

Biophysical allergy therapy, Retrospective study from a medical practice

Description

P. Schumacher Summary ft Moyses

Introduction

Between September 1989 and October 1990, Dr. P. Schumacher of Innsbruck carried out a study of around 200 allergy patients which will be summarised here.

In his book *Biophysikalische Therapie der Allergien* [Biophysical allergy therapy], in which this study is described in detail alongside numerous other useful tips on treating allergy, he writes: Our own experience now covers well over 1000 such individual patients, all of whom have seen their allergy completely eliminated, no matter what form it took.

Added to these are the many patients treated by other colleagues. These colleagues — doctors and non-medical practitioners — learnt the method in our seminars and have been using it successfully in their practices, in some cases for several years now.

It is difficult to obtain a quantitative overview, yet the extensive feedback we receive shows that the method is also used elsewhere with considerable success. We felt it necessary, at least at the start of this development, to present some statistics independent of our personal experience.”

B. Schneider² demonstrates that therapeutic action can also be verified through retrospective studies from medical practice when he suggests “assessing effectiveness by systematically observing success and failure in practise’ as an alternative to conventional double blind studies. Schumacher published just such a study back in 1991, understandably causing a great sensation.

Patient selection

All patients, mostly children and adolescents, undergoing BICOM allergy therapy within a 6-month period were recorded on a list, regardless of age, diagnosis, severity of the disease and type of allergen. To be included in the study the diagnosis of allergy had to be confirmed by one or more allergy tests and there had to be an identifiable and confirmed link between the allergy and allergic reaction. So the study group was not specifically selected but consisted of the spontaneous patient body within a certain period of time.

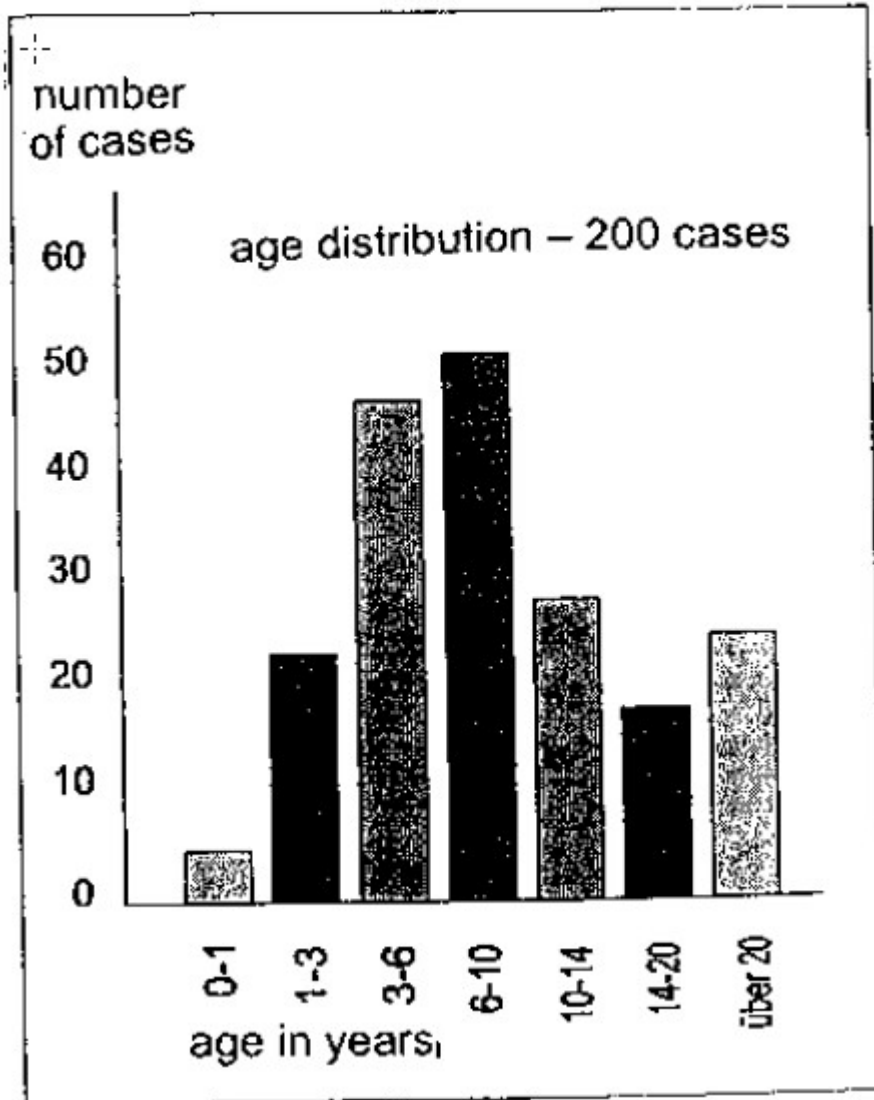
A total of 164 patients with 204 cases of treatment were recorded. Results were gathered using a questionnaire. Questionnaires were sent out 5 months after treatment was completed. Patients with several allergies received a separate questionnaire for each allergen treated so that each series of treatments could be assessed separately.

The investigation lasted 6 months so that the interval between treatment and feedback was 5 months minimum and, at most, 11 months. 200 of the 204 questionnaires sent out were returned, giving a 98%

response rate.

Patients were asked about tolerance, side-effects of treatment, relapses and overall assessment of the success of treatment. Since the study mainly involved children and adolescents, most of the questionnaires were completed by parents.

The tables indicate age distribution and frequency with which allergies were detected. As expected, wheat and cows' milk were the most common food allergies with goose down in the case of inhalation allergens. Hay fever was excluded from the program due to its special peculiarities.

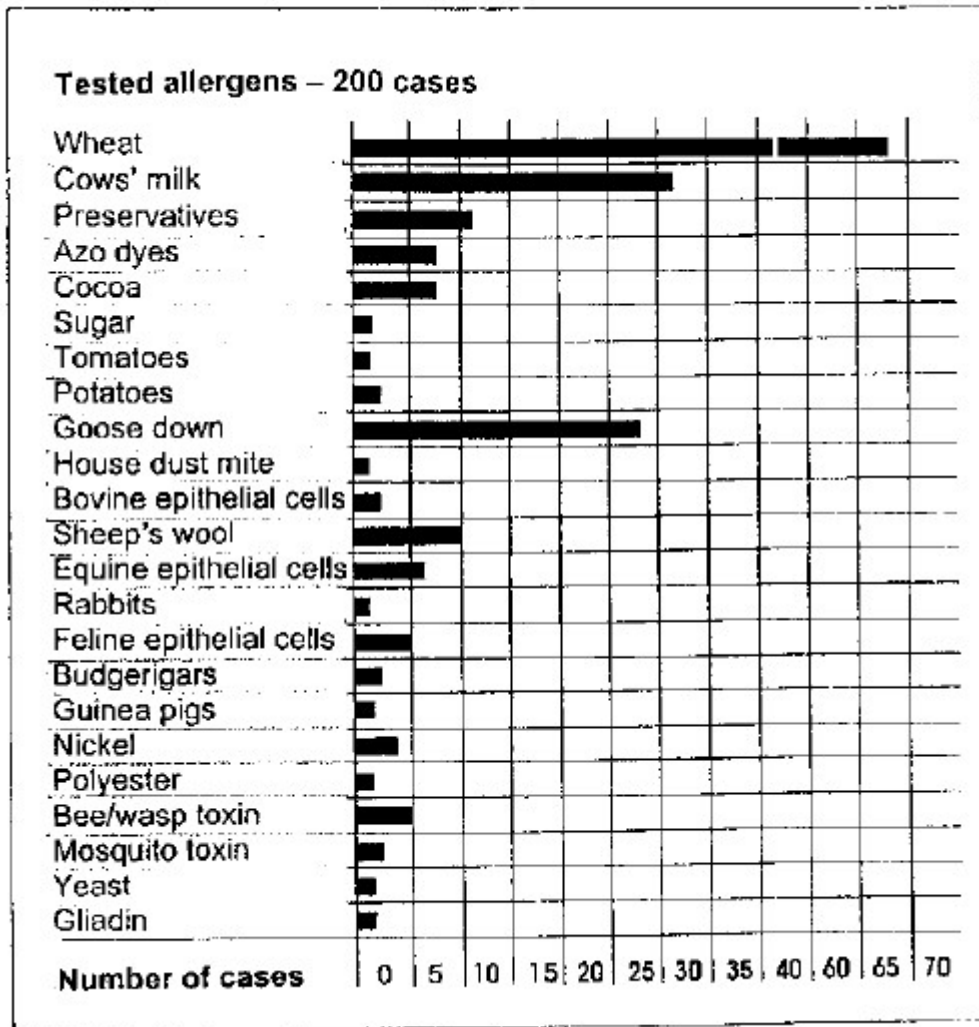


Treatment

took the same form for all patients, namely just one BICOM therapy with the inverse oscillations of the allergen diagnosed and 8-fold amplification. Complete allergen abstinence was a pre-condition of starting treatment.

Abstinence could be stopped once treatment was completed. After treatment, the patient no longer had

to avoid contact with the allergen but was instructed to report any further allergic reaction immediately.



Evaluation of therapeutic results

The patients or their families carried out their own evaluation. They could choose from the following criteria:

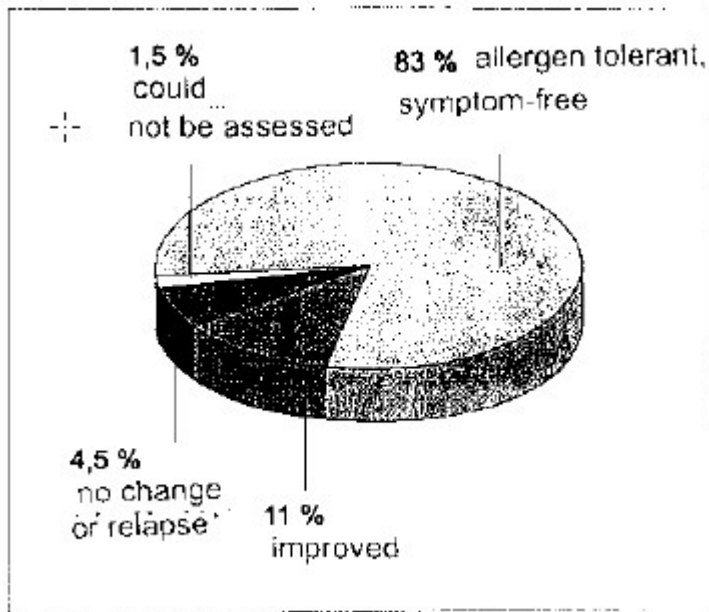
1. The allergy has disappeared, i.e. since completing treatment the patient has tolerated the allergen without suffering a reaction. The allergic reactions observed previously have not reappeared despite contact with the allergen.
2. The allergy has improved, i.e. symptoms of the allergy are still discernible but gradually much less marked.
3. The allergy continues unchanged. There is no discernible sign of success.
4. There has been a relapse, i.e. although the symptoms initially disappeared, the allergy to the same allergen has recurred.
5. It is not possible to assess the therapeutic result at the moment.

Results

83.0% of cases were treated successfully, i.e. the reactions observed previously no longer occurred despite contact with the allergen. The patient was able to tolerate the allergen permanently and unrestrictedly without a reaction.

11.0% of cases had improved. The symptoms of the allergy were still discernible but gradually much less marked.

4.5% of cases were therapeutic failures. There was no discernible sign of success or the same allergy recurred despite initial improvement.



Discussion

With younger patients who display a better reactive state and who do not have additional severe stresses, preparatory, supporting or additional therapeutic measures are not necessary. A different therapeutic approach is often required for adults with multiple stresses.

The group assessed as “improved” comprised a total of 22 cases. Closer examination revealed that the symptoms still present had been misinterpreted and were only indirectly associated with the actual allergy process. For example, 8 cases in this group were patients with neurodermatitis who still displayed residual mycoses in the cutaneous areas affected, yet the allergy-induced neurodermatitis which had been the original cause was healed.

The follow-up check on the remaining 14 patients in this group revealed that either non-specific symptoms had been confused with allergy-induced symptoms, such as non-specific coughing due to infection in asthma patients or non-specific abdominal pain following completely cured allergic colitis, or that symptoms were still present from allergies which had not been identified.

A follow-up check of the group of therapeutic failures with no change in symptoms or with relapses revealed that, in 7 cases, abstinence had lapsed during the treatment phase, i.e. the patient was not

kept strictly and consistently apart from the allergen. In 2 cases in this group there was evidence of a continuous lapse.

Two years' experience with meridian-based allergy therapy Retrospective study from a medical practice

J.Hennecke

1. Introduction

Originally, an allergy could only be treated effectively by deactivating the allergy process through abstaining from the allergen for an indeterminate period of time. For purely technical reasons, about six treatment sessions were then also required. Therapeutic failures arose if the patient could not observe the abstinence period strictly enough or allergy abstinence was not possible at all.

The idea of treating the allergy via disturbed acupuncture meridians originates from kinesiology. I transferred this idea to BICOM therapy. This approach does not use physically generated inverse oscillations, instead energy blocks are released by stimulating certain acupuncture points.

Stimulation was carried out with the BICOM device with the pathological information being picked up from an immunocompetent region of the body (cervical spine area) and directed to the appropriate points after being modulated through a H+Di circuit (program 530). Allergen abstinence was not necessary with this type of treatment and one therapy session was generally sufficient.

With considerable creativity a number of therapy versions were developed, all operating, however, according to the same basic principle: "energetic hyposensitisation" by removing energy blocks while in contact with allergens. However, experience soon showed that "energetic" therapy is easily disrupted by other energetic blocks, such as geopathy, scar interference fields, emotional blocks leading to a recurrence of the allergy treated previously.

For this reason, a therapeutic approach was developed whereby, using a series of connected BICOM programs, the patient would be placed energetically in a position to start allergy therapy and achieve effective and lasting release from allergy.

A pilot study was carried out on patients in my practice to objectivise therapeutic results and uncover and improve on the approach's weaknesses.

2. Method

The study comprised patients (mainly adults) who had been treated with meridian-based allergy therapy in my practice between June 1991 and June 1993 and whose course of treatment had been completed.

Allergy test

The allergens were determined with a kinesiological muscle test (generally Deltoideus medialis). Only allergens detected by this method were treated, regardless of any previous skin or RAST test.

Substances from Dr. Schumacher's test sets were tested, together with substances brought by the patients and some of my own ingredients (e.g. vaccines). With small children the test was conducted through a surrogate. Following therapy, the patient was also tested kinesiologically on all allergy contact zones (abdomen, costal arch, thymus, temples).

Allergy treatment

Meridian-based allergy therapy was only carried out according to the original recommendation and was generally delegated to staff.

Device input: flexible applicator cervical spine area.

Device output: two button applicators to stimulate the start and end point of the bladder, kidney, stomach and spleen-pancreas meridian, each for about one minute.

Allergen: on contact zone beneath the navel (conception vessel 6), if repeating treatment, also thymus or temples.

The other versions of allergy therapy were not routinely conducted so as not to make it harder to evaluate the therapeutic results.

As many pre-tested allergens as possible were treated, regardless of whether central allergens (milk, wheat), symptom-triggering allergens (house dust, pollen) or allergic stress (vaccination, pesticides, heavy metals).

Additional programs

The treated allergies reappeared after a while if a geopathic stress or a scar interference field was ignored. These obstacles to treatment were always tested out kinesiologically and treated before each session of allergy therapy. The patient was also naturally informed about the need to cleanse the area where they sleep of harmful effects. The geopathy balancing and elimination of scar interference programs were used for this.

All patients were tested kinesiologically whether they accepted treatment from a psychological viewpoint, i.e. whether they wanted to be healthy. Where "psychological reversal" of this kind was present with the result that the patient was not prepared to seek to be healthy, a special program (991) was conducted to prepare for allergy therapy with rescue drops in the input cup and the patient connected only to the device output.

To stabilise general metabolism, a non-specific metabolic program brief therapy for nutrient points was also conducted before each allergy treatment session to compensate for impaired processing in the vitamin and mineral balance.

Additional treatment

Intestinal mycoses: most allergy sufferers exhibit intestinal colonisation with Candida fungi and the consequential damaging effects on the immune system associated with the intestinal wall.

In addition to an antifungal diet, a three- to four-week course of nystatin (after prior therapy for lactose

allergy) was prescribed and the intestinal flora were subsequently built up (symbioflor, mutaflor or omniflora).

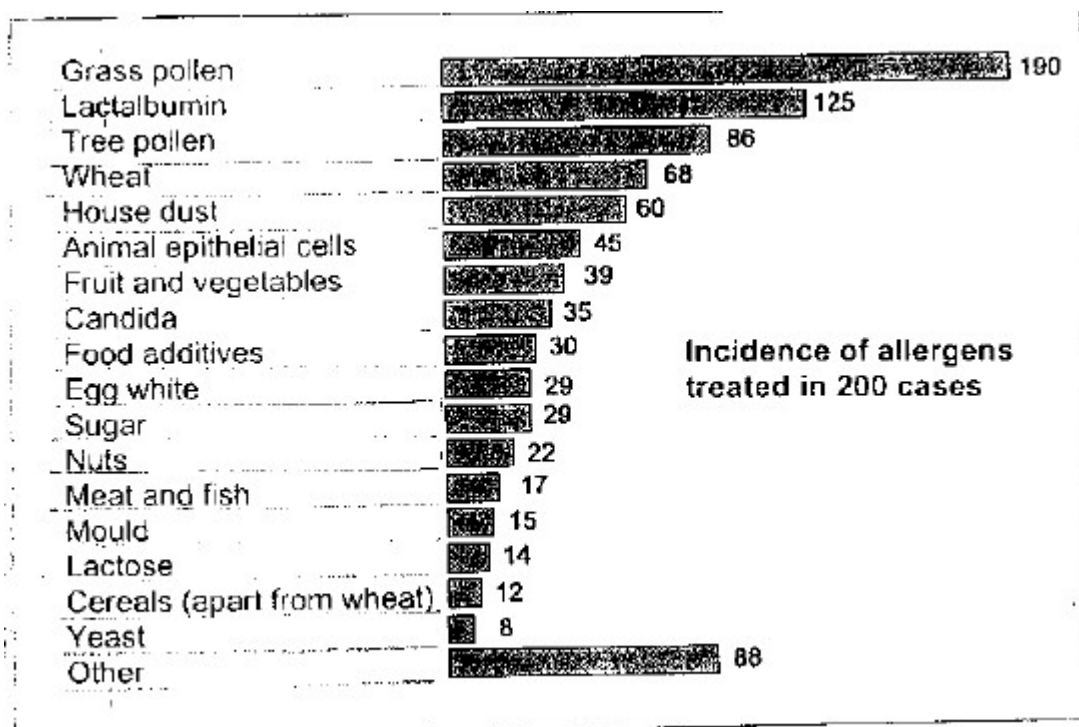
Amalgam stress: all patients were alerted to a possible link between toxic stress from mercury and the occurrence of allergies through damage to the immune system. For financial reasons, only a few patients were able to decide on amalgam cleansing. If amalgam cleansing was carried out, this was followed by BICOM elimination therapy and a prolonged course of selenium, zinc, vitamin C and homeopathic remedies.

3. Evaluation of the study

Patients experienced some difficulty in assessing the success of their therapy and completing the questionnaire. In the case of symptom-triggering allergens, the patient can check the therapeutic result immediately. With masked allergies and allergic stress factors where therapy does not involve abstinence, the connection between allergen and symptoms is not obvious to a patient. Consequently he cannot judge whether he is insensitive to a single allergen; he can only judge whether, following completed treatment, he is symptom-free, his condition is improved or unchanged. The situation can only be clarified by our own testing and checking.

A questionnaire was used which was sent to each patient either immediately after completing a course of treatment or in May 1993. The first 200 questionnaires completed and submitted were analysed. Fig. '1 shows the frequency distribution of the allergens treated.

4. Experience of treating various allergens



Tab. 1: Allergen frequency

detailed information on the peculiarities of treating allergies induced by house dust, animal epithelial cells, foodstuffs, contact, medication, etc’.

5. Results

Since treating the individual syndromes achieved different results, it was important and interesting to record these separately (table 2). The overall result can be seen in figure 1.

Allergically conditioned skin diseases — This group contains neurodermatitis, endogenous eczema and other forms of chronic eczema, between which even dermatologists experience difficulty distinguishing. Yet this does not matter for the diagnosis and treatment of the underlying masked central allergy. We always encounter one or more central allergies such as milk, wheat or Candida, an indeterminate number of superficial foodstuff allergens and often also symptom-aggravating contact allergens such as tap water, house dust, pollen, clothing, cleaning products and ointments.

The longer the disease has been in existence and the older the patient, the more complex the therapy as the number of allergens usually increases, frequently changes and also non allergy-induced components are more common. Added to which, stresses from amalgam, toxins, viruses and superinfection of the cutaneous areas by bacteria and fungi complicate the picture. Unfortunately the results from treating adults with neurodermatitis are not as good as those for most children.

	total	no change		improved		symptom-free	
Allergic skin diseases	68	8	12%	21	30%	39	58%
Pruritis	20	3	15%	10	50%	7	35%
Allergic conjunctivitis	16	1	6.5%	5	31%	10	62.5%
Allergic intestinal disorders	13	2	15.5%	1	7.5%	10	77%
Allergic respiratory tract diseases	46	6	13%	21	45.5%	19	41.5%
Pollen allergy	69	16	23%	21	31%	32	47%
Total			15.5%		34.1%		50.4%

Tab. 2: Results broken down according to individual syndromes

If treatment is carried out without abstinence, it is almost impossible for the patient to evaluate the immediate success as there is no unmasking or deterioration in their condition on contact with the allergen. Ultimately they can only judge whether their cutaneous manifestations heal completely without being able to attribute this to the treatment of a specific allergen. This fact obviously makes it harder to evaluate the completed questionnaires. It is only in classic contact eczema that the connection with the triggering allergen is evident.

Similar mechanisms to those described above underlie the various types of allergically induced exanthema and we have therefore included them here. Treatment is usually less problematical and

easier to evaluate, if the triggering allergens are known or were found.

Of the 200 cases investigated, 68 patients had cutaneous symptoms. Of these, 39 were symptom-free (58%), 21 improved (30%) and 8 showed no change (12%) following therapy (table 2).

Pruritis

Masked allergies play a major part in itching with no visible rash, but other disorders such as diabetes, liver and kidney disorders and psychological factors also cause this condition. An allergen which is found and treated is often just one aspect of the problem. Of 20 patients with pruritic, 7 were symptom-free (35%), 10 improved (50%) and 3 showed no change (15%) (table 2).

Allergic conjunctivitis (all year)

Allergically induced conjunctivitis may occur in isolation or linked with other allergic symptoms. It quite frequently accompanies palpebral eczema (often wheat allergy) and allergic sinusitis. Of 16 patients with allergic conjunctivitis (none of whom were allergic to pollen), 10 were symptom-free (62.5%), 5 improved (31%) and 1 showed no change (6.5%) (table 2).

Allergic intestinal disorders

This group includes chronic diarrhoea, chronic constipation, non-specific colitis, irritable bowel syndrome, Roemheld's syndrome, umbilical colitis and so-called "functional abdominal pain." The intestine is almost always colonised by Candida and must be treated in addition to allergy therapy. Allergies to milk, lactose, wheat, yeast and Candida play a major part. Foodstuff allergies are always present in Colitis ulcerosa and Crohn's disease. Allergy therapy alone is not sufficient to treat the problem, however. Of 13 patients, 10 were symptom-free (77%), 1 improved (7.5%) and 2 showed no change (15.5%).

Allergic respiratory tract diseases (all year)

This group includes bronchial asthma, chronic obstructive bronchitis, recurrent spastic bronchitis, chronic cough as well as chronic sinusitis. Here too, milk and wheat represent the most common central allergens. Frequently encountered symptom-inducing inhalation allergens are house dust, mould, down, feathers, animal hair as well as dust and solutions to which the individual is exposed at work. Foods (apples, nuts) also trigger shortness of breath. The patient can generally easily judge whether they no longer react to these allergens or whether the reaction has diminished, although masking occurs here too. Factors unrelated to allergy (physical and emotional stress, fungal infection) play a large part with this group of patients. Of 46 patients, 19 were symptom-free following therapy (41.5%), 21 improved (45.5%) and 6 showed no change.

Pollen allergy

In our practice, pollen allergy sufferers represented the largest and unfortunately the most difficult patient group. We waited at least one pollen season before analysing the results. Following therapy, 32 of the 68 patients were symptom-free (47%), 21 improved (31%) and 16 showed no change (23%). There are a number of important reasons for this not wholly satisfactory result which are important for BICOM users and which are dealt with in a separate report”.

Other indications

As well as the classic allergic disorders, a range of syndromes exist in which allergens also play a part, contrary to educated opinion. These include migraine, rheumatic disorders, psoriasis and colitis. Allergy treatment can only represent a corner-stone of the total therapy however. Yet cases arose where allergy therapy alone cured the condition. Migraine which had been present for a year disappeared completely with one treatment session for lactalbumin allergy. In other cases, a food allergy was the cause of impaired vision, arthritis, back pain, cardiac dysrhythmia, finger stiffness, tenderness, dizziness and depression.

6. Side-effects

Of 200 patients, 6 reported extreme tiredness and physical exhaustion following therapy. 4 reported an immediate improvement in their overall condition. 6 patients experienced a deterioration in their allergy symptoms in the form of an initial exacerbation. Rashes intensified in 4 patients and 2 patients experienced increased coughing. All adverse side-effects disappeared within a few days.

7. Summary and discussion

The overall therapeutic result of our pilot study on 200 allergy sufferers is as follows:

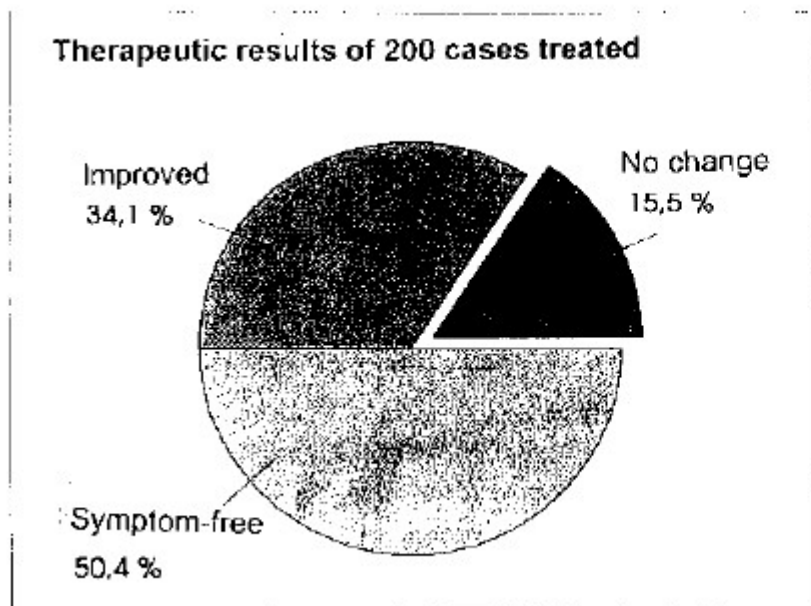


Fig. 1:
Symptom-free 50.4%
Improved 34.1%
No improvement 15.5%

Considering these were mainly patients who had been treated extensively with conventional medicine and were still suffering from the side-effects of this, these results are impressive. However, it is these very problem patients who we, as BICOM therapists, want to endeavour to treat in a more satisfactory

fashion.

Unsatisfactory therapeutic results and therapeutic failures may be caused by the following:

1. Hypersensitivity to the allergen has not completely disappeared
In certain circumstances, treatment must be carried out twice or three times in the case of very strong allergens. If this is still unsuccessful, a different version of therapy should be tried. Therapy blocks should also be looked for.
2. Hypersensitivity to the allergen disappears at first, but then recurs
Here too therapy blocks are generally present (geopathy, scar interference fields, emotional blocks).
3. Hypersensitivity to the allergen disappears, persistent or recurring symptoms are caused by another allergen The only solution here is to search thoroughly for new allergens and test and check them.
4. Hypersensitivity to the allergen is eliminated and the symptoms are largely caused by other factors It is primarily a case here of toxin stress, mould infestation and intestinal dysbiosis. Our main task in the next few years will be to focus on this area.

Treatment of people with few allergies and small children generally produces better results than with adults suffering from multiple allergies. The more the therapy can be tailored to the individual, the better the results. Smaller practices with intensive patient care have the advantage here, Busy practices can only cope with the large and ever increasing number of allergy patients using methods which can be applied routinely and delegated.

Many good approaches can definitely be improved further. All 8/COM therapists are also amateur researchers and, only by all users actively exchanging their experiences, will we find ways in future to satisfy all our allergy patients.

Category

1. Scientific Studies

Tags

1. Allergy patients
2. Biophysical allergy therapy

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