Introduction to the Guest and Topic

Hi. This doctor can't hold talk with another episode of the Peptide Summit. And today we'll be interviewing, doctor. She, Sam Rabaa, who's a leading premier gastroenterologist in Los Angeles.

It'll be talking about the significance of non digestive symptoms in patients with digestive disorders. And I have to say, he's one of the few gastroenterologists that really look at the whole body and diagnose systemic illnesses instead of just saying, oh, we'll scope them all your guts.

Fine. Really? Quintessential medical detective, holistic physician. Proud to say he's a friend and a colleague and, send a lot of patients to, and just all get raving reviews.

He thinks outside the box, and does a lot of unique, therapies and, testing. He's developed test, that he has that are, unique for Sibo and other things like that.

He's, basically, leading again, leading integrative premier guests, neurologist in Los Angeles, I think all over the country, in the world, he lectures all all over the country, in the world, he incorporates anti-aging, functional medicine, an integrative, holistic approach, to digestive care.

And, well, most guys are just now learning about probiotics. Like, is so far ahead. It's it's pretty amazing. He's medical director of the LA integrative.

Guess where allergy and nutrition. His approach is not just holistic. And I also I don't know what to call what we do. It's also integrative. He blends the best of Western medical, and scientific research, but the concept of whole body relationship to one's health.

And really, I think you just practice better medicine and continually does research and learns. And he's so generous with his knowledge, and lecturing all over the country that draws huge crowds.

He's a big fan. He has the, told by my girlfriend, the sexiest voice in the sexiest gastroenterologist in the country. So I welcome, Sam, doctor of bar.

Thank you for being on the summit. It's, it's a pleasure. I'm looking forward to, more interesting info from you, but thank you very much for that introduction.

I really appreciate this invitation, and I must the admired the work that Doctor Holdsworth has done in, providing the community with a variety of services that is hard to get to, if you will, all under the same roof and, you know, like, we can continue to collaborate with each other in that respect in, so I came up with the idea of the subject of, based on, this significance that we had seen obtaining a more detailed review of systems where we see a patient with digestive problems and issues come to us.

They either have symptoms or they have conditions. From digestive point of view, symptoms are about ten symptoms like appetite, nausea, vomiting, abdominal pain, diarrhea, constipation, bloating and sometimes bleeding and the number of illnesses that may.

Underlying these symptoms is over 300, you know, so there's a lot of overlap. And nowadays I'm learning that we rarely find, patients who would have a single entity problem.

There was a time you go to the office, somebody come with a strep throat, you give them an antibiotic kit, and you're done. And you just don't see any more that we know that the patient comes in.

There must be an array of underlying physiological, the arrangements that they need to be addressed, and to be able to address those and understand them is very important to know what other symptoms non-gay non digestive they're presenting with.

And as such, we need to be a good historian and be able to be a good listener. And this is such an important that we actually put our data together for over three years, and we submitted this for publication and verbally, we have heard that the article has been accepted.

However, it is this final steps need to go through and once it does go through, then it would be available online.

Why Non-Digestive Symptoms Matter

You know, to everybody, that is awesome because it's very difficult and I know the laypeople don't know, but trying to get something published that isn't just standard dogma, is very, very difficult.

And if you come with the new concept, it just gets Pooh poohed, you know, and it's tough and, and, lecture. Bah lives in an environment where he has, you know, works at Cedars.

So he has to, you know, deal with the standard physicians. And, you know what, that fine line. So he the reason he can do it because he has a lot of respect from those physicians.

And, and he's doing a lot of amazing, integrative things that they're like, I have no idea. So if a doctor doesn't know, it's, you know what it is? It's it's crazy. It's quackery.

So it's amazing that, how many years you've been in that dual role where dealing in that hospital space and in your colleagues in that area, and also in this, I think, exciting, integrative, functional, whatever you want to call it, space.

Thank you. And the, you know, after a while at least, if I can say for myself that one there is to, be humble and be a student at heart and continue to be observant and learn from the experiences that the patients shared with this kid.

I mean, nobody comes to my office. You know, unless they truly have a problem. So it is our role to see if we can begin to it and learn from that. It.

And to this day, I must say that I still learned something new that I didn't know. And that's because somebody is willing to share their experience with us.

Yeah, I know that's a lot of doctors are willing and, I mean could job. But I, I'm curious, like how does it work with your like standard GI colleagues.

You know, where they're kind of stuck in the past to me. And, do you try to teach them or convince them or is it not worth the the trying? And no, I would never say it is not worth trying.

Yeah. I mean, for, colleagues that we have sat down and talked generally in an informal way, they made the notation of that, and then sometimes they run into a scenario where they say, oh, you know what?

This sounds like another patient that Sam Rayburn was saying, maybe we should look into it. For example, you have patients with gastroparesis or cyclic vomiting syndrome, things that, you know, they don't have clear explanations in the practice.

We treat them, but we never know how did we get to that point. Now the patient has this type of problem. Get and I think as we learn that our bodies have a lot to do with the way it interacts with environment and when things go wrong, I mean, the microbiome somehow gets affected, the autonomic nervous system gets affected, the brain gets affected, and a variety of symptoms start to manifest themselves.

And as such, that's why, you know, we like to pay attention to those other symptoms that do not necessarily give.

For example, I would say about half of our patients have an issue with fatigue.

Location fatigue is the predominant symptom, isn't it? I may talk to a patient and I say, okay, you have digestive symptoms and non digestive, but which one really predominates.

What brings you here. And at times may say, oh you know what. My digestive symptoms, you know are there. I'm really bothered by the non digest digestive symptoms.

But the reason I want to come here because I think maybe the GI is doing something to the other one that almost the patient has is sense that the correlation may be there, that an imbalance in the digestive system may be turning on the inflammatory process, and they're feeding it elsewhere.

But the problem is really originating from the from the digestive tract. And I think more and more research is, is showing that. And but I think the compartmentalization of medicine now, it's like the standard GI like, okay, I'll fix your gut.

I don't care about that other stuff. You go to your, you know, family practice or internist. Yeah. I mean, I'm sure that it if the visits were modeled in a way that there was a lot more time allocated, physicians would have time to spend to analyze these things here.

But to when I practice more of a traditional model, I mean, the approach would be problem focused the same way that is CPT codes and the coding system is designed, which is basically based on the number of problems problem 1 or 2 or three.

And the approach would be problem focus as opposed to allowing one to be completely holistic, holistic is good, but it needs two things. One is the mindset and the willingness of the doctors and the patient to get into that arena of thinking.

But at the same time, in this time, it is an element of time to be able to do sharing and bounce back and forth. You sometimes is one sentence or one buzzword or something that brings the thought process that you want to pursue it.

And diagnostically, I think is always important to know what we're dealing with, because if we understand it, then we could be more focused. What needs to be done?

At least that's the philosophy that, you know, I have taken and I, I totally agree with that, where I'd like to get a lot of information upfront and paint a picture.

Right. And don't hang your head on any one test. You know. Exactly. I mean, as you know, I mean, there is no such test that is 100% rule you rule out.

I mean, we still have to correlate what this means with the clinical picture. And that's why it's very, very important. It I mean, I recently had a patient and I think we chatted about this briefly.

The patient has been ill for almost seven, eight years, has been to multiple institutions and lost weight from the range of 100 to the range of 70s. Looks active and he has abdominal pain and goes to the hospital for nutritional support.

We did a mercury test at mercury level was high for somebody who was 70 pounds and number more than ten is a high number, and at the same time, the Lyme disease markers, for example, in this particular patient, were positive, which was which correlates with her travels to a lot of exotic areas.

And if this study showed that the antibody that was positive was the one that we call the exam and obviously would be the experts in that one, which means that maybe this is something new, but the patient has been ill for years.

So especially as we saw the patient reported that he would believe that is a false positive. But in fact, there's a ten year story with the patient. You know, that the patient ended up in that clinical setting.

I would want to just say this negative. Maybe there's another explanation. And as we spoke the other day, you know, we mentioned that perhaps the immune system did not get a chance to go through evolution to evolve from that preliminary stage of exam to the ICU.

And maybe there was an evolution every block into this, you know, immune system recognizing that has to and to do this. And I believe this has been well described in the literature.

Yeah. In many conferences I've seen with reference to this has been addressed, but I cannot quite relate as how and infectious it is, especially I would call this false positive, not seeing how this may be correlating to this story.

You know, there's a story attached to it. You know. Yeah, it's I think I don't know, it's influence where they can admit it because their colleagues will get on them or it's giving in to the so-called alternative area.

And I think you see a medicine, you have kind of a standard ivory tower, you know, doctors. And they say one thing and all this evidence comes up and it's like a fringe group supposedly evidence, evidence, evidence or show like, you know, la la la la.

I don't see that. No, I don't like that study. I don't like that study like that study. And don't confuse me with the facts. And they just refuse. It's it's nuts and it's shown that, you know, these people have terrible natural killer cell low one immunity.

There's 20 stuff inside the cell tissue. So that's a cell. And these people are like this. Now, if you don't have one, you can't convert it to IgG. Now you give peptides or, you know, treat the infection.

All of a sudden it switches to IgG. And so I think more people will find come up with IgG positive. That is chronic. Then IgG and then IgG. And they say oh must be a false positive.

You know, and it's crazy. They just don't want to believe it. They don't want to believe the literature. So it's a very complex I think, and, and, and I think this would eventually evolve.

I don't believe it's going to stay like this. I think this science eventually is going to pick up because the momentum or, the number of patients with ill is significant.

And I think you just to evolve, you know, I'm not sure we're going to be in our lifetime if this is going to evolve. It is. I'm sure it's not going to stay like this. It but going back to the symptom complex, you know, people do come with headaches, you know, weight loss, hair loss, visual problems, eye burning, tongue burning, skin rashes.

You know, a lot of these other things that pop up as when you speak to somebody who comes with digestive manifestations, I think they tend to seem to need to be studied.

So what are the most common and digestive symptoms people come in with? I mean, the common ones, believe it or not, at least half of our patients, they have excess gas, bloating, and what I call signs of symptoms of that fermentation and is generally associated with some level of absorption, which may end up into, another step of micronutrient deficiencies, but it may also end up into, stimulating the immune system, causing mast cell activation and symptoms that are related to the mast cells, that basically one will lead into another scenario, kind of a different cycle.

Leaky Gut, Inflammation, and Hidden Causes

You know, mast cells are becoming, you know, much more, like in the forefront of all these problems and what percent of people that come in with a GI problem, do you find other systemic symptoms?

Again, I must say that in my practice over the last 15 years has evolved. We tend to attract patients who might have been a little bit more complex. Yeah. Did they think it may be complex?

So they have been two other physicians who I mean, I would say given take probably 80% of a patient be non-touch GI symptom because they've been scalped 100 times and they're, you know, I mean, usually I mean we are getting some front liners coming.

That is oh, I want to go directly to a more integrative model or holistic model. So somebody could look at everything together. And we're seeing this more and more.

And interestingly, as more of the younger population that is making that connection, that maybe they they want to have that approach of is, you know, possible for them.

But by the time they get here, I think a lot of our patients, they have non digestive manifestations. And I think if these will give us a little telltale, what might be underlying this here and generally is an environmental issue.

I mean obviously you're right. Issues such as, you know, stress, lack of sleep, eating a lot of sugary, I mean, all of those things and alcohol, they have an enzyme.

I'm in trouble. I had no, I mean, excessively, I mean all of those things, they have a role. But we're seeing now beyond that, you know, a lot of our patients already, they're intelligent, have done the research.

They're doing the right things. Many of them are gluten free or dairy free or sugar free. You know, I'm not even going to say which more free you got to become.

They have to say, okay, how did I get to this point? Yeah, okay. And I remember I had one patient who came from new Jersey one time and, said, what's the problem is that, look, I can't really eat anything.

I'm down to lettuce and chicken. Okay? So obviously something like this has, you know, a significant degree of intestinal permeability issues that is reacting to that degree.

Just. And I speculated and through and causing all this inflammation, vicious cycle. Exactly. I'm going to talk to you a little bit more about that. But just to finish just a story, I mean, I said, well, where do you live?

I said, you know, I live in East Coast. And I said, would you have a backyard? Yes. Every backyard. You have animals. Yes. I guess if we're doing gardening as animals and know how to do, you know, greenery, and it's very likely that they picked up something.

And the testing that she brought clearly showed that there was an evidence of an infection there. That could explain this. When you compare to the other patients that but it, it remains the question is how, how do we make the diagnosis in what is what is the thought process that we think?

And if you look at this study by the Canadians, a few years ago, they look at women with irritable bowel syndrome, and they use, some sort of microscope that goes through the endoscope.

And they looked at the number of holes in the guts that they, in patients who presented with ideas for irritable bowel syndrome. And they call these extrusions, I call it dropouts or cracks in the wall.

I mean, that's the actual actual like, holes. Yeah. What happens is that there's cells that there basically die off, which should. And then there would be an empty spot.

There it is the stem cell at the bottom of the lining of the gut that has to rapidly replenish that and fill up the gap. And in animal studies that turn around is about 15, 20 minutes.

Well, that's a very fast turnaround. You need a lot of amino acids. There's the strongest stem cells with immunity.

And if you don't have that there will be more holes going out.

Not, you know, feeding in you know, like I mean, talk about leaky gut, but it seems like they even get septic, you know? Well, I mean, we're not talking about the leaky gut in a institutionalize scenario.

So it was, you know, things that have gone wrong. And again, with the increased intestinal permeability or the so called leaky gut, which is now in even traditional, you know, medical journal, this term is being used a muscle, you know, reserve device using it.

The there are several mechanisms for that. I mean, one is that you can have this still have a problem so things can leak through the cell. Then you can have the cellular space, the space between the cells and where the tight junctions are.

And the another one is actually this scenario of dropouts where you have cells that they're shutting off. There would be a bit like that one break of the wall is gone, but there's not adequate time to replace that.

That means that these, you know, what do you do to stimulate the stem cells? How do you support the proteins that they put the tight junctions together?

Again? Because if we work on doors, we may give the patient a better chance to reduce their food reactivity or skin rashes and so forth. And is not an easy task.

And it does take time. But I mean, that would be the thought process to to think about and start from there. Yeah. Because like, you know what the food sensitivity testing, we have some people that like they have antibodies to everything, you know.

So you know, their gut is just so permeable. And and how would someone have basically malabsorption. Can they have malabsorption and leaky gut right now?

Of course you can have both of them. And the leaky gut is really just a general term, which means that the lining, is not completely intact, and it's turning on the immune system, reacting, but generally that comes from a reason.

The reason is commonly infection next to the wall, which could be a bacterial or a fungal overgrowth of parasites with a combination of those. Then you may have even heavy metals floating around.

You can have toxins to move. Being around and adding to the fungal, you know, overgrowth, if you will. And sometimes there are additional infections in the body, something we call the stealth infections or cryptic or hidden infections.

And that's the concept that it is not well acknowledged at this time traditionally, but I think for some illnesses, some bugs, you know, it is known, but not across the board.

And I think eventually this is going to evolve. But issues with the stealth infection they commonly have, evidence of enemy ability issues. Yeah, I think that's the problem.

So many infections are hard to detect. And you mentioned fungal and I think standard GIS, they don't even believe in it or, or can you, talk more about fungal overgrowth in the gut?

How what's your suspicion? How do you diagnose it? How do you treat it? Because I think that's a big issue that, a lot of people have issues with or feel they do.

They read about it. How do you approach that? Or what do you see? What what makes you think someone has like fungal overgrowth or a fungal issue? Well, I mean, I think the first step is to listen to the story and this story can tell us about the risk factors.

And I think that's, you know, that's going to guide us. Okay. This could be a reality. For example, a woman who might have been on birth control or maybe receive this is an antibiotic who was under a lot of stress.

I mean, this becomes a potential scenario for, a female that can start to accumulate fungal elements in the gut. The small bowel is generally very clean and doesn't really have a high number of these bacterial fungal element.

But when somebody comes with gas, bloating, rumbling noises, burping, flatulence, I mean, those are signs of fermentation means the gut is not clean. Now, conceivably when you look at, for example, a child that is born and the child may have thrush in the mouth, well, that's a nice and warm environment.

And this the immune system could not handle it in a newborn. And the mouth. Shush. Well, there's no reason not to believe the same thing cannot travel further down in the gut.

And in some instances, when the fungal elements become invasive, somebody, somebody's baby, quite ill and may have a fever or be in intensive care unit.

That type of scenario is well recognized in the classical books. And is this. But the model that it would look more like a functional model? There is not adequate testing for it, so it's a little bit difficult to diagnose.

It is hard to pinpoint. You really need to know the story. You have to be a good clinician, and you need to be able to open to the possibilities and see what happens.

I mean, we started to look into this, you know, and I remember when I walked out of the a conference in the anti-aging medicine and there was a two hour presentation on this.

I think my head was spinning, you know, so it was I've never heard of something like this. I got the book and read it, and I said, well, maybe it is. Let me try it and see what happens.

And we realize that this is actually quite common scenario. Now there are things we can do to we can do to further substantiate that idea. But nothing is generally going to necessarily replace my clinical judgment.

That's still I mean, I think that's the first thing I did right now. Yeah. Okay. And then if I can get some support, it's nice because the patient would also be happy to see that, hey you, can we use.

Yeah. I mean we do sometimes antibody against fungi. And now they're not pretty that they do antibody against numerous fungi. Whereas some of the labs such as, you know, quest or lab quality management and have like 1 or 2 antibody models to use, but you can go elsewhere and get more.

Fungal Overgrowth and Methane Patterns

We can look at organic acids, and we could do almost 8 or 10 different markers of fungal. This virus is in the urine. That could be supportive. I'm not saying is it hard and fast food, but it's painting the picture.

Yeah. I mean if the story fits now, if the story doesn't fit, if somebody said, I feel fine, I don't care about it, it's okay. But if this story is there and that would be supportive.

I'm also a believer that to, you know, something fungal growth in the stool samples has significance, especially in a male patient. I have not seen, any male patient with presence of fungal elements.

That feels good. Usually you said. And, in a male patient, in a male patient and a woman, you can say, well, they have estrogen or hormones or maybe more stress.

Maybe it's more, you know, the environment could be more conducive to growth of the fungi. But in a male patient, to me, if I see fungal growth, even in the small animals in his two sample and their specialized labs, that they would do this.

Not every lab is capable of, do what? What lab? You can say like. Well, what labs do you like to to use? What what I, I advocate any particular to that, but I can tell that generally the one that has been most helpful as far as growing these elements is the doctor's data is somehow they do allow these ongoing to grow, and they report what type of fungi you can see.

And as I started to look at hundreds of these samples, I was coming across names I had never heard of these, you know, fungi. And then when I looked them up, I said, well, this is an opportunistic fungal, you see, after kidney transplant or liver transplant in outpatient practice, where do I why do I get these elements growing in people's bodies?

So it may be a little telltale. Again, I don't think anybody should go with one element story here, but, you put the pieces together, it may tell you that.

And sometimes when you see this, you have to look at what's causing the immune system to be challenged. Is it alcohol? Is it a stress, lack of sleep that eating habits, you know, or is it presence of toxins or mold?

Maybe somebody was exposed to a moldy environment and, if you know more toxins, your immune suppressant that promotes the growth of their own species.

Okay. Thank you. I'm just going to do I kind of like to grow my own species. So they create a milieu that would support them, and we see them see these things.

I, I think everything's just exploding. I think 20 years ago there weren't that many people. Now, I mean, just you go to a cocktail party. I mean, if you only talk to people like everyone's sick or their family member sick or their friends sick, and they've been in multiple doctors.

I mean, these multi-system illnesses are just I talk about pandemic. I mean, I think it's it's just crazy. And they've they just are told that, oh, it's psychological.

Just live with that type of thing. You know, I've heard that too, especially like, you know, with the, with the fungi. I've heard Guy say, oh, if it was fungal, they'd be in the ICU.

You know, you know, that's the you know, it's really a spectrum. And the end of the spectrum is easier to see it. But one has to be really ill. And in our practices, obviously we're not coming across that.

Okay. Yeah. That's not medicine. It's not like all or none. Everything is a continuum. Exactly. Yes. Because you know, what about in the lower level. Could that be a fracture?

I mean, something which was very interesting. And you said the I gave a podcast with this, with Doctor Jacoby on a Sibo conference, was the relationship we had seen in patients who had methane?

Yes. C h or under breath testing. And it's always a puzzle as how people really have access methane. And we talked about choline, which is, you know, and carnitine stuff that you get in food and like egg yolks and red meat and these that can increase the T in a O.

They somehow they can also increase the methane production, at least based on what we have seen. But so it was very interesting was this is of fungi that when there was excess methane we could see some evidence of fungal scenario, other fungal infection or fungus anatomy that the maybe somebody says to sample now showing fungi.

But on the breath test I'm seeing business submitting. So when I looked into this I did one search and I look for an article to see what does it take to grow meeting in the lab archaea.

Okay. It was, you know, small creatures. How do you grow this thing in a lab? And so p gurus and gurus and PhDs, they came up with the IT menu or some sort of concoction, if you will, that it will allow this thing to grow.

And I noticed that parts of that there were fungal elements involved. And then I studied it a bit further. I realized that fungi they like oxygen, so they're going to suck.

The oxygen on the other hand, are K of they need to be anaerobic. So another match okay. So to really treat them, you know, if you see a lot of methane, you have to think, where is the fungus?

You know, like, yeah, maybe one is feeding. You know, maybe that's one of the mechanisms. So it's thing, you know, it was a little fungus to bring you the up.

I mean, obviously this is a great subject. If somebody is open to study it at the university level. Okay. Beyond the private practice, you know, offerings that we do and see.

Yeah. But you know, I'm a little bit sometimes reserved about treating medicine with antibiotics if I perceive that as a presence of fungus, because theoretically you can make the other one worse.

Theoretically. I'm not saying that this is. Yeah, okay. That's interesting. Or I was reading some studies on, you know, C diff and pseudomonas that they need campylobacter.

Did you need to grow. Yeah. And you know C diff can be very difficult to get rid of. And but if you kill this other one then yeah it may go where there's all these symbiotic relationships.

So kill one. Then you get rid of the other. It's interesting. It's interesting, like how little we know. You know, it's like like the more you learn, the more you learn.

You don't know. And all this stuff that's going on, you know. Exactly. Yeah. You know, I think I think it's good that one is open to possibilities. And and see what you know, what comes up on this that is, is a consideration that so so currently when you get methane positive what what's your typical treatment or what what do you, do the further workup or.

I mean, that's the, if the first thing is that, you know, if I see somebody with high methane is what are the level of symptoms because occasionally, you know, patient may have very little symptoms.

Emitting is high. And I'm not sure if I just want to treat all of that, you know, just to get rid of some small level of symptoms. It may be that the business of medicine is working as a biological marker.

That tells me there's another layer behind it. That's okay. What are the symptoms of going on? Is it the fatigue? Is it the headache? Is it the sweating?

Is it the skin problems? Or somebody has methane but they don't really have constipation. They have more of a diarrhea problem. That means that there's some other player into that to maybe going on to first we have to decide if we want to treat it or not.

But additionally, the good research shows that if you use a, you know, rifaximin and neomycin that works in about two out of three cases. Now, in our own practice, if I see some evidence of fungi, I probably would address the fungi first, and I make some dietary changes, like the ones that we mentioned in the mission to reduce the level of fatigue.

And then I subject the patient into treatment. But I do give the patient generally an option to see if they want to go traditional or they want to go nontraditional.

I love that you work with the patient and I turn to a patient. I'm I can tell you what to do. I'll give you advice and give you info, but it's their body.

And have you treated with the methane patients like just, let's say, antifungals and see what happens. No thank you. I mean, I cannot say we have done that, at least in a structured way of doing it.

The concept, which really fascinated me. And it was one of those. Yeah, that's so interesting. Okay. But when we looked at our patient population, almost 80, 90% of that, they had some level of fungal, either the organic acid was abnormal or they had antibodies or were treating them for fungus or somebody else was treating them.

There was some fungal scenario. And this meeting, and in those cases, I rather make sure that the fungal element is somewhat is under control. I am not convinced that if you just treat the fungus, the maintain is going to go away.

And that's why other other players and why they get the fungus. Yeah, yeah. I mean, and if you look at the Me back in 2014, 2015, I shared in a ten minute presentation that we were seeing a lot of civil patients showing evidence of positive serological markers with Lyme disease.

Now, the word chronic Lyme is not recognized, and I cannot type in the computer. And my medical record is not going to give me a diagnosis like that because not to recognize it's still there, but are great practitioners just probably like ourselves, that they do believe these infections can become chronic and they modify the immune system.

And the presentation would be something like a persistent Sibo or a recurrent Sibo, or my Sibo doesn't go away or my numbers are really high, or I have Sibo and I have a fungus, and which one do I treat as if either your your one or the other?

I mean, this is where you have to think like an onion and have layers that you know, one has to go into. Yeah. And it was on a a Sibo summit or presentation.

I said, well, I think C was more of a symptom. Oh my gosh, the host got so mad because, you know, it was Sibo as the cause of everything, you know. And I go, well yeah, but it's a chicken or the egg, you know, like why do they get the Sibo.

Because they got gut dysfunction from something else going on. And they don't want to hear that, which is funny. But I mean, in harmony with what you said, you know, one of our slide presentations we did mentioned that certain patterns of signal and how they respond to the treatment is will tell you that there may be another layer, behind it.

And indeed, we prepared that video and and I put it on our website at no charge is available for the patient to be able to see that, you know, you can divide Sibo based on hydrogen and methane and hydrogen, methane and hydrogen sulfide.

But how about if you also give it a pattern based on the response to the treatment. Did I just have a quote of course, over facts, I mean, and it went away.

And that model, I called it The Easy Rider, based on the movie from the 1960s, you know, The Easy Rider. But, there are other panels that I call the relapsed or, or persisted or a blend which could be a blend with the with the fungus, you know, here or another pattern I called it incongruent means that you treat to see what the Sibo goes away, but the patient doesn't feel better.

That means that there's a lack of clinical correlation with the test. And obviously that means that there's another player into this. And there are many interesting cases that we have come across.

Some of these, we put it in that presentation, for people to see. Yeah, that's awesome. Well, what is the website that people can go to is my website, the l.a integrative gi.com, and the video is right on, on the first page of the website.

SIBO, Chronic Infections, and Advanced Testing

I mean, this is the presentation I gave at this Sibo conference, but they were willing to work with me for me to receive that one back, as a trade off.

And the I can put it at no charge for the patients that. Yeah. No, which is nice because we normally, for everyone doesn't know when you give a talk at a conference.

They own that. And so you it's rare that you can get that back and put it out. So that's awesome. So your website again and a integrative guy.com. Great, great.

And let's see what, what typical patterns do you, really kind of like alarm bells for certain conditions. I mean, you mean as far as the single pattern or, or just like anything like where you see someone comes in with irritable bowel with diarrhea or whatever the headache or or what, what patterns do you write?

Kind of is the, you know, if you look at the GI symptoms and somebody has alarm symptoms, they say weight loss or and eat or difficulty swallowing in gastroenterology, those are alarm symptoms.

And obviously it requires investigation. But you can also come up with sets of alarm symptoms. And to the non GI all symptoms. And I think energy to me is one of the major factors because it suggests mitochondrial dysfunction. And you know, it's you know, when you look at economy of energy in a person, if the energy level is retained, you know, the prognosis is generally better.

So is one of the questions that we asked and is one of the areas in target to improve the performance, functionality and the energy. And but other things is sleep pattern, anxiety, inability to fall asleep.

Many of these things suggested possibility of mast cell activation, release of histamine or other mediators. And these this is not something that came overnight.

There's a whole probably an array of things that went wrong in the background. And we need to see how you can reverse that. And at times you can do testing for mast, that activation.

And it may show, but sometimes the testing may not. Should you have a good judgment with the tests are so basically in sensitive and like what percent of patients let's say have Sibo or just I mean and are totally fine, you know, nothing else.

You and like where it goes along with you treat it and it's it's gone forever. Whatever. Like what percent is that versus where hey, there's other stuff going on, you know, if you asked me this before 2005, this is probably about half of all our patients.

We treat them, they say thank you, and they're gone. We're not seeing that anymore. I mean, interestingly, if you look at my presentation, I put a question to the audience who are doctors?

And I said, if patient comes with Sibo, what is your confidence level that you're going to treat this patient and the problems are going to be resolved.

And I can tell you that said, you know, overall the confidence level is low because there are so many confounders that one has to understand. How did the patient get to that point? Okay.

And to see what maybe just the the the tip of the iceberg, and I would say about maybe one out of three probably will be fine, but two out of three, we're going to have to continue to deal with scenarios.

And before 2005, it was just, oh, you got Sibo treated. I mean, it seems that they respond well to that. I didn't have to worry about too much. And you can see well, is it the population has changed.

The illnesses have changed. Yeah. Am I seeing a different type of patients coming to the office? Is hard to know. I mean, maybe they were not just they didn't have that many involvements in and but we're not seeing the same thing again.

And I think the other dogs are relating to that as well. Yeah. So I think yeah, I think it's so multifactorial. I think too,

because watch what you get good at.

You're getting, you know, known for all these complex patients. So you're going to get those. But like you said other standard docs are seeing it to where, hey, what's going on is just treat the Sibo and went away.

And now now what does it so what kind of, test do you do, for these patients with the common tests that we do, is comprehensive food sensitivity and allergy testing at these occasional use, allergies.

But, you know, for the ease of it, we may just use the IGP mediated allergies, and then we use the food sensitive beauty models. A lot of not all of that.

And nowadays we focus also on the, peptides that are in the wheat, because people may be reacting to the minor molecules. And those can give us an indication that some components of the grains that they overlap, they may be driving the inflammation.

But as a general rule, the more of these others you see reactions is suggestive. Probably more PFOs or cracks or it's function of the tight junctions.

And the question, how do you return that back to normal? How do you manage a leaky gut? Probably, yeah. Other tests we do. Again, organic acid, comprehensive analysis, heavy metal testing.

Sibo, breath testing, the stool culture and a something by PCR. We have also done some work in obtaining intestinal juice from the upper GI tract. It is a fascinating area for us.

I mean, some examples of these in that video presentation. And I remember, if you years ago, we had one patient who was having epigastric pain and the and it would not go away.

When we looked it was bile in the stomach. And I speculated that the bile in the stomach is probably backing up because the gut is not clean. And that means is that there could be parasite fungi, Sibo.

And the patient did have Sibo, and there was evidence of a parasite as well. And that was picked up by the testing module. And that's hard because it is so much.

Yeah. I mean you have to be patient and use some what you call a clean catch technique used to be able to obtain the intestinal juice and send it for microbiology using PCR technology.

And you know, it just happened that some parasites DNA got picked up. Yeah. And I think yeah, parasites are such a, I think so much the a bigger thing and it's, maybe too much information, but, we're at a friend's house.

I night the dog, like, I get bait, some raccoon poop. So I'm looking like, oh, my gosh, are these the parasites that they get? So, like, ordered, you know, all these antiparasitic.

So I'm going to start taking some myself and, Yeah, it's it's scary what's out there. You know, people who travel. I think it seems like everyone that goes to India comes back with the parasite.

But the challenge is that you can't always find it in this stool sample. And, yeah, the patient may end up with upper GI symptoms. More pain in the upper abdomen, burping, bloating.

Discover something that in medicine we call functional dyspepsia. So but is a term that we don't realize that okay. What is it. You know, like some of it may have H. Pylori.

Helicobacter pylori. But if part of our patient is that there's a portion of them, they had contamination of the beginning part of the small bowel, bacterial, fungal or parasitic or a combo.

And this causes it back up of the contents into the stomach. It irritates the stomach. It looks like is a stomach

problem. What is it downstream. The downstream problem.

Yeah. And you find that BPC 157 helps set that, you know, tightens the lower sphincter or tight tightens the upper. But it's like it's still the lower sphincter is kind of relaxed.

Let it go. So it's still could back up in there. Yeah. The BPC 157 is really helpful in many ways. First of all, it has a general anti-inflammatory effect.

It has protective effect on the gastric lining. And it also has protective effect on the intestinal lining. I mean, I always say that think about it of whatever surface needs to heal.

I will leave the BPC 157 works with them. And I had mentioned this previously in our personal conversation that we had so much interest in this 15 amino acid peptide that back in 2017, I went to Croatia to it with their love technology to go to the source.

Yeah. And I said, have the video that, you know, he took me around to show the animal studies at his lab. But the research on this, it actually goes back to the 1990s, where they even did some studies on as often during the course of where you put acid on is obviously mucosa and causes damage.

But if the mucosa is treated already with APC 157, then presence of the acid is not so much damaging to the to the light. And we use that concept to treat some of the patients with gastroesophageal reflux disease.

I cannot tell you exactly what impact it would have under this sphincter pressure, because I don't have the data. And if you do, please educate me. But I do believe that it does help with the surface healing.

And indirectly, I can see that that's going to help to improve the esophagus sphincter at all, because the more damage you have to do, because I would just think to more inflammation means that probably more malfunction of the valve.

And that translates to a vicious cycle that is going to go kind of like everything is vicious cycle, isn't it? And yeah, the, interview we just did before where we're talking about PPC, she's an expert in pelvic incontinence that the BBC was shown to basically stop, stress incontinence, you know, the sphincters relax.

And so it seems to be very good at healing the sphincter tones. I'll shoot you over some studies on that. Which is interesting. And then, I think you're just kind of starting to play around with the, the tb4, frag, which, studies show helps the tight junctions heal the tight junctions.

I don't know how much you've noticed, with that or TB, TB frag four is also something we have incorporated, particularly, when there's an imbalance in the immune system.

For example, if the two is very active, you know, and we like to see that, you know, that and that may help to reduce food reactivity, for example, or pains or aches in the general inflammation that go from that.

And I think it works well, in combination with the BPC 157, okay, the combination of both, it's good. And if one can take it before meals the morning, in the afternoon, you know, at one point that could be incorporated into the treatment regimen.

Yeah. Because you look at the effects are kind of similar, but they're very different mechanisms. And, and we were doing the, TV for with stem cells because they boost stem cell function.

And we had a little miscommunication. Know. Yeah. But they were giving like a whole vial to patients and and I'm like, oh my gosh, has been doing it for a couple months.

And I'm like, well, there are side effects. Like no one said. People with like, fentanyl go, oh my God, my muscle pain's gone, you know? And is it really a immune modulator?

And also heals traumatic brain and, you know, heart, all those things. So they're very similar in, in helping, healing but a different mechanism. And just curious, when you see the methane producers, what percent do you think is, Lyme or Tickborne or, that type of infection or.

With our practice is significantly with patients who have been, bitten by badgers. So when we looked at the, our data, I can see that, for example, in the last two, ten years, we have a screen around maybe 15, 1600 patients for vector borne illnesses.

And I would say about a third of those patients, that's over 500 patients. They have a clear evidence that is such infection present, because you also have the borderline serological markers.

But, you know, there are times that the markers are not borderline anymore. Yeah. And what test are you using for that? I mean, depends on the labs. I mean, there's several labs that we use.

I mean, depending upon patients interest and budget. I mean, I can use even sometimes traditional labs. Yeah. We'll use the genetics student use by health.

You may use the advanced lab. I mean, they're different labs and just depends on what you're dealing with. I've also recently used the this the German technology.

You know, in the lab is in Minnesota. And that's a cellular reactivity. Looking for interferon gamma and oil to release from the lymphocytes when they are put in proximity of the bugs with maybe the line bacteria is Bartonella, but here you can see some level of reactivity.

And on occasion I use that as a backup plan in case I'm suspecting the other test didn't pick it up because as we talked about, there is no test. There's 100%.

Okay. I mean, absolutely not. The only thing that creates tenacity, you know, to keep going, is just listening to the patient and just believing that there's something is wrong.

Yeah. You're not just making up the story here. Yeah. And and it's probably the patients have been, times of many doctors spent a lot of money and, you know, trying to help.

So it's. Yeah, it's, it's a fine line. Some, like, now we're even picking up stuff on standard quest and, you know, lab core, which nothing was ever positive.

And now we're finding, you know, bands that are you don't see in normal people, you know, it's like less than 1% of normal people, but it's considered a negative. Okay.

Well with less than 1%, all people have it where to come from, you know? Right. We don't actually have in the same experience that we're seeing more positive markers.

And again, is it the patient's responses are different. We are the laboratories technologically or doing something differently. But I wouldn't call these false positive.

It was something I mean, I need to know what the story is that goes with it. Because for somebody who has been chronically ill, you know, I mean, I mean, I can't just say, oh, but this is a psychological problem, you know, it's yeah, I even if we see a 41 kilo Dalton band on a patient on quest or lab core, I don't think I've had a patient who didn't end up having Lyme.

You know, let's consider the most likely false positive and then it, but when they have the symptoms, okay, you know, something's going on. And if you dig deep enough, yeah, you'll find it.

And they end up now having it. Even now, the standard tests, they call it negative, you know, but there's evidence of something going on. So I mean it's true at this, it could be a discussion that a person might have been exposed

to that environment.

And maybe the immune system is handling it, but it may be something else. You know, what you think is is huge is like, you know, we check the immune system when that's off, okay?

It allows us to show the patient that, hey, there's something going on. So we got to now dig deeper. And that's what sounds like your process. Start there. And and keep going.

Tenacity as you said. Exactly. And it's going to hang you there. You know, you've got to. Yeah. So, yeah, you're treating these complex patients. It's, gift and a curse.

And, and so, yeah. Like, kudos to you for helping these patients that I know the patients have come to you. I've been everywhere oftentimes, you know, and, and you get them better because I hear from them.

So we do our best, let's put it that way. So it's nice and always taken out of the box. And, you're just such a pleasure also to, speak with always learn so much when when I talk to you and, thank you.

Proud to say you're you're a friend. So I, I thank you for being on. I think it's been great. I think people will get a lot out of this. And, just also learn.

Hey, there's hope, you know, and, because they've been told by ten doctors that, nothing's wrong with you that, hey, go to a bar, you know, so, thank you.

Thank you. And I thank you on behalf of the patients that you see as well. So thank you very much, doctor. All to appreciate it. Great. Thanks so much.

Thank.