Introduction and Steven Harrisu2019s Background

Welcome to another edition of Mycotoxins in Chronic Illness. This is 2.0. We're back again. And, today it's really a great pleasure to interview Doctor Steven Harris.

Steve is a person I've known for probably almost 20 years now, 18 years. And, he's a board certified family practitioner. But more importantly, he is just an amazing physician and someone who I have, shared many patient with, many patients with and learned a lot from, especially in the area of Lyme disease and two point infections.

He's, president, founder and CEO of Pacific Frontier Medical, which is, his wonderful clinic. And, so I'm going to start off and first, I'd like Steve to share just a little bit about what got you into this field.

So I always thought that I was going to be doing international medicine, jungle medicine, war medicine. And as I was having these dreams, my, my father, Nick Harris, was, taking a chance on, and immunology, offshoot, of, Berlioz's Lyme disease.

And he developed, helped develop one of the early Western blots and, and as he was doing this, he started realizing, how many patients maybe actually had this, this infection and, started talking to patients.

He actually has a, as a scientist, many people would call him talking about tests, and then the conversations would turn into life stories. And, he's he's always been a very good listener.

And, and so we would sit around the dinner table and talk about his day and this new burgeoning concept of Lyme disease, in the, in the late 80s, and, and then as I went through medical school in the 90s and started seeing the, the controversies developing about what is Lyme, how do you get it?

How do you treat it? How do you diagnose it? How do you address these, this ever growing population? I started working with, with my dad in his lab at Hygin.

X is the name of the lab, and, and became quite a bit more interested in the science of it and then started attending conferences and learned from Greg Buck, Joe Burrow, Scott O, John Drew, Richard Horowitz, and, and, got to see these people who were in the trenches at a very early and Charles Ray Jones, of course, at a very early, juncture in this field.

And what they were going through and, and how much of a difference they were making in people's lives. And so, as I had gone through medical school and saw how doctors could close in on themselves and probably out of anxiety that they couldn't fix everybody, many doctors would develop a, a reactive approach where they would act like they knew everything and, and I was seeing behind the scenes that they didn't know anything, really, especially about Lyme disease. And they were becoming more and more entrenched in their their wrong belief system.

And so then patients were being the, the end product or the, the victims of, of all of this internal, doctor, anxiety and reaction going on. So, so I became very interested and then I, worked with decided I wanted to stay in the United States after residency for a year or two, just so I could get my feet wet.

Understand how things worked in a medical system that was supposed to be functioning, a well-functioning medical system, and then then go off into, into Latin America and Southern Africa and such.

And so I worked with an amazing doctor, Theresa Yang, in San Diego, and Santi, and she ran the only free and nonprofit Lyme clinic, at the time in the country.

And we were it was basically jungle medicine as it itself down there. We often practice with the lights off, because

there was no, there was no money to pay the bills for, for the power and and not only that, but the patients were the sickest patients that we never learned about these patients, even in inner city in Washington, D. C., this was a whole new class of of patients, and the complexity and the pain and the fatigue and the brain dysfunction, and, and it was just amazing.

It and so many of these people were tick borne disease patients. And there was the belief at the time that there's no live in Southern California. And we saw the stories where it with the tick bite and the rash and even allowing to even have a rash, which was another part of the problem.

And then, and then the way that the disease progressed and the way that they were treated by other doctors, and it became just absolutely fascinating how much medicine and how many different strand of medicine were involved in these patients.

And so realize and then I realized, at the same time, because we had an amazing neurologic chiropractor who work at the office, and then we had a naturopathy doctor who work at the office that that, that allopathic medicine by itself wasn't going to work.

Sufficiently for these patients. It just there wasn't science wasn't far enough. So learning from patients and learning from naturopathy doctors and neurologic chiropractors and, and Doctor Yang and all of these other doctors who came before me, you who came before me, by quite a bit.

The, so it's a whole new field that we didn't learn about in medical school and residency, and I did quite a bit of alternative medicine and complementary medicine through residency.

And had and had lived in Mexico for a while and worked with, Mayan, worldview health, practitioners and such. And so I was already aware of herbal medicine and aware of, of other aspects of, of of medicine and traditional Chinese medicine and such.

But watching what it took to get some of these patients better, was really where my journey started and where it's continued. It hasn't. I mean, in 20 years, it hasn't changed all that much.

It's the same journey. And and so I feel quite fulfilled, but also very humbled because I, I wish I had a cookbook, where I could go through the 62 steps to get everybody help everybody get themselves better.

But it's reinventing the wheel every time. And it is amazing. It is extremely intellectually and spiritually rewarding, but it's also it's a grind.

Lyme Disease, Chronic Illness, and the Limits of the Antibiotic Hammer

Reinvent time. That wheel every time. Yeah. That that that's I mean yeah it warms my heart to hear your story. I mean just because it helps, you know.

Yeah, it it's just my experience over and over again that, you know, there are some people who are lucky they'll go find the doctor who's a specialist in this aspect of the inflammatory process, and they'll get better.

But the patients who we tend to see, are a mix of problems. It's, because, you know, as you said, it's like when you were watching down there, it's all aspects of medicine are involved in Tickborne disease.

And in fact, just as a little segue, you Segway here, actually, Segway here is that, you know, people are wondering, this is mycotoxins and chronic illness.

Well, in my mind, mycotoxins generally don't become a problem for most people until they've had an underlying chronic illness and tick borne disease is at least in maybe because it's self-selection.

But in my experience, the most common chronic illness to bring people into the medical toxin and mast cell and

other kind of falling apart world, you know, like it's immune dysregulation.

And that's what these bugs do. They dis regulate our immune systems, you know, so, you know, and it's interesting because, you know, on the other, on the other hand, from from that story I did, I did I would test people for we would do shoemaker panels.

And I don't think micro toxin testing directly was available. Not in those days. Yeah. But but we did a lot of inflammatory testing. We did a lot of autoimmune markers. We did a lot of viral testing.

We did parasite testing, you know, which has its own problems. But, and so we would find a lot of things that were positive, of course, the various fungi and, and, and all that.

But, when we found Lyme and we found, BRCA and then eventually Bartonella, the first probably two years, it was just trying to find a bigger and bigger hammer.

Right. And and it was that that was the part when things really shifted was that, you know, I could no longer hold on to the hammer because it was so big.

And I would smack that nail down and I would wait the 12 or 14 months and say, oh, you're hurting in 14 months. The hex, what? You know, and, and sure, for some people it was great.

And it did. And then of course, we detox people and we, we did a lot of that, a lot of functional medicine with it, but, it was, Yeah. And you say it perfectly that to dance, with the patients and so learning how to do that dance without all of these chronic complex illness patients, and, and I think that there there's a time for many of these patients who have tick borne diseases where that hammer can, can work, but it doesn't have to be the whole time.

And many of them are ready for a hammer at first. There has to be that. But. And just to let people know when when you're saying hammer where like, it means, you know, antibiotics and also need antibiotics is our big hammer.

Yeah, yeah. Metaphorical hammer. Yeah. The metaphorical hammer. But but that that I at least I think that's what we were referring to because I know I call it walking into the front door, you know, when somebody comes in and they're sick, you know, the straightforward thing here, here's the antibiotics and, you know, and then they get better.

That's the nice story. But that's usually not who what we see. And you know that's not the story that I see. Yeah I mean gosh, I've done this, I don't know, 13, 14,000 times.

And I've maybe had that story a hundred times. Yeah, I know, but it's a very powerful story, though. It makes you happy. It's like being in the emergency room again, you know, and they come in, you know, and they're short of breath there. And heart failure.

You give them the the I. V. Lasix and they're breathing comfortable. It's like, wow, what a hero you are. But and that's what doctors live for. But the reality is a little messier than that.

Or a lot messier. Yeah, yeah. Oh, no. For sure. You know, and then and then over the years, you know, it's interesting because you do see new theories come up and, and then you see new treatments come up, and then you see then you when you're looking, especially when you're listening to, to all of the or so much of the media and the patients and other doctors, so many different, theories and so many different, ideological agents and so many different, you know, ASP acts of pathology and then treatments come up and then there's like a, you know, you see, you watch these bandwagons over time, you've seen this where it's like something like nanotech, you know, becomes like the most famous, the best thing.

And it's great for everything, you know, and then, the, then cold, stone cold start meaning. And that's like the end all be all. And we this is what we do.

And if you just get close to me and everything's gone. And so we see this over time. And a lot of these things have stuck, but we're finding the way to put them in.

And so that's where it's really important is like, you know, looking at the patient, the whole patient and all of the pieces together and then trying to find.

And with that, you know, it's, you know, we use that, that metaphor a lot, but the layers of young and it's more than just the onion because there's, there's a lot of other pieces that go with it, not just pulling layers out, but, but it's interesting to watch some of these things come and go and then come back, for example, the like, what's with respect to to tick borne diseases and other chronic illnesses?

The, the Marshall Protocol, when every the Marshall Protocol for years. And I just totally fell out of favor and now there's there's a real place sometimes for it like it, it work sometimes really.

Well, and it's trying to find working with each patient where they're at and how to get them to the other side, how to help them get themselves to the other side, I should say, because that's that's the key piece, is that that is a, relationship that you're working together with.

Yeah. So what I actually. An interesting it just said, mind your brain a little bit. What is there a particular flavor of, you know, a how do you say, hey, are there a few key symptoms that kind of push you, like one direction or the other for what you for?

For what you think needs to be treated first? And you know, when you're looking at a complex patient comes in, is there, you know, I my my my, reference for this is so old that nobody gets it anymore.

It's the old Groucho Marx TV show where that duck would drop down. And if you said the magic word, you got $100. You know, but you'd have to be like everybody who knows what that references is almost dead. So.

But but it's it's the idea that, you know, in medicine, you know, when you go in, in the seven minute office visit, you know, if you say the magic word that my joint hurts, you know what?

They're going to give you a non-steroidal, you know, and the conversation, but in our world, you know, while you're listening, what what flavor of symptoms push you to, like to to making your decisions and that.

Okay, well, first of all, it's a complicated question because, well, it's it's a even 4 or 5 years ago, I would have answered it differently, right? 4 or 5 years ago, I would have said, okay, if you have, you know, major about like after looking at yeast and after looking at mold and after looking, you know, at other GI issues, for example, if you have major GI issues and you have anxiety and you have brain fog and you have nerve pain or brain fog, nerve pain or, pain in the bottom of your feet and costal margin pain, tenderness or some stress on your back or back in your groin.

All right. We got to look at Bartonella and then I it was a decision between hey do I do Bartonella Berbizier first. Do you have head pressure. Do you have very vivid nightmares?

Do you have night sweats? Do you have er hunger, shortness of breath? Do you have major neurologic symptoms? You know then I'd say okay. They got but busy and Bartonella.

Which one. How am I going to do it first. Yeah. And then there's benefits for doing both, you know. But it's not like that anymore. Like it's become more formalized and it's become more subtle since then because of this thing that we didn't really I don't know, maybe I wasn't looking, but, but back 20 years ago, mass health, mast cell activation syndrome, it didn't seem like it was such a big thing.

Like, we didn't really know it. I didn't know it. And and so there was, I think we used to call it hexane, I think you called a hurricane. And then it was and and it was, you know, patients have the symptoms are much more like some of them are more subtle, but sometimes they become so pervasive that you just can't proceed.

You just can't cut to the chase. Even if you know that the bezier is the thing that's causing them to feel that way, or Barton is causing them to feel that way.

Like you have to work out like now I find, you know, and I it could have to do, you know, with glyphosate and it could have to do with it that there's more mold and that there's more emfs and 5G.

And so mold is more polarized and more pissed off than it used to be, you know, in the way it acts in our body. Who knows? You know, and, that there's for some reason we can't just hit, you know, we can't use that hammer against a nail anymore.

We have to prepare. We have to make the conditions proper in order to go in and cut to the chase. When it's time to cut to the chase, you know, that's my favorite time.

It's like, okay, you know, smash and grab, bam bam bam. You know, I that's I love that time. But, you know where I can use my three IB antibiotics and have maybe someone on disulfiram at the same time and, you know, and just go, you know, hell's bells.

And, but I don't get to do that very much. I my, I know, I, I know what you mean, because. Yeah, you are now dealing with patients who, you have to say, may I, because their systems are so sensitive.

If you push hard. Yeah, yeah. The good old days are gone, you know, and sometimes, you know, and I think to my detriment, having, having had so many patients who come to me who've been sick for years, and have been to so many different treatments, treatment approaches and in different clinics and such, and have, I don't know, failed or partially failed or partially recovered and then relapsed, you know, having these, these really storied, complicated, experienced, super knowledgeable, patients who are really self aware and sensitive and know what they want, a lot of them and know how to get there sometimes, if you listen to them.

But the, it's, they, they can't just go straight to the chase. You can't cut to the chase anymore. And and the dance, it's different. I mean, each each time. Sure.

There's, you know, we look at all of the all the things, we look at the viruses, we look at them all. We look at the hormones, you know, we look at their, you know, ability to detox, and, you know, so to my detriment, sometimes there are patients still who come in and all they need is just some stupid treatment, you know, and they do walk through that door and they could be part of that 100, you know, but I'm a little traumatized from so many traumatized patients, that, that I sometimes am a little bit too delicate.

Mast Cell Activation, Treatment Sensitivity, and Preparing the Body

So it's like you know, especially when I try, you know, when I go, with homeopathic spirits or LDI or, or naturopathic and naturopathy combos, you know, and I want to do that first and I say, well, let's see how your body reacts.

And then, you know, once we do that, then we'll, then we'll use, then we'll debug with the pharmaceuticals. You know, sometimes just debunking with the pharmaceuticals first.

I used to do that most of the time. And then I would just wait and see what happened. But now I've had I've seen too many people, thankfully, through other people's stories, you know, I haven't, you know, gotten into that much trouble myself with that.

But because I've heard it so many times, it's the recurring theme. But let me, let me just, you know that I this is I, I this would be a great training video for doctors I realize because so I mean what you are describing, what has to be thought about.

But let me just reference this for, for our listeners a little bit more specifically is what just so they make sure that they're getting it because we're talking a little bit in our code is that, you know, what?

Doctor Harris is really seeing that I think that most of us have is that antibiotic therapy, can be so effective and so powerful. But in this day and age, by the time people come to those of us who are, you know, kind of in the, I guess the subspecialty range of, of treating Lyme is that if we go in with the antibiotics, too many people get significantly worse, you know, because their systems are toxic or too toxic.

They're too sensitive. They've got other so many layers, as Steve was talking about, whether it's mold, Michael, you know, Michael toxins, mast cell, all these complicating issues that, you know, to go in there and just knock down the load of that of, of, of tick borne disease is too much.

But every once in a while, that's what's needed to get the system to actually move. And we don't know who those people are anymore, because we've seen so many people get sicker when we lead with the antibiotics, you know?

And, I might add and that's that's why I know for me too, is that antibiotics are something that are used now second, third, fourth line, you know, long, you know, until we try to make sure the system is cleaned up as best we can.

And one other point that makes life even more frustrating is that sometimes the most sensitive of the mast cell people can actually tolerate drugs much better than they can tolerate anything else, which is amazing.

You're right, you know, especially to that end, what I find. And when I get patients who have been through things in the story, the the two hour story is about their mast cell experiences.

You know, it's everything is more times than not, if I use some ivy zither medicine or some stuff, try ax on, and I go low dose, you know, and I work it up.

That's usually they, they really tolerate it. And it's amazing, you know, Hallelujah. I know most people don't think that because. But they don't realize is that the a lot of the subtler things are rocking their immune systems, and it's the immune system that's the issue.

And the antibiotics actually are anti-inflammatory. And as well as killing the bug. Yeah, yeah. And everything just, you know, and sometimes because they're the chemical, your body doesn't even try to work with it.

It just like takes a back seat and lets it do its thing almost. Yeah. You know, it's it's, it's, it's the, the complexity of, of this world and I, I always I mean, this is, it's, I know that it's a patient.

It's sometimes hard to hear this because, you know, you, you know, when you've been suffering though, and you've been, walking into walls, so to speak, going to different practitioners and being given something and just getting sicker.

It's kind of can be disheartening to hear that, that that is your faith a bit. But the important thing to remember is that you know, you're with the right practitioner when when you walk into the wall and it hurts, they don't keep insisting that you run into the wall.

You know, they listen and back off, and then we'll readjust, you know, and realize, you know, I think that's I think that's really important that, you know, that there's ways there's so many ways to get in there.

Right. And then it's I think that's where that experience comes in with when you've seen it like okay, so sometimes it works. Sometimes a little touch of this will work, sometimes it doesn't.

And then you just have to know quickly when to back off, you know. And when I take a different approach like let's just say what that cell person, that we tried a little, you know, 100mg of I. V..

Is it for my son and just wasn't it wasn't the right thing, just didn't work. And then, you know, probably, you know, your options would be. Well, do you try a different antibiotic?

You probably not. You know, because this is probably one of the easiest ones to assimilate. You're not doing any direct killing that way. You're going inside the cells, you know, it's, you know, plus it's not working that well.

If someone's really acidic, you know, so there's so if you use something easy and you get a sense that the body's just shutting down, then you take a different approach.

And so, like, if I was on a time crunch, right, and someone said, and I've had this and it's, it's horrible. Like I have three months in. If I'm not better in three months, that's it.

I'm not going to keep on treating, you know. And so they give you a timeline, which is what, you know, the, but so in that approach, then what I would do is say, okay, like look and see what kind of inflammatory markers are and then probably do something like, you know, we were just talking about before I got on, the, do something like a for recess or plasmapheresis, chase it with IVIg to decrease some of that, you know, neuroinflammation.

I mean, this is after testing. So you know, what you're doing and you know that you can be safe with it and hopefully get insurance coverage for at least the IVIg, if not the, for instance, the, you know, and and then you can then the, can you make the conditions.

Right. So then the actual treatment that's needed will then be able to be tolerated. Right. And so sometimes you don't need to go that, that hardcore.

Sometimes you can just use something like Lexa NOx or CYP or some of these other peptides. You know, Simonsson, you know, beta for whatever. Or you know, even his diet, you know, some of these little things you can use to decrease, you know, mass cells, chroma and sodium, you know, whatever.

There's a million things out there, you know, or you do the cane protocol, you do membrane stabilization therapy first, you know, like there's a million ways to get someone to the treatment.

I don't necessarily I mean, I love the membrane stabilization therapy, and I think there are some things that it actually is a treatment in itself for.

But I often use it to get me somewhere. I use a lot of these things to get me somewhere. I don't think that plasma is the end all and be all for almost anything, but, you know, get me somewhere, right?

Band-Aids. But they let us. Yeah, they're just haters. Yeah. They're facilitators. They're excavators, you know, so you can put whatever you want to put into that hole.

Yeah, I love it, I love it. I mean, this is what I mean. And I just want patients to understand that in the complex, you know, if you're if you've been going to several doctors and you're still not getting well, it's step back and not and just realize that you have to keep opening the possibilities.

One of the depressing things that's not depressing, but one of the frustrating things is when people come in to see me and there are 100% sure they know what they have.

And that's fine, because, you know, I always believe that that deep intuition is the guy, and we have to honor and acknowledge it. But sometimes it's that deep intuition that's also been, focused by the fact that they saw a list online that said, these are bbca symptoms, you know, and we've joked about that for years.

You know, one man's BBC, his list is another man's Bartonella list. You know, it's there's flavor, but the body only has so many ways to make noise, you know, I mean, and yeah, and there's different flavors of headaches and different flavors of head pressure.

But at the end of the day, you can get there by inflammation. You know, your brain fog and your mood. Which brings me to another point that I'm really excited about.

You know, as far as a not a specific treatment. Yeah. You know, it's I talked to Doctor Paterson the other day, who's publishing this paper, you know, and I don't know, I mean, you know, maybe.

Oh, I'm sorry I said yes too quick. This is the problem with talking to you is that we can talk in code. That doctor, Bruce Paterson, who's, didn't a lot about, quote, long haul Covid and and about the function of of how a piece of the of the spike protein stays in our white blood cells.

And I'll let Steve go on from there. Well, so so talking to him, and I don't know if this is going to be part of his paper that's coming out. There's a paper coming out in the British Medical Journal imminently.

And the, he was talking about, you know, and. Sorry, let me just backtrack a little bit. One of the biggest, debates between who has chronic Lyme as an infection and who's sick with post treatment, Lyme disease syndrome.

Is it an active infection, or is it the junk that's left over that your body thinks is still going on? So you're just making the inflammation? Like that's kind of a hallmark of the treatment debate, right?

That's we're all like yeah the infectious disease society versus the international Lyme. So they're fighting it. Right. It's and and so there's a lot of evidence, that both things are probably happening that the bacteria are there like for Borrelia, at least for line, there's not a ton of actual organism.

It's not in a similar to syphilis, but like syphilis, there's like every single cell would be infected. And Borrelia, you know, it's going to be one of, I don't know, 1,000,003 million cells are going to be infected, actually.

And so there's so few cells that are infected with Borrelia. That that one. Yes. One packs a punch, but that punch is the immune response, right. And that there's we know, having done this and, you know, and we see this with tuberculosis and a lot of other things, the whole latency, you know, there has to be some sort of trigger.

Was it steroids? Was it an accident? Was it, something I think. What what do you mean? The latency is that you can have this bug in you, and it can be kept in check by your immune system until a stress happens.

Yeah. And the point is that, yes, the people who are sick with with chronic Lyme, the infection is definitely one of the paramount things. Right. But that the inflammatory response is also really important.

And so we look at there's a few like different kinds of cells that we think about. And one of the first models was that whole toll receptor toll like one where you get a very nonspecific immune activation, even if it was just one.

But the whole body is going, you know, crazy. And it sends a cascade of reactions like, I mean, that's a little bit what a Herkimer is like. A Herkimer specifically is that we're organisms, you know, probably from quorum sensing, where organisms communicate with each other that a few of them die.

When colony die, they send signals to a bunch of other ones, and the bunch of other ones then die, and they release their chemicals in the body, responds to the chemicals by making their own chemicals.

Which which which then causes the hurts that which make you or the sensation that we call that. So, you know, I mean, a lot of this is science and is still being worked out, but at the end of the day, there are bugs, but there's also what, the bugs?

You know, what happens to the with the immune response, even if they're just seeing pieces of the bugs, maybe not the live bugs all doing them. And so what Bruce Patterson is, is finding with his chronic Lyme patients, is that he think he finds that monocytes, have, you know, we'll take membranes because we know that that Borrelia.

Sorry. I'll go back. Rarely are our kids, that have a, a cell wall and a cell membrane and that many of them will lose those, those pieces of their organism.

And to make a so-called cyst or lister form, they, they go into these hard cysts that become a little bit more

treatment resistant. Some people think they're dormant. They're probably not dormant, but, that when they lose that the, that, that cell membrane and possibly even cell wall is being, taken up by the monocytes, and there's a whole immune response.

It's happening.

Immune Response, Chronic Infection, and the Long COVID Connection

And it's a very similar mechanism immunologically he's finding to long haulers Covid, and that the, that drug mayor of Iraq. But, using a statin pravastatin, may actually work for probably not the infection piece, but for the major piece of the symptoms with some of these Lyme patients, you know, super preliminary.

And, you know, I'm don't want to put the, you know, the cart before the horse, but just that concept is really exciting. I'm not going to get on the bandwagon yet, because I've seen these kinds of things happen too many times over 20 years.

But for example, that's a really exciting piece that if we could get not have to do plasmapheresis and IVIg followed by antibiotics, right. But and we could use something like a Maryville of that would decrease those that those chemicals without screwing up the immune system like the, the arthritis drugs, you know, steroids do.

Because you can sometimes accomplish this with steroids temporarily. But it's, you know, it's instant gratification. Yeah. Yeah, that one's a, a devil's bargain.

Sometimes. Well, yeah. No, this is. And, you know, it's funny, I, I, I think the first time even before doctor, I before you Patterson. These talk to me about the, you know, thinking that there was a glycoprotein, front line, you know, was one of my patients, like I've always said.

I mean, I learned everything from my patients and from you. I, you know, it's like they're out there thinking about this right off the bat, you know, as soon as he came out with a long coat with, with his monocyte concept, you know, for, for Covid, some of these people on some of the line forms were already like, oh, okay, let's do this test.

Oh, yeah. Yeah, yeah. You know, I mean, it's that's why I say the patient population that, that the, the blessing that we have, is that, that some very, very smart people get these chronic diseases.

And I said that they are a constant source of inspiration to me. And, and knowledge because they, they have the, you know, they, they just reading and you never know what they're going to bring to us.

But so you were getting on, so I hope I didn't derail you from where you were going, but I know the point just being is that, you know, that there's the people talk about, can I get rid of this infection?

And, you know, and it's a hard concept, one and I say, you know, my, my typical line is that, well, the tests aren't good enough to prove a cure. You know, maybe the T-cells are better.

You know, they're they're pretty good, for that. But, the, but you don't prove cure. You just you just can prove if someone's negative, you know, you don't find bugs, you don't find B-cell, you know, antibodies, you don't find T cells that are, stimulated, and they have no symptoms for a very long time.

Okay. Does it mean there's no organisms there, you know, or does it mean that their immune system has actually been able to, like, create a stalemate?

That's probably never going to be a problem? You know, so we don't have we we don't know enough yet about that whole concept of cure. But what we do except I mean, in kids, probably, if you treat them really past resolution of symptoms, you know, usually especially if their, their bodies are still growing.

And I still think that that kids whose bodies are still growing can, you know, can eradicate, but there are so many

different ways to work on this. There's the Band-Aids, there's the, where you can decrease symptoms, but you don't want to just decrease symptoms and have things waiting, you know? Right.

You always do that. So so you do need to work on the infections and then get to the point where the immune system can take over. You know, like when we use antibiotics we forget we maybe they told us this once in medical school, but we forget.

And it's but it's the major thing. Our immune system is still doing more than 90% of the heavy lifting. The antibiotics are just making that 10%, you know, so the body doesn't have to do 100% of it.

So it's still our body that's doing it. So if you can use those antibiotics to bulk enough, then the immune system, if it's working in a lot of times, and then probably what this conference is about in previous conferences that you've had, it's about is that, yeah, there's a lot of immune dysfunction that we're looking at when patients have such chronic illnesses.

When there's the and don't forget the parasites we haven't even talked about, you know, GI parasites and other parasites and, and helminths and, and all that.

Yeah. But I, I would love some thoughts on that because, I mean, that's another one I call these, you know, I don't mean black box. The, the, the limitation has been on our ability to test for, you know, we, you know, we grew up with the idea that, you know, if you didn't see it on a test, it was it.

The illness didn't exist. And yet we've had to, like, walk into this world where really, you know, so many of the things we're treating, we're still treating based on tests that are far from perfect.

You know, I always tell people a blood count can vary, but, you know, but if it varies by more than three points, there's either you're bleeding or there's something wrong, you know, but it can vary a little bit.

But we're doing tests that can really vary dramatically depending on the time that you do them in the lab, that you do them. It. I mean, and the other thing is, I mean, you can, you know, there's ways to interpret them.

That could be totally opposite the opposite, you know, way that that they are like, if someone has an IGF positive antibody test. Yeah, that means that they have a new infection, which is what the textbook say.

Or does it mean that they have a persistent infection, which is what we actually see? You know, there's a lot of science behind why. But it's not all that, you know, it's older science.

And then there's still a lot of unknowns. But why people don't turn a lot of their exam into IgG. And then when people see ECGs, on their antibodies, the older antibodies, do we say that they're immune to this infection?

I mean, that's what we're doing with vaccines, I hope I mean, you know, I'm speaking to the choir, but just for for your listeners, that when you give a vaccine or you get an infection, the standard story is that your IgG that you get, get exposure, you make it your first response, which is an exam response.

That IgG response will last for maybe up to four months, then goes away as it's going down your IgG response, which are your memory cells are smaller, they stick around and then they help you, your body confer resistance for the next time and that that your body has that exposure.

And so that's the story that you that you typically hear. That's why we make vaccines and all that. For the most part, the, but the, there's certain infections, like trypanosomiasis.

Lyme disease, there's some syphilis data about this that there are and, and a few other infections where that, I mean, we even see this with, with Epstein-Barr reactivation and things like that, that you can have a recurrent or IgG.

It's not necessarily the same molecules because they do get broken down, but the there's these persistent infections that are really good at being chameleons, and they look different to the body at different times.

And so when they look different, they come out and the body says, oh, new infection. And so they make an IGA. And so there's, there are different ways to interpret that IgG.

Sometimes when I see someone that comes in, especially partners of, of patients or people who are healthy, or healthy health workers that that work at the labs, and they say, oh, my GPS positive.

Oh my gosh, what do I do? And I say, well, you just had some exposure, you had some antigen probably that you were exposed to. You have no symptoms. You have nothing.

No. IDM your age is positive. You probably have just some immune awareness of it, but it doesn't mean that you have an active infection. So whereas another person would say, well, I'm CDC positive I must be really sick, you know, and they're not related.

So and and this is what I think the great, great problem is that the sickest people we see are AGM positive and IgG negative. And it's very hard. But they go to their, you know, stillbirths kind of saw that, you know early on I mean it was one of my biggest take home messages like back in the 90s.

He's like they're not going to turn it until they start getting better. You might have to treat them with I. V. antibiotics for a year before they actually test positive, you know?

And sure enough, I mean, I cannot tell you how many times I see that. Yeah. But but if you if they go to an infectious disease specialist, the ADM is a false positive, right?

Because they got bit by a tick or they had their likely exposure more than three months ago, so. Right, right. So yeah, I, I and I've never figured out and they really believe in the false positivity of those very strongly.

But I think clinically we've all seen this too. I mean, like, you know, we're not making it up, you know, I mean, it's it's what we see over and over and over again, you know, but it's very difficult for patients because especially if you're in a family where people have them believe that you were that ill to begin with because, you know, your regular blood count was normal.

And you go and get your, your, your Lyme testing and your exam positive. You're still nothing wrong with you if you go to the infectious disease doc. It's a real difficult situation.

No, it's hard in the in that time is. You know, I wouldn't say it's wasted because, you know, obviously every day is precious, but it's a day of health that's given up, you know, potentially, by being told, I mean, that's one of the hardest parts is that when you throw in when doctors, you know, these people who are supposed to be helping you are telling you that you're not sick and you know that you are.

You know that you feel that you are. And then you start hearing this more than once. Three, five, 12 times. That actually ends up creating part of the illness piece that the hormones and the neurotransmitters that we make when, we have that call it rejection or insecurity and anxiety, that contributes to people being sicker.

And so that those are the people that you and I see, you know, that that has to be unraveled to, you know, we're not psychiatrist and the but there is so much a piece of the cellular memory is the way I look at it that becomes part of this process.

Oh, yeah. You know what we talk about that I'm, I, I lots of times through this series is how important the, the, you know, your central nervous system is, is really running the show and when it it and when it's in a place where there's inflammation in it and it's perceiving danger, it's going to upregulate your immune reactivity.

And so whatever thing we do that, that you instead of your body going like, oh, I'm dealing with this infection, it

goes, oh, I'm dying. And so you really you feel a feel sicker, but you get more depressed, you get more anxious.

And that doesn't help the people you know who, unfortunately, are in families where if they're more anxious, they're just told, to increase their depression.

Well, I mean, you just I mean, yeah, I mean, doctor Navios, you know, whole, worldview notwithstanding, the, you know, psycho neuro immunology, which has been around for a really long time.

I mean, if you feel bad, your immune system is going to be bad. Yeah. It's hard wired. I mean, it's just it's just how the system works, and we really have to, we have to respect that.

And that's where, you know, all the mind body work is so helpful. You know? I mean, that's what we can. We can turn down an out-of-control immune system, you know, but some people can.

Parasites, Morgellons, and Alternative Treatment Strategies

And I think that's what we always have to differentiate here. You know, there's some of us are going to be great athletes and some of us aren't. You know, I always love the people who are marathoners, you know, I mean, like my my joke, you know, like, you know, push hard, you know, don't give up.

And, you know, unfortunately, I'm the kind of guy who, you know, yeah, you can push me, but left to my own devices, my first question is, you know what? When's lunch?

You know, what? Are we going to sit down and talk about this? Enough with the pushing and you know, and so and it's the same thing with people who can meditate.

Some people can sit and meditate, and it just comes to them like, you know, just like perfect in other people, they have a more restless mind that's not going to work.

And we really have to be aware of the differences in people and not insist that just because my uncle meditated and, you know, he cured his Lyme, you know, might not work for you.

You know, be nice, know that different things are going to help different people. I just hate to see that bully pulpit used, but, But, Kenny, Kenny, back at you, you were.

You just. We touched on something. I'd love to get you a little bit. I got lost in testing, you know, but in the idea of of where do you see I'm throwing something totally from left field.

But where do you see the parasites in all this? Well, you know, it's interesting, especially when you throw in, you know, these nebulous rope worms. Some of the theories about that, and the pictures and the, you know, the way that it can just devastate people, not to mention Morgellons, which I look at it as parasitic in nature.

And I use the anti-parasitic for and that's really where I've learned the most, you know, interestingly, is with the the more Dylan patients, because I think that we haven't found a way to, to address that piece, whether it's an offshoot of Lyme or or relapsing fever, Borrelia or with Bartonella, you know, whatever that has to happens to be.

One thing is sure. Is that the only thing that I have found that's come close to addressing Morgellons is really high doses of lots of anti-parasitic.

So in the course of treating those patients, I've treated, I've used as many anti-parasitic is there that can be found, you know, in not just this country.

And so I become very familiar with how high of doses I can get, how to use it, which kind of strategies pulsing straight through. But what's, what's been really interesting, doing that is that for many of the, the Lyme patients and the tick borne disease illness patients in the chronic, chronic complex illness patients maybe, who aren't that

actively infected with tick borne disease, that the antiparasitic really have their place, you know, and it's been a place where, where I've had to become, I don't know, like Socrates, if I could, where I know that I don't know, but, you know, just knowing that, I don't know and knowing that, you know, the, there's certain symptoms that really seem to respond to anti-parasitic, there's certain presentations, that if, and I do the testing and I try a lot of the testing and, and now, you know, it's it's difficult.

There's a few people that do very specialized stuff. Doctor Cahill, who's probably retired at this point. So I think he's still getting a little bit amazingly good.

I think you, you know, and, so and, New Mexico and Nigeria, you know, and there's, there's a bunch of people who are doing specialized things. But, you know, for all of the testing that I've done, I'd say maybe 10% something will come up.

And, you know, it's, but I haven't just treated the people who are positive. I have treated some people, you know, who are positive for the parasite test and so there's patterns or subtle patterns.

I think that that if that we're looking for. And so I'll use a lot of the antiparasitic and a lot of times, you know, we were talking about finding a way in, you know, whether it's a plasmapheresis in the, you know, getting working on the mess.

I said the anti-parasitic treatment, like, if I try my stuff that I do know, like, you know, obviously it makes more sense as a scientist, as someone who's like, you know, trying to keep their medical license, you know, to treat things that I do know, you know, and that I have evidence that I'm doing the right thing.

Right. You know, but if I do some of those things and I'm finding that I'm hitting a wall, or a patient's hitting a wall that, sometimes going around and doing the anti parasite protocol, one it's a it can be much easier on the gut than the antibiotics.

You know, you can really and there is crossover, you know, I don't want to use the I word in public but the I, the that drug has. No, no, I, I think we can I think we can say is that ivermectin is one of those drugs that I up until Covid, I didn't understand why it works so well.

I was amazed over the years we've been using it for like, what? I don't know, probably almost 20 years. We've been, you know, I think it was Dietrich's thing where he's like for, you know, parasite with that protocol.

Yeah. With the, you know, you use the the parasite quanto. Yeah, yeah, yeah, I albendazole whatever. I mean and interestingly enough, I ran. So, you know, when, when Jay Rogers was doing his high pass Bartonella studies, Prandtl actually came up as one of the best things for Bartonella.

I mean, it doesn't get absorbed very well, but, you know, so the you, the albendazole, the, thiamin is all, you know, I mean, I know a lot of patients, especially with Magellan's, have used non non-human the of those drugs, you know, but the, those are great.

Even me benders are sometimes all work. Even when my op ed is all doesn't. Which is weird, but it does, especially in the high doses. Of course, the, you know, the, night is ox.

Night is my drug. I mean, I use it probably more than anything else. And, and they are working on, something that gets more systemically absorbed, you know, the, the, diethyl carbamazepine is something that it's been amazing for a lot of these patients.

You see, we can't get it very easily, you know, but, the, you know, not everybody has microfilm area, but Willie Burt before did say there was a microfilm area.

And most of these text that was super related to the Lyme patients. And so way back when he, you know, talked about this microfilm area. And so DSC works for lots of people.

But yeah, it you see. Oh, well, two, you said I mean, right. We have a whole talk in the last five minutes right there to expand on. But just I think that the take home message is that not everybody needs these all these treatments, but is that there are subsets of patients who the way in is, you know, the parasite is imbalance in their immune response because parasites are designed to live with us.

Most of them, they're you know, like most of these bugs aren't designed to kill us. The ones we treat, you know, and do the way they live with us is they alter our immune response.

And sometimes that's fine. Sometimes it's to our benefit. The one of those stories is that, you know, it helps decrease autoimmune diseases if you get these parasites when you're young enough. But when we get them when they're older, they don't generally dance with us as well, you know.

And so treatment and also the fact that the ticks, carry a lot of different things, you know, I mean, it's not just, you know, Bartonella and Lyme and but there's a family.

God knows what that take is. Carry. Yeah. I mean, just, back to the parasites. I mean, it's interesting and back and get to bring it around since I know we're out of time.

But just to my, you know, to my original journey, I actually my first case of mast cell activation syndrome that I saw was as a resident and, and and it was it was an amazing case.

And it turned out, that she had strongyloides and, and it was really from that when I started looking, treating Strongyloides and watching how the mast cell responded and watching all of the symptoms, how they got better.

That really got me so interested in some of these occult parasites. As they and I've seen them in the amount of depression, the amount of headaches, the amount of, like, extreme anxiety and delusional, you know, I mean, they, disorders, so many parasite related conditions, you know.

Yeah, but but but but the problem is, is that if you happen to have something like Magellan's, you know, it's going to be told that you have delusional parasite ptosis.

Yeah, I, I always tell people, shut up when you go to see the specialist, do not talk about the symptom more than once, because if you keep going about it, you're going to get that diagnosis.

If you're focused on your symptom, you're in trouble. Welcome to the world. Well, I mean, it's interesting because it was, you know, one of the things that I did see it in San Diego 20 years ago.

You know, in Doctor Yang's clinic and the thing that that crosses over with that is, is meta methamphetamine, addiction, because there's people will scratch the same way.

And the sores will look similar, you know, so there's, you remember them? They're hills. No, I mean, that that's the problem is that, you know, there are great there are people whose psychological issues will manifest as physical diseases, but there are far more people who have physical diseases that manifest with psychological symptoms.

And we just don't understand the physical etiologies. I mean, that's, you know, it's it's like, you know, the psychiatrist are always talking about the functional, you know, symptoms, you know, as though, like, you know, these symptoms don't have physiologic, you know, operating, they're not caused by something that they, they always look for the psyche as the cause and the I mean, you know, I mean, just going back to Victorian times, I mean, the perfect thing was, you know, everyone had hysteria, conversion.

We ended up calling conversion disorder. How many conversion disorder cases have we seen, you know. Right. Exactly. I have seen several people were diagnosed with that.

But when I spoke to them, they did. You know, they were normal people. They were sick. And and now I actually can help them. I remember in residency I just was impressed by, like, they just weren't being listened to.

Right.

Testing Limits, Patient Listening, and the Nature of Chronic Illness

You know, I mean, that is the point is, is it's the problem with medicine is that we would rather label than listen, you know, it's quicker. Anyway, I can't believe we've covered so much all over the place.

They said, we we have, of course, here one of these days, the good doctor Harris, we have to, just, because you, you know, I don't know, maybe I like you so much because I think we think alike, but.

But it's just that. Because, you know, you have and we each have, you know, like windows and different pieces of this, you know, it's just amazing. It really is.

And there's so much, there's so much knowledge that's not written down, you know, and that I mean, look, I mean it goes back just to maybe last point, when we talk about, and I labs has this the same issue and, and medicine that at large in the scientific evidence body is, you know, is evidence based medicine and how much anecdote do we need before it becomes part of the evidence?

Well, yeah. Well, I know there was a guy. I hate this line, but, this guy is this, infectious disease guy from New York, and you're talking about Covid.

He's big line was, you know, the plural of anecdote is not data, you know, but on the other hand, you can't, you know, I'm where I disagree. Is that, like, how many pieces of data do I need for an anti-gravity device?

You know, I mean, like, if it works once we got something, you know, and so that's, that's the thing is that in and we have to honor that we're treating.

I mean, the thing about chronic illness and I'm with my favorite line about chronic illness is that it's not about what you have. It's about how your body is reacting to what you have.

You know, that's the difference. It is total. It's so important. It is so important because you get people with the exact I mean, not that, but theoretically that experiment, the exact same conditions, they're going to totally behave and feel differently than it.

Yeah. Yeah. I mean and that that's what that's where the evidence based medicine falls apart. Because it is when you start just measuring, what do you measure you need on because you're going six people can have the same bug, but they might react to that bug totally.

I mean, as we see I mean, you know, I mean, these days with Covid, I mean, just all any infection, everybody reacts. You know, it's interesting. We keep having these last points, but yeah, go on for an hour.

It's okay. Is that the. I do think that that things have changed a little bit. Yeah. Back to back to what I was saying before. It has changed over the every 7 or 8 years.

Like what those symptom complexes which what are highlighted, you know, right now, you know, one of the big things is we do see that that triad of the fatigue and the mast cells and the desire to know me, some of them with hypermobility, you know, and it's like that is a group that and maybe we weren't looking and it's true that possibly we just we're blind to it, but it just seems like who I saw before is different than who I see now.

Well, I think they're sicker, but I think partly because I remember, I mean, I, one of my patients who I accidentally somehow sent for a surgery in like 2002 or something like that.

You know, she's, you know, now we're sending her for CCI, for CCI, because even though she, you know, and I remember, I would always be surprised by how hyper I never put it together.

Okay. It wasn't that smart, but I would always because I my, my I used to do a lot of osteopath. I would see these really hypermobile hips in all these patients.

I always be like, wow, these people are all yogis. You know? And I just didn't add it up to the fact that there's something about the increased connection between inflammation, excess inflammation and hypermobility.

And it might just be, you know, genetic being on the same gene. Maybe there's no causal factor there. They're just hooked together. But still, I think it might have always been there, but we didn't know enough to make to know that it was important because I think I saw it.

I just didn't, you know, because I because I remember Richie started to mention it. I mean, that's where or going way off topic or supposed to end. But just the thing is, I mean, that's why I always give kudos to the good doctor Shoemaker, who sometimes can be doctor Shoemaker.

But still he, he, he really noted early on that, you know, he was seeing these, these long limbed people, the that there arm length was, was, was more than their height.

Again, something that goes along with hypermobility in a lot of people. You know, he was noticing he was I mean, that's why I have to give him a lot of credit.

He's an incredibly astute clinician. You know, he really was. I mean, I have to say, I, I think I've learned from, you know, I've learned from all of you guys.

And so I thank you. So it's a I know that the Giants like. Yeah, we all got lots of them to stand on, thank God. Anyway, really, Steve, it's a pleasure to chat with you.

I hope, you know, I, I know we we've I've missed you always open my eyes every time we talk. I think a little bit wider and a little bit bigger. And so thank you so much.

And I was looking forward to doing this again. Thanks. For.