Chapter 22

SEQUELAE TO INFECTION
FAR ADVANCED ARTERIOSCLEROSIS

With Senile Dementia

CASE No. 55

Mr. P., age 93. He was treated in April 1933, with an injection of the serially arranged Carbonyl groups. He was a painter by trade and for some years was experiencing the effects of advancing arteriosclerosis. I had personally observed this change as I saw him at long intervals when I checked up on his wife, who was one of my first cured cancer patients. This woman had had a complete obstruction of the pylorus to involve the liver and other organs. She made her recovery on two injections of the Carbonyl Catalysts in 1918, and remained well thereafter. It was at a call to check her condition that she showed me her husband lying in bed on his right side with knees bent some and unable to move at all. All the muscles were spastic. He could not speak and had to be fed and cared for like a baby. The heart was dilated and palpation of the radial artery showed a high blood pressure.

He presented a marked arcus senilis and heavy tortuous nodulated pipe stem blood vessels. In the previous year he had had several “strokes” and passed into senile dementia. The whole condition was an extreme senile change. The skin elasticity was completely lost.

A dose of the Carbonyl SSR was given and in a month a definite improvement took place. In seven months, he was able to dress himself and walk about. He was rational and discussed political matters expertly. In a year, he was able to lay a small cement sidewalk in front of his home and do other work. At that time the blood vessels had lost 80% of their sclerosis and all nodulations and the extreme tortuosity. The skin had lost its cyanosis and had regained its elasticity. The blood pressure had fallen to a high normal range for his age, 180 over 110. He remained well for three years longer and then died suddenly.

In this case, the reversal of sclerosis depended upon the oxidation chains that converted toxin into its antitoxic type of structure and so the recovery was progressive to its limit even after it was well established. Upon the removal of years of accumulated, incompletely oxidized metabolites of tissue cell and/or germ origin, the sclerosis’s function, which was their absorption and inactivation, no longer had any utility and subsided as the toxic factors were burned to completion.

CORONARY THROMBOSIS IN EXTREMUS

CASE No. 56
Dr. H. B. Mueller

Mr. L. E. had been under the care of Dr. H. B. Mueller for only minor complaints for some two years before the present complaint developed, on January 16, 1944. After a short, easy walk on January 16, 1944, a numbness accompanied by pain occurred in the left arm from the elbow down to the wrist. Almost immediately afterwards, pain developed in the epigastrium and extended up into the throat. It was in the arm and precordial area. He never had suffered such severe pain before in his life and he was frightened. The pain passed within a few minutes and he went home. But in twenty minutes, the pain recurred with full severity and did not respond to nitroglycerin until two hypodermic injections of morphia were given (½ grain).

Family history: shows that his mother died of senility at 89, and his father was still in good health at 86 years of age.

The past history: showed three or four years of occasional attacks of "palpitation." They were transient after he remained quiet for a few minutes and so were soon forgotten. Bowel action was regular with no nocturia, except once during the past month. Sleeps well for more than 8 hours out of 24. Has a mild cough, slightly productive, smoked a package of cigarettes per day but recently reduced to three per day. Can do considerable work ordinarily without undue fatigue. No dyspnea. Weight remains regular at 157 pounds. Height: five feet, ten and a half inches. Age 47 years.

Physical examination: at the time of the attack, showed a man in complete collapse, snow white, heavy cold perspiration, almost pulseless, shallow gasping breathing — in a dying condition. He was given two micro-micrograms of the SSR system of Carbonyl groups on January 20, 1944. He responded dramatically within the next half hour, but was held at complete bed rest on a light vegetable diet and without any medication, whatsoever. He was kept in bed for eight weeks and after an additional month had passed, he was well enough to climb daily, without any discomfort, three flights of stairs up to his apartment. He was fully active and back to work within six months.

On April 15, 1944, his physical examination showed the heart apex to be in the 5th interspace one inch inside the M.C.L., the sounds were not well heard, no murmurs, pulse Mod. Vol., regular in force and rhythm, 85 per minute. Blood pressure 96/68, right, reclining after rest.

Electrocardiogram: on this date showed rhythm regular at rate 85, P and PR intervals are normal throughout, T_1 shows a late sharp dip. T_2 and T_3 are upright and normal. T_4 is deeply inverted. QRS complexes show low amplitude. QRS_1 — + ½—1; QRS_2— —3; QRS:$_3$— —5. There is absence of the R wave in lead IV.

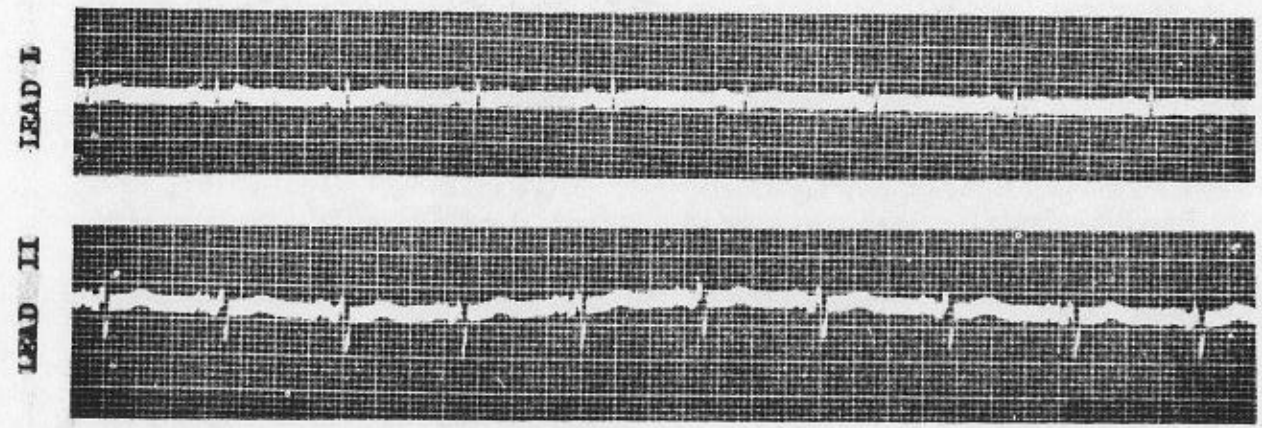
Conclusions: Low amplitude of QRS complexes, inversion of T_1, absence of R_4, suggest *healed infarction at apex of left ventricle.*

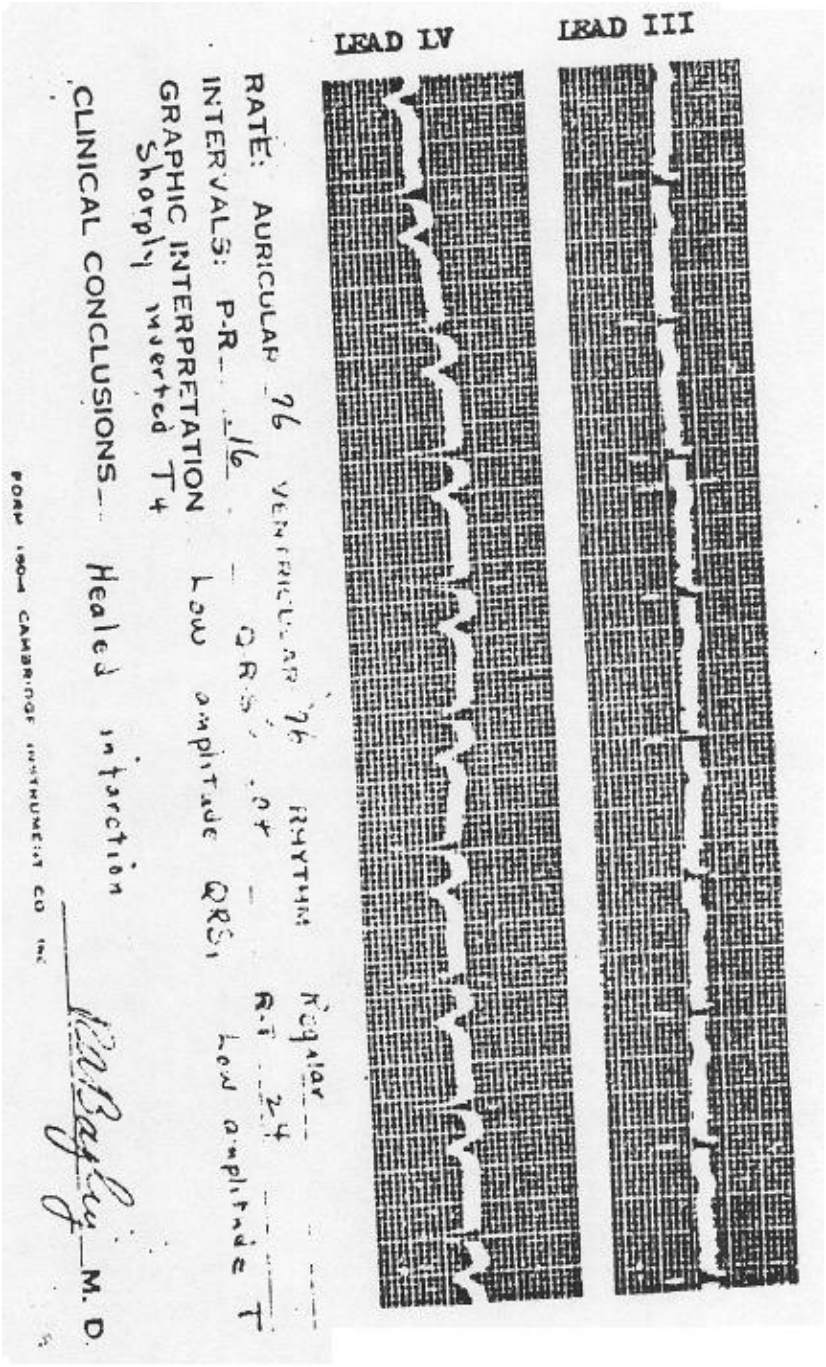
(signed) R. A.

ELECTROCARDIOGRAPHIC REPORT

No. 13447 DATE 3/27/46

PATIENT E[redacted] Mr Lambert AGE REFERRED BY Mueller





Electrocardiogram: taken two years later, March 27, 1946 by the same expert reads as follows and is submitted. Regular rhythm at rate 75, P, and PR intervals normal. Amplitude of QRS_1 — 1½. Low T_1, Inversion of T_4.

Clinical interpretation: Low amplitude of QRS complexes and inversion of T_4 indicate healed lesion — probably posterior infarction. There is improvement over previous tracing.

Remarks: On this date, patient appears well clinically. Blood pressure is 110/70. The pulse is regular at 76. The heart shows no enlargement, and there are no murmurs.

(signed) R. A. Bagley

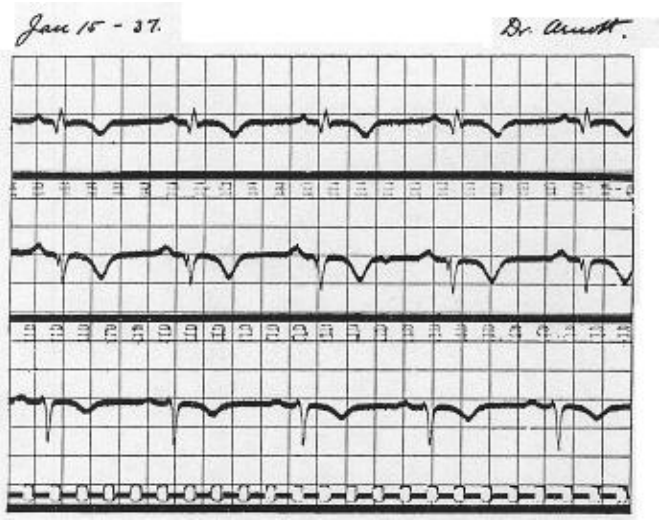
Dr. Mueller last saw this patient on June 27, 1951. The patient felt so good at the time that he thought medical observation was no longer needed. This was over seven years after Treatment. He continued in good health until the fall of 1955 when he had, what was reported as, a subsequent attack of coronary thrombosis and died. This was over eleven years after Treatment, which was a long period of good health.

We attribute this subsequent attack of coronary thrombosis to a return to the living conditions that were etiologic in producing the disease in the first place. It took over eleven years, during which no further Treatments were given, to restore sufficient pathology to again cause another coronary infraction. Had this patient remained under medical observation by his physician, followed the recommended dietary living and received subsequent Treatments, if and when advisable, we feel that he would be living today. Thus, this case also illustrates the importance to the patient of continuing under proper medical observation and healthful living.

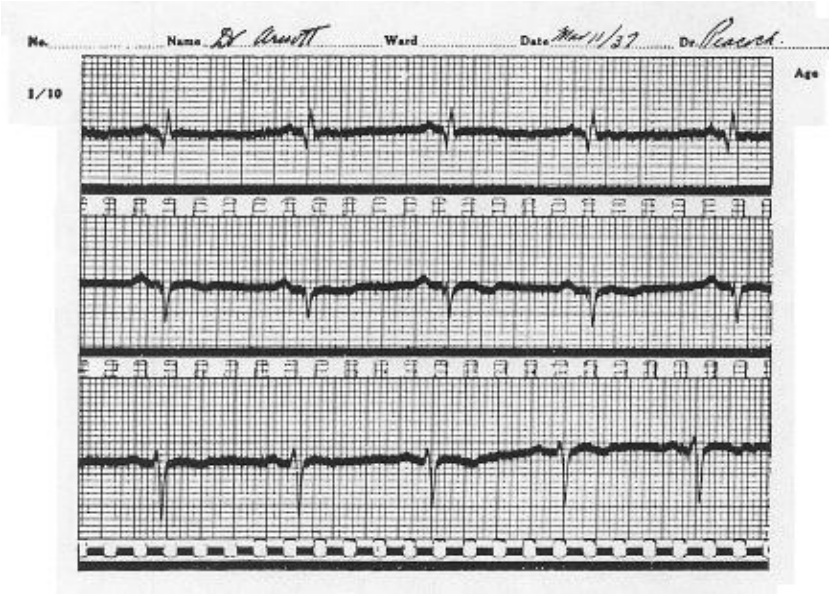
CORONARY OCCLUSION

CASE No. 57
Dr. David Arnott

Dr. A., age 64, brisk and active habits, was taken with a mild attack while walking on December 2nd, 1936. This passed within a few minutes, after resting. Two days later an extremely severe attack followed, while he was resting. Repeated heavy doses of morphia hypodermically influenced the pain only when sufficient to stupefy him profoundly. The slightest lengthening of the intervals between injections was followed by severe pain. On December 8th, 1936, the SSR was given subcutaneously in a dose of two cc. of the 12X dilution. Considerable relief was had in one hour. Eighty-four hours later, another dose was given after which the pain soon disappeared entirely and has not returned. The opiate was discontinued after the first injection of the Catalysts and none has been required since. A careful convalescence was followed with strict observation of the diet and of good bowel hygiene.



Electrocardiogram I, taken as soon as possible after Treatment,
shows profound pathology.



Electrocardiogram II, taken eight weeks after the first cardiogram, shows good recovery. This was taken three months after Treatment.

Effort was reduced to a minimum until the repair of the lesion was satisfactory for ordinary activity.

An electrocardiograph could not be taken during the first attack. Cardiogram I, reproduced here, was made five weeks later. It still shows a profound pathology. The tracing taken eight weeks later, Cardiogram II, shows a good return to normal. He remained active and well for nearly fifteen years and died at the age of 79, years from a prostate operation sequel.

BRIGHT'S DISEASE

CASE No. 58

Mr. C. L., lawyer, age 40, let his insurance payments lapse and to be readmitted was required to pass a physical examination. The urinary findings showed advanced chronic Bright's disease in harmony with symptoms of elevated blood pressure and severe migraine headaches, which lasted three days to a week at a time. He was given 2 cc's of SSR in March 1925, and made a steady recovery so that the headaches ceased after the sixth week. One year later the urinary findings were normal so he applied for readmission for life insurance. The company physicians examined him on surprise occasions and secured urine specimens by catheterization. After a year of such tests they concluded that he was cured, and accepted him on the usual basis of a healthy man of his age. He lived in good health, free from nephritis and migraines, for twenty-three years and died from an abdominal injury.