Dr. Jess Armine

and

THE LOST ART
Why Are We Still Ill?
Historically Speaking...

We have the best food
We have the safest water
The best science
The best healthcare

We have the technology,
we can fix him…
One Reason only:
We need to rediscover a lost art…. 

Notice I did NOT say “Lost Science” 

Famous Lost Artwork
Why? (I’m gonna get it for this!)

- There is no such thing as scientific certainty.
- When research is performed, the researchers seek to limit or eradicate as many variables as possible.
- As clinicians, we must take this information and apply it to a human being who has innumerable variables.
- See the conundrum? What is the resolution?
- Being comfortable in shades of gray and I assure you…there are more than…
I Matters Not

How many courses you’ve taken
How many degrees you have
How much you know

If YOU CAN’T PUT THE PIECES TOGETHER…

It’s all for Naught!

IT STARTS WITH A COMPLETE HISTORY
The Art of Taking a HISTORY

Listen to your patient, he is telling you the diagnosis”

Sir William Osler, Bt
(Founding Father of Johns Hopkins Medical Center)

REMEMBER, In Real Estate, It’s “Location, Location, Location.”

In Health Care it’s, “History, History, History!”
The Old Tyme G.P. Knew the Value of the History... What Happened????

In Short….Managed Care, National Health Care

The average provider is limited to 8 min per patient (including documentation time)

There’s no time to perform an adequate history.

This valuable source data is often “downgraded” to forms or the use of inadequately trained personnel

When full histories are not being performed, insensibly the concentration will be solely on the chief complaints. The result is treating from the “top down” instead of from the foundation upward.
Who Should Take the History?

ONLY the Health Care Provider (HCP)

Preferably, The HCP who will be caring for the patient

The training and experience of the HCP is required in order to ask the proper questions, travel the right roads and glean the relevant data from the history
Basic Principles

1. Take a Timeline (look backward and forward in time)
2. Look for a Baseline
3. Look for Temporal Relationships (deviations from the baseline)
4. Ascertain the reasons for the deviation (may be multiple/intermittent/varied)
5. Look for the downstream effects (the snowball effect)
6. NEVER, EVER SAY (or think) “THAT CAN’T HAPPEN”
Taking the History

Start With This

If you use forms or ask the patient to submit a narrative, let that be your “jumping off point”. There’s no substitute for asking the questions.
Suggested Order

Acknowledge the chief complaints first without dwelling on them...these are the questions for which the patient has consulted you.

Family History

1. Pregnancy
2. Birth
3. Infancy
4. Milestones
5. Immunizations
6. Early Childhood
7. Grade School
8. Menstrual Period
9. High School
10. Post Graduate
11. Relationships
12. Traumas
13. Courses of Treatment (what worked/what didn’t)
Chief Complaints

Initial brief review of the chief complaints accomplishes the following:

➢ Allows you to understand the patient’s chief concerns
➢ Assures the patient that you will address same.
➢ Builds the patient’s confidence in you (you are listening to them)
Family History

Immediate Family (Mom, Dad, Siblings, Maternal/Paternal Grandparents, Aunts, Uncles, “Kissing Cousins”)

Look for trends that:

- Correlate with the patient’s symptoms
- Correlate with polymorphisms in pathway planners
  - This can be instructive in present time or be predictive for their children.
  - Can tell you in what manner the patient’s snps may express

*Dr. Mikovits: “Familial History is the key to diagnosis”*
The patient is the usual informant.

Of course, depending on the situation, it may be the parents informing about their own children. Siblings or significant others may have valuable contribution in the history taking process.

Clearly, the patient cannot remember their own birth, infancy, developmental milestones, etc. In some questions, your patient may need to respond by remembering stories told to them by their parent(s), siblings, or other family members.

(Hint: If they have heard no stories or negative commentary from any informational source, I usually assume that the development proceeded normally)
Ask:

Was mother exposed to toxins, microbes, stress?

Did mom get immunizations during gestation (Rh incompatibility)

What was mom’s general health:

- diet, drink, drugs, etc.
- Mom’s exposures (industrial, toxic, heavy metal, where did mom live?)
- Was the pregnancy expected, accepted by mom and family? (extreme psychological stressors will affect the developing fetus)

Did mom use Tylenol?


http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3673819/

Remember, most women will not know if they are pregnant until well into the 1st trimester. This is the time of greatest rapid fetal development. Hence, it is good to explore this area because minor damage may engender a big problem.
Remember the **Cell Danger Response**:

- **Chemical/Physical**
  - Heavy Metals
  - BPA, Benzene
  - Heat, Salt
  - Shock, Radiation
  - Trauma

- **Microbial**
  - Mold, Fungi
  - Bacteria, Parasites

- **Psychological**
  - Yelling, abuse
  - Isolation, abandonment
  - PTSD

Naviaux, R.K., Metabolic features of the cell danger response, Mitochondrion (2013),
http://dx.doi.org/10.1016/j.mito.2013.08.006
CDR Causes Changes In:

- Redox
- Lipid Dynamics
- Creation of Proteins
- Bioenergetics
- Protein Folding and aggregation
- Cellular Electron Flow
- Cellular fluidity
- O2 Consumption
- Vitamin Availability
- Metal Homeostasis
Birth
Pre and Post 1965 (roughly)

Pre
Women were taken to the delivery room….men went to the smoking room

Post
More Family involvement and more family oversight
Clinical Pearls About Birth

Ignore APGAR score
(Appearance, Pulse, Grimace, Activity, Respiration)…..Everybody Lies

Look for:

- Indicators of fetal distress. Crash C-section? Use of vacuum extraction, forceps, etc.
- The length of labor. Use of pain meds?
- Was the baby rushed to NICU?
- Was the baby quiet, blue? Did baby swallow meconium?

Symptoms of cerebral hypoxia @ birth is usually associated with cerebral palsy. Often, the baby with show signs of excitation from the “get go” as opposed to excitation building overtime. There are many more birth injuries than are recognized.
Infancy
Ask: What Kind of Baby Were You?

**Good Baby**: Means that you Fed Well, Slept Well, Pooped Well. *A good start in life.*

Fussy Baby: Colic? Squirmy?
When did it start?
What ameliorated the symptoms?
What made the symptoms worse?

Did the baby dislike clothes? *(Hypersensitivity)*

Did baby have trouble sleeping *(slightest sound awakens baby?)*

Feeding? *(tongue tie? Food allergies? GERD?)*
Immunizations

1. Did the patient receive the usual immunizations of the time?

2. The usual schedule? Alternate schedule? None?

3. Immunization reactions? (Did mom give the baby Tylenol to prevent fever? - Effect on Glutathione and possible causation for autism)

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3673819/
Early Childhood

Ask the patient about their earliest memories of childhood

➢ Social?
➢ Friends?
➢ Active (a study in perpetual motion)
➢ Shy? Painfully Shy?
Grade School

Ask: “Looking back using your present knowledge, would you say that you had”:

❖ ADD/ADHD
❖ OCD
❖ Difficulty in focusing
❖ Clumsy? (lack of primary neurologic organization)
❖ Were you bullied?
Adolescence
Middle School/High School
An Important Time

Which Begs the Question:
Why Do Teenagers Act Like…Well… TEENAGERS?!!
The Pre Frontal Cortex

From: The Brainwall © Dr. Jess P. Armine 2015
Ask:

1. What changes occurred upon menarche? Cramps, Mood Changes (PMS, PMDD-Sometimes the family is a better historical informant here).
2. Were there changes in habits like isolation, moodiness, drug use, ETOH use, changes in friends
3. Was there worsening in prior ADD, OCD, etc. ?
4. Hyper religiosity, joining cults (prey on adolescents…why?),

Consider

1. Expression of genetic predisposition. CYP1B1 (estrogen dominance), COMT, MAO, GAD, ALDH/NAT (aldehyde pathway-think yeast and increased acetylaldehyde)
2. Trauma or longer term effect of root causes (Lyme, toxins, PTSD) exacerbated by the hormonal changes and stressors of adolescence.

Sometimes the stress of adolescence is the “straw that breaks the camel’s back” and allows what was underneath to finally express.
As the patient is relating their story, listen for indicators of physical, emotional or sexual trauma. Things like:

❖ Repeated UTI's or vaginal infections in small children
❖ A significant deviation from the baseline (an energetic child suddenly becoming shy)
❖ Nightmares, insomnia, sudden onset OCD, behavioral changes at any age (maybe explained away as age appropriate).

At some point, if not addressed, you may want to gently ask about trauma.

Caution!!!: If you learn about sexual trauma, please do not open the door (unless you are very well trained in this arena). Your questioning may, inadvertently, make the patient relive the trauma.**

** Assess the patient’s support systems. Have they received counseling? Do they have an available counselor?
College/Post Graduate

Similar to High School, this is an important era in someone’s life.

Consider:

Education: What was their major? How did they handle the transition from high school to college?

Social: Were they a “party person”?, Overuse of ETOH, drugs, stimulants?

Listen for signs of trauma again (many left safe, familiar environments and were thrust into unfamiliar surroundings)
Adulthood

Ask about their professions (Stressors, toxins, mold, etc.)

If/when they married, the attitude of the spouse (supportive/unsupportive)

When did they have children. Note any difficulties in pregnancy, the birth process, raising children.

Important:

Listen for the timing of any changes that occurred in the patient's health. As an adult, looking back, they can usually give you a timeframe when things started to deteriorate and/or events that worsened their condition. It is our responsibility as the healthcare providers to help them explore these events. This is where you will shine!
Remember...All The While

You are developing a **therapeutic trust** with the patient. The trust you build will allow you to make a more accurate assessment of the patient as well as assure compliance with your treatment plan.

*In doing so, you will avoid the following pitfalls:*
Review The Studies

Only after you have taken a history should you review, with the patient, the laboratory studies and go over their genetic profile.

In this manner, you'll be able to put the genetic polymorphisms into the proper relief and utilize the laboratory studies as they were originally intended. That is, to rule in or out the etiology (cause) or assess the downstream effect of the root cause(s). Always, always remember the limitations of the testing. *Clinical presentation is primary.*

Remember the golden rule

Treat the patient not the test.
Circle Back

The Chief Complaints:
➢ What treatments were offered.
➢ What did not help
➢ What did help**

** Learn to “Follow Crumbs”

If a treatment helps…even if it doesn’t make clear sense…ask “why did that help”? If you did your due diligence…it will be apparent
Example From Actual Patient

60 y/o female c/c: I have been sick all my life!

Presents with ME/CFS, POTS, Fibromyalgia, Stage III Kidney Disease, MCS, Sjogren’s, Tinntitus

Family History

Mom: Graves, Psoriasis
Dad: Ulcer
Aunts/Uncles: unknown

MGM: + CVA
PGM: + CVA

MGF: + Stomach Ca
PGF: unknown

ONLY CHILD

Pregnancy: Forceps Delivery
Baby: No issues
Milestones: On Time
Immunizations: usual for the time (1955)
Age 5-6: Started stomach upset (stated that a lot of tension in the home)
Age 7-8: Fell and developed ingunal hernia, vaginal infections**, upper lip infection.
Age 8: High Fever (passed out), hernia surgery, flu like symptoms, tired, achy. Started chemical sensitivities.
Age 11: Sun Sensitivity, Hypoglycemia, POTS, headaches, rash in response to ASA
High School: allergic to everything, CFS, MCS (missing lots of school). Describes herself as a “loner, survivor”
College: symptoms remained. Studied Psychology
Age 35: paint exposure and was sick for 5 weeks and worsening of CFS for 2.5 years. Also, home was sprayed for roaches….immediate explosive diarrhea.

** Vaginal infections, UTI's, in young girls, always consider sexual abuse
Diagnoses

IBS
ME/CFS
Fibromyalgia
POTS
Concussions
Binge eating disorder
Complex PTSD
PDD-NOS / Asperger’s

Sensory Disorders
Chronic sinusitis
Urticaria
Kidney Disease
Angioedema

Treatments:

Multiple Medications (antibiotics, psychotropics)
Salt (POTS)
Counseling
Everything really started at 7-8 years old

Birth

5-6 y/o family stressors

Microbial
- Mold, Fungi
- Bacteria, Parasites

Chemical/Physical
- Heavy Metals
- BPA, Benzene
- Heat, Salt
- Shock, Radiation
- Trauma

Psychological
- Yelling, abuse
- Isolation, abandonment
- PTSD

Infection, fevers, surgery, CFS, MCS, photosensitivity, POTS, hypoglycemia

Dysautonomia

Chronic, progressive inflammation

What should I do now?
What Happened at 7-8 years old?
Revisited time frame with patient

Interesting story:
Patient said that she and 2 other girls her age (7-8 y/o) used to crawl under a fence into a farm because there was an apple tree

**BUT**
She added that they started caring for *feral cats*.

**More:**
Pt told me that she kept in touch with the other girls over the years and, interestingly, they were both chronically ill from that time frame forward!! (Different expressions. One has MS…the other cancer.)
Case # 2:

A Tale of a Mom and 2 Kids

Mom: 35 y/o female

C/c Mood Swings, CFS, Throat Pain, Joint pain, cognitive decline, dizzy, headaches, difficulty emptying bladder, low libido, cravings (sugars), insatiable appetite

As a child, no significant issues with the exception of warts around her cuticles that were resolved by Tagamet.

Acne as a teenager and adult, took Accutane.

After college developed exhaustion, insomnia, some cognitive problems.

Cognitive issues worsened after having children.

Developed enlarged lymph nodes, stomach problems, throat pain, hormonal issues, sugar cravings.

Progressive worsening of her symptoms globally over time.
Mom

**Table of Parameters**

<table>
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<th>Parameter</th>
<th>Low</th>
<th>Normal</th>
<th>Elevated</th>
<th>High</th>
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<tr>
<td>Epinephrine</td>
<td>Red</td>
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</table>

**Figure 1. Circadian Cortisol Profile**

![Circadian Cortisol Profile](image)

**Results for this specimen:**

For results according to the CDC Criteria, please refer to the attached MDL Test Result form.

**Result Interpretation:**

- **IgM Result**
  - CDC Criteria (Antibody, CDC*)
    - Negative (Non-reactive): No bands or less than two bands from: 23,31,34,39,41 kD
    - Equivocal: N/A
    - Positive (Reactive): Two or more bands from: 23,31,34,39,41 kD
  - Alternate Criteria (Antibody, Alt*)
    - One band from: 23,31,34,39,41 kD
    - Two or more bands from: 23,31,34,39,41 kD

* Bands presented must have an intensity greater or equal to 60% of the cut-off control band.
Daughter, now 7 y/o

- Full term
- APGAR 9-10
- Gained weight quickly
- Quickly, rashes on face and bottom
- ? Blood in stool (peds said she was too young for that)
- Baby was breast fed but reacted to mom’s food choices.
- Mom tried the 6 food elimination diet and baby did well.
- Breastfed until 15 months but symptoms returned when foods introduced unless made by mom (all organic)
- 2.5 years old started strep infections, high temp fevers
- Extensive antibiotic use
- Developed OSA from large tonsils
- Pre school teachers stated that the child “zones-out”
- 2013 developed anemia, body aches, low iron, JAUNDICE
- Takes iron daily but still struggles with fatigue
- Recently became itchy, tics, excitation
- Good long term memory. Bad short term memory

Doctors are unconcerned

!!!!
Son, Now 3 y/o

Healthy Normal Pregnancy, APGAR 9-10
Within the first few days of coming home from the hospital:
Rash on face.
Rash on bottom (groin and buttock).
Tremors and severe sweating while feeding
Needed to pry his legs open to change diapers.
Severe nasal congestion.
Episode of cyanosis (diagnosed as GERD)
Episode of black tarry stools…found to be severely anemic (endoscopy and colonoscopy negative) diagnosed at T Cell mediated allergies.
Hit all milestones on time.
Coordination and balance problems
Vitamin/mineral malabsorption
Drinks a lot of water
Bruises easily, keratosis pilaris all over his body
Reacted to all immunizations
Wakes several times a night and is unable to settle himself. Very light sleeper.
Bouts of very high fevers
Anxious, nervous
Now his back, neck and arms ache
Too Weird for Me…Circled Back and Re-Interviewed Mom

Immune dysfunction (clearly)
Learned that the father is estranged
Learned that father was taking Suboxone (Buprenorphine/Naloxone 8mg/2mg)
Mom was concerned that the medication may have caused illness in the kids…further questioning revealed that **dad was a heroin addict.**

Top 2 considerations:
1. Perinatal Lyme, Yeast
2. Any of the assorted illnesses that can be contracted by the use of IV needles, including HIV, and passed to mom and baby.
Want to be the Master Diagnostician?
Want to successfully treat the previously untreatable?
Learn to add intuitive insight to the diagnostic process. If you do,
Then this will be said of you....
Also, Embrace the Following Concepts

I have no data yet. It is a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts.

(Arthur Conan Doyle)

And...

“When you have eliminated the impossible, whatever remains, however improbable, must be the truth.”

- Sherlock Holmes
Rediscover: THE LOST ART!!