

# Rheumatoid Arthritis in a Young Male

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This patient is a 30-year old white, single male who is a college graduate and is employed as a salesperson. His past medical history revealed that he had always been healthy and "very athletic" until 1985 when he started to experience various joint pains, fatigue, and stiffness of the back and neck. The pain grew more persistent and so severe that he had to take a temporary medical disability leave from his job.

He was seen previously by several physicians including a "Rheumatologist". X-rays of the hands, feet, hips, shoulders, knees, elbows and neck showed changes that "suggested psoriatic arthritis, but was more consistent with rheumatoid arthritis". Degenerative changes were more pronounced in the feet and hands. Various laboratory tests ordered over a period of time showed normal blood chemistry profiles and CBC's. An urinalysis was positive for blood which cleared spontaneously on later testing. The erythrocyte sedimentation rate ("sed rate") was "elevated" while tests for the rheumatoid factor, ANA and HIV were negative. His mother, father and one brother were all alive and in apparent good health with no history of arthritis. The patient denied alcohol and tobacco use. He also stated that he had a "CAT scan of the brain" as part of his diagnostic treatment. His eventual diagnosis was "seronegative rheumatoid arthritis". A history of medications prescribed for this patient included "Ibuprofen (1000 mg 5 times a day); one multivitamin per day; Prednisone, 20 mg tapered to 5 mg over a 12 day period; Tolectin (600 mg 3 times a day with meals); Relafen (1 g every a.m.); Methotrexate (10 mg once a week by injection, later increased to 12.5 mg)". He also had various treatments and exercise through physical therapy. Even with this treatment and

medications, the pain progressed and the patient became more debilitated and moderately depressed. He was seen at the Center as a self-referral where a complete physical, psychological and laboratory profile were performed. His major complaints at this time were swelling feet, muscle weakness with pain, fatigue, lethargy and multiple joint pain. He was moderately depressed and stated "that suicide had crossed his mind".

Laboratory results performed at the Center laboratory showed cytotoxic allergies to 17 different foods as well as Tylenol, sodium nitrate and nitrite (+1 reaction). He had a 2+ reaction to avocado, celery, chicken, cucumber, whole egg, honey, mustard, pork, saccharin, cane and beet sugar, vanilla, Baker's and brewer's yeast. He had a 3+ (very strong) reaction to cabbage, orange and tomato. A test of biological age showed 33 years (actual age 30 years). An urinalysis was normal while urine Indican was 2+ (normal is 0 to 1+). The urine vitamin C level was zero. The patient showed mild anemia (hemoglobin 12.8 g/dL, hematocrit 38%). The platelet count was 519,000 (normal 140,000 to 440,000). A ferritin level was normal while the serum iron was low, 9.0 mg/dL (normal, 35 to 140). The erythrocyte sedimentation rate was 77 mm per hour while RBC zinc and magnesium, thyroid function tests and vitamins A, C, B<sub>1</sub>, B<sub>3</sub> and folate were normal. He had suboptimal levels of vitamins B<sub>12</sub> and E. His "buffy coat" (WBC) vitamin C level was low. A rectal swab was positive for parasites. Hair analysis showed elevated zinc, magnesium and calcium. RBC membrane fatty acid profile showed an elevated alpha linolenic level. A 26 plasma amino acid showed an elevated cystine and low histidine, alanine, tryptophan, lysine and serine. Results from the chemistry profile revealed a low albumin and A/G ratio and a high total protein and globulin.

Since the Center is interested in the total patient, as well as his environment, questioning revealed that the patient had many electronic

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items in his bedroom and slept on a heated water bed. An examination of his bedroom was conducted with a "gauss meter". The reading from his water bed was 4 milligauss; directly over the heater it was 10 milligauss! The upper health limit for prolonged exposure is around 2 milligauss. While sleeping, he was "triangulated" by an LED clock within inches of his head; a "boom box" on the right side of his bed (which had the highest gauss emission); and a television at the foot of his bed.

Treatment of this patient consisted of restricting cytotoxic sensitive compounds; histidine (500 mg a day in a.m.); B<sub>12</sub> by injection (100 mcg weekly for seven weeks); vitamin E (200 IU twice daily); Evening Primrose Oil (one capsule daily); vitamin C (1000 mg 4 times a day); and Flagyl (500 mg every six hours for 7 days). He was also referred to a physical therapist for water aerobics and stretching exercises.

His bedroom was "electronically neutralized" during sleeping hours by unplugging all electronic devices.

The patient returned for follow-up visits after one week and two months of treatment. At the six month visit the patient stated that he "... is feeling better and better ... instead of seven days of total pain and despair, my down cycles are getting shorter and my up cycles are getting longer". Clinically, his depression is almost gone, he has less pain and has a very positive outlook on life. To insure adequate tissue levels, the patient has been started on intravenous vitamin C (15 grams in 250 mLs of Ringer's Lactate) once weekly for four weeks.

This case illustrates how important it can be to evaluate multiple factors which might be related not only in a direct causative way to a disease, but also as possible suppressors of immune system response.