

FIBROMYALGIA: THE ANATOMY OF A PHANTOM ILLNESS

ImmuneSupport.com

03-20-2002

Research Breakthrough Shows Fibromyalgia and Other Chronic Conditions are Actually Caused by New Group of
"Neurotoxin-Mediated" Diseases

By Ritchie Shoemaker, M.D.

Editor's Note: Ritchie Shoemaker, M.D., named the Maryland Family Practice Physician of the Year 2000, is the author of a published book on chronic, neurotoxin-mediated illness, "Desperation Medicine." To read more about Dr. Shoemaker and his work, please visit <http://www.chronicneurotoxins.com>.

WHAT CAUSES THE MYSTERIOUS AND DIFFICULT-TO-DIAGNOSE ILLNESS KNOWN AS "FIBROMYALGIA?"

This is among the most perplexing questions in all of modern medicine: What can be done to help patients cope with its debilitating symptoms – including severe fatigue, muscle aches with trigger-point pain, insomnia, diarrhea, bladder irritation and headache, among other miseries?

According to the editors at the New Yorker magazine, the fibromyalgia epidemic has now reached epic proportions. Today, nearly six million Americans (most are Caucasian women) suffer daily from this maddening malady, which leaves many barely able to function – even though their symptoms often seem vague and difficult to pin down.

BUT ARE THESE PEOPLE REALLY SICK?

Yes, says Dr. Jerome Groopman, writing in the November 13 issue of the magazine, fibromyalgia is a very real and very threatening medical condition – although the illness is caused not by germs or organ dysfunction or aging, but by the "stress" inflicted on middle-class white women as a result of living in the modern world!

Describing the fibromyalgia epidemic that has swept across the U.S. in recent years, Dr. Groopman suggests that the disease is psychosomatic – and that the chronic symptoms it produces are actually triggered by emotional hang-ups among "neurasthenic" women of middle age. As Dr. Groopman points out near the end of his interesting essay on the epidemiology of fibromyalgia:

"The vocabulary of medicine is woefully inadequate when it comes to describing the complex interactions between mind and body. Although we are gradually accepting their inter-connectedness (it is all right to say, for example, 'I am under a lot of stress at work, and my lower back is killing me'), no terms exist to describe how physical experience, is imprinted on the molecules of the brain. No terms explain how emotion and perception – thoughts and fears and uncertainties, formed by electrical charges at neuronal synapses and by hormones on cellular receptors – transform themselves into what we feel as physical pain. So we fall back on language that is incomplete, encompassing only fragments of a biology beyond our comprehension."

Sorry, New Yorker editors, but on this issue you failed to see the bigger picture – and to understand how so-called "fibromyalgia" actually fits into a much larger disease scenario in which an entire new family of environmental illnesses has been attacking millions of mostly undiagnosed Americans in recent years.

Although Dr. Groopman does a good job of describing both the spread of the fibromyalgia epidemic and its key symptoms, he soon runs afoul of the same problem that has stymied investigators of this disease for several decades: the lack of an accurate "biomarker."

Locating such a diagnostic tool would allow physicians to diagnose the illness with pinpoint accuracy, and also to precisely measure the effects of therapy from day to day.

Although many physicians don't know it yet, a small but growing number of enlightened U.S. physicians has been using a biomarker of this kind – in the form of a physiologic test, called "Visual Contrast Sensitivity," or "CS"– for the past several years. And this tool, occasionally described in the neuro-

toxicology literature during the past few decades, now promises to change the way that modern medicine understands (and treats) at least a dozen new environmental illnesses – ailments that continue to puzzle most American physicians, who haven't been educated about them up to now.

Unfortunately, Dr. Groopman appears to be a member of this *unenlightened* group. His well written but ultimately unsatisfying essay fails to grasp the larger implications of its own central proposition – the notion that some new kind of disease mechanism has crept upon the modern scene, sickening millions of patients and leaving befuddled physicians feeling thoroughly helpless to identify or combat it. In fact, there is now substantial research to show that **this new constellation of diseases is chronic and neurotoxin-linked – and that fibromyalgia represents only one of its symptoms.**

The disturbing reality is that in recent years, fibromyalgia has become a medical phantom – one of those handy “catch-all” diagnoses (including “irritable bowel disease,” “chronic fatigue syndrome,” some types of “depression” and several other vaguely defined ailments) that physicians turn to when they don't actually understand what's happening to their patients.

Without a biomarker to guide them, most disease researchers have not yet recognized that the symptoms most frequently associated with fibromyalgia are often caused by a new kind of disease process – and that the frightening illnesses which result from it are the direct result of massive, chemical-based changes in the human habitat during recent years.

Best defined as causing “chronic, neurotoxin-mediated illness,” these little understood diseases make people sick by producing low molecular-weight toxins (aka, “ionophores”) that “hide out” in the body's fat-containing tissues, where they remain impervious to the germ-fighting “antibodies” which endlessly patrol the human bloodstream.

Linked closely to the kinds of ecological changes powerfully described 60 years ago in Rachel Carson's classic book, “Silent Spring,” the alarming new illnesses include such toxin-mediated disorders as Chronic Lyme Disease, Sick Building Syndrome, Chronic Fatigue [Syndrome], Chronic Soft Tissue Injury and several waterborne maladies involving toxin-forming blue-green algae and one-celled dinoflagellates, including toxin-forming ciguatera and Pfiesteria.

Although you haven't yet heard much about chronic, neurotoxin-mediated illness from the mainstream U.S. health news media, the disturbing fact remains that millions of Americans are now struggling with chronic and debilitating symptoms from disease agents spawned by our rapidly deteriorating environment. They're sick for one basic and easy-to-understand reason: the human immune system is not equipped to fight off these new “pollution diseases” – because they do their damage outside the bloodstream, where blood-borne disease fighters cannot attack them. And yet a recent medical breakthrough (so far unknown to most of science) has now provided physicians with a bedside physiologic test, CS, that can be used as a reliable biomarker for diagnosing and then treating these threatening toxin generating illnesses.

Even better, an effective new treatment puts the offending neurotoxins exactly where they belong: at the bottom of the toilet.

While treating more than 1,000 “chronic” patients in my family practice during the past few years in Maryland, I have been able to bring them good news again and again – the news of a discovery proving that these “environmentally acquired” diseases can be accurately diagnosed, then treated with a simple new medical protocol that begins healing most patients within 36 hours.

The bottom line: I never wind up having to tell my patients what so many American physicians have been saying in recent years: “Sorry . . . but you're just going to have to live with your fibromyalgia.”

Instead, I'm usually eager to explain to them: “If you have the CS biomarker present, my treatment protocols have been proven to work in published studies.”

After more than five years of intense scientific research, I've developed a safe, accurate method for detecting the presence of neurotoxin-based illnesses in patients, along with some powerfully effective treatment protocols based on a harmless, inexpensive and FDA-approved substance (cholestyramine) that has the potential to end the daily suffering of millions of "chronic" patients.

For those struggling with new, toxin-based illnesses such as Sick Building Syndrome, Chronic Lyme disease, Chronic Fatigue Syndrome, Ciguatera and Pfiesteria-Related Human Illness Syndrome, this discovery offers a priceless opportunity to end the misery of chronic illness virtually overnight.

Of course, the discovery of this new family of toxin-based pathogens also sheds light on the raging controversy over "fibromyalgia," which actually turns out to be just one small symptom of the much larger disease-syndrome that is chronic, neurotoxin-mediated illness. Make no mistake: these ailments are very real and very disabling. And that's because they are the result not of "complex interactions between mind and body" (as Dr. Groopman and some other members of the American Medical Establishment would have us believe), but of complex interactions between neurotoxins and body!

Take note: If a physician says you have fibromyalgia, you need to understand that his or her words represent only the beginning of the diagnostic process, rather than a final diagnosis. In order to understand just how these new "environmental diseases" poison human beings and leave them suffering for years at a time, let's step back for a moment and take a brief look at how toxin forming pathogens interact with the human environment.

PATHOGENIC TOXINS: THE "GUNFIRE" OF DISEASE?

Some of the most complex and interesting human diseases are the result of the work of organisms that produce poisonous substances (toxins), which operate in one way or another to disrupt or even destroy cell functioning. As any zoologist or botanist will quickly tell you, the biological process in which living creatures produce and then deploy toxic weapons against both predators and prey is nearly as old as life itself. Poisonous snakes serve as a good example; they manufacture toxins – aka "venom" – to help subdue their prey, or as a weapon to fend off potential attackers.

Almost as frightening, at least for humans, are the toxins manufactured by various types of "streptococcus" bacteria. These powerful germs can destroy host DNA, muscle and red blood cells at will.

Along with their thoroughly nasty cousins – the "flesh-eating" staphylococcus bacteria that trigger "Toxic Shock Syndrome," "Scalded Skin Syndrome" and other dangerous diseases – this group of pathogens has likely been a tormentor of our species since those distant epochs when we first began to walk upright.

But the toxin-producing germs are hardly alone in their quest to take over human cells by first poisoning them. Another huge group of organisms that use poisons as a kind of "cellular gunfire" are the fungi. These curious organisms have in recent years enjoyed a pretty good reputation among Homo sapiens, since many of the toxins they produce as weapons against bacteria are today used as human antibiotics. (Many other toxins are known contaminants of food, soil, water and buildings. Some mycotoxins have been employed as biological weapons, e.g. Seran gas.)

What is life-saving penicillin? Seen from the perspective of the fungi, it's nothing more than a means of seeking a "selective advantage" in the struggle for survival by poisoning competing bacteria. (Toxins are frequently antibiotics, as in this example, and many fungi "export" their toxins to kill competing organisms.)

But you can be sure that the bacteria, themselves, are not standing idly by, while their competitors develop increasing ability to manufacture and employ lethal toxins. Take the scourge of cholera, for example. What causes the rapid, diarrhea-induced rapid dehydration that kills so many victims of this dreaded disease each year? The answer is toxins: poisons that are produced by the cholera bacteria after it successfully colonizes its human host.

Botulinum, gas gangrene and tetanus are other ugly examples of ways in which bacteria have learned to synthesize cell-threatening toxins, in order to stay on an equal footing with their evolutionary competitors.

SHORT-TERM VS. LONG-TERM TOXINS

The toxin-mediated illnesses described above include some of the most threatening pathogens known to the human species. Yet there is one merciful component in all of these ailments, and its name is "duration." Almost without exception, the bacterial, viral and parasitic organisms that cause these chronic illnesses cease toxin-production when they, themselves, die. And if the patient survives the attack, most pathogen-hatched toxins will soon be flushed out of the body, allowing the patient to regain his health. Survive the diarrhea and enervating dehydration caused by cholera, for example, and your exhausted system will gradually cleanse itself of the toxins left behind by the now-vanquished pathogen.

In most humans, this "flushing out" of the "leftover poison" takes certain predictable forms. For starters, the toxins are excreted in urine or stool. But they can also be neutralized and transformed by the metabolic machinery of the liver enzymes. Or the body's immune system can attack and destroy them, molecule by molecule, as the healing and cleansing process unfolds. It's a highly efficient system, if you think about it. Kill the invading germs, and the bug's leftover toxins become a mere nuisance – garbage left on the street until the sanitation crew comes along to sweep it away and hose down the affected area.

But ask yourself: What would happen if the body were unable to clean out those toxins, and thus restore the cells to their normal, healthy chemistry?

What would happen if a group of disease-producers went through genetic changes because of a pollution-altered environment and then manufactured chemically altered toxins that the body couldn't eliminate? According to the latest scientific research, many of today's toxin-formers have never been observed in such numbers before.

These new toxin-producers include the following:

- dinoflagellates, such as Pfiesteria, ciguatera and chattonella;
- fungi, including stachybotrys and fusarium;
- bacteria, such as pseudomonas fluorescens;
- spirochetes, including Lyme disease- causing borrelia;
- algae, such as rapidly reproducing microcystis and cylindrospermopsis.

These toxin-spawning pathogens are now causing chronic illness in an ever-growing population of sick patients. Armed with a large arsenal of disease-triggering poisons, the "toxin diseases" are all around us. Today they can be found in estuaries, oceans, rivers, closed-circulation buildings, chemically treated farmlands – and in millions of American backyards, where insecticide-sprays often trigger the growth of mutant fungi or bacteria.

Even more ominous, from an ecological standpoint, is the invasion of suburban shrubbery by Lyme-bearing ticks, as the soaring deer population brings this scourge to America's back door. These days, with tract developments and shopping malls booming everywhere, no backyard can be considered safe.

Another disturbing example of rapid biological change fueled by chemicals can be found in the freshwater lakes of Florida, where a toxin-producing blue-green algae, cylindrospermopsis, first took up residence in 1995.

Astonishingly, these toxic microorganisms -- newly resistant to standard algaecides – now account for 95 percent of the total algal biomass in the Ocklawaha Watershed (the source of the St. John's River, which joins the Atlantic at Jacksonville).

In other words, a life-form that would normally represent no more than one percent of 4,000 botanical species in that habitat now accounts for 95 percent of the biomass! Where else in biology have we seen such overwhelming dominance of a micro-organic habitat develop in such a short period of time?

The bottom line here is simply that the ever-increasing use of chemicals in our contemporary lifestyle – along with changes in our physical landscape – has helped to create new "habitats" for toxin linked microorganisms. And it's not just chemicals that create new environments for these pathogens.

In many ways, our high-tech, increasingly mobile culture, itself, is to blame. Example: As millions of city dwellers and suburbanites move into rural areas and occupy former farmlands, they alter habitats by providing food and cover. They also help to eliminate predators for a growing deer population – and in this way enhance the habitat for ticks that transmit Babesia, Ehrlichia and Lyme disease.

Make no mistake: The common link among all of these brand-new, environmentally altered organisms is that they manufacture compounds (called "neurotoxins," because they injure nerves) which ultimately attack many tissues – including those found in muscles, the eye, the brain and the sensitive linings of major organs such as the lungs and the gastrointestinal tract.

The key point to remember is that these molecules are so small, they can move from cell to cell without having to rely on blood vessels for transportation. So what happens when these released toxins end up circulating through the fat-containing tissues of a human being?

The answer, of course, is chronic illness – which turns out to be the source of many different kinds of symptoms, a few of which have been lumped together by physicians in recent years and then mislabeled as "fibromyalgia."

In this nightmarish scenario, the body cannot excrete or metabolize or immunologically rid itself of the disabling toxins, which gradually pile up after repeated environmental exposure, or as a consequence of the unchecked growth of a toxin-forming organism (such as a Lyme spirochete) within the host. The problem is that they travel endlessly along a circuit that links fatty tissue reservoirs – including nerves, brain, muscle, tissues lining joints, eyelids, sinuses, lung and bile. Shielded in this way, the offending toxins can move about freely, without having to face attacks by antigen-primed white blood cells.

These subtle, often misdiagnosed new illnesses represent nothing less than an "evolutionary leap" in human pathology. For the first time in medical history, we cannot diagnose a group of diseases by using a standard blood test or culture. Those once invaluable diagnostic tools can tell us nothing about the new threat – since the "stealth toxin" employed by the invaders does its damage without being alive.

All too often, patients with these neurotoxin illnesses wind up being diagnosed with Dr. Groopman's fibromyalgia – after which they're routinely handed a prescription for a psychoactive medication such as Prozac or Xanax. (Many also emerge from the doc's office with a knee-jerk referral for counseling, or psychotherapy.) But these patients don't need help for depression, since the culprit that prevents them from enjoying life is actually "brain-fog" caused by neurotoxins.

The grim reality is that most are struggling with a toxin-based illness – and effective treatment requires a method for flushing poisons out of their fatty tissues, if they want to start feeling better. To accomplish that, my new treatment protocol consists primarily of a toxin-binding medication – but a toxin binder that will not itself be absorbed, or produce its own disease-exacerbating side effects.

**MARGIE PUSEY-CARELLI AND CHRONIC LYME DISEASE:
STRUGGLING TO PENETRATE THE "FIBROMYALGIA SMOKE SCREEN"**

Ask 59-year-old Margie Pusey-Carelli to describe the nightmare that is chronic Lyme disease, and this normally cheerful and upbeat Maryland grandmother of three won't hesitate. "I'll never forget the day I couldn't find my car!" moans the talented painter and furniture designer, who often displays her wares at craft fairs throughout the mid-Atlantic region. "I came out of a Lowe's hardware store one Saturday afternoon about a year ago, and I started looking for my Chevy Lumina van. "Let me tell you – that was a big van, and it was painted bright green! And there were only about 25 cars on the parking lot! Well, I spent at least 40 minutes walking around that lot, and after a while I became terrified. I was in a fog, and I just couldn't think. I'd been sick for more than five years, with all these symptoms nobody could figure out. Some of the doctors told me I had fibromyalgia, and some just said it was depression. I had

muscle aches and headaches and cramps. I was so tired all the time, I could hardly crawl out of bed in the morning. And the medications I took didn't seem to help at all. But that was the worst – that awful afternoon when I couldn't find my own car! Right then, I decided to get serious about my health – and to start looking for a new approach that would actually bring me some help.”

As soon as Margie Pusey-Carelli walked into my office in October of 2000, I could tell that she was very sick. Dizzy and profoundly fatigued, she barely had the strength to make it from her car to my waiting room. After she'd caught her breath, I asked her to describe the symptoms that had been tormenting her – many of them for nearly ten years.

Her list included:

--headache	--vertigo
--muscle aches	--impaired memory
--aching joints	--bladder irritation and urgency
--shortness of breath	--depression
--sensitivity to bright lights	--reduced sleep
--profound fatigue	

By the time Margie mentioned Symptom No. 5 – “sensitivity to bright light” – I was already attuned to the likelihood that she had contracted a chronic, neurotoxin-mediated illness. While treating more than 1,000 victims of this ailment, I'd long ago become familiar with the endlessly repeated list of complaints from patients whose bodies were struggling helplessly against a tidal wave of toxins.

Still, there's no doubt that “sensitivity to bright light” often provides the key clue to the neurotoxin puzzle. As a matter of fact, I've been treating so many of these patients in recent years that as soon as I hear the litany of neurotoxin-symptoms begin, I quickly ask: “Do you drive your car at night?” When they respond by saying, “No, Dr. Shoemaker, I don't even try to drive my car after dark!” I can be fairly certain that they're getting neurotoxic effects along the optic nerve. And when I quiz them about this symptom, their faces usually light up – because my questions tell them that I actually understand their illness!

Could I prove that Margie had a neurotoxin-based disease? As always in these cases, I quickly gave her the standard Contrast Sensitivity Test. Her scores confirmed what I'd suspected – the fact that the neurons which registered contrast in her optic nerve by distinguishing among black, gray and white had been seriously compromised, almost certainly by toxins from some organic predator. (The Contrast Sensitivity Test functionally creates a binary output system, by assessing the nerve-function of contrast in part of the optic nerve. The assessment provides an accurate model for the overall effect of neurotoxins on the patient's system.)

Because her symptoms – when taken together – strongly suggested chronic Lyme disease, I decided to test for that first, even as I ruled out confounding medical diagnoses. Bingo. Within a few days, her special blood-work (the tests that normally aren't run) had returned from the lab and her situation was suddenly crystal-clear. Although Margie couldn't remember being bitten by a tick or coming down with the telltale “bull's eye rash” (despite having visited areas where others had been bitten), the results from her physiologic tests and serologic tests were indisputable. They showed that she'd been carrying the Lyme bacteria (and its devastatingly destructive neurotoxins) for at least five years, and probably longer.

Having confirmed the diagnosis, I treated Margie with three weeks of oral antibiotics. (Although it's true that Lyme disease involves both an infection and an intoxication, the organism must be killed as the first step in any successful treatment.) I warned Margie that she would probably have to struggle through a physiological “withdrawal syndrome” (known medically as the “Herxheimer Reaction”) for a few days, while the antibiotics destroyed the spirochete.

A courageous fighter, she didn't hesitate. During the next few days, she endured the considerable discomfort that usually accompanies the “Herx.” Yet we were both pleased to witness the unmistakable signs of this reaction (with the accompanying temporary fall in her CS scores), because they showed clearly that we were indeed attacking the actual source of her ailment.

After three weeks of antibiotics, however, Margie's symptoms still raged unchecked. Nor had her CS scores improved. Why not? It's simple: although the Lyme "bug" was now dead, its endlessly circulating toxins had been left behind to continue attacking Margie's system.

So far, so good. At this point, I turned to the second phase of treatment, which includes the Lyme Protocol I'd first presented to a Regional Meeting of the American Society for Microbiology (April 10, 2000). While following the protocol, most patients experience a second and much more severe reaction than the Herx, which I call the "Intensification Reaction." This second round of muscle aches and headaches and intense fatigue *usually accompanies* treatment with cholestyramine, as the Lyme neurotoxin is mobilized, bound and finally eliminated. But its effects can be (and should be) blunted by pre-treatment with pioglitazone, thus allowing patients to endure the first few weeks of cholestyramine therapy without fear.

The good news about cholestyramine is that it acts quickly, and Margie was greatly encouraged to see many of her symptoms beginning to recede – some of them only 48 hours after going on the CSM regimen. As usually happens with chronic Lyme patients, she also discovered that her improving CS scores provided a compass that would guide and encourage her throughout the remainder of her therapy. Today, less than two months after starting the Shoemaker Protocols, Margie reports that "I've got my memory back, and I'm not dizzy any more! The vertigo has lifted, and I'm full of energy. I don't need that pill for frequent urination anymore, either! I spent last night painting some cedar chests for a crafts fair, and I can't wait to bake Christmas cookies with my grandkids next Saturday.

"I feel like my life has been handed back to me. Sure, I still get occasional headaches and muscle cramps, but nothing like before. As I continue the CSM therapy, I get better every day. I don't dare to think this – but when the last toxin molecule is gone, however long it takes, I desperately want to be able to say: I'm going to be cured!"

"Back a few years ago – when the doctors were all telling me that I had fibromyalgia or irritable bowel syndrome or whatever – I nearly gave up hope. Thank heavens I learned about the CS test and the CSM therapy in time. I feel like I've been given a brand-new lease on life!"

THE PATIENTS CRY OUT FOR HELP . . . BUT NO ONE CAN HEAR THEM!

For ten million desperate Americans today, toxin-mediated illness is as real as the agonizing headaches, aching muscles, fatigue, cough, light-sensitivity, night blindness, shortness of breath, chronic pain, non-specific abdominal pain and impaired cognition that constitute its major symptoms. Instead of obtaining relief from these agonies, however, millions of chronic patients are being told that they're suffering from fibromyalgia – and that the source of the ailment is "all in their heads!"

Such inaccurate diagnoses rendered by otherwise competent doctors are understandable. After all, if physicians can't administer a clinical test to scientifically validate the presence of low-molecular-weight neurotoxins, how can they hope to convince skeptical observers that the poisons are really at work in the bodies of their victims? Is it any wonder that – in the absence of an authentic biomarker – doctors all across America continue to misidentify neurotoxin-linked illness as fibromyalgia or depression?

But it's also true that being able to "name" the patient's disease accomplishes a crucial task for most physicians. Once the name-tag has been applied, patients can be sent on their way, usually with a hollow-sounding bit of reassurance as they walk out the door: "Sorry, Mrs. Smith – but you're simply going to have to learn how to live with your fibromyalgia!"

Imagine the daily life of a patient suffering from a chronic, toxin-mediated illness. The fatigue and the aches and pains are very real – and yet no one can even prove that the disorder exists, because up until now, medicine hasn't managed to come up with a reliable and accurate diagnostic tool for positively identifying these new diseases.

Day after day, the victim struggles to find the strength to get out of bed in the morning, and why not? With so many organs not working properly because of retained toxins, is it any wonder that the patient often can't find the strength to make a cup of coffee? (But they really aren't sick, are they? They're merely tired and mildly depressed, as they grapple with the combination of fibromyalgia-related "brainfog" and "muscle fatigue" symptoms that physicians such as Dr. Groopman consider "merely psychosomatic.")

It's a brutal scenario. And there's more: because the victims of toxin-mediated illness – unlike those suffering with such old-fashioned complaints as asthma or diabetes, soon discover that their painful symptoms also change from day to day.

Depending on which organ isn't working right because of the fat-circulation of soluble toxins, the symptoms can shift without warning, and within a few hours. Fatigue, weakness, muscle ache, headache, difficulty with memory or concentration or both, red eyes, blurred vision, hypersensitivity to light, nasal congestion, sinus congestion, cough, abdominal pain that defies anatomic diagnosis, metallic taste, wheeze and shortness of breath that acts like asthma – that's only a partial list of the afflictions caused by toxin pileup in the human body.

Now add nausea, abdominal cramps, secretory diarrhea and joint pain that acts like rheumatoid arthritis to the mix, and you can see why some of my toxin-afflicted patients stay home from work for months at a time. Yet they rarely succeed in obtaining disability compensation for these ailments, because no test confirms the diagnosis.

Oh, they'll be given a diagnosis, all right: "Irritable bowel syndrome." Or maybe it will be "stress," or "sinus problems," or "memory loss due to age" – anything in order to process them through the medical care system. But the most egregious of these wrong-headed diagnoses, by far, is that old standby: "fibromyalgia."

Instead of actually treating the patient for a disease that "doesn't exist" (such as chronic Lyme disease), why not invent an entirely new one (such as fibromyalgia) that will be acceptable to our medically misguided society? Question: Why do the influential physicians and health researchers who dominate the U.S. Medical Establishment keep getting it wrong?

A big part of the problem, of course, is that missing biomarker. Most practicing doctors in this country have yet to learn that the simple, five-minute test of "visual contrast sensitivity" (CS) provides crystal-clear (and reproducible!) data that can pinpoint the physiologic effect of symptom-causing toxins on the optic nerves of patients. (Nor have they yet caught on to the startling discovery – thoroughly documented in my new book, *Desperation Medicine* – that a common, FDA-approved substance, cholestyramine, can be relied upon to start clearing these toxins from the body within 48 hours.)

BUT LACK OF KNOWLEDGE ABOUT TESTING AND THERAPY IS ONLY PART OF THE STORY

Because it's also true that many physicians in this country are still handicapped by an arrogant, patronizing attitude in which they blame the patient for symptoms that do not provide a quick, easy diagnosis. (Take a close look at Dr. Groopman's *New Yorker* essay, for example, and you'll see that he describes those "middle-class Caucasian women" who suffer from fibromyalgia as conflicted, unhappy souls – many are struggling with divorce or other family troubles – whose emotional misery has triggered their illness!)

Is there any doubt that this strategy, sometimes described as "blame the patient," actually provides cover for the doctor's failure to make an accurate diagnosis? Question: Why didn't Dr. Groopman take a full neurotoxic history of his patients, before launching his speculations about a possible links between their emotional deficits and their physical health?

The answer seems obvious: if a caregiver's investigation into an illness looks at everything but the cause of the problem, you can feel sure that nothing "out of line" will be diagnosed!

The embarrassing truth here is that physicians who diagnose such vague ailments as fibromyalgia rarely bother to assemble a neurotoxin history. Why not? For one thing, the specialists – the cardiologists and the pulmonologists and the orthopedists, among others, are all focused first and foremost on their own specialties. So we usually wind up hearing a lot about “mitral valve prolapse” in fibromyalgia, and “hyperventilation,” and even “costochondritis,” respectively.

The primary care docs often fall into the same trap, as well. Confronting patients with three or four complaints, they frequently come up with “psychiatric” diagnoses – after interviews that typically last less than five minutes.

In the end, if we can name the disorder (even without a convincing test to prove our case), most patients will accept the diagnosis. And the truth is that only rarely do physicians actually want to spend time with “whiny, wimpy, complaining” patients. (No sooner have I fixed Mrs. Jones’ Reflux than she’s begun complaining about her constipation!) You’ve heard the derogatory terms some doctors use for these helpless patients, haven’t you? Kookaburras? Crocks? Gomers? And you’ve surely heard the medical jargon a consensus of physicians routinely uses in dismissing patients who seem to carry around a litany of endless symptoms, overblown verbiage that includes such outrageous exercises in non-meaning as “neurasthenia” (lack of energy for normal living!) and “dysthymia” (inability to enjoy a normal life!).

It all sounds just a bit ludicrous, doesn’t it? But you can be sure there’s a medical strategy hidden behind such useless euphemisms. In this case, that strategy is designed to get the *doctor-without-a-credible-diagnosis* off the hook. The solution: Invent some medical criteria for the term “fibromyalgia” and suddenly the patient has a disease that the doctor can’t be expected to fix, because it’s “incurable!”

**SO HOW CAN A PATIENT WHO DOESN’T WANT TO BE TOLD THAT HER ILLNESS IS
“ALL IN HER HEAD” FIND A WAY TO MAKE THE DOCTOR LISTEN TO HER?**

Here’s an approach guaranteed to rattle the cages at the “All-In-Your-Head” School of Medicine: The next time a struggling “fibromyalgia” patient sees her physician, she might try asking him about the possibility of doing a “neurotoxic history.” If the practitioner doesn’t know what she’s talking about – or says there’s “no time for that kind of complicated interview” – the patient should go ahead and gently push him, as follows:

“Doctor, how long does it take to ask me about chest pain? Ten questions, perhaps? We all agree that a good history is important. If you were treating a heart patient, I think we’d all agree in a court of law that you’d be negligent if you didn’t ask the standard ‘chest pain list’ of questions, even if that meant asking twenty questions.

“Doctor, I know you try to define my illness carefully, before you send me for an EKG or a lung scan or a \$2,000 Persantine-Thallium Stress Test. So, doctor, what makes it so hard to ask me about a problem that’s almost as common, lasts forever, and saps the vitality of my life, even if it doesn’t kill me?

**SO LET’S ATTEMPT A NEW KIND OF DRILL, SHALL WE?
I’LL BE THE PROFESSOR-PATIENT, AND YOU BE THE LEARNER-DOCTOR, OKAY?**

“I will tell you that I’ve been ‘tired’ for eight months, and you are the third doctor I’ve seen in the last six weeks. Here are copies of the CBC, sed rate, metabolic profile, thyroid test and Lyme ELISA. And they all are normal. I can also tell you that if you start asking the right questions – unlike those last two doctors – you will quickly begin to see that my symptoms point towards a treatable chronic, neurotoxin based illness.

“And finally, let me emphasize one last point: My problem is not depression. All set, then? Great. Here we go!”

1. Doctor: Are your eyes sensitive to bright light?

Patient: Yes. Excellent start. Especially at night, doctor. Headlights really get me!

2. Doctor: Do your muscles ache?

Patient: Oh, yes, and especially the day after I do normal physical activity-things. Good question! The other doctors all said I had fibromyalgia. (But remember: fibromyalgia is usually just a symptom of a much larger neurotoxin-mediated problem – it isn't a final diagnosis!)

3. Doctor: Do you have irritable bowel disease, or abdominal pain?

Patient: Oh, yes. One other doctor wanted a barium enema . . . and another asked for a gall bladder sonogram – even though my gall bladder had already been removed.

4. Doctor: How about diarrhea that wakes you up at night?

Patient: No . . .but what a great question! It shows that you're looking for Pfiesteria, ciguatera and cylindrospermopsis. The symptoms for those neurotoxic conditions often do include secretory diarrhea.

5. Doctor: Do you cough?

Patient: Oh, yes. But I don't smoke, and nobody in my family has asthma. I feel short of breath a lot, but my pulmonary functions are normal – even though I have to stop for breath halfway up a flight or stairs.

6. Doctor: How about your memory?

Patient: A perfect time to ask, Doc. Don't hit me with that one right off the bat. (I'm kind of defensive about that one!) But you bet. More and more, lately, I find that I have to write down a list of what I'm going to do. I know I'm losing it, but I just don't want to admit it. My friends and loved ones will tell you quicker than I will that my memory is going bad! Even worse, I have to read newspaper articles several times, before I can assimilate the new information.

7. Doctor: Okay, I think I see how easy this is. Tell me about your headache.

Patient: How did you know I had one? Very good, doctor. It's a pounding headache most days. But I get one almost every day, at around ten o'clock in the morning. And by the way, Doc – that's the first clue that I have sick building syndrome and not Lyme disease.

As you know, the ELISA is worthless – and a negative blood test doesn't ever rule out Lyme disease.

8. Doctor: Do you have stiffness in your hands in the morning?

Patient: No, but that's a good Lyme question.

9. Doctor: Are you real dizzy if you stand up quickly?

Patient: No, I don't have chronic fatigue syndrome.

10. Did you have a high-velocity auto accident before you got sick?

Patient: No, but I think you've got it now. Let's go do a Contrast Sensitivity test, then focus in on possible sources of water intrusion in my office at the bank – the building with the leaking roof.

- (1) We'll collect culture for fungi such as stachybotrys, and we'll send off a dust sample for mycotoxin analysis. (Don't forget to do these tests!)
- (2) Then we'll do some pulmonary function tests in order to obtain an additional measure of improvement.
- (3) We'll also schedule a Heidelberg Retinal Flow Meter Test, just to dazzle those nay-sayers who don't yet know that neurotoxins cause hypoperfusion of capillaries. That chemistry is very complicated, and the HRF Machine is an awesome device. Ask your doctor if he's seen or heard of it.

As thousands of patients have been discovering, doctor, my chronic symptoms will be much improved after two weeks of cholestyramine.

But I'll relapse quickly if I go back into the building without CSM to protect me from the mycotoxins, only to once again shed my symptoms and improve my CS scores (and without any confounding variables!), once the CSM therapy is re-instituted.

There are 14 of us in the building who stay sick. One other woman has also been wrongly diagnosed with fibromyalgia, three supposedly have "depression," four are struggling with "allergies," two are in counseling because of "job stress" and four others remain unaffected. And a lot of the people who come

in every day with deposits or checks are sick, too, doc. Thanks to you, a whole lot of people aren't going to feel miserable all the time.

Doctor: Ten questions in less than three minutes! And four minutes remain for the CS test, along with an additional two minutes for prescriptions. The HMO won't kick about that!

Patient: Well, just think about it. There are at least 5 million people out there with sick building syndrome and 2 million with chronic fatigue. We've also got at least 1 million with chronic neurotoxic Lyme disease and 2 million with chronic soft tissue injury. And yet I wonder how many of them are walking around with "fibromyalgia" heading the list of problems on their medical records?

As for the remaining victims, their numbers may still be small, but they're growing fast. Don't forget about the chronic muscle pain, fatigue and diarrhea in the ciguatera victims of Hawaii, Australia and Japan! (In too many cases, their disease also winds up being called "fibromyalgia.") And what about our old pal, cylindrospermopsis? It's chewing a path right through central Florida, as we speak.

Doctor: I want to help.

Patient: Great. Speak to your physician colleagues. I'll be glad to serve as a "teaching case" for you.

Doctor: You know, when you started talking about being tired, I was getting ready to write a prescription for the new SSRI antidepressant. But your symptoms, when put together as a distinct syndrome, have nothing to do with depression. Each symptom taken individually is not diagnostic of the illness.

But the group of symptoms, when taken together, is incredibly powerful. They are part of a new syndrome that's easily recognized.

Whatever "fibromyalgia" is, it now seems clear that you don't have it! And it also seems clear that these chronic, neurotoxin illnesses are much larger in scope than a "disease" which turns out to be nothing more than a symptom.

You know, it's remarkable, but I now realize that I would have spent more time doing a "depression history" than it took to complete your neurotoxin history, and I would've given you an incorrect diagnosis in the bargain!

Patient: Now hold on. You must remember that neurotoxins cause cognitive problems more unusual, more severe and more diverse than any described in the DSM IV R Handbook. Sure, you'll find classic symptoms of depression in some neurotoxic patients – but don't be misled if they feel guilty that they can't function as well as they did before becoming ill.

"Oh, it's my own fault," is the kind of thing they'll often say. "I'm tired, fatigued. Who has the energy for intimacy – or the extra drive required to get to junior's baseball game after a hard day at work?" Family disruption is common and suicide ideation is routine. You will see patients with road rage and panic reactions that go away when their Lyme is treated. You will see anxiety, mania and frank psychosis in Pfiesteria and sick building patients, but especially in Lyme.

When you're ready to write a Ritalin prescription for a child or an adult with ADHD, think first of impaired short-term memory, and reduced ability to assimilate new knowledge. The actual cause of these cognitive impairments is easy to find, once you have a biomarker. And the CS test takes so little time. (Of course, you'll also find some patients with neurotoxic illnesses and a normal CS score, but that group comprises less than five percent of the total neurotoxic population.)

At this point, there's simply no doubt that CS is light years better than any other diagnostic test to show neurotoxic effects. Use it as an important part of your diagnosis – but not as your only diagnostic test.

Remember that you must also have symptoms and exposure that make sense, in order for the CS Test to make sense! After all, the neurotoxic history is simply an embodiment of the “systems approach” to medicine – an approach based on the idea of “getting the big picture.”

Doctor: You know that I'm skeptical. It's hard to believe this simple tool can help as much as you say it will.

Patient: Is the reflex hammer a fancy bedside machine? How about a pin for detection of pain, or a feather for detection of light touch? Using CS as your biomarker will soon become a reflex for you, as subtle as the wisp of a feather and as sharp as the tip of a pin.

There's no denying that CS testing and CSM treatment are new tools in the medical battle against biotoxin mediated illnesses. But penicillin was once new, as well. What's needed now is “continuing education” on the use of these disease weapons, and the way to get started is by disseminating the opinions of enlightened experts on ophthalmology, toxicology, rheumatology and neurology to their colleagues.

Once a few specialists recognize the value of Contrast Sensitivity in diagnosing these illnesses, then the primary care movement can begin to respond to the demand for patients for help.

The medical profession may move slowly – but once the movement starts, the dam will burst. It's time to acknowledge the reality: Contrast Sensitivity is here to stay (along with CSM and the Shoemaker treatment protocol) for as long as toxin-formers make us sick.

Physicians are more likely to accept a new idea if it proves useful in the effort to improve the quality of patient-care, or if it helps increase revenues. CS testing accomplishes both of those goals – but you, the patient, will have to become an advocate for your doctor, at first!

So what's the bottom line on all of these new scientific discoveries that are about to change the way physicians diagnose and treat chronic, neurotoxin-mediated illness? The key point: “fibromyalgia” is almost always an illness caused by low molecular-weight, biologically produced neurotoxins. It's a chronic disease – and it's triggered by the chronic carriage of extravascular toxins. Until recently, there was no biomarker (whether in blood, x-rays, MRI or psychological tests) that would permit physicians to reliably diagnose and treat the illness.

But those days are over now, and physicians who share Dr. Groopman's opinions need to catch up! The biomarker is the simple, five-minute neurotoxicologic test called “Contrast Sensitivity.” It's reproducibly reliable, inexpensive and portable. In short, it's a physician's dream. By using it in tandem with cholestyramine therapy where appropriate, American physicians will soon discover that even the most severe cases of “fibromyalgia” can be rapidly cured.

It is my sincere hope that the enlightened readership of the New Yorker will teach its physicians how to assemble an accurate neurotoxin history, as the first step on the road to conquering this debilitating disease. It's time that we stopped blaming patients for diseases that are “all in their heads” . . . and started listening to them when they come to us for the medical help they so desperately need!

For more information, visit <http://www.chronicneurotoxins.com>.

Dr. Ritchie Shoemaker

1604 Market St. Pocomoke City, Md. 21851 410-957-1550

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