Systemic Lupus Erythematosus

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Case study

47-year-old female patient

The patient receives the initial diagnosis of SLE (Systemic Lupus Erythematosus) as an “incidental finding” during a nephrological-urological consultation

In September 2017, the female patient, born in 1970 and owner of a pharmacy, received the initial diagnosis of Systemic Lupus Erythematosus (SLE) as an "incidental finding" during a nephrological-urological consultation. Due to acute urinary urgency, previously elevated nitrite levels, and a glomerular filtration rate in the upper normal range, the treating physician arranged for an immune analysis, which yielded the following results: positive antiglomerular and thyroglobulin antibodies (679 U/ml - Ref. 0-115 U/ml), ANA 1,160 (Ref. >0-10), and positive ENA antibodies indicating collagen diseases (SS-A/Ro-60-Ak >282 U/ml, SS-A/Ro-Ak > 240 U/ml, and SS-A/Ro-52-Ak >240 U/ml - Ref. > 0-10).

There has probably been a latent hypothyroidism-Hashimoto's for years. The patient takes 1/4 tablet of Novothyral 75 per day (Levothyroxine sodium 0.075 mg and Liothyronine sodium 0.015 mg per 1 tablet) and various micronutrients (including Vitamin C, Q10). Other conditions the pa-

mg per 1 tablet) and various micronutrients (including Vitamin C, Q10). Other conditions the patient suffers from are recurrent arthralgia and myalgia.

It should also be mentioned that a stool diagnosis revealed dysbiosis, reduced secretory IgA, normal values of Calprotectin, and various pathogenic Clostridium species.

- Epigenetic factors, caused by a diet high in sugar, grains, and dairy protein with little natural and fresh foods, as well as by enormous chronic stress in the workplace.
- Environmental toxins: 9 large amalgam fillings.
- 2 root canal-treated, infected teeth.
- Vaccinations: Diphtheria, Tetanus, Polio, Rubella, Hepatitis A+B (Twinrix approximately 5 years ago) and FSME (in 2011)
- Long-term oral contraceptive (Seasonique)
- Possible genetic factors: The father was an alcoholic and a heavy smoker with smoker's leg. He also suffered from diabetes and dialysis-requiring kidney insufficiency. The mother had high blood pressure and arthritis.

The following warning signs were probably not given enough attention:

- Chronic constipation for years.
- Premenstrual syndrome (PMS) as an indication of hormonal imbalances.
- Chronic fatigue as a possible warning sign of liver stress, possibly due to toxins or EBV infection, as well as mitochondrial disease.
- Recurrent migraine-like headaches (2-3 days per week), often accompanied by tension in the neck and head area and only partially relieved by conventional painkillers.
- Recurrent joint pain.

Findings and diagnosis after initial visit (December 2017)

- The immunodiagnostics (> Fig. 1) show persistently elevated ANA autoantibodies as well as strongly positive autoantibodies against SS-A/Ro, which is consistent with a systemic rheumatic autoimmune disease (collagenosis) such as SLE. The C-reactive protein is slightly elevated.
- The HLA typing suggests a genetic predisposition for gluten intolerance (DQ8 positive) and the allergy diagnosis (> Fig. 2) shows borderline gliadin values (1:50 - Ref. <1:50 = negative).
- In the immune status (> Fig. 3), a selective immune deficiency can be observed in the T8 cells and cytotoxic T8 cells (T8c). Natural killer cells (NK cells) are also relatively low. Overall, this seems to impair the antiviral immune defence, as T8c and NK cells are considered the main weapons against viruses. The B lymphocytes CD19+ CD5+ are increased, confirming the autoimmune tendency.
- The protein profile (> Fig. 4) shows elevated levels of haptoglobin, indicating chronic inflammation as well as a possible liver strain. In addition, the elevated IgA levels suggest a chronic inflammation in the area of the mucous membranes.
- The serology (only ELISA) indicates EBV persistence (negative EBNA IgG antibodies) as well

as a possible CMV reactivation (positive IgM antibodies). However, this could also be a cross-reaction with EBV. A chronic HP (Helicobacter pylori) burden is suspected.

- Various vitamins as well as trace elements are increased, probably due to continuous substitution, which was prescribed by an orthomolecular physician or was initiated by the patient

Verdachtsdiagnose:
Lupus eryth., ED 09/2017, rez. Herpes labialis, NMI rez. Cephalea migräneähnlich, PMS, chron. Obstipation

Immundiagnostik **Durchgeführte Untersuchungen**

Untersuchungen	Ergebnis		Referenzwert/Erläuterung
anti - Colon AAK (Affe; Colonocyten, Gobletzellen)	**neg**	Titer	<1:10 = neg.
anti - Colon AAK (Ratte; Colonocyten, Gobletzellen)	**10**	Titer	<1:10 = neg.
anti - neutro. Gran.-Cytopl. AAK, cytoplasm (cANCA)	**neg**	Titer	<1:10 = neg.
anti - Proteinase 3 (PR3) AAK	**<2.00**	RE/ml	<= 20 RE/ml: negativ; >20 RE/ml: positiv
anti - neutro. Gran.-Cytopl. AAK, perinukl. (pANCA)	**neg**	Titer	<1:10 = neg.
anti - Myeloperoxidase (MPO) AAK	**2.17**	RE/ml	<= 20 RE/ml: negativ; >20 RE/ml: positiv
anti - Magen-Parietalzell-AAK (PCA)	**neg**	Titer	<1:10 = neg.
anti - Pancreas-Inselzell AAK (ICA)	**neg**	Titer	sollte auch mit unverd. Serum neg. sein
anti - Thyreoglobulin AAK	**105**	IE/ml	<100: neg; >100: pos.
anti - Thyreoidea-Peroxidase (TPO) AAK	**<10**	IE/ml	<50:neg.; >50: pos.
Antinukleare Autoantikörper (ANA-Gesamt)	**200**	Titer	ab 14J: <1:100=neg., bis 14J. <1:50=neg.
ANA-Gesamt Fluoreszenzmuster	**granulär**		
			AC-4 nach ICAP
ANA-Subsets: anti - ds = native DNS AAK	**neg**	Titer	<1:10 = neg.
ANA-Subsets: anti - Ribosomales P-Protein AAK	**neg**		neg., schw. pos., pos., stark pos.
ANA-Subsets: anti - Gesamthistone AAK	**neg**		neg., schw. pos., pos., stark pos.
ANA-Subsets: anti - Nukleosomen AAK	**neg**		neg., schw. pos., pos., stark pos.
ANA-Subsets: anti - PCNA AAK	**neg**		neg., schw. pos., pos., stark pos.
ANA-Subsets: anti - Centromer (CENP-B) AAK	**neg**		neg., schw. pos., pos., stark pos.
ANA-Subsets: anti - Jo-1 AAK	**neg**		neg., schw. pos., pos., stark pos.
ANA Subsets: anti - PM-Scl AAK	**schw.pos**		neg., schw. pos., pos., stark pos.
ANA-Subsets: anti - Scl 70 AAK	**neg**		neg., schw. pos., pos., stark pos.
ANA-Subsets: anti - La/SS - B AAK	**neg**		neg., schw. pos., pos., stark pos.
ANA-Subsets: anti - Ro-52 AAK	**stark pos**		neg., schw. pos., pos., stark pos.
ANA-Subsets: anti - Ro/SS - A AAK	**stark pos**		neg., schw. pos., pos., stark pos.
ANA-Subsets: anti - Sm (=ENA) AAK	**neg**		neg., schw. pos., pos., stark pos.
ANA-Subsets: anti - nRNP (= ENA) AAK	**neg**		neg., schw. pos., pos., stark pos.
ANA-Subsets: anti - Ku AAK	**neg**		neg., schw. pos., pos., stark pos.
ANA-Subsets: anti - Mi-2 AAK	**neg**		neg., schw. pos., pos., stark pos.
anti - Endomysium (IgA, Coeliakie) AAK	**neg**	Titer	<1:5 = neg.
anti - Gewebstransglutaminase IgG AAK	**0.05**	Ratio	<1=neg;1-2=schw.pos;>2-5=pos;>5=st.po
anti - Gewebstransglutaminase IgA AAK	**3**	RE/ml	<20=negativ, >20=positiv
anti - glatte Muskulatur AAK (SMA), IF	**neg**	Titer	<1:100 = neg.
zirkulierende Immunkomplexe (CIC)	**<25**	µg/ml	< 45:neg., 45-54:grenzw.; > 55:erhöht
hoch-sensitives C-reaktives Protein quantitativ	**0.34**	mg/dl	< 0.3

Fig. 1: Immunodiagnostics (December 2017)

Allergy diagnostics

Examinations	Result	Normal range / Explanation
Prec. Ig-total AB: Gliadin	**50** Titre	<1:50 = neg
Prec. IgA AB: Gliadin	**neg** Titre	<1:50 = neg
IgE total concentration in serum	**6.6** kU/l	20-100 kU/l
Type I allergy screening: div. trees (birch, oak, grey alder, hazel, willow)	**0.02** kU/l	RAST-Kl. 0, negative (0-0.35)
Type I allergy screening: early flowering grass pollen (cocksfoot, timothy, ryegrass, bluegrass, meadow fescue)	**0.02** kU/l	RAST-Kl. 0, negative (0-0.35)
Type I allergy screening: herb pollen/flowers 1 (ragweed, mugwort, saltwort, ribwort, white goosefoot)	**0.06** kU/l	RAST-Kl. 0, negative (0-0.35)
Type I allergy screening: herb pollen/flowers 2 (mugwort, goldenrod, nettle, ribwort, white goosefoot)	**0.03** kU/l	RAST-Kl. 0, negative (0-0.35)
Type I allergy screening: various mites (house dust, dermat. farinae, dermat. pteron., cockroach)	**0.03** kU/l	RAST-Kl. 0, negative (0-0.35)
Type I allergy screening: div. nuts (peanuts, shell nuts, coconut, almond, Brazil nut)	**0.03** kU/l	RAST-Kl. 0, negative (0-0.35)
Type I allergy screening: various fish/seafoods (cod, shrimps, salmon, mussels, tuna)	**0.00** kU/l	RAST-Kl. 0, negative (0-0.35)
Type I allergy screening: various foods (cod, peanut, hen nut) (cod, peanut, chicken egg white, milk protein, soybean, wheat)	**0.06** kU/l	RAST-Kl. 0, negative (0-0.35)
Type I allergy screening: various citrus fruits (orange, lemon, grapefruit, tangerine)	**0.05** kU/l	RAST-Kl. 0, negative (0-0.35)
Type I allergy screening: various moulds (Alternaria tenuis, Asperg. fumig. Cladosp. Herbarum, Penic. notatum)	**0.05** kU/l	RAST-Kl. 0, negative (0-0.35)

Fig. 2: Allergy diagnostics (December 2017)

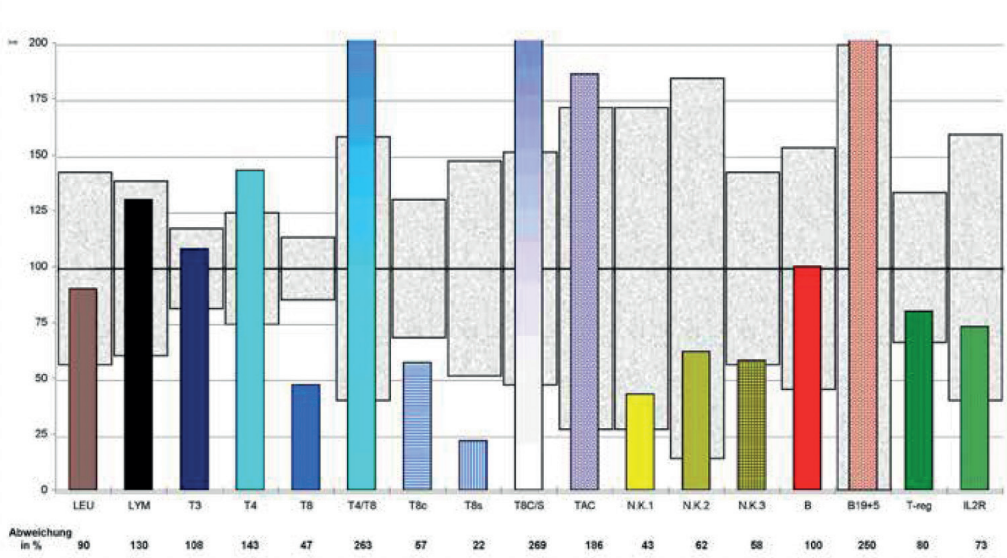

Fig. 3: Immune status (December 2017)

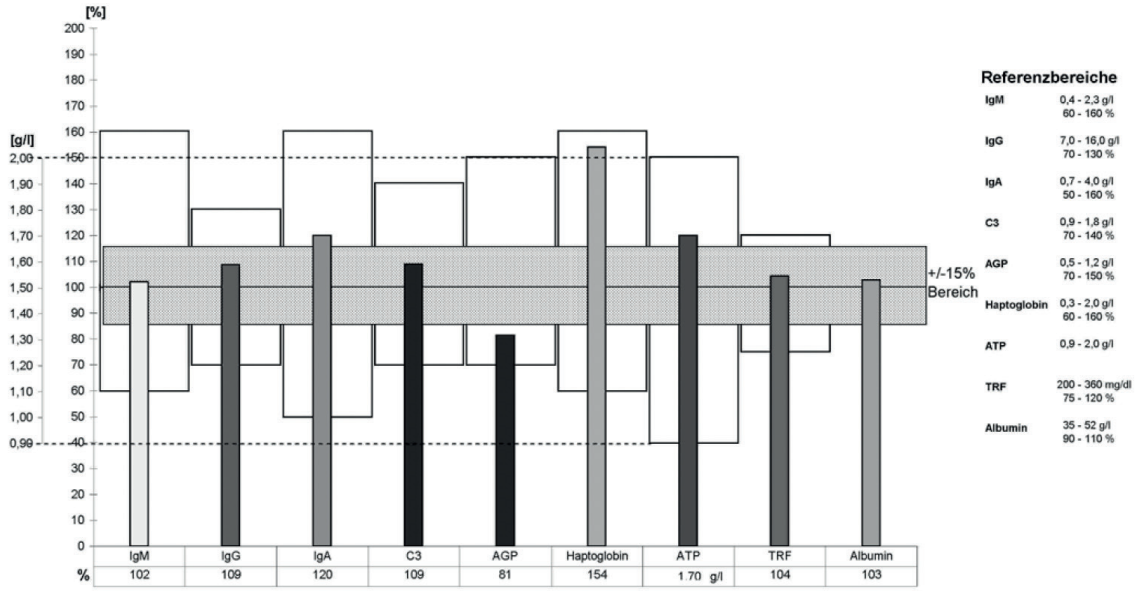

Fig. 4: Protein profile (December 2017)

Treatment recommendation (December 2017)

- The most important basic measure for restoring self-regulatory capacity is a natural and nutrient-rich diet that is gentle on the intestines (including a gluten- and dairy-free diet, with sweet treats only in the form of sun-ripened fruits, and a diet that is mainly plant-based and lightly steamed with fresh vegetables).
- The micro-immunotherapy formulas **INFLAM** (1 capsule/day) and **MICI** (1 capsule/day) are prescribed in alternating 10-day cycles as an anti-inflammatory basis for immune regulation in autoimmune diseases (haptoglobin is elevated, indicating chronic inflammation).
- The micro-immunotherapy formula **EBV** (1 capsule/day) is used to **support the immune system in EBV infections.** In addition, autologous **blood nosodes XMK** and **HLA-SMM globules C27** (SMM: specific modulating molecules) are prescribed in the evening to promote the self-regulatory capacity of the organism.
- In addition, pre- and probiotics are prescribed to regulate the intestinal flora.
- The patient is also recommended F.X. Mayr cure for intensive intestinal cleansing and autophagy enhancement.
- Note: The use of the micro-immunotherapeuty formula **CMV** was also planned. However, since the patient was doing better under the ongoing treatment, the EBV persistence was probably retrospectively in the foreground, hence the treatment was continued unchanged ("never change a winning horse").

Follow-up and treatment recommendation (March 2018)

Already in March 2018, many symptoms, especially arthralgias/myalgias, improved significantly. The intestine is considered to be the "root of the human plant and the base camp of the immune system", so that the individually tailored **F.X. Mayr cure,** in synergistic combination with **micro-immunotherapy**, certainly had a decisive, rapid effect. Mayr cure, in synergistic combination with micro-immunotherapy, certainly brought about a decisive, rapid and successful step towards health.

The treatment plan, consisting of the micro-immunotherapy formulas **EBV, INFLAM** and **MICI** as well as pre- and probiotics, autologous blood nosodes XMK and HLA-SMM globules C27, is continued unchanged. In addition, the micro-immunotherapy formula **MIREG** (1 capsule/day) is recommended, as it has proven effective in genetic dispositions and mitochondriopathies (SLE is an autoimmune disease that can affect all systems/organs).

Laboratory findings (October 2018)

- The immune status (> Fig. 5) shows an increased total number of lymphocytes (lymphocytosis). T8 cells and cytotoxic T8 cells are still reduced. However, NK cells (viral defence) have increased and the values of B lymphocytes CD19+ CD5+ have decreased.
- The protein profile (> Fig. 6) shows low levels of alpha-1-acid glycoprotein, which may be related to a liver strain due to herpesviruses.
- In viral serology (for organisational reasons, this was carried out through ELISA, but serological diagnostics by immunofluorescence is planned for 2019 in Germany), a negativation of the CMV IgM antibody findings was observed. In addition, there are still indicators of EBV reactivation: EBV VCA IgG-AK 287 E/ml (ref. < 20), EBV EA IgG 12 E/ml (ref. < 10, grey range: 20 - 40 E/ml) and EBNA 1 IgG 9 E/ml (ref. < 5, grey range: 5 - 20 E/ ml). The EBNA antibodies have become positive, which can be seen as a potential sign of better immune control of EBV.
- The C-reactive protein is in the normal range and the rheumatology serology is largely unremarkable. The thyroglobulin autoantibodies are negative (note: the immunodiagnosis was carried out in another laboratory for organisational reasons, hence the autoantibody values are not directly comparable with the results of the examination in December 2017, but nevertheless provide a good orientation):

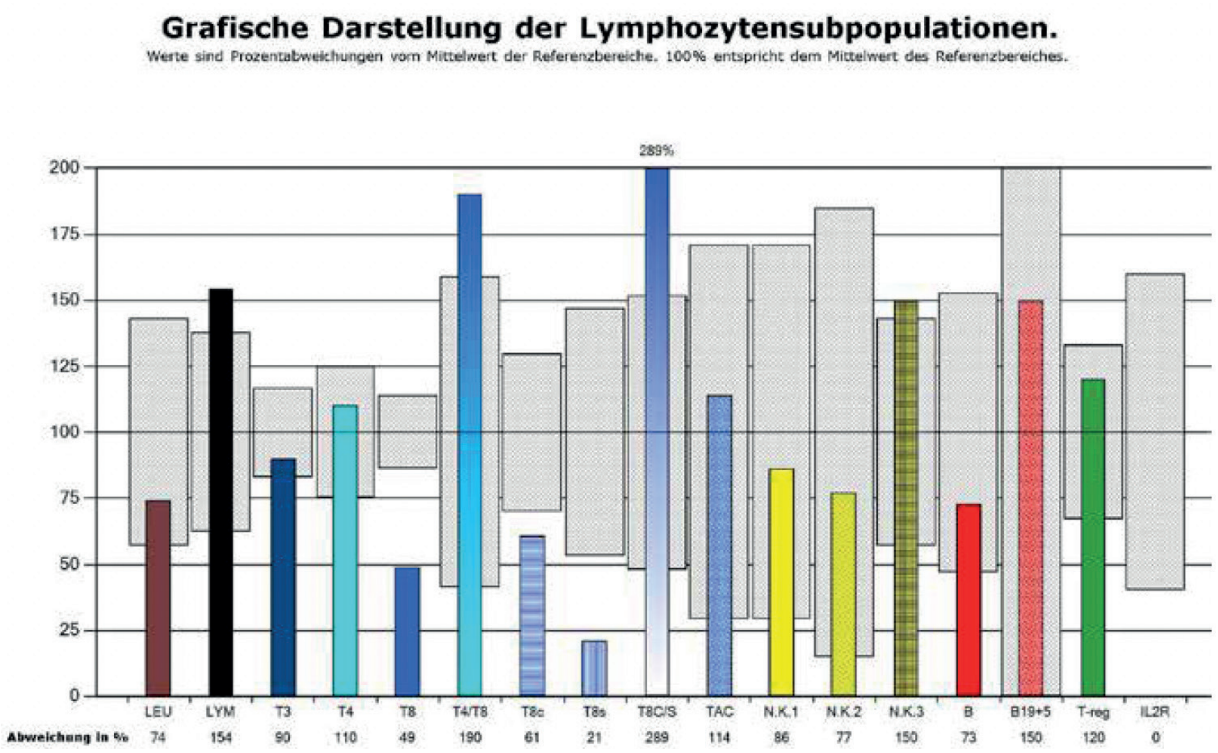

Fig. 5: Immune status (October 2018)

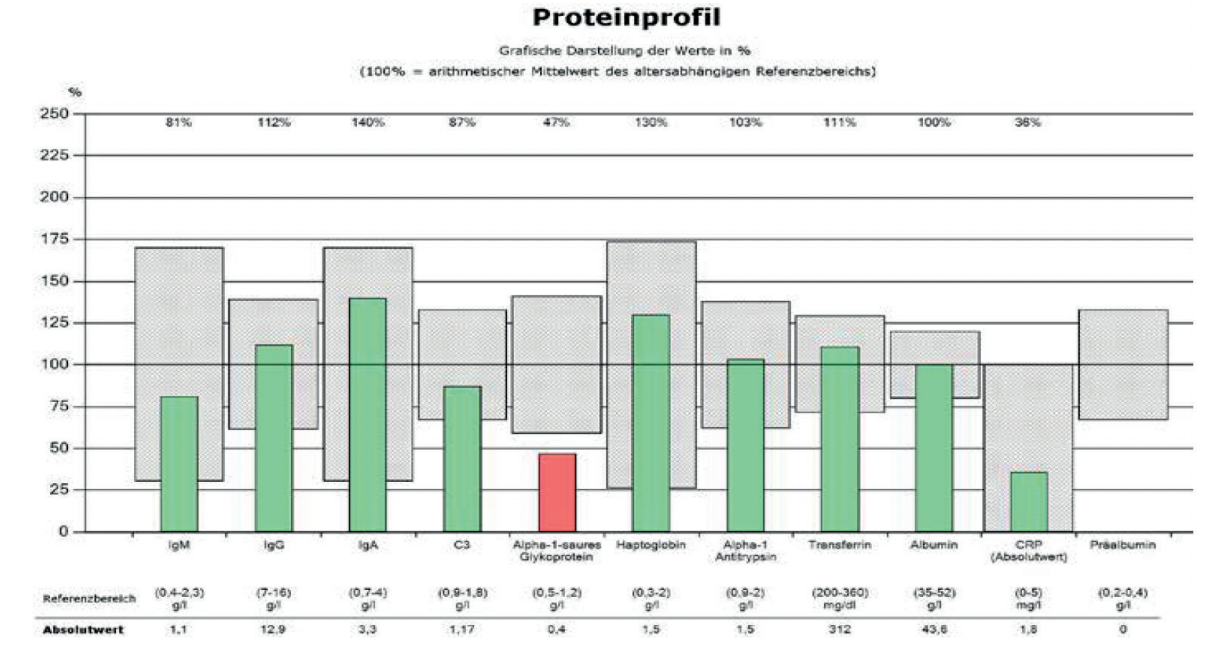

Fig. 6: Protein profile (October 2018)

Treatment recommendation (October 2018)

- An immune-boosting, antiviral diet is recommended, which has proven effective in the case of infections with herpesviruses (including Epstein-Barr virus, cytomegalovirus, varicella-zoster virus) and in general to relieve unexplained symptoms and restore health. This includes the following foods: wild blueberries (also frozen), raspberries, papaya, pomegranate, apricots, grapefruit, lettuce (to clenase the liver), celery, spinach, kale, cucumber, fennel, sweet potato, sprouts, coriander leaves, parsley, garlic (antiviral and antibacterial), coconut oil (antiviral) and ginger.
- In addition, various medicinal herbs and food supplements are prescribed to support the fight against the virus and to relieve the organism: among others, colloidal silver, liquorice root, nettle, lemon balm, curcumin, star anise, spirulina, red seaweed (removes heavy metals) as well as vital substances such as selenium, zinc, vitamin B12 (methylcobolamine) and L-lysine.
- Since lymphocytosis is present, the micro-immunotherapy formula **XFS** (1 capsule/day for 3 months) is prescribed and then again the formula **EBV** (1 capsule/day). The treatment with the micro-immunotherapy formula **MIREG** is continued unchanged and in stress phases I recommend her to take the micro-immunotherapy formula **MISEN** (1 capsule/day).

Current condition

The patient has a good general and nutritional condition; she feels more vital and is less tired. In addition, she no longer suffers from arthralgias as often as tension headaches and cervicalgias, so that she almost no longer needs painkillers. Furthermore, she has consciously reduced work stress (adrenaline can promote EBV activity).

However, transiently elevated urinary nitrite levels are again detected, although the patient remains asymptomatic. A “catious” amalgam removal by a holistic dentist is recommended in the long term (heavy metal exposure!).

Summary and discussion

Autoimmune diseases only manifest themselves after many years. Prior to this, there are years of complex stressors, such as malnutrition, toxin exposure (e.g. mercury) or chronic stress, which manifest themselves in increasingly frequent, diffuse health problems and chronic, misdiagnosed "mysterious symptoms" as warning signs from the cell systems. For example, this patient had symptoms such as chronic fatigue, headaches, neck tension, arthralgia and fibromyalgia, which were not given enough attention.

In many cases, viral infections - the "hidden epidemic" - are considered the true causes or triggers of autoimmune diseases. As researched and sufficiently described in the literature, herpesviruses such as the Epstein-Barr virus "hide" behind many exhaustion-related symptoms, autoimmune diseases (e.g. multiple sclerosis) and even cancer (e.g. lymphoma, mamma carcinoma).

These viruses prefer to attack cell systems that are exposed to strong internal and environmental stressors, such as the liver, spleen, thyroid gland or central nervous system. Like bacteria, they can be regarded as "survival artists": they adapt to the environment, mutate, become more active and possibly more aggressive.

A possible, very plausible hypothesis on the connection between virus infections and autoimmune diseases states that the immune system physiologically attacks virus-infected cell systems by initiating an inflammatory reaction (main immune weapon against infections). Neurotoxins are produced as by-products, which further burden the overall immune situation (psycho-neuro-immunology). Gradually, with a corresponding genetic disposition, autoantibodies are detectable in the blood, which may indirectly indicate how high and aggressive the viral and toxin load is in certain organs/organ systems.

This patient was lucky that the diagnosis of SLE was made relatively early by a competent nephrologist and she was spared a further year-long odyssey. In addition, this systemic autoimmune disease may have manifested itself late (at the age of 47), as she had already taken F.X. Mayr cures in Gröbming several times and was well substituted orthomolecularly. The laboratory testings carried out in my practice revealed even more specific indications regarding the viral and inflammatory immune burden. From a therapeutic point of view, micro-immunotherapy and the big step towards intestinal health with a change of diet, antiviral nutrition and the recent F.X. Mayr cure have fortunately led to a rapid alleviation of the symptoms in this very cooperative and attentive patient.

The further stabilisation of the overall immune situation will still take some time, as relief from symptoms does not mean healing. However, the first step towards recovery has been taken and, if the patient remains consistent with regard to lifestyle and the application of gentle **low-dose immunomodulation with micro-immunotherapy** as well as the other treatments, a cure in the sense of restoring homeostasis in the organism is quite probable.