Introduction and Dr. Horowitzu2019s Background

Hi, and welcome to another episode of the Healing Lime 2.0 summit. I'm your host, Doctor Mariah Hinchey, and today we're going to talk about multiple inflammable triggers, poly microbial infections, biofilm and persistent drug therapy, and chronic Lyme disease, as well as the new frontier in chronic disease management.

Here to navigate with us through all of this is my co-host, Doctor Richard Horowitz. Doctor Horowitz is a board certified internist and the medical director of the Hudson Valley Healing Arts Center, which is an integrative medical center specializing in the treatment of Lyme and other tick borne diseases.

He has treated over 13,000 Lyme and tick borne disease patients in the last 30 years, and is one of the founding members and past president elect of the International Lyme and Associated Diseases Society.

Additionally, he's the past president of the International Lyme and Associated Diseases Educational Foundation. Doctor Horowitz previously served as the member of the HHS Tick Borne Disease Working Group and the New York State Department of Health, the tick Borne disease Working group, for dedicating his life to helping those stricken with this devastating illness.

He has been awarded the humanitarian of the Year award by the Turn the Corner Foundation and other awards from Project Lyme. He is also the author of two bestselling books on Lyme disease and chronic illness, Why Can't I Get Better and How Can I Get Better?

He recently released his first science fiction climate change novel, Starseed Revolution The Awakening. He will be releasing his third science book on comprehensive answers for chronic disease late in 2025 or early 2026.

So be on the lookout for that. And his top accomplishments because there are many, include the creation of the first validated Lyme Symptom Questionnaire for pretest probability and assisting the diagnosis of Lyme disease.

We call it the H.m Q, and we will be talking about it in a few minutes. Secondly, he developed the first effective short term oral generic protocol for the treatment of chronic Lyme and Bartonella, known as Dobson combination therapy.

Thirdly, he developed the first clinically proven multifactorial model to assist in the diagnosis and treatment of chronic Lyme and associated diseases, called the episodes.

And we will also be talking about that. And he was the first doctor to diagnose BRCA and the lower Hudson Valley over 25 years ago. And lastly, he published the first article in the world literature on the use of glutathione for the treatment of Covid 19.

So welcome, Doctor Horowitz, thanks for joining us. Or meet us today. Thank you. Well, it seems like I've been a lot after all of these years. You can't even recognize it.

Hey, I shortened it to. Thank you for being here. Any anything you'd like to tell our audience before we, you know, jump into the interview? No, I mean, I think you know, the main thing for this interview today, because we really have so many excellent, speakers for this summit, is really just giving people an overview of what I have been finding is keeping people ill, with Lyme disease.

So, as you said, we'll talk a little bit about the screening questionnaire. H. M.. Q I want to go through some of the basics of the M6 model, because that's some combination therapy is turning out to really be highly effective for the vast majority of people.

But the things that are interfering is if you have active bbca, if you have active Bartonella, if you have mold, if you have long Covid, apart from other eminence factors, it is interfering.

So I want to give people kind of a lay of the land to say, hey, you're still going to get some help from home, but if you didn't get the full help, let me show you where to look. Right.

Because that's what we're finding. But you know, this really a lot of hope for people these days. I mean, this the scientific literature has supported biofilm persistent protocols over ten years ago.

Thank God for Johns Hopkins researchers and even Shopee from the University of New Haven. Kim Lewis lab, Stanford. I mean, I wouldn't be doing what I'm doing if it wasn't for their great work.

So, yeah, so let's go over it a bit. But bottom line, we have hope. I mean, you're seeing it in your clinical practice. I'm seeing it. People are getting better.

So we'll discuss a little bit today. Some of the, the functional medicine approaches we found that have been so effective in patients. Wonderful. So let's start by talking about the HMC screening questionnaire.

So I know that you recommend using that in conjunction with testing. But let's start off by talking about really what it is and how successful it is in predicting whether or not someone should go to that next step of testing.

Yeah. You know, it's it's it's important to have a pre screening questionnaire because we're in the middle of a Lyme epidemic.

HMQ Screening Questionnaire and Lyme Diagnosis

It was about 3 or 4 years ago. Bmkg Global Health talked about 14.5% of the global population having been exposed to Lyme. Brilliant. Bergdorf. Right.

So that's 1 in 7 people on the planet. And the CDC would give us figures that it's, you know, almost a half a million, 476,000. But as you know, earlier this year or actually in 2025, last year they talked about Medicare rates being seven times higher than the screening numbers they were having, which if that were true, this puts us over 3 million people a year, which honestly is not that surprising that 1% of the US population is getting bitten by ticks and getting Lyme every year.

I mean, not really that surprising for you and I considering what we're seeing. So, you know, not everyone is going to go run to the doctor and get a Lyme test.

So you really want to have a sense as what is really the probability. I do have Lyme. So we approached this years ago with State University of New Pulse researchers, Doctor Melissa Cetera and my good friend Phyllis Freeman, who has helped me to publish a lot of the work we've done.

And we looked at a questionnaire. We took it from Doctor Boris Scholars initial work with these 38 questions. But what doctor B had not done is he didn't validate the questionnaire statistically.

So we started giving it scoring. I started doing like zero, one, two, three as far as frequency or severity. And then we started adding other sections, healthy day scores from the CDC.

Likelihood you have Lyme based. Did you have any rash. Have you seen tick bites. And the most important is do you have migratory pain? And you know, the thing we learned in medical school is that the most important thing you could ever do with patients to get a diagnosis is that send out blood tests, but take a proper clinical history.

It turns out that migratory joint pain, migratory muscle pain, and especially migratory nerve pain, tingling, numbness, burning, stabbing sensations that move around your body that is the hallmark of Lyme in both the acute and chronic phases.

So when we did this questionnaire, we validated it in three medical practices, 1600 people. We also had a group that were healthy patients who participated, and we managed to validate it so that if your score was over 63, you were two standard deviations above the mean, very high, likely you have chronic Lyme, especially.

Again, if you've got symptoms that are coming and going with good and bad days, you've got this migratory joint pain, muscle pain or nerve pain moving around your body.

Women will usually notice right before, during or after the menstrual cycle, the symptoms will get worse because hormonal changes do affect, the pathology of Borrelia.

And finally, when you do the Lyme testing, you know, it's it's the game I play with patients. You may have heard me talk about this. I call it Lyme bingo that, you know, if you get any one of these five bands on an immuno blot and thank God the FDA approved I genesis immuno blot, even for home use.

23 usb-C, 31 Usb-a, 34, USB 39, and the 8393. So if you score high in the questionnaire and you've got any one of those Borrelia specific bands, and also you go to a local lab and you check for earlier and a plasma, Rickettsia like rocky Mountain spotted fever, acute fever, tularemia.

Right. If you're checking for these other tick borne infections, soft tick relapsing fever. Briefly. Miyamoto. Hard tick relapsing. And you get any one of these positive.

You've kind of confirmed of course that you've had a tick bite. So it's very useful because we also follow the same questions when we're treating people.

We'll get a score when they come in. Let's say their score is 70 or 80. And then we treat them with some combination therapy, and then we'll watch the scores go down over time.

And kind of exciting for me. We just submitted just a couple of weeks ago, and our 34 planning grant with the NIH to try and get money. Mouse deniers on board.

I'll be speaking to the University of Arizona and Andrew Wiles Clinic about this, but we're trying to get a couple of partners on board. But we're looking for NIH funds at this point to plan out a randomized, multicenter, placebo controlled capstone trial.

So that's the gold standard of medicine. Everyone at that point will say, okay, you know, what you've been saying actually is true. And, we're hoping that will come through by the end of 2025 and that we'll get the, the DAPs on study done by, you know, at least started sometime by the end of 2026.

The wheels are turning a little more slowly than I would like, but, we had to apply for the grants, and, it. Boy, I'll tell you, it's it's a lot of work.

And thank God for even garlic consulting in the Carolinas. They they helped me with it. And they were they were just tremendous. But yeah. So that's the questionnaire, the Lyme band you're looking for.

And hopefully we will have a randomized trial, proving all of this at some point in the near future. That's great. And to make it clear to our listeners, so we're talking about using this, using this questionnaire as a tool, not only to predetermine if you're likely to have one of these tick borne diseases, but also so it can be used to monitor progress of treatments.

And it can also be used in this clinical diagnosis. Because what you're saying and I want to make it clear to the listeners, is that it's not this in conjunction with getting a positive on a test, if you're seeing any of these five specific bands, that's showing that your immune system is actually making antibodies to the proteins that are specific to, for example, if we're talking about Borrelia.

And so instead of relying on a positive or negative, which none of us ever recommended anyways, this is kind of

additional proof or ammunition that helps to build that clinical diagnosis.

That is really the appropriate way to diagnose any of these infections. Correct. And there's only seven degree, seven different diseases in medicine that cause migratory pain.

And, it's it's a bad joke, but I tell doctors, unless they graduated at the bottom of their medical school class, you should be able to tell the difference between, for example, something like inflammatory bowel disease with Crohn's or ulcerative colitis, which can cause some temporary migratory pain or gynecological arthritis or having strep with acute rheumatic fever.

Ryder syndrome, systemic lupus is probably the most difficult one because a lot of the irises of inflammation do overlap. And you can see temporary effects also with migratory pain.

But again, you can look for the autoimmune markers of lupus. In that particular case. So there's not that many diseases. Hepatitis is also one of them.

You know you check the AST alt, you see what's going on. So when you when you realize there's only seven diseases in medicine that cause migratory pain, and Lyme is one of them that automatically tells you once you've, you know, you don't have diarrhea and your liver functions are in high and you haven't had, you know, strep and rheumatic fever or Ryder syndrome, you don't have lupus.

There's really nothing else left. And so, you know, a lot of the line groups, I mean, God bless them, they're trying to find more sensitive markers and blood tests.

The Lyme c looks like it may be getting approval later on from the Arizona group with Tammy Crawford and Holly Ahern. But, you know, as a clinician for you and I, we've been able to diagnose Lyme for years using the tools that are out there.

So it's not like, we don't have any tools right now to do it. Yes, we should improve the tools for early Lyme, absolutely. No question. But we do have tools like the HMC and looking at migratory pain, looking at the bands on immuno blots, which have really been quite useful, for the way we've done this in the last couple of decades.

Yeah, absolutely. Thank you for developing that. Sure. Okay. So moving on. Tell us about what advancements in treatments, have been made over the past couple years.

Specifically addressing biofilms persist or cells, you know, there's really tough to treat cases of Borrelia and Bartonella. So, you know, years ago, when I published the first study with Doctor Martin Atkinson, bar on, and we didn't know at the time it was hitting the cystic, round body, you know, cell wall deficient forms of Lyme that this goes back like 25 years.

We were finding we thought that was the reason why Lyme would persist. So, you know, putting aside the political controversies, does it exist? Doesn't it exist?

Yes, it exists and it does persist. It's not even a question. There's hundreds of literature supporting it. That's more medical politics. That's not medical science.

But putting that aside, the reason we thought is Lyme providers, we thought it was mostly these cystic forms, otherwise called cell wall deficient forms as forms, all forms.

It turned out that, yes, there was some truth to that, but the main reason wasn't the cell wall forms were penicillins, and cephalosporins were hitting it, or cystic forms hitting using plaque winnow, grapefruit seed extract, flagellation.

It is all or intracellular forms. Zentrum max the tetracyclines doc c minnow clones. They go intracellular that was part of the answer, but not the full.

The most important answer turned up about ten years ago. John Hopkins. Researchers like Doctor Yunxiang had reported that Borrelia burgdorferi is a biofilm persist or bacteria.

Same thing with Bartonella. Now, when they called it a persistent bacteria, it wasn't from our perspective that we didn't know it persisted. It was that oh, you mean it persisted like tuberculosis, like Mycobacterium tuberculosis or leprosy, which is these particular forms of the bacteria that go completely dormant and they can be under biofilms.

So part of the reason you have sero negativity and the antibodies are negative is these bugs are hiding in the biofilms. The antibodies can't see them.

And if you don't open up the biofilms where these bugs are hiding in these dormant phases, you're not going to get the antibiotics to go where they're supposed to go to kill the bugs.

But the problem is, even if you open the biofilms and you use a cell wall drug for the, cell wall forms of lime, or use plaque one or grapefruit seed for the cystic or zero max rifampin intracellular, you're still not going to get these persistent forms.

This requires things like mycobacterium drugs. So when Hopkins researchers basically published this I looked at the literature and I said, gee, you know, I was looking for an excuse when I was at Mount Sinai years ago doing my internal medicine training.

I treated a lot of TB there because it was during the early stages of the HIV epidemic, and we were seeing patients come in with tuberculosis in the lungs.

Am I mycobacteria? Maybe I'm intracellular. And I one of my main teachers actually was an infectious disease doctor.

Biofilms, Persistent Infection, and Dapsone Therapy

So I got really used to using I and H rifampin present amide. All the TB drugs. And I was looking for an excuse all these years to use them. And then Hopkins comes out and says it's a persistent to your.

And I went, okay, great. So I went to the literature and I looked at the mycobacterium drugs. And when I came across DAP zone because I knew that rifampin and dap so and kill leprosy.

It took a year. If you take rifampin and DAP shown at 100mg dose, it would eliminate leprosy from the body. So I said, all right, let's look at that. So when I looked at the qualities of the the drug, great penetration into the central nervous system, to the point now I never have to use I. V.

drugs, ever. I mean, the only time in the last few years I've had to use IB Re7 with someone with an early M rash with, Bell's palsy that was not responding to high dose doxycycline.

And and it did resolve but great penetration into the CNS. It hits these persistent forms of the bacteria. It's used in autoimmune diseases like Besets.

We see a lot of autoimmunity and has anti-malarial properties. So it has some effect on Berbizier and it's anti-inflammatory. It stops something called Mylo peroxidase.

So it kind of like checked off all the boxes you would want in a drug. So whereas, you know, most researchers have to go through thousands of drugs and the FDA drug library to find something that would work.

I knew from a clinical perspective as a persistent bacteria, this looked like it was going to work. So what we did back in 2016, we published the first study on its is a novel treatment for Lyme.

And at the time, I was only using doses of between 25 and 100mg, sometimes alone, sometimes with rifampin,

sometimes rifampin, doxy and shown. We still found that it had a great effect on eight major Lyme symptoms.

Just headaches was the only one. We didn't have statistical significance, but that's kind of how we discovered it. And then over the last nine years, we now have at this point, there's ten articles published on DAB, some combination therapy.

Nine of them a by ourselves, by Doctor Phyllis Freeman and myself and John Fallon in the last couple and one by Tufts University, where they showed that in the animal model Monica Ember showed this rifampin and shown kills Borrelia in the mouse model.

So we have a culture study where DAP shown alone lowers the biofilm persist for forms. If you add another drug like doxy lowers it further, you add a third drug like rifampin to dioxane.

DAP zone lowers the biofilms further, and if you add a fourth drug like doxy rifampin zero to DAP zone, it works even better. Now. I did things completely backwards.

I first did the clinical studies and then I went, I wonder if this actually works against the biofilm forms. And lo and behold, it did. So we've got culture studies proving it, animal studies proving it, retrospective studies about almost 400 patients.

And now we're applying for a randomized, multicenter placebo trial. So, that's kind of how we came up with it. But it took me years to figure out the dosing of DAP daptone, to figure out what dose was needed for Lyme.

And it turned out one month that 200mg twice a day if you just had Lyme. No active bbca, no active Bartonella, and you finished it off with a four day high dose DAP, some pulse 400mg for four days.

It looks like at least retrospectively, the vast majority of people would go into remission. The ones that didn't go into remission there was usually active bbca.

They did have Bartonella. Those people required a six day pulse of high dose DAP on at least four times, like every two months, a two week pulse. And again, these people had to not have long Covid.

They couldn't have active mold. Those were the things that were primarily interfering with their getting better, assuming the other variables, had been addressed.

So, extremely effective. You know, last year when you and I were co-host, I did adoption documentary, with 18 people. And this year people are going to be very excited to see another DAP zone documentary where we have nine people, including a doctor who's been regularly using DAP, shown explaining his success.

So I'm really hopeful for the Lyme community. My wife at this point is six years in remission. And, you know, it's really it's a wonderful thing because so many people are still suffering.

They're wondering, do we have answers? And we do. And, but that person does have side effects. So maybe we should discuss just a little bit kind of how we kind of work around that. Absolutely.

And so before we get into that, I just have a question. Do you have kind of like, like a percent success rate? So like you mentioned, for for patients that didn't also have BCR or Bartonella after that first month of treatment, like is there a percent success rate that you have analyze.

Right. So in the studies that we did previously, when we looked at double dose taps on 100mg twice a day, a roughly about 50% of the people would go into long term remission for a year.

So that was 50% success rate just on a for eight, eight and a half week protocol. What it turned out over time, though, I mean, we're seeing much better success rates, but over time and I've not and in fact, I published in the last couple of years successes like those people that did fail double dose apps on why did they fail.

Oh, we had a treat. The Babs here with Tiffany Quinn. We'll talk about this in a second. We had to get rid of the mole. It was mostly the Bartonella. I mean Bartonella, I think you're seeing it also in Bartonella is showing up, and that's just Bartonella. Hensleigh.

Cat scratch. But, all these different forms of Bartonella. Bartonella have been so nice. Bartonella. So it's a BFA maxilla form is I mean, it's 18 plus different pathogenic strains, and it's showing up in the vast majority of people.

It is way more difficult to treat than even the Lyme. But ultimately we did fine in most of these patients. Once we kept at it and we said, all right, you finish the adaption.

Let's say you cleared your body of mold. And and by the way, we're now finding also with mold, we have to keep checking people's sinuses for mold spores and biofilms, because we're finding in some of these people, when we've detox the mold, we're finding that it's reactivating not just from the environment.

It's kind of like you are the moldy house. The moldy house is not right affecting you. But once we do all of those things and address it, I mean, I'm giving you an average estimate, but I would say the success rate is probably at least 80 to 90% long term success.

And it may even be higher. But the patients right now that I'm struggling with that are still not better. And the only ones, by the way, left that I'm treating here, they still have active mold and they've not cleared it.

They still need pulses. For Bartonella, the BBC is still a problem. Or they have other variables and long Covid by the way, is also now becoming problematic because I'm trying Morava rock and atorvastatin for these patients.

You and I can get into this a little bit later, but I don't know. I mean, I'm not seeing huge results yet. I'm still in the middle of evaluating it. It's not like I've got hundreds of people on it.

But and you know, I know you've had some success with natto kinase and using other things there, but that seems to be kind of the nail in the foot theory.

Like when the the patient goes into the doctor with 60 nails in the foot saying, I have pain. And they only find, you know, one nail, say, come back in a month.

I still have pain. The Long-Covid piece is definitely something that I'm seeing into for you. With the success. And, you know, I hope over time we'll figure out better solutions.

But this is kind of an evolving field for all of us. Yeah, absolutely. And I think, no matter what your approach to treatment of the vector borne disease is as if long Covid is there like that, that definitely throws a monkey wrench in whichever approach you're trying to use, and it needs to be addressed.

All right. So tell us some of the things that, doctors who are going to be using Dobson should be doing to kind of ward off or prevent side effects of Dobson therapy.

Before we talk about what to do when things go sideways. Okay. So the first thing is you have to be G6, PD positive glucose six phosphate dehydrogenase.

It's an enzyme in the body. I've only had two people in 13,000 plus that have been negative. So it's very likely you are going to be G6, PD positive. But if you're not, the risk of hemolytic anemia getting more anemic from that zone or having higher elevations in hemoglobin where you don't carry oxygen in the well in the blood, those are going to be the major problems.

But that being said, most people would g g6 be positive. Women. I like them to not be anemic. Like you should try and rule out iron deficiency and B12 deficiency or anything causing anemia, because one of the major side effects of dapt shown is a reversible anemia, and on the average, you're going to drop about four grams of hemoglobin by the time you get to double dose.

So going into quad, I've seen 5 to 6 gram drops, but they always come back to normal. So the thing that doctors and patients need to get used to is, the higher your level of hemoglobin, like I have a gentleman I'm treating now, he's got a hemoglobin of 16.

I mean, someone like that, I literally I'm not exaggerating. I could close my eyes and throw a dart at the dart board. Never even get a blood test for the next nine weeks.

And the guy would be fine, because when you start that high, even if you drop to a hemoglobin of 12 or 11 or ten, you're going to barely feel it. And as long as you stay on high dose Luke avorn 100mg twice a day and say sequel XR from Xamarin, which is L methyl folate, we use 120mg a day.

We're reversing the anemia generally within it takes, you know, 4 to 8 weeks, but it's usually back to normal by eight weeks. So anemia is one of the biggest factors you're going to see.

And with the side effects I call it do no harm H for her x's. So you've got to make sure. And it's part of the protocol. People take a lot of glutathione NK alpha lipoic acid. Why.

Because those three supplements block an inflammatory pathway called NF kappa B. It's one of the major inflammatory pathways that causes inflammation in the body.

Those supplements will help to block it. And you can take high dose glutathione when you're having high SES. And and it does help the vast majority of people unless their detox pathways have have some issues.

So the Hertz's are an issue. You may have to use lymphatic drainage. You may have to use more glutathione. We stimulate the NRF two pathway with things like curcumin, broccoli seed extract, resveratrol, green tree green tea.

We block Nlrp3 inflammasome, in most people with low dose naltrexone and low dose melatonin, things like fish oils for prostaglandins. So if you read the protocol that's been published, all of these supplements are there, including probiotics.

We're using four different probiotics to protect the gut. We literally have not seen a case of C diff diarrhea in years because we're using something like 500 billion bacteria, all established good bacteria twice a day in these patients with prebiotics.

So, you know, you have to make sure you don't get loose stools, but it seems to be working. The other side effect of dapt shown is called hemoglobin Amia.

It's where you don't carry oxygen well in the blood. And you'll get some blue hands or blue lips. So the way we reverse it is methylene blue. Now the problem with methylene blue for people listening you cannot use pulse oximetry at home if you're using DAP zone to say my oxygen levels are going down because methylene blue stops your pulse oximetry from working properly, the only way you're going to know your mass hemoglobin level is to go to the lab.

That being said, we developed a protocol after the last 8 to 9 years, and the top dose of methylene blue we use, we slowly increase it from 50 twice a day to 300 twice a day over about 4 to 5 weeks.

If you do that and you stay on a low histamine diet, because if you take histamine foods with methylene blue, your blood pressure can go up. You can't be on any psychiatric drugs like SS or rise snris.

Tricyclic. You can get what's called serotonin syndrome, high fever, stiffness all over your body, irritability. Those are the potential side effects of methylene blue.

And the problem is you will get a little bluish from methylene blue. Now methylene blue is a really interesting drug because they're using at low dose for mitochondrial dysfunction.

They're using it for Alzheimer's disease. And it's a very interesting drug. But if you go up slowly we find that hemoglobin levels. By the time you get to quad zone it averages about 5 to 6% in about two thirds of the people.

So you might be a little uncomfortable with some shortness of breath and a little fatigue and headaches, but nothing terrible. And the highest lately I've seen, was about 18%.

Somebody living in Colorado at 7000ft and low oxygen tension. And I'll tell you, they didn't even have any shortness of breath. They were so used to being at that altitude they tolerated it.

So do no harm is anemia. Rashes are is the rashes. People that are sulfur sensitive from bactrim. So from the toxins all trimethoprim you got to be careful.

But I find that even people that can't take bactrim we'll give them an h1, h2 blocker like Zyrtec, cetirizine with some famotidine Pepcid we block h1, H2 receptors.

They can take DAP on. I haven't seen anybody lately that has not been able to tolerate the drug. Unless they have some severe or sulfur sensitivity, like Stevens Johnson syndrome, where you're you're peeling your skin.

And I haven't even ever seen a case of that in my whole clinical career. So. So that being said, yes, there are side effects, but not treating Lyme disease properly and leaving this bug in your body causing inflammation, I mean, it's been associated with Alzheimer's disease causing amyloid plaques in the brain.

We see people getting joint replacements after having it for decades, where the orthopedic surgeon goes in there and says, My God, what's going on in your body?

There's so much inflammation. You do not want this bacteria in your body. And the only other persistent drug that's out there is disulfiram. And we have had some successes with disulfiram.

You can use that for people that are G6, PD negative. And I have used it with some success, but it takes a long time to use the drug.

Managing Dapsone Side Effects and Supportive Care

It's a 14 day half life. The houses are terrible. You've got to watch for neuropsychiatric problems, increase neuropathy. But those are really the only two drugs that are out there right now for persistence.

So, the only other approach I would say to people looking for answers is Kim Lewis group looked at pulsing antibiotics years ago for persistence. And that's kind of what we do for Bartonella.

Bartonella is also a biofilm, persistent bacteria. So once we've used the nine week DAP zone, it's just two weeks of antibiotics every two months, and it's only six days of the episode.

So once you've gotten through the initial DAP zone protocol, there's really hardly any DAP zone you're taking. And there are people that will do the two week pulses without DAP zone and even still get some success.

So, you know, we would need like a multicenter, randomized trial looking at all these variables to see the best way of doing it. But it seems like it is working for the vast majority of people who are taking it.

It's great. So for our listeners, I would like to make this point clear, but I want you to correct me if I'm wrong. So I have had a handful of patients who have not been able to make it through Dobson.

But I will tell you that a majority of them were not given instruction or they chose not to hear it. You know, I understand how patients sometimes don't hear what we say to them, but in all instances, the patients were not taking the overrun.

They were not taking my full folate. They were not doing anything to inhibit the novel, kappa beta. They were not inhibiting. And all three, like they weren't doing any of these things.

So I think it's just important to put out there that this isn't just about taking Dobson in combination with other antibiotics or Dobson with methylene blue.

It is very important to take either lucho for veran and or methyl folate like for sure that's not an optional that's not an after you start having symptoms.

This is something that you need to take so that your body can tolerate this treatment. Absolutely. No question. And and in fact, the entire protocol for those listening because I you know, I put it out there so that everyone has access to this protocol. Patients and doctors.

The paper we published in microorganisms, the journal Microorganisms, September 2023, has the entire Dobson protocol. With what? Probiotics you take exactly the names of the probiotics I'm using.

What biofilm agents? Oh, you're taking cinnamon clove, oregano oil from, doctor inspired formulations. You're taking biocide and you're taking stevia, but from neutral medics.

Right. You're taking compounded peppermint oil from every little bit of the protocol. Exactly. The way I do it is in that paper. So it is available to everyone. There's really no reason.

But yes, you do not want to do this protocol without understanding the side effects, and following the blood test properly. But if you do that, you should see a great success rate.

I mean, that's essentially why we're going for an NIH randomized trial. It took me nine years to tweak this protocol to figure out how to reduce the side effects and get to a point that I knew the success rates I would not be applying for an NIH multicenter grant if I didn't already know the results.

But you're absolutely correct, Mariah. People have to follow the instructions carefully. And so my advice would be if your doctor if it's not someone at Doctor Horowitz's clinic in Hudson Valley that is doing, you know, that is prescribing that you find and download these instructions.

And if your doctor has not walked you through them, you walk yourself through them and you also go back to your doctor with those instructions and make sure that you're following them so that you do it and you do it right.

And I do have for those who need it. I do have a consultation model. I don't put it out there, but I'm sure we're going to be having don't know how many patients will be watching this.

But I do have a consultation model that I will get on the phone or a zoom call with patients and doctors and run through the protocols and hold their hand.

So for people, for example, that don't feel comfortable doing it. Hey, doc, I've never done it. I don't feel comfortable with it. I have a consultation model that they can contact my office, medical at h v h A.com.

It stands for Hudson Valley Healing Arts Center. And my office can get back to you and explain to you how the consultation model works. And we have had doctors, who have access the model.

In fact, one of the doctors, Doctor Moss, who I interviewed for our own documentary this year, he access the model he's been having great results with it in his patients.

He's got some great stories of kids with Bartonella, whose psychiatric symptoms got tremendously better, but he felt a lot more comfortable. He took the training course that I have, which, again, you can access this on our website can get better.com.

Just look under there. You'll find it. I would suggest for doctors wanting to learn about this, maybe take the training course. It's about 20 hours of training, but it's well worth it.

It's not expensive to do it. And then you have access to me. And if you need the consultation model. But but again, it's out there and it's free. You do not need to do this. I put it out there.

So the entire world has access to this protocol. Because we are in the middle of a worldwide epidemic. We sure are. And to make it clear, these consultations are for medical professionals.

This is not for patients to be calling and trying to do that. So I just want to make that clear. Correct. You have to have your doctor on the line because it's not me who's going to be prescribing.

It will be your doctor who will be following my advice diagnostically, therapeutically, they will be following my advice on how to, you know, what are the doses that someone rifampin?

I will give them the entire protocol and they can contact me as it goes on. In fact, I've had a couple of doctors who've been sick themselves who have access the model, and they got through it, and they're both doing much, much better.

Recently, I just had two of them. So, yes, it's a doctor. It's not patients who do this alone. You have to have a doctor willing to prescribe the dapt zone.

And this includes in Europe, because I just recently had a patient in Bulgaria contact me who's looking to have a Bulgarian doctor do this for her. Yeah, yeah.

I just want to make it clear before you have literally thousands of patients calling the office. And then my office will not be happy about that whatsoever.

Oh, definitely not. Okay, so let's start talking about the, sets. So talk to me about the overlapping, sets variables and kind of just how they apply to chronic illness in general.

So, you know, the problem with most chronic diseases, and it doesn't matter whether you're calling it chronic fatigue syndrome, fibromyalgia, long Covid, every chronic disease we are dealing with is due to inflammation, every one of them.

And in fact, in this new book that I'll be doing with Simon and Schuster, I'm pretty sure it will be out early 2026. We are showing in this that when you address the broad range of chronic diseases, it's going to be a very broad ranging book, way, way beyond Lyme.

There will be a section on Lyme, but there'll be a section on the ABCs of Chronic Medicine of A. D. D., ADHD, autism spectrum disorder, Alzheimer's disease, the bees for Borrelia, C for cancer, cardiovascular.

We're going through these chronic illnesses and showing you how the M6 model works. Now, how does it actually work? So if you have inflammation and inflammation is the reason why you have fatigue, headaches, pain, memory issues, sleep disorders, irritability, psychiatric issue, it's always inflammation.

So you have to figure out where the inflammation is coming from. The first six factors on the M6 model is number one infections. So we're talking bacterial infections like Lyme Bartonella, viral infections.

Reactivation of Epstein-Barr herpes virus six could be long-covid parasites like the B0, d fungal infections. Whether it's Aspergillus cysts in your lungs or Candida in your GI tract.

But for different types of infections that can drive inflammation. So after infections comes environmental toxins, heavy metals and mold toxins. They will cause very similar symptoms to what you're seeing with chronic Lyme disease.

Then two of the next or with the GI, you've got the microbiome issues of the gut where they've shown that if you have too much private tela species or too much Clostridium species, not enough accommodation, Bifidobacterium, you're going to get inflammation in your body.

And that's the case. Whether it's autism, whether it's Alzheimer's, whether it's chronic Lyme disease. The fourth GI is leaky gut with food sensitivities and mast cell activation.

The fifth inflammatory factor is having vitamin, vitamin, mineral deficiencies, which we're finding in a large percentage of our patients. Because when you're detoxing all these environmental chemicals, you're using it up and the sixth is insomnia, because Lyme patients generally have a really rough time falling asleep and they keep waking up and that will keep driving an inflammatory response.

So I call these first six factors on the M6 model, the six rivers of inflammation that go into an ocean of inflammation.

The M6 Model for Chronic Illness

So then you've got these downstream effects of what is the inflammation doing. Well, it affects your mitochondria the part of your cells that make energy because there's nothing surrounding the mitochondria like your DNA of histones to protect it.

There's nothing surrounding the mitochondria protect from all this oxidative free radical stress. And that's why we use a lot of these supplements. And why, after Daptone, we do a one month mitochondrial regeneration.

But the inflammation goes into your brain and affects the hypothalamic pituitary axis. We get most of our patients have low adrenal function, a lot of men have low testosterone.

Some women go into early menopause. So it affects your hormones. It affects the autonomic nervous system. We get Potts dysautonomia where you'll get fatigue, dizziness, standing up feeling like I'm going to pass out.

I do pass out anxiety, cognitive issues, palpitations. Now those symptoms from Potts can also happen from long Covid right. They'll happen from other causes.

But they look like Lyme and they smell like Lyme. But you're not treating those with antibiotics. That's your autonomic nervous system that has to be regulated through vagal regulation and autonomic nervous system dysfunction, kind of limbic retraining.

And then you've got things like autoimmunity, immune dysfunction. Lyman Bartonella can both wipe out your immune system, low immunoglobulins and subclasses or T-cell exhaustion from long Covid or autoimmune reactions that are happening within liver dysfunction, neuropsychiatric symptoms and finally, deconditioning.

So those are the ten downstream effects. And we find in the vast majority of our people, most people have at least eight of these 16 factors that are making them ill.

But interesting, you might have, you know, 12 of them could show up, but it might primarily be you treat the Lyme and it goes, oh my God, I feel great.

I've had patients where I just treated their adrenals and they went, that was it. Like even though I have Lyme and I have mold, it was like the low adrenals was the main key.

So you don't know when it's positive. What is the major factor? You can try and guess based on the symptoms, but that's really the message model. And the reason it has to be approached is it's not enough to just do some combination therapy and biofilm agents, because all of these other factors driving inflammation will still cause fatigue and headaches and joint pain and memory problems.

You got to get to all the underlying sources of inflammation. So it's kind of a paradigm shift of how we're looking at

chronic illness. And ultimately, you know, assuming later on in life my research capabilities get greater after this.

That's on trial. The next one is a DARPA grant from the NIH, where it's a much bigger grant where you look at all these chronic diseases like chronic fatigue, me, fibro long-covid, chronic Lyme that all have the same symptoms.

Yet the etiology may be different, or maybe it's all limited. It could be that in all these different diseases, right? We've got different infections.

But still mold and toxins are overlapping. Right now. Medicine doesn't have a common denominator model to address all these chronic diseases. That's actually this new book that I will be doing with Simon and Schuster.

So we do have answers, but when you're working with your doctor, just get the checklist. You can find it. You don't even have to buy my books. Why can I get better? How can I get better?

I published this in Health care in 2018. When you look at the message model. So again, it's available, but you want to do the M6 model using persist your biofilm.

Otherwise you're not going to get the full effect of of really trying to get you across your healing journey and get better. Yeah. And I think, you know, a lot of this comes back to I think the, the common denominator is the infection or inflammation.

Sorry, inflammation driven immune dysfunction. I think that's really what is at the heart of any chronic disease. You know, that we have even even right down to cardiovascular disease, not to go down a rabbit hole.

But, you know, it's kind of like obviously the antimicrobials that we use are important. But, you know, I think everyone needs to realize if they already don't, that no antibiotic is going to take any infection to zero, right?

It shrinks the load in the end. It's a functioning immune system that has to come in and stop that infection from replicating and growing back. And so I love your model because it addresses all of the things in the human body that need to be addressed to restore that proper immune function in the end, so that the person gets better and stays better and doesn't become that statistic of once you have Lyme, you always have Lyme.

You know, I know your point is great. And the thing about it is, I've had patients with immune deficiency who've tried pulling them all, who have tried treating the line, but they absolutely did not get the full effects of this protocol.

Because you're right, the immune system has to be able to handle the bugs. I mean, with that stone, you'll lower the load of the bugs. And you know, when I get lucky, right, you'll do an eight and a half to nine week protocol.

And if again, if you don't have Bart, you don't have the B0, you don't have mold. You may go into long term issue. You got a 5050 shot. It's going to happen.

But if your immune system is affected, you're not going to get the full effect. So you're right. I mean it's an excellent point. You have to go through the full admissions model to make sure you're looking at all of these different factors.

Yeah okay. And so the last we touched on it a little bit. But talk to us because you know Covid is still a very real thing. It's in our environment. It's never going away.

You know everybody has to deal with it. How does Covid in the spike protein, impact a patient that has tick borne disease and, you know, create a lot of roadblocks to actually getting better.

And of course, this feeds into, you know, the Amsterdam model. But I think it's important for patients, consume extra to and medical professionals to really understand that it does impact the treatment.

Yeah. So what we're finding so there's a there's a test from Radiance Diagnostics. This is the lab that Bruce Patterson had founded. And if you go on the website dot Covid long haulers with an s.com, you will see that there's

two different panels you can do.

I ordered the 14 cytokine panel. And what's really interesting about this panel is it'll tell you whether your Lyme is still active because he checks things like TNF alpha which comes from NF kappa B activation.

And he will check Il6. Again. You're getting this one F kappa B activation. But things like IL four or SEC 40 or interferon gamma or CCL five rents. These are markers of long Covid.

And what Bruce Pattison and others are finding is that these spike proteins, the monocytes in the body, some of these spike proteins are hiding in places in the body.

It might be in your vessels, in your vasculature or in other places. And your monocytes are activated trying to get rid of these spike proteins and therefore the inflammatory response is not shutting off.

And we have definitely seen it interfere in the success of some combination therapy. But the problem I'm having is, is the protocol that Bruce Patterson has developed, which is essentially three months of mirror rock.

It's an HIV drug, but it's not a classic antiviral. It's just helping the monocytes to kind of lower inflammation that help with the spike proteins. It's 300mg twice a day for three months, very well tolerated.

We don't really see problems with it. You're going to do it with a statin. Most of the time, like a tour of a stat and ten milligrams or pravastatin. That is for some of the, also the inflammation we're seeing in the platelets, the SDC 40 L that's indicating platelet activation.

That's what these statements are working on. I've done this for patients. And, it's not a large number, maybe 12, 15 patients. I have not yet seen massive results.

So I got back to Bruce and I said, Bruce, what am I doing here? He said, well, I initially he said, you know, it could be two months.

Long COVID, Spike Protein, and Final Takeaways

I tried two months, nothing. I saw no results. So now we're doing three. And he said, well, if by the end of the second month going into the third, you don't see a result, add some colchicine.

Colchicine is an old anti-inflammatory point six milligrams a day. They used to use it for gout. They use it for other things. We've started to add it now.

I'm not sure that the reason I'm still not seeing the effect, and they haven't gotten through the finish line yet, is some people and you brought it up earlier.

It may just be that we do need to use some that'll kinase to kind of open things up and find where the spike proteins are hiding, right. So the immune system can get rid of it.

I there's a lot of unknowns at this point that we're dealing with, but I'm not yet seeing the full results. But the problem I'm facing is some of these patients that are taking the protocol still have Bartonella fishes that are positive.

They've not yet finished the multi tox. So the problem I'm facing is when you've still got nails in your foot saying I have pain and they're all driving inflammation.

It could be that once I get rid of the part and I do enough pulsing and I've, you know, gotten rid of the mold completely and we've again check the sinuses.

Then maybe the Maverick and Pravastatin protocol will work better. But this is kind of, you know, a question mark

for me because I'm really wanting to get to the end of this.

For most patients, as you do when everyone does, it's like, so they don't have to suffer for the rest of their life. And I must admit, it is becoming a problem in some of the patients.

Fortunately, most of the people will still get better pulling the mold, addressing the Bayesian part. And, you know, for Bbca, during our summit, you're going to hear from, Jeff Dow from 60 Degrees Pharmaceutical and Tom Moorcroft.

And I had a great talk on Tiffany Kuhn for a bit. But yeah, you should listen to those. Not even a doubt. We are seeing better results using these protocols for a bit easier than some of the other protocols we used to use with membranous other max clindamycin and quinine, lots of malaria and herbs.

Not to say they don't help, but we're having a rough time getting rid of the parasite. This newer protocol with the fennec when is helping. So there's definitely hope for people.

But this is kind of an ongoing, you know, question mark of what exactly is the best protocol. And I'm still waiting to see the scientific results from it.

Yeah. Well, I think we're all excited to see the results from your study. And, you know, for the listeners, too, it's like different protocols work differently for different people.

Right? This is not a one size fits all. And again, I think that, Said's kind of like highlights how every single person is different and needs a different focus and therapy in addition to whatever you're using as your antimicrobials to really heal the body, which is what the summit is all about.

So thank you so much for joining us. Any final thoughts you'd like to leave with our listeners? No, I mean, I think really the major thing is, and I'll always usually end with this because I have very little filter between my brain and my mouth is there is hope, there is hope and more hope now than ever before.

I mean, we only really kind of discovered the answer for Bartonella only a little over a year and a half ago, when we started pulsing more of these two adoption protocols for patients.

I mean, otherwise Bartonella was interfering. And and by the way, there's still more work to do on this, right? There's still people that I've seen still Bartonella fish positive sometimes and people after doing six pulses, but they're still loaded with mold.

And there's other reasons why they may not be responding, but ultimately there is hope. We're having much greater success where people do not have to stay on antibiotics for the rest of their lives, where people don't have to be doing detox protocols for the rest of their existence, or herbs for their, you know, forever.

And the herbs clearly are useful. I mean, way before, you know, you're getting good results with herbal protocols that I used to myself also. But we've got to address these biofilms and persistence and the message model with doing this, it's really provided me with tools that I didn't have years ago.

So I'm really encouraged for people to let them know that hope does exist to not give up. Please speak to your doctor about learning these protocols, because ultimately it's the most effective and shortest term protocol.

I know how to get people's health back. Wonderful. Well, thank you again for your time. Thank you for being here for our summit. And to our listeners at home, thank you so much for joining us.

I hope that this is helpful on your journey to healing from Lyme and co-infections, and we'll see you at another episode. Bye bye.