# Allergy vs Mycotoxin response and the place of  Low dose Immunotherapy Transcript

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## Introduction to LDI and Its Origins

Hello. Good afternoon, and welcome to another episode of Mycotoxins in Chronic Illness. Today, we're gonna have a great conversation with Ty Vincent. Ty is a, doctor of osteopathy who, graduated in 2005.

And since 2014, he's been doing some really exciting work with allergies. And, something he has developed called LVI. I'm going to let him talk to you about it, but I can tell you, it is, a technique that has revolutionized my practice.

And I find it very, very helpful. And Ty. Yeah. So tell us, what is LVI? Eric. LDI stands for low dose immunotherapy, which is an adaptation of a couple of previous therapy systems, the first being EPD or enzyme potentiated desensitization, developed by Len McEwen in London back in the 1960 time zone, time frame and then adapted in America to what was called LDA or low dose allergy therapy by Doctor Butch Schrader.

1990s. I learned LDA from Doctor Schrader in 2008 and used it for allergies, and they had a narrow number of autoimmune conditions. They had antigens for at that time as well.

So after I learned that, I thought that there was a much broader application for the treatment conceptually, and I started finding other conditions and things I could treat by adapting new antigens, developing new antigens for new conditions, drawing correlations between well known and described autoimmune syndromes or chronic inflammatory conditions, and B antigen that seemed to underlie the immune response to them.

And over the years since then, about 2009, I started first developed developing my own antigens. I have about 100 different things now, for a wide array of autoimmune and inflammatory problems and allergies, I made my own allergy mixtures.

Since then, in the last few years, for environmental chemical foods, essential oils, artificial colors, just a whole host of things, pretty much anything a person reacts to and in a negative way that causes symptoms.

If I get a sample of that thing, we can potentially desensitize them or restore immune tolerance for the thing. And the exciting area is, is in the area of internal organisms that live within our microbiome that end up setting off autoimmune syndromes or chronic inflammatory problems that are becoming increasingly common.

And then anything else in the outside world that's an allergen that people react to. You can presumably restore tolerance to anything that exhibits that kind of reaction pattern.

Yeah. You know, I first of all, I just want to thank you so much for for the work you did. I considered streamlining LDA because, I used to use LDA, but not often because I, yeah, I'm just not that kind of person who's going to tell people to live such a restricted life, even for three days.

So, I quickly was, being playing fast and loose with it, but what you have done is taken, I mean, concepts that people were that there was a doctor from New Zealand who was doing some work with injections and extracts and things like this back in the 80s and 90s, but it was so complicated that unless you made it your life's work, you couldn't do it.

And what you have done is given us in the field this tool to use, in such a delightful, easy manner. I mean, you've taken it, you've taken away a lot of the, bells and whistles.

I'd say that that aren't that don't seem to be necessary. Let me and made LDA a much more LDI, a much more, user friendly tool.

## Challenging Old LDA Rules

That's true. I found that LDA carried with it a lot of dogma that had been, brought down from the EPD decades with doctor McHugh and some beliefs and dogmatic feelings he had about things that I challenged one by one, by breaking the rules and seeing if you still got the same results.

So if you still get the same results without following the diet and the lifestyle avoidance and using the urine of this enzyme and all those things, if you get the same results without all that, then those things don't matter.

And you said the the LDA and EPD protocols were so restrictive and so draconian. I used to follow them myself with some of my children to treat their allergies, and we all hated it.

I did it with them out of solidarity. And, I was really glad when some of my patients began breaking the rules and telling me that they didn't follow the diet, and it worked great anyway.

And I was like, oh God, thank you. That's great. Can I just went further and further away from it? And I proceeded from there to challenge every one of the rules that the dogma that had been handed down.

A and really the only thing, in the world of LDA that holds true is that if you, if you overdose someone have a negative response, or if you have the correct dose that you found, you have to wait seven weeks to reset the immune response and give that dose again, or give a weaker dose again.

That seven week rule is pretty much the only thing that I still find valid from all of the dogood. But thank you for that. That was I was going to ask you that question because I've I've played fast and loose with all these things and and I was just the other day I was wondering, that seven week rule of, you know, if you get the right response, you know, do you really have to wait since you've made it?

So, you know, we we're feeling very comfortable of if there's no response going, no moving on. Within a week or two right away. And, because it didn't it did. Right.

That was if the dose has no effect, it didn't count. Like literally mathematically was irrelevant. So why wait? You don't have to wait. But if you have a response and you did affect the immune system, then the seven week concept comes into play.

However, and we're getting way ahead of the the discussion. But if somebody has a positive response that is short, like it only lasts a month instead of the full seven weeks, you can give them a proportionally smaller fractional booster dose, I call it within the seven week time frame, and you can get away with that, but you can't usually give them the whole dose again early because it'll be additive.

Anything that any doses you give within a seven week time frame are cumulative. They are mathematically additive to one another. And that's a concept that that I developed because like the old LDA dogma was you have to just wait.

Even if the dose didn't do anything, you have to wait a whole seven weeks. And that's just not true. It's more of a calculus based. They viewed it as a single point in time event.

That was a high amplitude and and close. But really what you're dealing with is antigen immune response patterns that are cumulative and incremental. And they follow more of a calculus based area under the curve concept, with a certain rate of attrition and a certain rate of accumulation.

And I'm a big math nerd, so it makes total sense to me. Okay. The people difficult to conceptualize, but I'm like, look, they all add up both ways within a seven month time.

And so think about it that way you can incrementally add to what you're doing. And you could conceivably this is where a lot of people ask, what's the difference between LDA and homeopathy?

It's a very common question. Yes. Because we're we're clearly in the homeopathic range with our dilutions. But the rules of engagement, you know, the way I use this therapy is just totally different from homeopathy. Yes.

If you if you found the perfect dose for someone that lasted 50 days each time they took it with a 100% response, you could give them 1/50 of that dose every single day and maintain and achieve the same level of response.

You know, you would hit a steady state and you would accomplish the same thing. So traditional homeopathy is like a daily or multiple times a day dosing and whatnot.

And you could conceivably use it that way if you wanted to. But why you take something every day if you can take it once every 50 days. Yeah. Well, you know, I think I realized that I just I just had a wonderful time.

But for the for our listeners out there, we'll go back and try to fill in the details of how we got here, you know, because so, you know, so how do you use LDI, for chronic illnesses?

I mean, you know, for basically the chronic, you know, basically, yeah, the chronic illnesses line, but it's the focus on mold and differentiating between the mycotoxins and the mold allergies.

And we'll spin from there. Well, again, like we talked about at the beginning, LDI only works for things that are immunologically mediated. So, mold is a complicated topic because some of the mold related illnesses people deal with chronically are toxic.

You know, it's a toxin mediated effects, not necessarily immune mediated. And then a lot of those people have both. And it's confusing for the patient and the practitioner to try to figure out which one they're dealing with, especially when the person has both.

So what I tell people is, you know, that the toxin mediated part of their illness should be fairly static, like their symptoms should be fairly consistent day to day.

They don't change based on where you go.

## Using LDI for Mold and Mycotoxin Illness

Like if you go on vacation to the beach for a week, you should still feel like health the same as you did when you were at home. Pretty much. It doesn't tend to fluctuate a lot based on that day's exposure, right?

Whereas the mold allergy part for, you know, the mold immune reaction part, it will change dramatically based on exposure. So those people get out of if they're home is where they're being exposed to mold or their workplace.

If they just leave that place for a week, they'll feel markedly better. They might not feel normal because they may be more than one thing going on. But then when they get re-exposed back in that same environment or a new mold exposure, like to go to a thrift store is one of my favorite mold exposure places.

So books. Yeah, yeah, oh yeah. Yeah, I'm like, I don't know where I don't want to find mold, go to a thrift store. There's like old couches and clothing and books and any kind of textile and material that mold a girl on is in there, and it's a cornucopia of mold species in all cases.

So when you go into a place like that and you rapidly experience symptoms, so the time scale is really the clue, you feel that symptoms come on within minutes of entry, and then you leave and your symptoms dissipate over the next, you know, hour or two.

But you know, that day then that's that's an allergic that's an immune mediated response. That's not a toxic. So I have to guide people through that. I'm like, there's your baseline.

I feel terrible all the time stuff which may or may not respond. That may require long term micro toxin elimination to

get rid of that part. Right. And then there's the amplitude, you know, up and down, off and on based on exposure part that is clearly immune driven.

And that's the part we can get rid of with low dose immunotherapy. Right. You know, and what what makes me what's interesting is that dance, you know, that can be there between the classical, you know, IgG mediated immune response to mold and, and the fact that, you know, when we used to do skin testing, we would see mold antigens often react in day two and three rather than on day one.

You know, not IgG. Yeah. So it's not IgG. The mold is kind of unique that way. So you can and I have to explain this to a lot of people when they've had skin testing done, like you said skin prick testing.

And they say oh I didn't react to mold. I said, is there any chance that you remember the day after your test or the second day after your test? Those spots got red and itchy.

Then, you know, they're not even back in the office then and the doctor doesn't catch it right? And they go, yeah, I did. I had some of those get itchy later like mold classically will exhibit a delayed type hypersensitivity response like tuberculosis.

Right. Right. So TB as you read 48 hours later because it's a micro bacteria, it has that fungal type of cell wall molecule that causes delayed type hypersensitivity responses.

Same thing. And so that's pretty common. And that that makes it a little tricky to identify some of your mold allergic patients because they don't have symptoms within minutes of exposure.

So it's it's it can be a challenging area. And when whenever we're in doubt, one of the nice things about LDI is we can give you all the antigens in the world that you don't react to, and nothing happens like it's completely safe to give you something you don't need, which is different from pharmaceuticals, right?

You give somebody a bunch of drugs they don't need. You have problems to contend with from that. Yeah. Well, without you're just giving somebody a signal to to really restore tolerance to the immune system.

And if you already tolerate that thing, it's a net zero response. So there's no harm in trying it if you wonder if it's there. Yeah. That that is one of the great positives of LDI is that so many other times when we when we in the idea of a trial of therapy, the trial can can have untoward side effects, you know, and but the nice thing with LDI.

Yeah, I mean, I always try to explain that to people because some of them, especially when we use the lime, the light, they go, oh my God, you're going to you're going to I'm going to blow up.

But I said, well, only if this is your issue, you know, it's there for you to take the five antigen mix. You know? Right. And then if you do have a negative response, you just learned something critically important like that is your antigen, you know, so that if people do have a negative response, it's sort of like doing the prick test in the allergist office.

We're going to prick you in the skin. And if it swells up and gets red and itchy, that's the one that you need. That's the one you reactive in this case.

So the negative reaction is a systemic inflammatory response that is unpleasant. So you know those who of us who use LDI, we try to get where we think the patient might respond in terms of dilution range and start somewhere weaker than that and titrate towards it.

So you try not to overdose people early on. But when when people are mysteries, you know, like I have a number of chronically ill people with a lot of the typical symptoms that you could check off boxes on either of the mycotoxins, the mold list or the fibromyalgia questionnaire of or three toxins of forever.

There's 100 things that could be a lot of times now I just I just give them a strong, concentrated LDA dose of like

five things at a time. Just bam, bam, bam, bam, bam and see if any of them make you worse.

Right. It's sort of like doing that prick test on the back. And when people get a little, you know, tired of everything taking so long to figure out, sometimes that's the appealing course to take.

Yes. You know, I think that's a really I mean, useful because it's yeah, if we do things one at a time, when we have 20 choices, it can take a very long time.

So, you know, so basically so what you've used LDI for obviously allergies. But what makes you so interesting is how you've applied this to chronic inflammatory illnesses of all sorts and types. And what was the gist.

Just for a little background on it, I mean, what were the first illnesses that you played with? The first thing so the first mixture of organisms I put together myself was yeast.

Candida. Because I saw person after person after person, and the majority of them were middle aged women, like a lot of them, he developed some kind of yeast problem, it seemed like.

Right. All these indicators I get Vegemite is that I eat sugar every time I take antibiotics, I get all these symptoms of the operation. They have, you know, irritable bowel symptoms.

They have fibromyalgia symptoms, just everything from head to toe. You can imagine that's inflammatory. And then I would give them flu kind is all in my stat.

And you know antifungals and their symptoms. The symptoms might go away entirely or go away 80%. And they would they would stay on the antifungals for weeks and then stop them and their symptoms would just come right back, generally within 48 to 72 hours, almost without fail, their symptoms would be back in full force.

And in the world of integrative medicine and alternative medicine, the dogma there, the belief is that, oh, well, the yeast is just hiding and waiting for an opportunity to reemerge.

You know, we have this kind of anthropomorphism, one thing we do with microorganisms, but I don't think it's valid. I think those are fairy tales. So based on all of my experience working with allergy, my thought process was, well, what's happening is we're suppressing the antigen exposure.

And then when we allow the antigen to re, you know, gain its prior numbers and you get antigen re exposure, you get a return of symptoms because it happens so fast.

And so then I thought, well then that's an immune response. All these people who are dealing with these chronic symptoms that seem to be yeast associated.

And so I purchased some Candida organisms and put them together and made my own serial dilutions. And that's the first one I tried using. And every one of those people who fit that pattern, I described responders like those.

They stopped getting all their chronic symptoms. I no longer had to give them antifungal zero. So it wasn't that they had yeast overgrowth or infection, it was that they had a yeast sensitivity.

And if you think about it, it doesn't take very much for the body to develop that sensitivity pattern because yeast lives inside all of us all the time.

And, you know, this is very similar to mold, right? Everyone's exposed to mold all the time. No matter what you try to do. It's everywhere. It's ubiquitous indoor and outdoor environments.

So those kinds of things that are fungal in nature, they don't have a place in the human biome.

## Yeast, Gut Organisms, and Autologous LDI

You know, it's pretty easy to develop hypersensitivity patterns. And yeast is an internal organism that is also a pathogen. Like if you become immunosuppressed, you get horrible yeast over.

Yeah, it takes over Aids patients. You have to patients. Yeah. They all have to take chronic antifungal suppression or they will die from you. So we have a we have a very tenuous relationship with yeast in our body.

And I find that is still to this day, 12 years later, that is the most common microorganism die that people have problems with. So that was the first.

And then from there I started playing with some of my I had some inflammatory bowel patients, and I got a mycobacterium mixture that was working for a portion of those people with Crohn's or ulcerative colitis.

Research shows there's a connection with mycobacteria in the gut, and then some of them would respond to use also. So the next thing that I that I stepped into then was what I call autologous LDI.

This is probably 2010, right. And inflammatory bowel people were the first people I tried that. And because clearly they're reacting to something that lives in their right eye track, they hadn't responded to the yeast or the mycobacterium mixture.

So I would just take a sample of their own stool and dilute it and sterilize it with a millet filter. It's pretty simple. Procedure. And then give them an LDA dilution of their.

And this is what I started to call it LDA. I think them over. I called it tallgrass LDA, then proprietary term. So then they I had some early cases with Crohn's and ulcerative colitis that responded miraculously to desensitization using their own stools.

Not oh, I've really hit on something. And actually that was till 2009, because in 2009 I started lecturing about this concept for the Environmental Medicine Academy.

And after I spoke about it for the first time, people were just completely blown away, just at the idea. The concept? No, but no one would try it like nobody else would try to do it.

Yeah, it's amazing and anyone can do it. And it's really simple and cheap. And yes, this, this there's a whole world of possibility here with chronically ill people.

You need a $10,000 machine, that's all. Yeah. Right. You don't need anything but bottles of water and syringes. It's super easy, you know? And so I was really just dumbfounded why more people weren't wanting to pick this up.

And so I just I had to develop a lot of these things on my own over the ensuing years. And then now I, you know, I have just dozens and dozens and dozens of antigens and some of them to this day, have shown no applicability for anything.

But that's what you do, you know, you try it and see. And a lot of the chronically ill people that you see that a lot of our colleagues see that are mysterious.

And you throw 20 therapies at them and none of them work. I get those people, too, and we just try groups of antigens at a time. And see if any of them have a response.

And many of them, they still don't. So there's still, antigens to be discovered out there for people. They're still, you know, it's sometimes maybe there's something else that has the, the foot on the accelerator of the immune system that's making it so irritable.

I mean, who who knows? I mean, because basically what I say is most of our patients have problems with, modulating their immune responses, you know, and so I come from different, different things.

So I, you kind of answered it, but but I guess when we think who who would be your ideal candidate for LDA, LVI, LDA, lda, lda, a person. So the ideal candidate is somebody who knows exactly what they react to.

So I don't have to figure it out right? I mean, I get a lot of corn allergy people. So corn allergy is becoming extremely prevalent. And people who become reactive to corn have to have a very, very difficult time avoiding it because they begin to cross react with all kinds of other food items that have corn residues in them.

Corn derivatives and process. Yeah, many of them. The crops react with chemicals, chemicals that are made from corn products. And so I have a lot of new corn allergy people, because somebody on the corn allergy support groups online posted our videos.

So I get them a lot. They're my favorite people to work with because we know exactly what they react to. They respond beautifully, you know? So but if somebody is allergic to cats, it's just as easy, right?

I have other things like chronic, some chronic immune mediated things where the antigen is very obvious, are super fun and easy to like. Sarcoidosis response to mycobacteria.

Psoriasis responds to skin fungi, a mixture that I developed several years ago. You know, some of these things, there's almost a 1 to 1 correlation between the disease entity and the antigen.

Osteoarthritis is actually one of my favorite things because I developed a collagen mixture that works for that. So when when it's a discrete, very well described condition and I know that there's a likely antigen or just a few of them to choose from, those are the most fun.

Super, super easy. I don't have to think about it anymore because I already know what's good, what's going to play out. And then there are the people that have complicated chronic illness problems with all these symptoms.

And and it's just completely unclear what's going on. And we don't even know if they have an immune mediated cause. Right. They could have mold toxicity.

They could have. Yeah. You know, they could have, heavy metals toxicity. Yeah. They could have kinds of hormonal abnormalities which I no longer manage for people.

And then those cases nowadays I'm like, look, I don't want to waste a lot of your time and money on this. If we really want to find out if LDA is even going to work for you, we just throw collections of things at them in larger clusters.

And I have this more efficient manner now where I deal with those people, because I would take literally three years with those patients to try to rule out all the antigens.

We had available one by one from a safe dilution point. And now my because I've worked with so many of them and the success rate I have is up from about 50% with that crowd.

You know, your fibromyalgia, chronic fatigue, my I like 50% in my book is I mean, you know, is very respectable. One of the things I have a lot of trouble with is all the people who, sometimes I spoken to and, I meet who, you know, think they do 80 or 90% with this crowd and, I don't believe it.

You just don't. Yeah. You know, I mean, is that what it is? Is that maybe you screen really well, so you get the ones who fit your paradigm. But anyway, this is.

Yeah. Because these are difficult, you know. Yeah. If they were easy to solve, they wouldn't be showing up. But so that's right. And a lot of them a lot of them come with a lot of mind body damage that is caused by the chronic illness.

And there's so many layers to that that are in the way of their healing process. And that's not something that's easy

to deal with at all. You know, I get some of those people you just wonder, like, you know, this really seems like it should work. And, some of them are resistant to trying the doses the way I want them to, and they insist that the doses made them worse and that.

And they have to try a weaker dose. And I really don't think the dose made them worse based on the data we have. But we go along with it. And then they they just think everything makes them worse because they're so second baseline.

Right. And they have this intense fear of their illness getting worse. And they have a history of 20 other therapies failing them. So they have no optimism whatsoever.

And it's a set up for failure. And with a lot of those people, I'm left wondering if LDI might have worked for them, if I would have been able to do it.

My way. But, you know, no, you know, the immune, you know, I always remember is that the brain controls the immune system and the limbic system kind of controls the brain.

You know, it's hard to get that higher level of, you know, awareness to be in control. The, the reptilian brain wins most of the time. It takes a lot of practice to be able to suffer and still learn something new.

You know, I always say, you know, you really don't. Not many of us can learn how to swim when we're drowning. And, it's. So there's no better way. That's what chronic illness often does to people.

It leaves them in that state of of panic. And, you know, it's just hard.

## Who Responds Best to LDI

I mean, my heart goes out because especially in this day and age, if you don't have a diagnosis so many times your family begins to doubt that you're even ill.

You know, if you don't have a you know, so it's a hard that part of the psychological, you know, mind body layers that, that, you know, people don't have a good support system socially and at home.

And it's just that the people that are in those situations are their success rate. My success rate with them is is substantially less than 50%, you know, and then you get people that are just super troopers who no matter how horrible everything's been for them, they're like, yeah, let's try it.

You know, I know the right thing will be around the corner. If this doesn't work, I'll find something else, you know, and that that's a winning attitude.

It doesn't, you know, still doesn't always work, but at least their mindset isn't one of the barriers, you know, success. But I always like to I, I digress too far for an LCI, but I always want to remind people is that so much of this is is bred in your bone.

You know, I mean, because like people, people who are, you know, athletes and warriors by nature tend to think that they are they are special and they are special.

But they didn't get there because they did it to themselves. It's sort of like rich kids who, who, who start successful businesses. You know, if you start with the first million dollars, it's not so hard.

You know, it's reality. And that's that is the thing that people have to understand is that that optimistic mood, that optimistic stance in life is something that is probably about 80%.

And, you know, nature and you know, and you can nurture it, but it's, yeah. So you just I always because the people who who are really depressed sometimes they, they take it on and it's just, it's the cards you were dealt.

Now there's still that place to shift, but it's a lot harder than it been for those of us who come in with an optimistic attitude, you know, it's so just remember that when you're when you're when you're doing well, it's not all you exactly know.

I my with with LDI unlike any other therapy I've ever used honestly. And I've used all kinds of things going in hyperbaric oxygen. I learned acupuncture, actually a Reiki master level practitioner, like all kinds of things I've done in medicine.

With LDI, it's it depends the success depends so much on the patient and their understanding of what's going on, and their ability to evaluate any possible change in symptoms and communicate it back to me effectively.

And that's a big that's a big deal. So all of this at its heart, all the decisions I make are based completely on the information I get from the patient.

And I don't have laboratory data or objective things to go by. In most case, sometimes we do like we treat Hashimoto's thyroiditis. You can follow a TPO antibody.

You don't even have to ask the patient how they're feeling. There are occasional things like that. But in the most in most cases, I rely on the patient and they need to be they need to have a functioning brain.

And a lot of our patients have so much brain fog and distortion and everything that they just don't even know if something changed or not. And it makes it very hard.

But the, the, the relationship I have to have with people and their involvement in this therapy makes it very different from everything we've used before.

And the success is highly dependent on the patient. You know, it's not all about me or me figuring things out or giving them the right thing. It's a relationship, for sure.

It's very different. Yeah. No. And the details. Yeah, I mean, I, I, I know I would be a bad LDI patient because yeah, I'm one of those folks that would be like how how do you feel yesterday.

You know it's gone. Yeah. Yeah yeah. It looks they write it down I think I have type one diabetes and I've, I've been trying for seven years to find an antigen that works for my autoimmune disorder.

I mean, I have my type one diabetes is not an immune disorder. I have a Gad 65 antibody. I've tried the Gad 65 protein itself and that hasn't worked. You know, nothing's worked consistently.

So I've tried and failed with my own autoimmune disease for years now. And I have, you know, total compassion for people that we when we try everything we have and it hasn't worked and like, yeah, I, I get it.

You just have to keep coming up with new things, with new ideas. Yeah. So just I want to get back to, to a few things around mold and mycotoxins, but the thyroid issue, you know, I Hashimoto's is so ubiquitous these days.

I mean, like, it's I, I to be honest, I sometimes don't even think about, you know, other than treating, making sure the hormone levels are good and they're not eating too much wheat and, you know, the obvious things.

But I honestly, I hadn't really thought about. So you what are you what's in your Hashimoto's? LVI well, we do have one label specifically for that. What I've what I've found is the antigen that most commonly works is your Cynthia.

So the, the the gut bacteria, your. Yeah, yeah. And I don't know why but there's the molecular mimicry there I guess. And I would say that that has only worked 40 to 50% of the time.

And then I've had some people who have responded, it seems like to a, a broader collection of gut bags, I've tried H pylori, maybe a couple people age pylori.

Now we we've put your Cynthia H. Pylori, a bunch of campylobacter. Clostridium, you know, about a dozen different genera of gut bacteria we've put together into one compilation we just called GI.

And so now we just use that. So I don't know which one it is. It's a lot more a lot more efficient. And then gluten, you know, you have to wonder if gloop is the answer for some of those people.

So like I was saying, you can check TPO antibodies. And I've had people with TPO antibodies greater than 600 and give them the, the the gut bacteria and it drops down to like 400.

And then we give them a 0.5 C stronger dilution. It drops to 200. And you just have to space them out about once a month or so and do labs 10 to 14 days after.

And you you can prove that it's working. The catch, though, is that some people who have had Hashimoto's for a long time, their thyroid is damaged irreversibly.

And yeah, there's they're still dependent on thyroid hormone if you get rid of their autoimmune disease. Right. So it's not the most fun condition to treat because it doesn't in most cases.

Even if you're successful, they're not going to be free of taking the thyroid hormone. You know, I have to take thyroid hormone and I don't have Hashimoto's ever.

So it's just one of those things that isn't the most fun to treat. But if you get somebody early, right, they've only been diagnosed within the last couple of years, you can get them off of therapy.

Like I have had a couple people in that scenario where we got the immune process to stop and then they no longer need to take thyroid hormone. So it depends on where you catch them, right, right, right, right.

So this is I mean I so we can talk about all the applications for LDI. They're just they're just amazing. And so when you're using it. But I mean like in the old world you you have the idea, you know at this point you don't have the Michael Thompson antibody antigens to use, but you have a feeling that you can use that just the your mold pat your mold package, so to speak.

So tell me a little bit about the thought behind that. Well, we were we were talking about prior to the recording, whether or not some of these people who, who have mycotoxins related illness, whether the mechanism is not necessarily direct toxicity, whether it is immune response to the mycotoxins because you can have an immune reaction to anything, right.

And so to date, what we've had in our, environmental mixture within the mold subset is just I think I have about 50 or 60 different species of molds that are in there, and it's the whole organism.

So you purchase whole organism mold, you know, antigens. Yes. And theoretically there are mycotoxins within that. Right? They make them internally and release them into the air.

And so yes, there might be mycotoxins in there, but maybe they're not in there at the right dilution or enough of a representation for it to work. So it is theoretically possible that some of the people who don't respond are having an immune reaction to a micro toxin.

And then what you need to do to validate that theory is, is get a sample of mycotoxins and you know exactly how concentrated it is, and you can titrate it and use it for those people and see if some of them respond.

## Hashimoto's, Autoimmunity, and Immune Modulation

And it will be really interesting to find that out if we get some micro toxin samples. One of the ideas I've had for practitioners who suspect this is to maybe to just use the patient's urine, because we, we harvest micro toxins from human urine.

Whatever micro toxins are in, you are probably coming out in your urine and maybe you just get a urine sample and dilute it, you know, two C, three C because it's already pretty dilute.

And see if they respond to it. Right. That would be quite scary. Yeah. Yeah. You could get another cell. And theoretically that should work. And that's what I've other practitioners have asked me about this over the years.

So maybe we'll just use urine. Because, you know, the micro toxins are there. You can measure, and if you wanted to be super anal about it, you could find the concentration of the micro toxins in their urine and know exactly what your dilution factor is.

Once you dilute it further from there. But that's not important. No, you don't have to deal with that. That that makes me think that, you know, that was that's a it's funny things come and go.

But there was a period of time when we were doing a fair amount of urine hormone toxicology, you know, just like me injecting a CC of urine after you filtered it and throw a little ozone in there.

And, and every once in a while, people would have some major immune reactions and addict patients. Yeah. Wonder what? Where they can get better or worse, you know.

Yeah. There's an old classic technique where the people just put ten drops of their own urine straight under their tongue. And, you know, I've had some patients I've had, have done, I've tried that.

And they go, oh my God, I got so sick. I did that and I was sick for two weeks and could get a bed. And I'm like, oh, great. And we should just take your urine and dilute it.

Three C and try it from there. And maybe it'll reverse all of this, you know, because the thing about LDI is as long as you have the antigen, you can fix the problem.

Right? And you don't you don't necessarily have to know what it is. So that was where my concept of autologous LDI came in. I was like, I don't have to know which organism in your skin, your gut flora is the problem.

As long as I get a sample of your paint, it's presumably there. And what I've learned since then, why autologous LDI has a substantial failure rate is that if you have a really strong immune response to an organism, it won't be there.

Your immune system kills it. And so you get a stool sample from the patient. And the thing they reacted to all the way through their gut isn't represented.

And so what I found is that using my standardized mixtures of all these things I have, I do that first because if I have the right organism there, that's going to work, and sometimes using their own autologous sample won't because they've annihilated the antigen.

And it's not a good example. So that's good to hear since are making autologous stool. LDI is it's something I try not to ask the staff. They are not happy.

I my wife won't do it. Actually, what I should say is she can't do it. She has tried to process people's samples and, ended up vomiting and bailing out, and then, you know, I had to.

I was on a vacation once, and she tried really hard to do it because there was a colleague of mine from the Environmental Medicine Academy who picked up some kind of gut bug in Peru that almost killed him.

He was on IV replacement, having deep diarrhea, 30 minute every 30 minutes, 24 hours a day for weeks. And he was on death's door and, he responded when I got home and I diluted his stool and we sent it to him.

He's he's essentially cured. But but he he was going to die from that. And my wife really, really tried to save him but

couldn't do it. Yes. Yes. Well, gastroenterology won't be her field, but so, you know, basically.

So your whole concept of immune modulation has really, I mean, how is this changed how you look at standard medicine? Oh, God. You know. Well, I'm a family doctor from my basic training.

You know, and I learned I learned endoscopy. I was credentialed to do colonoscopies needs. I manage my own ICU patients, I delivered babies, I delivered my last four kids myself at home.

I've done something, you know, acupuncture. I've done something of everything in medicine. And there's a lot of there are a lot of conditions out there, that we are just taught are idiopathic.

If they're being honest, they'll say they're idiopathic. We have no idea why these things happen, but there are a lot of things that are chronic conditions.

And we make up stories about them like osteoarthritis. Right. Osteoarthritis. It's mechanical wear and tear. Well, how come some people can run marathons until they're 90 years old and their knees are still fine?

And then other people need knee replacements at age 35? Like it's not wear and tear. Yeah. You know, there are things like acne, which we are led to believe is just an infection in your face, but it's a bacterium that everyone carries.

It's not a youth. It's not an unusual organism. So we can get rid of acne in most cases by desensitizing people to probiotic bacterium at the bacteria that everybody carries.

We can fix osteoarthritis by desensitizing you to type two college. So osteoarthritis is truly an autoimmune process because it is a inherent reaction to your own protein.

Whereas almost every other autoimmune disease is not an autoimmune disease. It's an immune reaction to a microorganism. And I can prove that with many of them.

So my my use of this therapy over a decade now has completely changed the way I look at many chronic illnesses. And I try to explain my paradigm, you know, and my thought process to people.

And it's really for it, you know, like you have worked with this yourself and understand it for your you listen to me rant about things more than once, so you get it.

But a lot of most of our colleagues that are res, you know, in allopathic world, they're just completely happy with believing that these things just happen and we don't know why.

And you just manage it symptomatically, or at worst, you derail the person's immune system entirely. Like if you watch commercial TV every 20 minutes, there's an ad for some magic TNF or interleukin inhibitor that'll destroy your immune response and leave you like defenseless.

But it might clear up your surfaces. No, but, you know, this is just it's the model. You know, some, some immunologists and rheumatologist have been writing, you know, for the last 12, 15 years now that, you know, autoimmune disease is secondary to infection, chronic infection.

But they are a minority. And most people don't listen to them because all the pharmaceutical research and all the research money, you know, people always want evidence based research.

You know, that's the whole big thing. And I call it evidence, but research, because at this point of time, it's so expensive. Only if you can afford it can you do it.

Yeah. And if you buy a cell in a drug, you can't afford to do it. And the desire to protect us. The FDA has made the requirements for testing things so expensive that you have to be a pharmaceutical company to afford to do it, and

you can't.

They won't let you test things in universities in small, little settings. If it's not, if you don't have an eye and, you know, an investigational new drug, you can't they won't even test the stuff.

So anyway, it's like but then I go through the do you go through the $100 million testing, research development process? You have to sell your drug at $10,000 a month, or you're not going to make a profit, or you're not going to make the kind of profit that they want to make.

But so getting there so that that is the revolutionary piece is what you're doing is demonstrating what people are thinking.

## New Antigen Collections and Future Directions

You know, there's the theoretical people that, that, that, that the bugs are triggering our immune system. And it's not this like failed ability to recognize cells, you know, which I think is totally both of 90% focused.

There might be a little bit to that. Well, it's not much. It's it feeds into the molecular mimicry concept here. The tie in and the best example we have is rheumatic fever like you talked to.

If I talked to a doctor and they seem to think that I'm crazy for suggesting that an autoimmune disease could be caused by an immune response to a microorganism.

They're like that is maybe said, have you heard of rheumatic fever? Like, I know you have. So that's Streptococcus pyogenes in the throat. We know the M protein on the surface of the organism, which is called that for mimicry.

And then you can get neurological symptoms, skin joint, you know, gastrointestinal different heart valve deformities. Yeah. Every tissue in the body is affected by that.

And it's an immune response to one organism in the throat. And you know that. So why is it hard to believe that psoriasis could be a reaction to normal skin fungi living on the surface?

You know, and I can go on and on about examples and why. And then it's it's baffling to me that they will still just choose not to believe anything I'm saying.

Okay. You know, because I mean, that is human nature. You know, if, I know what I know and don't try to tell me something new, because then I have to rearrange my mind, and my mind is, well, ordered.

Yeah. The cognitive cognitive dissonance that it causes. Yes. Yes it is. So just just before the what, you know, anything. I mean, you've got so many exciting things that you're doing, but, any real, any new things that are really rocking your boat these days.

Well, you know, I have a new collection, a new antigen collection that I haven't even told people that I have yet because I, I like to play. I like to play with my own toys myself for a while before I share with the other children.

And I also, I also want to make sure it works for something right before I tell people, hey, this is worth using. Yeah, I have a collect, a very broad collection of internal molecules.

So they're not microorganisms, but it's, you know, I call it a neurotransmitter mixture, but things like dopamine and acetylcholine, orexin, you know, all these likes you've been arousal proteins, things that control appetite and metabolism. So ghrelin and leptin there are 37 different endogenous molecules in this mixture.

And I'm in the process of trying it with just all kinds of different things, you know, to see if it does anything for anybody. Insomnia, weight management, autism.

And so I'll, I'll just have to play with it for a while before I can tell people if it if it's worth anything and what it does work for. But I'm I'm hopeful. I'm excited about that.

And I gotta say that sounds that sounds very exciting because it's. The, the audit, I call that just the autonomic. I said the brain's response to the environment is really what modulates that immune response.

You know, the reason your immune system is shooting off is because somewhere it's thinking something is dangerous. It isn't. You know, it's a dangerous signal that tells you that that is what gets you to start reacting to stuff, you know, because otherwise, you know, we wouldn't react to anything or we would react to everything.

It's a little like memory, you know, you need a little cue to remind you to remember. And so and danger is the best cue the body knows. I mean, it's people.

It's just survival, self-defense. So, this it's very interesting. Who knows what these chemicals will, will, will do and what they are provoking in us because, you know, I mean, we've tried to get mask.

Yeah. If you haven't, if you have a human tolerance to your own dopamine, you're not going to be able to think straight. You're not going to be able to regulate your happiness response.

You know, then that could happen. I mean, I've used hormones as an LDA dilution, but that's what I was thinking of. Yeah, some people respond dramatically to hormones with this immune reaction.

You can actually measure anti estrogen antibodies now. And you know so we know there's an immune mechanism against hormones. And neuropeptides are not appreciably different.

They could also be antigens. So hopefully within the next year I'll be able to let people know that it works for some of the things that I have. You know, previously failed to treat successfully, but that is is is exciting.

And I said, I'm hoping that, you know, we can get more people to try LDI for the moles as we tease out the allergic component and also just the immune.

I still think there's a significant immune reaction that's happening that can, you know, that that delayed hypersensitivity that I feel that LDI can settle down as well.

So be really interesting and hopefully we can, enlist a few people and get you some antigens so you can play a little bit and let us know if they work better.

Yeah. You know, we could talk. Yeah, exactly. It's been one of those theoretical things that I've wondered about and haven't had the tool to, you know, to test it out just yet.

And, you know, I, I'm, I'm also currently trying for my own, for my type one diabetes. My mission before I retire someday, is to solve type one diabetes.

So I kind of have to for myself and then make sure everyone in the world gets that. And I hope the same thing works for everybody that ends up working for me, because it's, it's it's, you know, it's a disorder that I really don't think anyone should have to have.

But I'm trying some pancreas itself. Right now. Pig. You can purchase pancreas dried, you know, freeze dried pancreas from pigs and cows. And so I'm. I'm trying that one myself right now and we'll we'll see if that works.

It's the last is just just a 16 gauge needle and a good ultrasound. Yeah. I just I did get a little your own, but, you know, that might, but yeah, you know that that is the fascinating another fascinating world.

I'm just so glad that you're that you're using your mind in such creative ways, because, I mean, that's what's missing in medicine is creativity these days.

And it's nice to see you doing it and, giving us all a big help. And hopefully we'll we'll talk maybe in, you know, six months or a year, and we'll have something also, you know, some just to know if direct treatment of mycotoxins, if there is a big enough response.

The really excited to find out that there is this any another tool is always nice. If you want people, you can, you know, if you have a large population of these people in your practice, you can acquire.

If you can acquire the mycotoxins, you can make a dilution and try it. There are two well we we we work with also I I'll send it to you. Yeah. Send it back to me.

That works better. Absolutely. Yeah. I just want to let people know that they can find you at time. Vincent, is it just typing sitcom or. I forget what you're, you know, our our office is called global immunotherapy.

Global. The web and the website a mouthful, but global immunotherapy.com. And, if you people's my name, they'll probably find it. Thank you to the internet and search engines that are out there today.

Yeah. We also, for educational purposes for patients who want to know more about LDA. You if you go on YouTube and you put in time Vincent ldi we have 40 or so videos there that are all kind of on on more discreet topics one by one in terms of diseases we can treat or broader concepts with low dose immunotherapy for people to educate themselves more.

Yeah. Like that. That is great because I mean, this is a leap for a lot of people to make to think that, you know, this drop that they can barely see under their tongue is going to do something.

And, I can tell you that it does. It is it's one of my favorite therapies. And because when it works, it's just beautifully dramatic and changes people's lives.

It is. Yeah, it's worth a try as long as something like, well, is work for me, as I have no idea. You know, I can't tell you at the beginning, and people want statistics.

How likely is it to work? Well, if I say 90% likely and you're a pessimist, you may decide that 10% failure rate is too much for you. You know, and if I say it's 90% likely to fail you and you, you're an optimist.

You go, oh, I'll take 10%. That's better than Las Vegas odds, right? So statistics are useless. You just have to try it, see if it works, and do it efficiently and expeditiously so it doesn't waste a lot of time and money.

That's my attitude now. Yeah. And that's the other thing I want to say is that you do offer it without wasting a lot of people's time and money, which is really special.

So thank you again. It's been a pleasure. Tie. Yeah. More than happy. Thanks, Eric, for for.