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0134 Questions

The following represents three groups of questions posed by health care professional Shera Robazza, on behalf of Global Advocates 4 Myalgic Encephalomyelitis. I am also sending this as a written document because many of the questions are both difficult and complex and a few are both outside my understanding and also incomprehensible to me. Many of the answers to these questions are answered in greater detail in my two recently published books. M.E, and the Return of Polio to the USA and the second larger book, Understanding Myalgic Encephalomyelitis.

Questions: Global Advocates 4 Myalgic Encephalomyelitis

Note #1: Many of these questions are complex and so may take time to digest.

Note #2: Advertisement: I have just published the most authoritative, most complete and easy to read book on Myalgic Encephalomyelitis. Understanding Myalgic Encephalomyelitis is based on my examining of some 10,000 M.E. patients over the past 36 years and also my extensive meetings with the M.E. patients, greats in the USA, Canada, the UK, Ireland, Australia and New Zealand.

There is no exaggeration to say, I am the only physician in the world who has examined patients from each of the (a) L.A. epidemic in 1934, (b) the Iceland (Akureri) Epidemic in 1947-1950, (c) the Royal Free Epidemic in 1955-1957, and the (d) North America Pandemic in 1983-1992 and (e) the UK epidemics following the 1983-1984 onset of the epidemic in North America.

Those who have read this book believe it also answers most of their questions concerning M.E. posed in the following list of questions. Because many M.E. patients have difficulty retaining what they read, each of the 22 chapters is broken down into self-contained, easily read sub-chapters. So, you may read a small section in less than 5 minutes and find it understandable.

Our problem is that, not counting my time, the cost of producing the book and printing charges comes to over \$50,000. We have to sell another 500 books to break even, after that all funds go to the Nightingale Research Foundation. If we do not sell this many, Nightingale will be in trouble.

To assist the sale any purchaser of Understanding M.E., anywhere in the world, you can contact our office at office@nightingale.ca to make an appointment and I will get back to you personally

to give a personal 15-minute or longer reply to your questions. There will be no charge for this service to past or future purchasers of our book. To save us telephone long distance charges, we would prefer to answer by Skype or FaceTime. The book can be purchased at:

nightingalepress.ca

Global Advocates 4 Myalgic Encephalomyelitis Questions

Question 1: Reputedly, some M.E. patient never get the flu or colds. This is reputedly related to those patients who are reactive to Human Herpes Virus 6A, which reputedly makes them immune to many DNA and RNA viruses. Does this increase the risk of having a COVID 19 immunization.

The simple answer is NO.

The following is the more complex answer: This is an interesting question. Let me rephrase the question. If you have a test that shows you are reactive to HHV6A does this make it dangerous if you have an immunization against Covid 19.

This theory originates from the NIH doctors: [Syed Zaki Salahuddin](#), [Dharam Ablashi](#) and Robert Gallo. Let us look at these doctors.

Robert Gallo: He claimed, reputedly falsely, to be the discoverer of the HIV/AIDS virus. However, it appears he may have received the original data from Dr. Luc Montagnier of the Pasteur Institute, in Paris, France. It was Dr Montagnier who received the Nobel Prize and Dr Gallo was discounted.

Dr Syed Zaki Salahuddin: I knew Dr Salahuddin personally who I visited at the NIH in Bethesda and I found him to be a kind and generous man who was reputedly on of the co-discovered the HHV6A. He was sentenced to jail by the courts in the USA for theft of US government property.

Dharam Ablashi. This veterinarian was the partner of Dr Salahuddin. I know Dr Ablashi also. I believe he holds the patent for this HHV6 virus, possibly along with Dr Salahuddin. Ablashi also became man of the year to the CFS/M.E. Association. I believe this may have been related to an exchange of funds to the CFS/M.E. Association. Ablashi has not only vigorously promoted this virus and I believe in so doing has made possibly millions of dollars profit. I don't believe a word espoused by Dr. Ablashi. This current ridiculous theory is also promoted by Dr William C. Shiel Jr. but the original data of this theory all returns to the above group.

Personal based opinion of this question: I am NOT reactive to HHV6 and I also have not had HHV6. I have also not had influenza or a common cold for over 20 years. However, I have had had three severe enterovirus infections including (a) Paralytic Polio at 13, for which I was hospitalized and in bed for a year. Then (b) at the age of 28 I had Bornholm disease which can cause severe incapacitating chest pain, which normally lasts for a day and mine persisted for a year. Then during the epidemic of M.E which began in 1983 I fell ill in 1984 with M.E. and was unable to walk or even get out of bed for 5 months to go the WC. I slowly returned to work, seeing

one patient a day for 3 days a week. It took me several years to speak normally . I have now had both of the Pfizer COVID 19 immunizations without any negative reaction.

I personally believe any theory resulting from the veterinarian, Dr Ablashi to be pure rubbish. However I believe Ablashi is an excellent promotor and may have made millions on the basis of this patent.

Question 2: What is your opinion of the new 2021 NICE guideline for M.E./CFS?

Background: This is a guideline promoted by Dr. Charles Shepherd who also pretends to have had M.E. I know Dr. Shepherd who never had M.E. but did have adult Varicella (chicken pox). Many childhood diseases such as measles, chicken pox, infectious mono, rubella occurring in adults can cause disastrous illness and has a much-increased risk of death or very serious permanent injury. Dr Shepherd had a near death resulting chicken pox infection when he was a young physician, possibly at 28 years of age and as far as I know never worked again as a physician but possibly went on a permanent disability pension from the UK government due to this injury. I have no doubt he had serious brain injury resulting from the chicken pox. This is not M.E. This is one of the many causes of CFS.

Following the first world symposium on M.E. that Nightingale held at Cambridge University, Shepherd in a letter to the U of Ottawa Press, threatened to sue them if they published to book. This was the combined work of more than 50 eminent world-wide University professors and M.E. experts. They were producing Nightingale's book, The Clinical and Scientific Basis of M.E and CFS. The University of Ottawa Press immediately dropped us. Nightingale published the book themselves and we sold almost 10,000 copies of this book for a profit of over a million dollars. These funds kept Nightingale going for over 15 years.

Anyone who confuses M.E. with CFS doesn't know what they are talking about. So, when I see guidelines of M.E./CFS they don't know what they are talking about.

There is some good in only a few of the suggestions in these guidelines but any improvement is destroyed by Shepherd's statement as follows:

The New Nice Guidelines: recommends to consider the diagnosis of ME/CFS when patients present with symptoms of disabling fatiguability, post-exertional malaise, unrefreshing sleep, and cognitive difficulties, all for a minimum of 6 weeks (4 weeks in children and young people).

A: there is no such thing as M.E./CFS;

B: M.E. is a proven enterovirus illness.

CFS can represent the chronic features of possibly over 100 different disease, particularly if they injure the brain or the cardiovascular system such as Shepherds adult chicken pox.

C: All of the 100s of CFS diseases are called CFS because they have been insufficiently investigated, at any time after onset. So, the physician is unable to come to a correct diagnosis.

D: To most physicians, and my most I mean 95% of physicians, CFS has come to mean a minor psychological disease. It is called MINOR, so the insurance agencies then don't have to pay disability. This will unfortunately not change in our life time.

E: The term **CFS** should only refer to **Insufficiently investigated patient illness or I.I.I.**

F: By waiting for 6 weeks, this clearly places CFS into the field of psychiatry. Any knowledgeable physician knows, that unless an infectious disease is **(1)** prevented by immunization, **(2)** is treated immediately at onset, **(3)** the patient is liable to have **PERMANENT** chronic illness. Is that what Dr. Shepherd wants, permanent chronic illness? I believe any physician or committee who espouses waiting for 6 weeks to diagnose a disease is an **idiot**.

G: The only reason physicians can rapidly diagnose COVID 19 Virus infection easily, is that authorities were vigilant in developing a rapid test which can give a 1-3 hour rapid diagnosis. They developed this amazing inexpensive, Rapid Test within a few months. **Note:** That 66 years after the release of the amazing Jonah Salk polio Immunization, for which he didn't receive the NOBEL PRIZE, despite saving the lives of millions of people, there is still no rapid test for any enterovirus test other than Polio or M.E. until it is too late to do anything about it. The only rapid test for M.E. or Polio which takes less than several days is to do a spinal fluid tap and examine for enteroviruses or Oligoclonal banding. **Oligoclonal banding** is seen in both M.S. and in M.E. because it is a test of neuron destruction or injury in the brain caused by enteroviral infection in both these diseases. However, unless the patient is hospitalized at onset, these tests are almost never performed.

I believe, as long as the term CFS exists, M.E. patients will be diagnosed as a minor psychiatric disease by 95% of all physicians. I believe the new NICE guidelines are dangerous as was the original guideline.

Question #3: Clarification regarding Encephalomyelitis. **Does the WHO ICD have ME incorrectly classified as Post Viral Fatigue Syndrome.**

Note: The WHO code is G.93.3.

Simple answer is Yes and No! (a) In the WHO classification M.E. is incorrectly classified as CFS. **(b)** However, M.E. is correctly classified by the WHO as G9, a disease of the nervous system.

G.90-G99: refers to any disease involving the brain. However, most physicians are not aware of this correct subclassification. Other G diseases are as follows: (a) G0: diseases of the autonomic nervous system, (b) G91:hydrocephalus, (c) G92: toxic encephalopathy, (d) G930: other diseases of the brain, including, G930: cerebral cysts, G931: Hydrocephalus, G92: Toxic brain disease, G933: are other diseases of the brain which include:

93.0: cerebral cysts.

93.1: Anoxic brain disease

93.2: Toxic Encephalopathy

93.3: is then broken down into multiple conditions including:

Other G9 diseases including:

G93.0: cerebral cysts

G93.1: anoxic brain damage

G93.2: benign intercranial hypertension

G93.3: post viral fatigue syndrome

G93.4: unspecified encephalopathy

The reader can see that WHO classification clearly indicates this to be (a) a brain disease, (b) a post viral disease, (c) but incorrectly as a fatigue disease which confused M.E. with hundreds of other serious and non-serious diseases. However the CDC and NIH clearly failed to recognize M.E. as (i) a brain disease, or (ii) a post viral disease.

The problem has been caused **not** by the WHO but by the NIH and CDC and specifically by Dr. Stephen Straus of the NIH and what I believe was gerrymandering, bringing in his friends and colleagues into the CFS definitions, friends and colleagues, many of whom had never seen a patient and specifically had never been involved with M.E. or CFS patients.

Question 4: With SPECT scans being the most definitive test for revealing the M.E. brain injury why are so many so-called experts against accepting this as a biomarker for M.E.?

This question, in its own manner, falls into the previous question #2: M.E. represents a significant but variable brain injury as indicated in our book, Understanding M.E.

There are at least two good answers to this question.

- (1) Old SPECT scans involved multiple views of the brain from very different angles and to interpretate these scans required the physician to be able to mentally visualize the scan with stereoscopic abilities. This trait exists to varying degrees among nuclear medicine experts but certainly not to most neurologists and physicians.
- (2) However, if the physician utilizes a three-dimensional SPECT scan, such as Segami SPECT software he doesn't require stereoscopic vision, even an ordinary patient can easily visualize both the location and the severity of the brain injury.
- (3) This is a very good question for other reasons. Most and more likely No SO-CALLED M.E. Experts have ever made a full-time study of M.E. patients. If they think CFS is the same as M.E. of course they could be due to multiple other illnesses not involving the brain. The real problem is most physicians whether they will say so in public, consider CFS to be a minor, non-insurable psychiatric disease. Dr. Walter Gunn a retired physician from CDC told both Hilliary Johnson and I, that those at the CDC considered CFS to be a psychiatric disease.
- (4) Also, SPECT of the brain is NOT a biomarker diagnosing M.E. but is a mapping technique to tell how much brain damage has occurred with any M.E. brain injury. The SPECT scan will turns an invisible disease into a visible disease.
- (5) If the patient has anoxic, or chemical or chicken pox or post traumatic injury encephalopathy, SPECT will also demonstrate brain damage.

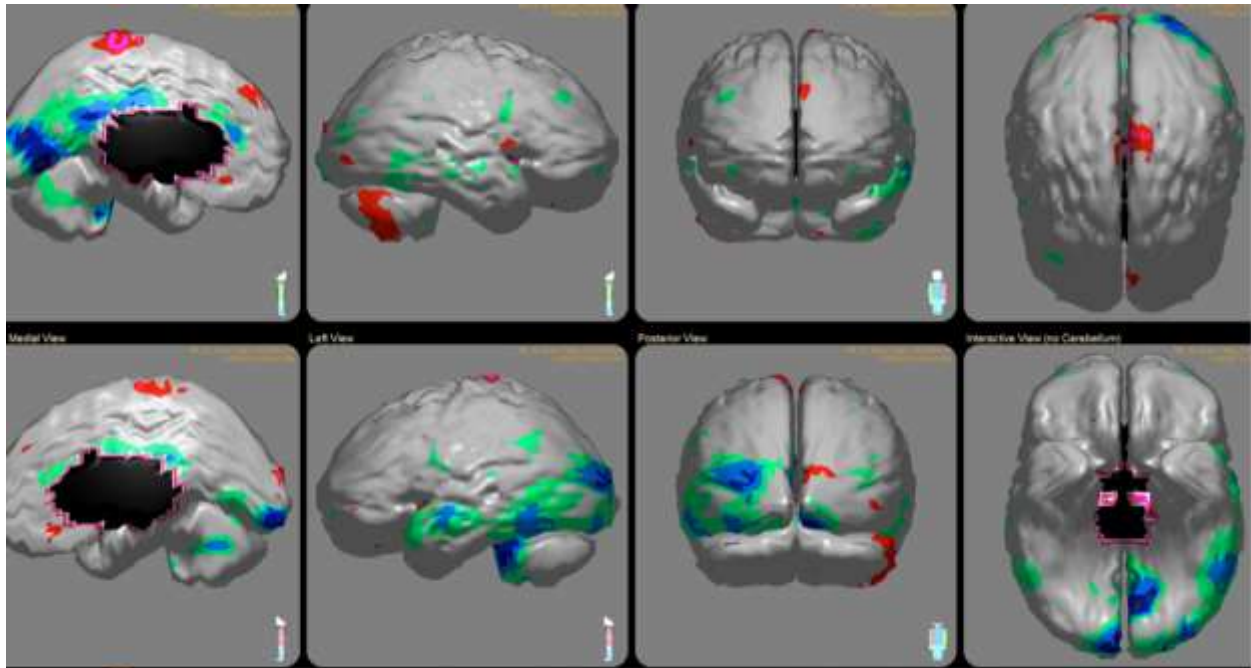
You only have to look at the new SPECT brain scans that have been in existence for the past 22 year to visualize the damage caused by the Coxsackie enterovirus which was recovered from the spinal fluid of this medical worker from Canada. This is a classical history of a case of M.E., where:

- (1) In August 3 years ago, a family of the grandparents and their two daughters and the grandchildren were at a holiday location beside a lake in Canada in the month of August.
- (2) Within a week one of the grandchildren fell severely ill with gastric problems and an encephalitis which caused the child to be immediately hospitalized in a Canadian children's hospital. The child was to recover completely over two weeks
- (3) Approximately three days after her sister's child was hospitalized, her aunt who was also a medical worker and at the same summer resort with the child, then fell ill with

a severe encephalitis, with very severe head pains and also hospitalized in a Canadian hospital.

- (4) A lumbar (spinal) puncture was then taken of the sick infant's adult aunt. The spinal fluid demonstrated the causative virus which was a Coxsackie enterovirus which is almost identical genetically from one of the three accepted Polio viruses. Reputedly, this Coxsackie virus appears to have been a mutation from a polio virus circa 1941. (see our book, *M.E. and The Return of Polio to the USA.*)
- (5) *Although some of the M.E. patients don't have all of the signs and symptoms of M.E., this health care worker did, the aunt immediately developed all of the signs of M.E. which included, (1) severe pain, (2) severe headache, (3) severe muscle weakness, (4) debilitating chronic intellectual (memory) and physical exhaustion made worse by even modest physical or intellectual activity. (5) balance difficulties, (6) gastric problems,*
- (6) *A routine SPECT done at the hospital failed to note the severity of her brain injuries. I obtained the brain SPECT scan and using Segami SPECT brain software we were able to develop the following accurate brain map.*
- (a) The black area is an artefact, it is an electronic cut through the Corpus Collosum. This has no meaning and is typical of all brain SPECT images, healthy or injured.
- (b) However, using the 20th century Segami SPECT software, there is very extensive brain damage shown and these were injuries involving the entire left temporal lobe, which is the memory centre of the brain. and the memory recall areas, In the left (posterior) optic/parietal cortex there is a major injury also to the visual memory storage area. Then in the area of the left and right cerebellum there is a major bilateral injury to the vermis. Not shown were the extensive injuries to this patient's basal ganglia which are injured in patients with Parkinson's disease which is associated with both muscle rigidity and memory loss.

*What is the Cerebellar Vermis? Feb 18, 2021 · Date: February 18, 2021 The cerebellar vermis is part of the cerebellum, the region of the brain responsible for **motor control & coordination and movement and cognitive functions**. The cerebellar vermis is a structure of the brain's cerebellum that has a narrow, worm-like shape.*
[www.wisegeek.com › what-is-the-cerebellar-vermis.](http://www.wisegeek.com/what-is-the-cerebellar-vermis)



This is M.E.

You have the viral cause. You have the 3-day incubation period, the typical monthly summer period of the polio M.E. injuries, you have the classical symptoms and physical disabilities.

How can the prejudiced CDC, the NIH and the archaic board of the CFS/M.E. association be so blind when any ordinary physician and the member of the public with primary school education can see these very serious brain injuries which agree with the patient's dysfunctions?????????

Further Criticism directed at the International Association for IACFS/ME: Chronic Fatigue Syndrome/Myalgic Encephalomyelitis.

For years this group has been run by PhDs who have never ever examined an ill patient and with few exceptions, not unlike the CDC administration, which have both been run by a coterie of university professors with little or no knowledge of investigative human medicine.

Question #5: How are this means of testing being shared to other professionals.

SPECT is not being adequately shared as most major medical journals believe that M.E. is a psychological disease. For example, I have been told, The Lancet, possibly the best

medical journal in the UK will not publish anything positive on M.E. as they do not believe M.E. exists.

Question 6: What is the alternative testing if patients are unable to obtain a dr's request for QEG or SPECT Scans?

The brain damage caused by M.E. encephalomyelitis, can also be seen on PET brain. However, if you cannot get a physician to order a HMPAO brain SPECT scan using Segami SPECT technology, go to your friendly lawyer and launch a legal action against the physician. One of two things will happen if you live in the USA or Canada, **(1)** this physician will immediately order the test, **(2)** or you will lose this physician as your doctor. **(3)** if you live in the UK I wouldn't advise this because the British Health System believes M.E. is a minor psychiatric disease and will probably support the physician.

Question 7: How does Brain SPECT findings relate to Post Exertion Neuro Exhaustion (PENE)?

PENE is a silly term some idiots invented trying to replace CFS and it hasn't really succeeded. In the end it is still CFS with all the lack of scientific merit as the two original CDC CFS definitions.

Question 7 b: Explain; the American ICD CM, which lists Myalgic Encephalomyelitis as G93.3 and which lists Chronic Fatigue Syndrome as R52.83

R52.83: This code refers only to the symptom Pain, This is not a diagnosis it is a symptom of 1001 injuries.

Question 8:

- The ICD-10-CM (International Classification of Diseases) This is a system to classify and code all (a) diagnoses, (b) symptoms and (c) procedures recorded in conjunction with hospital care in the United States. It doesn't get us anywhere in understanding M.E. or CFS.

Global Advocates 4 M.E. proposed a second group of questions which included the following:

Question #1: Can M.E. patients feel secure about corona virus immunizations?

The simple answer is YES.

However, in reality, any immunization represents a betting game.

I would estimate that if you took 1,000,000 (One million) patients with measles immunization, you might obtain up to 100 who may have a bad reaction to this immunization and maybe 10 who have a severe reaction to this immunization out of a million.

That works out to one person in 10,000 may have a bad side reaction and one person in 100,000 may have a very severe reaction to the immunization. However, if you took 1,000,000 patients who fell ill with wild measles who have not been immunized, you might find that up to 2,000 will have a severe reaction to the actual wild measles disease. This may include death, severe chronic brain injury turning the person into a mushroom, loss of vision, diabetes etc. If you are a native American or part native American these figures MAY be higher.

In the USA with a population of roughly 330 million there have been over half a million deaths. That is one death out of every 675 people who were infected by coronavirus, if everyone in the USA has been infected by corona virus, and that hasn't occurred.

However, only 29 million cases of corona virus have been confirmed. That suggests, using these figures, that roughly there has been **one death in every 70 persons infected** with corona virus in the USA. Compare this with approximately 20 million people in the USA have been immunized against COVID 19 and there have been almost no deaths definitely recorded which were caused by this immunization. Yes, of course, these are safe immunizations for all people.

Question #2: Why have the CDC and the NIH and the CFS/M.E. Association failed M.E. patients.

Answer #1: I believe the CDC and the NIH were totally and negatively influenced by Dr. Stephen Straus of the NIH. It is possible Dr Straus's judgement was influenced by the fact he had a frontal lobe brain tumour that I suggested to him, existed in 1985, well before the first sill CDC definition was published. Frontal lobe disease can severely influence your judgement. Also, when the NIH puts someone in charge of an administration there are no apparent checks and balances to remove that person unless they are involved in a major crime.

Answer #2: As repeatably remarked upon, the CDC administration believes that CFS is a minor psychiatric disease. **Question?** Have they been influenced by the insurance industry who doesn't want to pay disability to these patients. This is a real question since the largest single majority group of adult patients with M.E. are health care workers and teachers, the two

groups who are (a) most in contact with infectious disease, (b) are most exhausted due to their work load, which makes them most susceptible to acquiring an infectious disease. (c) these are the groups with a relatively high income and all are insured. By making M.E. and CFS minor psychiatric diseases, the insurance industry saves not millions but probably many, many billions of dollars every year. Now if you are head of the CDC and a senior executive of a major insurance “ when you retire with your low government pension, would you like to come to work with us for a salary of a million dollars a year for a few years so we can absorb your medical knowledge. Would you refuse? --- or do I just have a dirty mind?.

Question 3: Why if we can develop a 20 minute test to diagnose Corona virus 19 in a few months, why haven't the CDC and NIH developed a test for M.E. patients.

Answer (1): Few people die of M.E. immediately, so there is no impetus to develop such a test.

Answer (2): The CDC and no doubt those at the NIH responsible believe M.E. is the same as CFS and CFS is a minor psychological disease. So there is not possible test.

Answer (3): No one in authority and few physicians outside of virologists realizes that epidemic Polio was only an enterovirus almost identical to the enteroviruses which causes M.E. Also, almost no practicing physician today has ever seen a case of poliomyelitis.

Answer (4) I suggest you obtain a copy of my book:

M.E. and the Return of Polio to the USA.

Bill Gates foundation asked me to send them a copy of this book, but only a few physicians and not anyone in the NIH or CDC have ordered a copy.

Question 4: Why is someone not suing the NIH and CDC for gross negligence?

Answer 1:

The CDC and NIH would probably do what the insurance industry does. They would bring in senior physicians who want a research grant who might say anything to receive a research grant. Plus, since most physicians believe M.E. and CDC are the same, and most physicians believe CFS is a minor psychological problem, they might not even have to pay them off.

Question 5: Why is it that the majority of M.E. experts fielded by the CDC and NIH who constructed the useless (and dangerously misleading) CFS definitions have never seen any significant number of M.E. patients?

Answer 1: I believe the definition board members were selected primarily by Dr Stephen Straus of the NIH in the very good chance that they or their department would receiving a sizable NIH or CDC grant. The USA's leading and published M.E. expert, Dr. Alexis Shelokov, also a member of the White House Committee on Science, was not even allowed to speak at the CDC organizing committee assembled to formulate the original diagnostic criteria at the CDC in 1986, but physician's and PhDs with NO EXPERIENCE in this area were placed on the CDC definition.

I have always been suspicious if these members of the original CFS working case definition were not friends and associates of Dr. Stephen Straus, who I believe organized the committee to formulate this definition. Some might call this corruption.

Third set of Questions from the 25% Severe ME. Group.

Note: almost none of the questions in this group can be adequately answered. To many there are no answers.

Question #1: Is there anything patients can do on our own to help improve our health and situation? I have not been able to find help to help me feel better and I'm dealing with a lot of co-morbidities. I have found aggressive rest helps when crashing.

Answer: (1) This is an impossibly difficult and depressingly question to be confronted with and to answer correctly. It is a question akin to replying to a Polio patient who is permanently paralyzed in both legs, who understandably asks,

What can I do to walk again?

But let me try to answer this important question.

I have seen approximately 10,000 patients who came to me with a diagnosis of M.E. over the past 38 years. That amounts to about 275 patients a year.

Of those approximately 10,000 patients, I can recall only two of those 10,000 patients who had had a thorough investigation. That is a pretty damning statement to make of their physicians, and these are patients I have seen from Canada, the USA, England, Ireland, Australia, New Zealand, patients from the countries in the Arabian Peninsula and South America.

Of these 10,000 patients I have done exhaustive investigations of perhaps 2000 of them. In over 1000 of those patients, I have discovered the cause of their chronic illness was not M.E. But a plethora of different diseases, chronic syphilis, chronic brucellosis, 2 cases of plague (black death), toxic chemical brain injury was very common caused by pesticides and herbicides which are chemicals derived from WWII, which the National Socialist (NAZI) had developed as a last measure to kill the advancing allied soldiers. The list goes on, College professors who had brain damage from the synthetic dyes, patients who had been exposed to nuclear leaks in nuclear plants, Royal Canadian Mountain police who had been damage from stored contraband chemicals, members of the diplomatic corps who had been apparently damaged by Russia working unknown in Russian espionage surveillance, multiple tropical diseases in patients who had gone on holidays to a third world country.

If the physician only (a) listened to the patient, (b) taken an appropriate history, (c) done an appropriate physical examination, (d) done an appropriate screening examination, e) done an appropriate technical investigation. However, most of these patients have only had an 8-minute meeting with their physician, maybe 10% had a 45 minute investigation by a specialist. Is that medicine? Or is this a machine to manufacture spaghetti.

So to answer this very appropriate question, **the patient must first be listened to and to be examined appropriately**, and this is true particularly to a patient who (a) previously had a good job, (b) who worked in the teaching and (c) medical professions, (d) had children at school who brought home children's disease which are particularly dangerous to adults.

Because many of those I have seen as patients and who come with a diagnosis of M.E. have a treatable disease which they do not know about and their physician has missed.

Example from our book, a university professor who was sent to me by his physician, his specialist and his psychiatrist with a diagnosis of M.E. On investigation his brain was infected with chronic undiagnosed, untreated, syphilis. I diagnosed this and sent him to the Civic Hospital in Ottawa Infectious Disease Department and not only saved his life, but he was able to function again.

Question 2: What is your opinion on protein-based vaccines and inactive vaccines, as I had a bad reaction to both Hepatitis B and HPV (human papillomavirus).

Answer: This is a question within a question and due to its complexity, it is an impossible question to answer. I will answer it in part.

Recombinant Hepatitis B immunization has caused innumerable deaths and chronic illnesses in thousands of Americans who have been compensated in the millions of dollars to the patient or their families by VAERS system of the USA government. Unfortunately, we don't have such a compensation system in Canada. I have seen over 60 such cases including 2-3 deaths and two cases of blindness related to R Hep B immunization. The federal government published a paper after "examining" these 60 plus patients stating they found no significant illness in these people. This was published in the Health Canada bulletin and then in the Canadian Medical Journal.

I then sent out a letter to the 60 plus patients and received back more than 40 replies. **Not one of those patients had ever been seen or examined by anyone.** Shortly after the veterinarian who had been in charge of this department for the Canadian Department of Health, left the post for a better paying job which I believe was organized by the Canadian pharmaceutical company who manufactured the R Hep B immunization. I was strongly criticized by my medical licensing board. Nothing was done for these people who were all health care workers. No compensation was given. **We need a VAERS system in Canada, and a properly functioning one in the UK.**

Question 3: Would aggressive rest before or after a vaccination be helpful.

Answer: I don't think so. Most immunizations are totally safe and the alternative to being infected by the actual infection inescapably dangerous to a large number of people. A few like R Hep B, should be given to those in risk situations. Anyone working in hospitals or potentially exposed to blood such as health care workers, police, fire department workers, persons with multiple sexual contacts, ethnic groups who share sexual partners, anyone doing street drugs. The problem is how do you identify many of these individuals.

Question 4: How can I avoid an ANS reaction to an injection?

I don't know.

Question 5: Fully bedbound patients – should they be concerned about conditioning and the various physio treatments.

Answer: See answer to question 1: First you have to find out why are these patients bedbound?

Giving a disability a name does not mean a diagnosis. A physician can potentially treat a correct diagnosis but not a name.

Question 6: What to do when struggling with breathing and unable to move one's diaphragm.

Answer: You must first arrive at the correct diagnosis. Has the vagus nerve been injured. Has the patient had a polio type injury which is common to many M.E. enteroviral patients. See our book, M.E. and the Return of Polio to the USA.

Question 7: How often have I seen severe contracture / spasticity along the spine and around the head and face in M.E.

Answer: See our book for photograph and discussion of this. Probably about 50 cases and more by history without actually seen the occurrence. In our short book, M.E. and the Return of Polio to the USA and also our book Understanding Myalgic Encephalomyelitis I discuss this. Also, I suggest a new diagnosis: Hybrid M.E./Polio. It is impossible in some M.E. and some Polio patients to tell whether they have Polio or M.E. Two years ago, I did a house call to a 13-year-old girl in England who had this hybrid disease. Her doctors wished to send her to psychiatry. After two years, her doctors finally came to the conclusion she had Acute Spastic Myelitis, which in many countries is called Acute Spastic Paralysis, which before 1955 was called Polio.

Polio and M.E. are caused by enteroviruses which are almost identical in structure.

Question 8: Can M.E. cause connective tissue degradation and EDS type symptoms along with Mast Cell Activation or is that likely to be a separate issue.

Answer Question 8 part 1: Although I discuss this question in Understanding Myalgic Encephalomyelitis, I should have written a chapter about this fascinating genetic condition. However, there are a few good pages on **Ehlers Danlos Syndrome or EDS**.

EDS is a genetic condition which is caused by a genetic connective tissue misalignment which in turn can cause only hyperextension of the joints with no particular disease. I have seen perhaps 200 patients with this condition. I send these patients to the dermatology department of one of the North York hospitals in Toronto where they do a small skin puncture biopsy and then observed the biopsy under electron microscopy. With EDS you see what are called (1) flowers and (2) misaligned tissue fibres.

M.E. does not cause EDS, and most people can live a very normal life with this condition. However, if they are infected with an appropriate enterovirus and fall ill with M.E., these patient develop a more severe form of this M.E. This is a question for a book, not a paragraph.

There are several conditions that make M.E. patients worse and this is discussed in my book Understanding Myalgic Encephalomyelitis.

Question 9: Are there and potential treatments or therapies for severe sensory intolerance?

Answer: I am sorry, but this is outside of my field of knowledge.

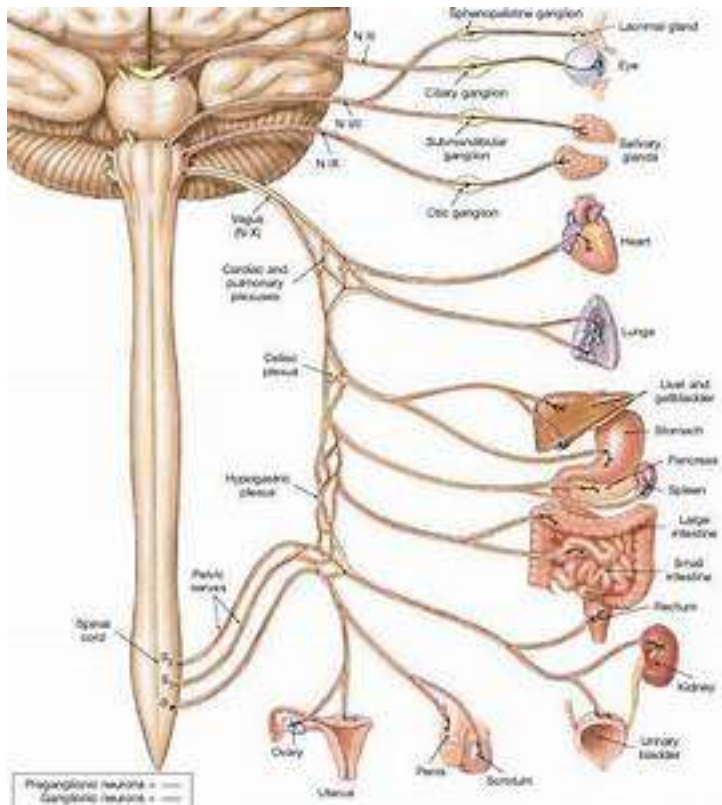
Question 10: Is vagus nerve stimulation, particularly for assisting sleep, something that is useful for us and if so, how do I recommend doing that?

Answer part 1: I don't know if the person posing this question, realizes it is totally outside of the experience of Western medicine. The question involves one of the two major branches of Yoga, Hatha and Raja Yoga. This question involve Raja Yoga, one of whose principal teachers was Swami Vivekananda. (1863-1902) who taught, service to God could be rendered by service to humankind. It is an excellent philosophy for physicians to follow. Part of Raja yoga is the control of some of the vagus nerve autonomic abilities, which western medicine does not believe it.

However, for those who do not have restorative sleep or those who have trouble sleeping, the system of Raja Yoga, will allow you to instantly put yourself to sleep and to awake refreshed. This is not an easy state to develop but for those who are successful, it can be an extremely useful talent.

Answer part 2: To give an example of the vagus nerve and the parts of the body controlled by the Vagus nerve, this can be best demonstrates n the following diagram.

The vagus nerve is probably the most important autonomic nervous system mediators in the human body. Western medicine believes the vagus nerve is outside of human ability to control. Yet it is here, that many of M.E. patients patho-physiological difficulties lie. Those believers in Raja Yoga believe otherwise.



Answer to 8 part 2: this is two questions. I only have 2 patients with Mast Cell Activation syndrome so I don't know enough about it to answer this part of the question. It appears to be a separate condition, but I don't know.

Question 11: What dietary intervention does Dr. Hyde recommend?

Answer: I don't understand this question.

Question 12: How does methylation impact on this disease:

Answer: Sorry, I don't understand this question or where it might be going.

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