Introduction to Dr. Eric Gordon

Welcome to this episode of the Reverse Alzheimer's Summit. I'm your host, Dr. Heather Sanderson, and I'm excited to introduce you to Dr. Eric Gordon. He has over 40 years of clinical practice and he's engaged not only in clinical practice, but also in research.

He has contributed to this field of chronic illness in multiple ways, including teaching others, publishing in the scientific literature, speaking engagements, and presenting news to the press and media in order to allow more patients access to cutting edge clinicians and research and solutions to very complex medical illness and particularly chronic illness.

So I'm so delighted to have him here today to kind of set up a little bit of the context of why we've missed the mark on Alzheimer's, how that is fits in this category of chronic illness and some of the things that we can do about it, particularly infections.

Dr. Gordon, thank you for joining us. Welcome. Oh, thank you. Thank you. Dr. Sanderson. And I'll call you Heather and feel free to call me. Please do.

Yeah, I just have so much respect for you. Thank you. Great to meet you.

Chronic Inflammation and Dementia

I think you've done an amazing job at just getting the word out and helping people understand, you know, this manner with people that we see these illnesses as though they're a thing, you know, and really understanding all the contributing factors that finally result in someone having an a quote unquote illness.

You know, we like to give things names. Right? This diagnosis and many people who are struggling with memory loss, whether we call it Alzheimer's or dementia or whatever we want to call it, they've gotten they're taking different pathways, if you will.

And I know that you and I are in alignment in sort of this con conceptual framework of how we arrive at these ICD ten codes or these diagnostic criteria and what that might mean.

But I want to hear, in your words, I always learn so much and find different ways to communicate with patients. When I have a doctor in front of me who I respect and who have similar ideas.

We all see it slightly differently. And I'd love to hear from you. Like, what's what do you see as the common denominator of the multiple risk factors that cause dementia?

Well, you know, I kind of bring it down to chronic inflammation, but that in itself, you know, I think it doesn't mean much to people, you know, okay.

Chronic inflammation, but we have to understand that inflammation is how our body has learned to defend itself. And, you know, self-defense is how the system works.

You know that that's what it's about. And the ways that we defend ourselves are things that are evolutionary, evolutionarily defined. You know, I mean, we're here today because our ancestors at least survived long enough to have one offspring.

So and how how the body survived past insults. And and it's and now we're having to deal with that genetics in the modern world. So I think that's one of the basic issues in why we're seeing so many of these, you know, chronic illnesses is that we've gotten very good at treating acute disease.

We we've really if you have an acute trauma, we're amazing, you know, have a car accident, God forbid, a bullet wound. And, you know, I mean, bad things.

Lead me straight to the emergency room. Right. Right. No pneumonias, heart attacks. I mean, you know, we do a very good job at that. But, you know, take any of those things.

The healing that has to happen afterwards is where are our own biochemical and genetic individual individuality takes over and that's where we get into trouble because it's easy for doctors to go down the rabbit hole of finding something that correlates with the disease process.

Okay. And and then we chase that correlation. And if that's an example, particularly when it comes to Alzheimer's. Well, you know, again, we've I think maybe a trillion feel like we might have wasted the past 20 years or that wasted but spent billions of dollars on chasing the idea that beta amyloid or tau protein, you know, was the problem.

But these are you know, these are the ways these are signs of chronic inflammation in the brain. You know, they're not necessarily the cause. But if you know, so if you have chronic inflammation in the brain, depending on your genetics, you might wind up with a lot of amyloid.

But, you know, it's finally coming to you. People are beginning to notice that lots of people who don't have Alzheimer's or dementias have plenty of amyloid in their brain, you know, so obviously it's not this sufficient, you know, cause there's got to be a lot of other things going.

And if we look underneath the hood, we see that, you know, the beta amyloid, the tau protein, even the alpha synuclein is all things that happen in depending on your genetics, which one shows up when you have chronic inflammation.

Okay. And chronic inflammation is how your body protects itself. And the thing about inflammation is it should be transient. Okay. And one of the things we'll we'll talk more about, I think will stick in in later is is one of my favorite topics is something that Dr.

Nabeel has called the cell danger response or now he's calling just the the healing the healing cycle because it is a cycle that has a start and a middle phase and an end and chronic illness develops when your body gets stuck in any one of those phases.

So you have an acute injury, you know, or an acute infection. So some cells are dying, okay? And your immune system comes in and has to deal with whether it's an infection.

And we'll talk a lot about infection later on. But but you have an infection. So your immune system starts to kill the infected cells. Now, then the cells have to recover from that and you have to replace.

So that first phase is what he referred Dr. Nabeel refers to as KDR. One is when the cells that are infected either have to kill the invader inside the cell or the immune system comes in, recognizes because of signals that the infected cell puts on the cell membrane.

This is an infected cell and the white blood cells come and will kill it. Okay, but then you have to. That's the first step. But the second step is you have to rebuild those cells.

Okay. And during that first time, the mitochondria during that first step in this cell danger response, the mitochondria are browny. Now, they're not using as much energy. Okay.

They're not using as much oxygen. Okay. And that's that's a protective mechanism. In the second step, you rebuilding. Okay. But the mitochondria still aren't back to normal.

Okay. And then in the third step, those cells that have been either recovered from the insult themselves or the new

stem cells are coming in and growing.

They have to learn to communicate with each other. Okay. That's the third step of restoring communication, becoming part of the whole again, you know, because it's very much like what happens when you get sick on the macro level.

Okay. When you get sick, you with you, you know, you withdraw from the community, you know, and then at the end, when you recover, you start interacting again.

So if you get stuck, either in that first stage of having inflammation, so your white blood cells are constantly trying to kill something. And when you're in that stage, you're making a lot of inflammatory signals.

Okay? In the second stage, you're still not making normal.

Cell Danger Response and Mitochondrial Dysfunction

Your mitochondria aren't working normally, and the whole cell is not working normally yet, and it's making proteins and some of those things can turn on the processes that will start increasing the, the, the beta amyloid or tau protein or even alpha synuclein.

I mean, because these are all these are all proteins that have been identified having to do with various different types of dementias because, you know, anything we're calling things Alzheimer's.

But really, I'm talking about there are multiple types of dementias. Right. Right. And so it sounds like, if I understand what you're saying is the causation, inflammation is part of that.

But really what we need to go back to, if we're going to address the causation are the manifestations of causation include this cell danger response, include beta amyloid plaques and alpha synuclein and and TAO proteins and protein misfolding.

But if we take that one step back and say, what triggered the inflammation, that's when we actually get to causation. And it's when these these inflammatory cycles get stuck in the iron position that we end up with a problem.

Do I understand that? Right. Yes. And the thing that what makes this so difficult is because we are so different. Okay. I mean, you know, genetically we are different and environmentally are exposures.

Who we are as an individual is like kind of a you know, we start off with the genetics, but then we have our environment, you know, and that can be, you know, your parents, which are always an interesting stressor on the environment and just the chemical exposures that you had the environment, all the environmental toxins, your diet, you know, any of your lifetime exposures add up.

But how they affect you is what's individual. Because one of the I think one of the great examples when we did a study with Dr., I said that Inovio is somebody who for me helped understand what I was seeing.

Okay. Let me just take a little a little detour and I'll come back to the main point in a second is that I was so confused because I said when I started treating chronic fatigue in early nineties, that was like my my thing.

I didn't understand. You know, everybody thought of this as a, you know, or like any of the chronic illnesses, just hypertension, for instance. Why in some people, you know, lowering using antioxidants and using mitochondrial support, things like CoQ10 and carnitine and de ribose, you know, help some people a whole lot.

And a lot of people didn't do much of anything. And especially as I saw people who were sicker longer and longer, and they come in with, you know, the shopping bag sign, you know, or a whole box of supplements and wasn't moving them, you know.

And I just didn't understand that because, you know, in the the model that was popular at that in the nineties and early 2000s was that if you gave people enough antioxidants, you were going to help them.

But it was clearly that wasn't working. And what Dr. Navarro's model explained was that they're not working because we were doing things that on some level were there to support the mitochondria and that.

And so we had this idea that the mitochondria were broken, okay, we're injured. But in reality, most of it is a normal response. It's just a normal response that didn't stop.

So that's where the KDR, the cell danger response is three phase process. If you're stuck, if you have cells that are stuck in any one phase of that and don't go through the cycle.

Okay. So you have both, for instance now, I mean, COVID is the flavor of the month, unfortunately, or the decade. Right? Right. You know, you have an issue where you have in some people, they have persistent inflammation that lines up with this long COVID thing.

And it produces a lot of, you know, brain fog in a lot of people. So if if the body is still trying to deal with either a persistent virus or perhaps the spike protein is not digested completely and gotten rid of it.

Still said signaling inflammation and the mitochondria in that cell will not be producing energy. So all the CoQ10 in the world isn't going to get that mitochondria to turn its electron transport chain fully back on.

Okay. And that's how how do you how. Do you get out if you're stuck in some part of this KDR and some part of this cell danger response, what do you do to kind of kickstart it, to get past that stuckness.

Pas? Well, that is where it gets interesting. Okay. Because, you know, so we we go to, you know, chronic inflammation, for instance, or a chronic infection.

Okay. Let's say people have a tick borne disease, whether it be Lyme, Bartonella, PPC. These are these are illnesses that in most people are acute illnesses.

We get them and we recover. If you haven't recovered, it's because your immune system hasn't been able to deal completely with the infection, whether you have it, whether the right whether the bug kind of is fully your immune system or whether your immune system has just become weakened.

And so you have to go back. See, this is where it gets confusing. If if you're if everything is working fairly well, well, you can treat people with an antibiotic or an anti-parasitic medicine and they recover.

But if there is toxicity because there has been, you know, a difficulty in your in how your body metabolizes some of these toxins. And that's where the genes come in, because one of the things that we've noticed, it's not the amount, the gross amount of a toxin.

That is the problem, because most of us, you know, when we when we measure toxic loads, we often find that many sick people don't have a whole lot more than healthy people.

Mm hmm. You know, just like cigaret smoking. It's not good for you. It's definitely a toxic load. But most people who smoke don't develop lung cancer or don't develop emphysema, you know, or bronchitis, chronic bronchitis.

But some people do because. So it's your genetics. It's how your body has evolved to deal with stressors that are failing you. Okay. Because you weren't designed for that for that problem.

I mean, do you think that there is something about the sort of layering things? So it's like childhood trauma plus genetic predisposition and plus toxic exposure, plus repeated traumas or stressors plus an infection.

And all of a sudden now somebody has this this burden, this overwhelming burden that's going to manifest as

disease or this dark or perpetuating process of inflammation.

Is that part of how you synapse? Absolutely. Because, you know, when you think about it, you know, I mean, just oh, I've just been looking at let me lately into ALS.

And when you look at something like ALS, which is, you know, a progressive neurologic disease that often can have dementia is part of it. But so and some of the same some of the same genes that will lead to ALS can lead to frontotemporal dementia in a different person.

Right. And so it the genes are only about one, you know, only about 1% of people with ALS have a gene that causes ALS. The other 99% have a conglomeration of of issues that lead them to the same outcome.

Okay. So it it it just depends on on how your body deals with stresses. And that's what gets, you know, that's why people are so frustrated and why medicine in general had does such a poor job, because medicine is aimed at what happens in 90% of people, 99% of people.

And so that's why they keep failing, because they're only looking for solutions that work for large groups of people. And that's appropriate if you're going to use a toxic drug.

But, you know, from your work and Dr.

Infections, Toxicity, and Individual Susceptibility

Reticence work, you know, we clearly see that for most people, if you just work on toxin load, diet stress, you know, and supporting, you can make big changes because as you remove the toxins, then this cell danger response process can work normally because usually there's a I shouldn't say usually, but often there's an underlying toxic toxicity, an underlying stress that has not that that's too much for that system.

You know, like you can measure efficiency. People look at glutathione, you know, and you can see that people who are who stay sick have very low levels of reduce glutathione on the part of glutathione that you need to help fight a viral infection or to help deal with oxidative stress.

So there's something that's sucking it down, or there could be a gene that's not allowing it to be made as effectively as it can be. But what makes chronic disease different than acute disease is that if you have pneumonia and we we see the bacteria that you have, we give you the right antibiotic that kills that bacteria.

And 99% of people would keep it, depending on how old you are and how depressed. But but people get better, okay. Rather straightforwardly. But in a chronic illness, it really becomes a game of individual pick up sticks, plus pin the tail on the donkey.

Trade right in this kind of simple model of there's one pill for that one infection and you just kill that bug and it's over and done, like with a strep throat or sometimes with the pneumonia that that model works.

But when it comes to dementia, we need a more sophisticated, more complex intervention to meet the complexity of this disease. While I have you here, I think of you as one of the preeminent Lyme experts and Lyme and Lyme co-infections we know are associated, particularly the Lyme.

SPEIER Very similar to syphilis. There's a neuro manifestation of Lyme. These are both skyrockets. They affect the brain directly and we see the beta amyloid plaques sometimes contain pain.

In fact, more often than not, from my understanding, the literature contains by records in them. And so it's as if these beta amyloid plaques are potentially being created, as you said, in response, it's an inflammatory and appropriate immune response in the brain to this chronic infection.

And as you mentioned already, I agree with you. I tend to think of Lyme and the Lyme co-infections as relatively

opportunistic. Many people are exposed to them and a few people succumb to them.

They actually create these overwhelming symptoms that can be debilitating and in some cases trigger, I think, dementia and Alzheimer's. So if someone thinks that this might be part of their process, part of their pathway of arriving at a dementia, what do you recommend doing about it?

Oh, well, again, this is the same circle. Okay. If it's if you're, you know, robust and healthy and physically, you know, and the infection was, you know, relatively recent.

Then the antibiotics, you know, or herbs do work. I mean, the main difference between the two is the herbs take a lot longer, but they're often effective.

But if there's a lot of neurologic effects, then I tend to think people do best with intravenous antibiotics. And what's frustrating is that they require prolonged therapy.

And that's something that the Infectious Disease Society of America has decided isn't necessary. But I think they're misguided. But what the big problem here is that by the time people have developed, you know, something that we would consider dementia, okay?

I mean, more than just brain fog, but really are having things that we can see. The hippocampus has truly shrunk. There's really there's problems there.

Then usually we have to deal with the toxic load and the and the chronic inflammation before we can deal directly with the infection. It's you know, but again, that I what I'm always concerned about is poppy is my is a population bias is because I tend to see people who are chronically ill.

And I wonder if we treat it, if people who who otherwise were fairly healthy and the only symptom that was appearing later in life was dementia. Those people might do very well with just direct treatment.

Okay? And by removing that inflammatory trigger in their brains might really help a lot. Now they'll still need support because this shouldn't have happened.

So they have excess inflammation then. Okay, but if we remove the trigger and then support them with I mean, and this is where a whole other slew of therapies come in, you know, this is where the peptides which which help resolve inflammation.

Okay. This has been not new, but relatively new. And it's popular, Adi, of using these small molecules, these small amino acids. There are things your body produces as you're resolving inflammation.

And if we give them, we're kind of giving the body the signal to help resolve the chronic inflammation. Because I love to know what your favorite peptides are here, how you thinking to wine or low 37 and by cleaner.

Well I used to repress them. Yes, but but I prefer I mean, you know, I think those are important when we're trying to kill it. But when someone is, you know, has dementia at or in that, you know, soft area before, you know, there's, you know, real maybe what we call just cognitive decline or the the the early the early things it's slowing the inflammation is often helpful.

And that's where things like the CFPB and TD for Frag and the BPC, these are or even yeah these are things that lower inflammation and I think are really helpful because the bug can be just a slow process.

Like it's sort of like having the fire alarm going, you know, and if we can just turn off the fire alarm sometimes that can let everybody relax because the fire isn't that bad.

You know, this is what's frustrating to patients. It has to be frustrating to patients. It's frustrating to me as a clinician is knowing in which order to do these things.

And that's what we've learned over the years. When I first started treating, I didn't really start treating Lyme itself until about 91. I mean, 2001, when I started treating chronic fatigue, I was hesitant to treat line.

And I think people should understand that. What makes many doctors hesitant to treat Lyme disease and these other tickborne infections is that the testing, though improving, is still not great.

And back in the late nineties and early 2000, it was really kind of crude. And the idea that you were going to use, you know, heavy duty, you know, antibiotics for long periods of time wasn't something we wanted to do.

You know, it's only when you start seeing the results that you get brave enough to keep going because, you know, antibiotics don't do good things for our microbiome and that I'm sure and you're I'm sure you have going to cover a whole lot about the microbiome.

And so we we hate to disrupt it. And unfortunately, when we're treating Lyme and we're using antibiotics, we disrupt the microbiome and rather significantly.

So it's not something to be done lightly. As a means to an end. And yet if we don't have testing that we can rely on, that makes it a much riskier intervention.

Right. We don't even know what we're treating. And this I beg to actually discuss this right. Why is the testing so so hard to do? Right. A lot of it is because the lifecycles of these bugs are very complex.

And so it's easy to miss. Plus, similar to like HIV or AIDS, they directly reduce immune function. And if what we're testing is an immune response, it can be basically you can get false negatives where we're told that there's nothing there when it's just a result of the bug being there, that the immune system is suppressed and they can't mount a response.

Do I understand that? Right. Well, that's a big part of it. Now, the good news is that the testing has gotten better. So as I say, I was hesitant in the nineties to do to treat this, because also in the early nineties I was in upstate New York and how foolish we were back then.

The infectious disease doctors told us that north of the Catskills there was no line. And I was in northern New York, and so there was no line.

Lyme Disease, Testing, and Treatment

That's what they told me, you know, and something about being in medical school, it's it's a great brainwashing machine. And it's you know, it's I've I depend on natural paths to keep teaching me that the stories I learned were stories.

And but anyway, so in the early in 2001 or so, Doctor Anderson, who was a natural path, joined my practice and he had been treating Lyme based on clinical symptoms because he happened to be in an area with a very high number of lot of cases of Lyme disease.

And he was in constant contact with Dr. Boris Schiano. I was called Dr. Bruce, kind of the the godfather of Lyme. He's somebody who had been treating it since the late eighties and really, really had a deep understanding of it and felt comfortable with the clinical diagnosis.

And when you start seeing people recover based on clinical diagnosis, you start getting much more brave. But what's happened over the last years is our diagnostic abilities have gotten better and better.

We're testing with more antigens, which is like more pieces of different Lyme subspecies, so we have a better chance of really finding the line. And also they've developed better things for calling the immunoblot, which are better ways to find to find the immune evidence.

Because as you said, many people with chronic Lyme, the reason they have chronic Lyme is because it's it can confuse your immune system. It can it can actually lower the cytokines that would allow the body to effectively kill it.

And there's also the RNA tagging and imaging that's now available through Doctor Bob Mulvaney is doing. Are you using much of this? You have to. You know, we were using I mean, the the T lab that started that this his test.

But also we use in fact infected lab which uses a T cell test because the T cells and the nice part about the T cell testing is that they're only positive when they're seeing the bug.

When we do, most of the tests that we've done have been based on immunoglobulins or what we call these are produced by. But part of this that the immune cells called B cells in the body and they depend on they they can be positive for long periods of time.

So many times we've seen a family where the mom has Lyme and is symptomatic or the mom in like the second or third kid when they go through puberty, start getting symptoms.

But the dad is asymptomatic. But when we tested him, they had high IgG antibodies. But we don't know, do we need to treat them or did they take care of it?

And what really confused the matter even more is that most of the time, yeah, I think a large number of people who have active Lyme have recurrently positive AGM antibodies and the infectious disease doctors have decided and this is the thing about medicine, it's not always based on a truth, but it's based on opinion that AGM is only present in the first, you know, 6 to 12 weeks of an infection.

And because it's not a very specific antibody, as your immune system sees the bug more and learns you make it, you did what they call class switching.

You start making IgG antibodies, which are more specific. The AGM is like noticing that it's a car and the IgG notices that it's a you know, it's a Tesla, you know, it really can be specific and line has a way of evading your immune system where you were.

In some people they don't make a lot of IgG, but they make a lot of AGM or they keep seeing Lyme again because lying can get quiescent. I mean, that's why you don't have persistent symptoms where you can have symptoms, you can have Lyme in your brain that is stimulating inflammation and maybe leading to dementia.

But yes, you're not having, you know, swollen joints or inflamed joints or a lot of other symptoms because it's quiet, but it's not gone. And while it's quiet, it's still stimulating your immune system.

This is just like we're seeing with the with EBV, you know, with EBV and mice. And I'm sure EBV with dementia. I mean, it's that it's the same thing. You have persistent, low level inflammatory drive because some cells are chronically infected and are chronically almost colonized.

They're there. And the bug is not making a lot of noise, but is making enough that that cell every once in a while signals to the immune system that it's infected.

And then you start getting the cytokines to calm the chemical messengers to come to the area, and then in your brain you have these, you know, your microglia get excited and start producing inflammation and then you're going to wind up with a lot of, you know, tau protein and beta amyloid around.

So this similar process happens with the sinus infections and dental infections are colonization as well. Do you refer patients out to biological dentists?

Do you have a process for treating sinus issues? Oh, well, both the now I'll do it in the order of which we we've been the jaw infection has been something that we've been dealing with for at least 20 years now.

I mean, it's turned out to be just when people weren't getting better. That is often underneath. And that can be from old wisdom teeth sites, any kind of, you know, dead, you know, crown teeth, especially root canals where the tooth is basically dead.

And, you know, you had the root canal done because it was infected. And it's very hard to clear that infection completely. Again, with an intact immune system and good blood flow, things do well.

But chronic and chronic dental infections is a huge issue for people. And it can be can from multiple reasons can just be because, you know, your immune system doesn't work so well, but often it's because there's a lot of tension.

We live in a culture, you know, we don't move enough. We spend far too much time looking at screens and even before looking at screens, just working at our desks, you know.

So there's a lot of tension in these muscles and that reduces blood flow, reduces lymph drainage. People forget about how important structure is, you know, because, you know, once again, it's the individual.

There are people who can have terrible structure, you know, really like, you know, bad backs in all kinds of identifying. And there are other people who just have a little bit off and do terrible look.

It's how we're built. You know, the people. One of the big things we're dealing with these days is connective tissue issues. Okay? Because chronic inflammation and ligaments, ligaments get a little lax when there's chronic inflammation.

If you already started life with lacks ligaments, if you loved yoga because you could do the pit, you could do the postures. Well, be careful, because if you're really, really good at it, you probably have lacks ligaments and you get chronic low level inflammation.

You can have more movement. And if that an excess movement is especially in upper neck, you can really start affecting your brainstem and your vagus nerve and be stuck in one of these chronic inflammatory loops and turn on your mast cells, which is another world. But all these I just talked to Kelly McCann right before we got in this call.

And so he's head over to Dr. McCann's talk. If you are curious about mast cells and how that can trigger chronic inflammation and this cell danger response.

I mean, it's because that's the thing is that we are such complex beings. Okay. And, you know, at the end of the what I was going to start writing the beginning, I go back to a point that going to make right in the beginning that I skipped over is that when you when when we did a research project on chronic fatigue with Dr.

Inovio, one of the amazing things we found was that we were looking at about 4 to 500 chemicals in the blood, something called metabolomics, just kind of looking at a mass of them.

We don't know what all those chemicals mean, unfortunately, but what we could see is that people shared only about 25, like when we looked at chronic fatigue people out of the other 40 chemicals that seemed to, you know, define chronic illness.

Okay, only about 25% of those were shared by everybody. Okay. But 80% of the abnormal chemicals were individual. So that's how that's why this is so hard when we're trying to find the smoking gun for chronic illness, there usually isn't the okay.

It just depends on your body. And that's what makes it so frustrating to the patient and expensive because it's not like, you know, we can do one test.

You know, people get very frustrated when they come to see doctors like us and they do a lot of tests. And, you know, why all these tests? And, you know, and it's because we don't know which ones are going to be abnormal.

Now, you know, clinical, you know, you've been doing this a while. You can also narrow it down. But not that not as much as we'd like. You know, I'll just add to that.

I, I learned my lesson the hard way doing that, thinking that I could take a history. And if somebody told me, Oh, I've never been exposed to mold, they don't need to do a mold test or I have no exposure to Mercury, I don't need to do a mercury test.

And then to get 12 months into a treatment, hoping to see a miracle happen, hoping to see dementia resolve or at least turn around and then feeling the frustration of waiting.

Because we're trying to save a few hundred dollars, waiting to run that test, only to find that it's egregiously abnormal and having to then start treatment when we could have started it a year earlier.

And so now I just ask patients, you know, if you can, I know that financially it's not always feasible, but do as much as possible right out of the gate so that we have as much data as possible to make the best decisions and prioritize interventions in a way that's really well-informed.

It's just too easy to miss something. If we don't, we're not able to do all the labs. And, you know, there's a lot of labs that are new and not everybody knows how to interpret them.

And there's there's a lot of nuance to it. But I, I really as a clinician value that data and getting it early on. Yeah, I, I second that because I, I started out treating farmers, you know, and I was doing what I call regular medicine in the eighties and you know, they didn't want to spend a nickel.

And so that that traumatized me. So the first I've been like to this day, I still make that can still make that mistake of thinking okay we're not going to spend that much money.

And I and you know, and it's like that with the tick borne diseases, you know, you get the history and you go, aha, I'm pretty sure, you know, this is either Lyme or Bartonella.

Dental, Structural, and Mast Cell Contributors

And so we're going to only spend because these tests unfortunately are expensive. And you're right, you often miss because the body has only so many ways of making noise.

And you know, and I tell patients, especially our patients, if they're on the Internet and they you know, and they've seen the list. Okay. Oh, I know I have this or I know I have I have mold toxicity because look, I have all these symptoms, right?

And that's great. But you still can have Lyme underneath that, you know, because you don't usually in my worldview, you don't usually develop a mold toxicity when you're 50 or 40, you know, unless you had something else that played games with your immune system, especially Lyme.

Because I said Lyme is good at suppressing your I'll ten, which will really let you not deal with mold well so it's it's this you have to look you have to look everywhere because those you know, just just put what you think you have if it's chronic it got there for lots of reasons and we don't know which one is going to make a bigger difference in your body, you know, so so getting underneath is important.

Yeah, I just can't emphasize that enough. Don't try to. This is it. Especially when when you know, as you've gotten older, you've had exposure to all these things.

Yeah. You know, and, and when you, when your body is, is still has a lot more reserve. I mean, one of the things is when you're 30, 40 and even 50, you have I always tell it you can get away with almost anything.

It's after 50 that that most people start running into trouble because we've lost our reserve. You know that or that

resilience. That resilience. Yeah.

You know, we lose function. But the body is so amazing, you know, we do it well. Dr. Gordon, I want to know, what are your secrets to stay in young? Oh, God, I you know, unfortunately, I think one of the main ones is one that you can't that you're just like, you know, born with is just an optimistic attitude and a curiosity to keep keep exploring, you know?

And that's the most unfair thing about life, is that a lot of what people think as they're they're doing something is really who they are. You know, like when I listen, you know, I was ever since COVID, I started listening to a lot of podcasts and I listen to all these really incredible people and, you know, but especially in the in the, you know, live longer field and they're athletes and they, you know, and for them, if they don't work out an hour or two a day, they haven't done, you know, but some of us are born that way, you know, might you know, we don't we're so it's you have to find the hook that that that that gives you joy.

I think that's what it is. You know, in this culture, you know, people are taught to work hard and struggle. And but I think the secret to to really a healthy life is to find joy, because it goes back to this cell danger response thing again.

Is that what turns off in chronic inflammation or what turns off inflammation is when the body gets the safety signal and the safety signals really come from the brain.

Now, local inflammation will always trump this, you know, because local inflammation is kind of screaming, but you can turn down local inflammation. But until it really gets the all clear signal from the brain, it doesn't go away completely.

You know, and feeling safe is what does that. And feeling valued, I think as well, you know, what you're speaking to. There's some good science around Becca Levy.

I've mentioned this on several other episodes because I'm just so impressed that inspired and empowered by her work. She's a researcher at Yale, a Ph. D.

researcher at Yale. And she some people have heard of the seven and a half years that you live longer if you have a positive association with a gene. She's the one who published that research.

And she also published some research showing that if you have the if you're positive for EPO, E4 if you have the genetics associated with Alzheimer's, you can completely eliminate that risk by living in a society that reveres the aged among them.

And so having this repository for the wisdom and experience that we've gained, having another generation behind us to to donate that, to, to give that to it, gives us a sense of purpose.

It also gives us that that will to live kind of what you're describing, this joy and that sense of safety and being valued as we age. And so I love what you're saying and it is absolutely validated by the research and so empowering because what I imagine is always Betty White.

I have I just channeled Betty White. It just keeps getting better. If we keep aspiring to have relationships, if we keep engaging. And as we get older, we, we provide like services as a mentor.

If we help others that are coming behind us by sharing our wisdom and experience, then that is helpful. It's almost a selfish thing to do, right? It's helpful for us.

And yet it also gives to society in a very impactful way. Yeah. So and that's what's happened in this culture is, is that we, you know, we started out, I don't know, about 50, 67, you know, just like, you know, making old people separate and just this idea of retirement, which is, you know.

Yes, you know, I mean, like retirement, if you're doing something with heavy physical labor, you know. Yeah, but but the joy, you know, no matter what you do, if we can teach people once again is skill set.

You know, everybody who has lived develops skills. And I know when you're young, it's hard to believe that there's so much to be gained from old people or older people.

But I remember, you know, I mean, like my mentors when I started off in medicine, I mean, those are the people that inspired me, you know, and being like, you know, the young bright ones had good new ideas.

But the new, I guess, new good ideas, you know, old age. And there's a there's, you know, it's just that the wisdom of being around a long time, of seeing pattern, of seeing cycles, it's so helpful because when you're young, you think that you can change the world.

I mean, when I started, we everybody talked about, oh, the kind of medicine that you and I do was going to be the dominant form within 20, 30 years, you know, and it's now 45 years later.

And no, we're you know, it's better we're not totally sidelined anymore, but still not the dominant form because things take a long time to change, you know, and it takes a lot of enthusiasm.

But we're seeing that we're seeing a lot of lot of I think a lot of physicians who are in our fields are continuing to work. The people who are stuck in the in the the unfortunate world of conventional medicine, which is causing burnout in doctors, you know, and hopelessness in doctors, because, you know, they're being confronted by chronic illness and they're being confronted by chronic illness with the tools that were designed for acute illness.

And that is that is thing.

Personalized Chronic Illness Care and Hope

Acute illness is a model that works really well for things that have a cause and effect, that are fairly linear and obvious, but chronic illness requires a creative mind, you know, and just it just the work that you've been doing where you bring together lots of people with different ideas until the individual gets enough and you need, you know, you really need a symphony of of of support.

I mean, I was going to say treatments, but treatments, you know, again, we when we treat when we treat Lyme, yes, we're doing treatments. But the thing that makes Lyme therapy successful is when we're also doing this symphony of of support that, you know, that you have been talking about, you know, I mean, I'm sure throughout your whole your whole series, I mean, because that's, you know, to be fair, that's the work that those in this field of alternative medicine functional that whatever the whatever the names happen to be is we're looking at the whole environment of the human being.

And because this is not a single a single cause disease for 90, maybe 99%, I don't know. But at least 90% of people, there's a lot of different things.

It's not going to be as simple as one pill or even a two weeks of one pill or one I. V. And it's going to take this I love that that image of this symphony of support and its balance.

Right, that there's kind of just going back to this concept of the wisdom of our elders, and yet they can get kind of ingrained. Right. We wanted that intergenerational wisdom transfer where they're getting that inspiration of new things and new ideas and that that sort of liberal and ideological youthfulness married with the grounding of wisdom and experience and that that I can only imagine a Lyme patient, you know, walking into a clinic where you see both of those and you get the benefit of both of those perspectives.

And a dementia patient getting the benefit of both of those perspectives. You can just see the value of this rippling across industries, across society and certainly throughout medicine.

And, you know, and but one of the most important things about being around a while is you understand that things don't change overnight. Yeah. So and so. Sense.

And that's what's so important in the treatment of, you know, when people say, you know, chronic Lyme or just, you know, it's it's chronic because your immune system hasn't dealt with it.

And that's and just like, you know, dementia, you're there because you've got a lot of things that have to get back to a more balanced response. And so it takes time.

And so the and the thought, the quality of youth is to think that you're going to change the world overnight. And unfortunately, we have to remember that most of the things the people who try to change the world overnight don't do such a good job, you know.

Because it can be a bit destructive. Yeah. I mean, I'm sorry, I, I, I won't go there. I always go to like, you know, pot Paul in Cambodia. But that's an old thing.

Nobody probably even know what I'm talking about anymore. But there was a man who started out with, you know, he really wanted to change society, but he was absolutely causing such pain, destruction and and so much death, you know.

But it started with good intentions. And the desire to do things quickly. Know usually does so relatively recent history that was just in the nineties.

But so and that's about the healing. The healing is that people come in and they want quick and and again sometimes that works. It's not that you shouldn't try but just understand that this is the the illnesses of aging need to be approached with a little bit of compassion and time and and being willing to experiment, you know, because it seems that there's not one size fits all.

And we do make mistakes, you know, as as we're doing. But if we go slow, we can keep rectify and keep changing the path. And, you know, it's there is no royal road to health when it's when you've gotten I mean, even when you're young, I mean, I just blend last.

I always want to make this point is that the reason I got into treating chronic illness is because I was really interested in optimal health. When I was before I went to medical school, I really wanted to learn how to help people with nutrition and and help people with structure and, you know, their bodies and very quickly was demoralized because there was so many different diets.

I mean, forget about medical school as useless, but I was really interested in all the things that were in health food stores in the sixties and seventies.

And, you know, the mucosal diet, the wheat free diet, the the macrobiotic diet, you know, and, you know, the Atkins diet. And they all seem to help some people.

And that is the thing is that when you're young, what your body needs is harder to figure out. But as you get older, as you begin to fall apart, we can then begin to actually figure out what your body needs.

Okay. It's unfortunate that we have to wait for that. Sometimes I think our tent, again, this is where I think our testing is improving our ability to look at the metabolic things, at the, you know, the balance of the hormones and and blood sugar and insulin and all and the gremlins and all these things that, you know, we only had hints of years ago.

I think we can probably help young people more than we could, at least for sure. We could always help them by knowing don't eat garbage. But but I think some things that help everyone.

Right. And help make progress. Right. But, you know, but even in even choosing between all the basic Whole

Foods diets, it can be not that easy to decide when you're 20.

Right. But it often takes a while until you can see where your body starts to be having a little glitch that you go, oh, you know, for that person, all those vegetable oils might not be such a good idea, you know, or for that one, you know, carbs for some people are great diets.

For other people, not so good. So figuring all that out because that's part of of health and it goes back to infections. If we don't have that figured out and you've had the infection for a bunch of years, we're going to probably make you feel bad while we're trying to treat you. And and that's not useful.

Never the goal never got to make you feel not. It's not it's usually not going to help it. But so just getting back to chronic infections and and the, you know, what we have to remember is that things like even Lyme probably, but especially things like Epstein-Barr virus and H six, these are these these we call the DNA viruses, the herpes family of viruses, which I think there's probably even better evidence for them having a lot to do with chronic inflammation in the brain.

But remember, these guys co-evolved with us. You know, they're not they're not things that we necessarily have to get rid of. But we and it's very difficult to do because they kind of live inside of our cells and and they actually probably help us a little bit if we keep them in the right balance.

So that comes back to it's not so much about killing everything as about restoring immune the balance in your immune system so you can keep it in check without causing too much inflammation because that's the secret.

And so that often means you have to remove the other irritants. You know, it's not so much just killing the bug because I think we get lost there sometimes.

You know, that's a put it into context of that individual that's like kind of precision medicine, functional medicine perspective. As best as best as we can do it as well.

And luckily, as I said, the tests are getting better and better. And I'm really hopeful that some of the research and the money that's pouring will maybe not pouring in, but going into researching long COVID milk is going to bear fruit.

I mean, again, for us, unfortunately for the people with long COVID, by the time they get anything to do, they better they better not wait for the centers of excellence to to help them.

They're going to have to go see their local natural gas and functional medicine doctors who will try these things long before. They're available at Mayo Clinic.

Exactly right. Mayo's a great place or. Yeah, again, if there's a clear a clear smoking gun there, great rate. Don't expect too much in terms of treatment.

No, it's just a referral to psych. Unfortunately. Yes, yes, yes. That that's usually part of the part of the package, you know, and it's a shame because we many of those doctors are excellent, excellent, excellent in in but their their hands are tied and B, they don't get to be free to try things anymore.

You know, and I think people have to understand there's a big difference in trying in medicine where if we're wrong, you know, there's a, you know, 20% chance that you're going to have something terrible happened to you and trying something where there's a, you know, a negligible, less than 1% chance that it's going to give you anything, you know, and unfortunately, the FDA doesn't seem to be able to discriminate between the two.

They're asking for the same level of proof for things that won't hurt you, for the things that will could possibly kill you. And and that that is a failure of the system.

And unfortunately, because of the economics today, you know, in the fact that pharmaceutical industry basically

has too much say at the FDA, that's not going to change.

Right. There's quite a few failures of the system, unfortunately. But that's right, because we're working outside of it in our own system that works well, that supports the human system and the human body and the nuances and has a bit of reverence for pieces we don't know.

Dr. Gordon, it's such a pleasure having you. I always learn so much from you, I. I just have so much respect. I look up to you so much, especially in the space of.

Of Lyme disease and chronic illness and fatigue and I just couldn't be more grateful for your time and participation on the reverse Alzheimer's Summit.

Thank you. Thank you for those very, very kind words, Heather. And I appreciate your work and getting I mean, just helping the world learn more that there's hope.

You know, I think that's the biggest thing is hope is what allows us to heal. So thank you. Thank you. Thank you so much.