results. I speak in reference to a patient who had been condemned never to recover.

In regard to the second group, patients without surgical operation, afflicted with enlarged tumor of the thyroid gland, has proved in the last four years that it is no longer necessary to use symptomatic medications such as Phenobarbital, and Lugol's solution. Neither is it necessary any longer to use the surgical approach. Following the administration of one dose of the Catalytic Agent, in less than three months after the injection, the patients show improvement in the functional symptoms, nervousness and choking sensations. They increase in weight, relax, and the majority of circulatory symptoms fade away.

In my experience, the absorption and disappearance of the tumor is the last evidence of the disease to take place. Slowly and gradually during the reactionary cycles of the medication, temporary enlargement of the glands take place. This is due to the increased vascular circulation. However, in the months to follow, the excess of the tissue is gradually absorbed so that at the end of the eight or nine months of the single treatment, there is a total disappearance of the tumor formation. This recovery is permanent.

I would like to illustrate one of our observations with **Figures 29 and 30. Mrs. Bertha Smith** was afflicted with a tremendous tumor (18 in. circumference). During the last year, the tumor became so enlarged that she was unable to sleep in bed. Her neck receded to thirteen inches in circumference after two doses of the Catalytic Agent. Today, this represents practically the convalescent stage.

Figure 29. Mrs. Bertha Smith. A frontal view of the enlarged and inoperable goiter, taken on February 28, 1947, before Glyoxylide was administered.

Figure 30. A lateral view of Mrs. B. Smith taken the same day, February 28, 1947, before Glyoxylide was administered.

Conclusions:

1. Under the Catalytic Agent, it is no longer necessary to use the surgical approach as a treatment of thyroid enlargements. The tumor is totally and gradually absorbed. Patients recover well without the necessity of surgical amputation.

2. The Catalytic Agents have been useful in the treatment of thyroid toxicosis after surgery has been unsuccessful. The Catalytic Agent not only controls the toxic manifestations, but also re-establishes the damage produced or developed by the surgical operation. Among these manifestations of hypothyroid functions, after surgery is the Myxedema on which the administrations of thyroid extract has proved unsuccessful even when used in large quantities.

3. The Catalytic Agents have also a prophylactic value in thyroid toxicosis without tumor manifestations, far more superior to any other treatment. This is particularly true of young people during the adolescent period.

4. The administration of Glyoxylide re-establishes the physiological function of the thyroid gland in size and normal activity, and prevents the development of the tumor formation by elimination of causative producing organism siphospora polymorpha.

5. Over the secondary complications: menstrual disorders, heart disorders and intestinal complaints, this medication has also shown beneficial results.

I would finally like to stress the simplicity and non-toxic effect obtained with the carbon Catalytic Agents. The people taking these treatments are patients made free of repeated frequent doses, as well as on the safe side of permanent recovery and unnecessary surgical intervention. On the other hand, the recovery process under this medication is far superior to any other medical treatment. This is due to the re-establishment of normal physiological balance between endocrine systems pituitary, adrenals and ovaries not obtainable with the other treatments.

It has been a pleasure to be with you here today. Thank you for your invitation and your kind attention. I Sincerely hope that my comments and illustrations on the Catalytic Agent as an Antidote to Surgery have been enlightening and beneficial to you.

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