Treatment of psoriasis with BICOM 2000 in the sanatorium

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INSTEAD OF AN INTRODUCTION
AN OBSERVATION IN VERSE
ON PSORIASIS PATIENTS

PSORIASIS IS A SKIN DISEASE,
which leaves its mark on the sufferer.

It surprises its victim when it appears,
it changes the rhythm of his daily life,
it is constantly on his mind, weighing him down,
caring for his condition makes demands on him,
it can isolate him from society,
it can threaten his existence,
and constantly reminds him of how he is forced to live.

If the sufferer recognises this and learns to live with it,
if he heeds the disease's requirements and characteristics,
his daily life will be much easier,
it will be a relief for him mentally,
and will remove some of his difficulties.
He will even be able to escape from these for a while,
perhaps even for ever.

Psoriasis is one of the most widespread skin diseases, affecting one in ten people. The impact of this visible and consequently very stressful disease is felt most strongly on a psychological level. All sufferers have a feeling of uneasiness, have the feeling that they are repulsive to others. They feel cast off to the far reaches of the world.

A PHYSICIAN'S THOUGHTS ON PSORIASIS YESTERDAY, TODAY AND PROBABLY TOMORROW AS WELL

It was many years ago as a young specialist that I first attended a dermatologists conference in Zagreb organised by Prof. Kogoj and his colleagues. In addition to the Yugoslavian specialists, there were also a number of participants from abroad, at that time the cream of expert knowledge in Europe. The main theme of the conference was psoriasis. The umpteen papers addressed its distribution, hereditary factors, clinical picture, laboratory diagnostics and naturally the chances of curing the disease. Prof. Kogoj summed up the two days of discussions with these words: "For two days we have heard outstanding contributions from distinguished physicians on the topic of psoriasis. We have learnt many things, some of them new, yet if someone now asks me what we have achieved that is new and what we can do to alleviate patients' suffering, I can only reply that we are no further on from where we started yesterday before we broached this topic."

Psoriasis is a hereditary dermatosis and therefore it is true here, as with all congenital diseases, that hereditary predispositions cannot be cured biologically without changes. Today we know that a large percentage of mainly dermatologically healthy individuals can be shown to carry the psoriasis condition without any clinical manifestation, yet this does not become evident as such as a clinical picture as the so-called trigger has not been activated. Many psoriasis diagnoses are masked by other dermatological diagnoses, e. g. seborrheic dermatitis, onychomycosis, mycotic dermatitis, eczema etc.

Genetic engineering would bring a change in the fate of psoriasis patients through intervention in the genetic make-up. However we hope that it has not yet got to that stage.

Even today there are still a lot of patients who are uninformed and unmotivated and who only demand of their doctor effective treatment to provide relief from their symptoms. These patients are already going down a road which *leads to a dead end*. The basic requirement for any treatment is that the patient cooperates with the doctor if the doctor is to ease their symptoms or even heal them completely.

44th International Congress for BICOM Users, 30 April to 2 May 2004, Fulda, Germany

DEFINITION OF THE DISEASE

The term "psoriasis" comes from the Greek word "psora", itching.

Psoriasis is widespread and occurs mainly as a chronic, inflammatory, hereditary skin disease which is not contagious. Typical features are reddish skin covered with scales and itching foci of various shapes and sizes.
Important factors in its development are:

- multifactorial hereditary conditions with varying stages of intensity
- factors which encourage the onset of the disease and are regarded as hereditary factors and finally
- possible skin lesions whose characteristics are typical of psoriasis – the visible aspect.

A diagnosis can often be made at first glance. Psoriasis occurs as an acute clinical picture or as a chronic recurrent condition with characteristic clinical features on the skin, scalp and nails.

The patient's overall state is not affected by it other than in very severe forms of the disease. These are normally healthy individuals and they live to a good age. Psoriasis patients tend to be overweight and suffer from hyper-lipoproteinaemia. In the second world war the number of psoriasis patients not only fell significantly due to the shortage of food, it actually no longer appeared. This was even clearer during the war in Bosnia and Herzegovina in the 90s at the time of the siege of the capital Sarajevo by the military blockade. Colleagues who were treating former psoriasis patients during the war noticed that they did not get psoriasis again and that the disease even disappeared completely.

The disease progresses in a strictly individual manner which differs from case to case. It largely improves in summer and deteriorates or reappears in winter.

INCIDENCE OF THE DISEASE

Psoriasis is one of the most common skin diseases, affecting around 2 % of the population. In comparison with other diseases, psoriasis is about as common as diabetes.

It is spread throughout the world, its incidence varying depending on geographical area and race. It is interesting that the white race is most affected, the Oriental race significantly less and Indians and Eskimos suffer only rarely or not at all. The disease can arise at any age, most frequently however between the ages of twenty and forty. It very rarely occurs in infancy or old age. The sexes are equally represented.

Many authors have studied the incidence of psoriasis in the family and established that this varies considerably from 4.4 to 90.9 % (Schnyder). Psoriasis is therefore a family disease – hereditary, the possible result of probably many factors and different stages (Ecks, Rassner). External and internal triggering factors can shift the disease from the latent phase to the manifest phase (emotional stress, surgery, alcohol, some medications, acute fever, hormonal changes, etc.)

Some information on the incidence of psoriasis by region: 2.8 % of the inhabitants of the Faroe Islands (Lomholt) were diagnosed with psoriasis. It is interesting here that the inhabitants of these islands are very isolated socially, economically and genetically, a very important detail. About 2 % of the population of north west Europe suffer from the condition (Hellgren, Braun). In the USA the incidence is up to 1.5 %. There are 3 million psoriasis patients in the USA and 260,000 new cases are recorded each year. I have already mentioned that there are significant differences between the geographical regions. So it is interesting that, on the islands of American Samoa, not one case of psoriasis was recorded among 12,500 inhabitants studied. Nor was psoriasis found in 25,000 inhabitants in the isolated regions of the Andes (Roock, Wilkinson, Ebling). I learnt an interesting piece of news at the flying medical centre when travelling through Australia last year. Through its flying doctors the flying medical centre looks after an area with a radius of 6,000 km. The flying doctors care for the farms scattered throughout the vast expanse of central Australia by plane. I enquired how high the percentage of psoriasis was among the population. An older doctor, the director of the centre, told me he had heard of the disease when he was studying yet he had never actually encountered it in this extensive region.

I have taken the following information from the register of the World Health Organisation:

Most recorded cases were in the **age groups:**

- 26 – 30 years (38 %)
- 21 – 25 years (33 %)
- 36 – 40 years (31 %).

Of these 60 % were **blue collar** and 16 % **white collar workers**. The **duration of the illness** was also investigated in the same survey.

- 18 % of sufferers less than 1 year
- 29 % of sufferers 1 – 5 years
- 20 % of sufferers 6 – 10 years
- 8 % of sufferers 11 – 15 years
- 25 % of sufferers over 15 years.

61 % of patients regularly **drink alcohol**, 8.7 % only drink occasionally, 30 % have never drunk alcohol.

The disease is also very rare amongst the Indians of North and South America. The proportion of the black population of North America with psoriasis is 1.4 %. It is very rare in the black population of Africa, particularly in the western part of the continent (Lomholt). In the Chinese province of Henan psoriasis was detected in 0.36 % of inhabitants. In Japan the prevalence is 0.9 % with a slightly increasing trend (Yasuda). It is interesting that the tendency in South Korea is three times higher than in Japan, which could be due to the different diet. The incidence of psoriasis amongst Arabs was not examined. According to some data, the rate amongst Egyptians in the Cairo area is 3 % (Yasuda).

HEREDITARY TRANSMISSION OF THE DISEASE

Psoriasis is most definitely hereditary. We know that the tendency for this disease is hereditary but not the disease itself. Heredity was investigated using family trees. The results were portrayed in the family tree. One case can be seen in the illustration **(Fig. 1).** This is the family tree of patient X. We can see that the great grandparents from the 1st generation were healthy and had no skin lesions. However, one of them had a tendency to this disease over a lengthy period. The evidence for this is in the 2nd generation where the daughter was affected (= the grandmother of the patient mentioned). In the 3rd generation her son had psoriasis (= the father of the patient), in the 4th generation it was the daughter of her son or the granddaughter of the patient. However, psoriasis also occurred in the daughter of her second son (= cousin of the patient) while the son himself showed no sign of the disease. He had the tendency to this disease however; i. e. he had a hidden form of the disease.

The largest known family tree for the disease of psoriasis was created by Abene and his colleagues in 1963. They examined 537 individuals from 6 generations and found 44 family members with signs of psoriasis.

We can see from these cases that there are no laws for heredity. There are huge discrepancies in the data on the incidence of these cases.

Psoriasis sufferers must be informed about the heredity of their disease, particularly about the high probability that the children of the sufferer may also get the disease. Parents who suffer from psoriasis must obviously know that they may pass their disease on to their children.

In any case, with two healthy or two sick children, one should carefully consider before deciding to go for a third pregnancy. We owe it to our descendants.

FACTORS TRIGGERING THE DISEASE

The most common provocation factors are:

- injuries
- alcohol
- cold weather
- warm weather
- medication
- being overweight
- sun
- pregnancy
- angina and other infections
- stress.

We list the factors in this order so that people are aware of the negative influence of the provocation factors mentioned and how they should be dealt with.

Injuries: This means external injuries to the skin, such as cuts, wounds, abrasions, burns and, not least, skin worn through work. Psoriatic lumps tend to appear at the injured points, e. g. along the wound, scratch or scar. Health and safety at work is important. It is important to protect the skin adequately!

We have no control over warm or cold weather. What we can do is dress appropriately.

Sun: In most cases psoriasis improves through the influence of the sun. This fact is well-known because the sun is a powerful healer and patients fight for a place in the sun. Only in a small percentage of cases does the sun not have a beneficial effect on the patient's condition and it is even rarer for the sun to cause this to deteriorate. This depends largely on the clinical picture. If it is an acute form of the disease with countless lumps on the body which developed following angina, for example, then sun is not appropriate. Likewise sun can ag-

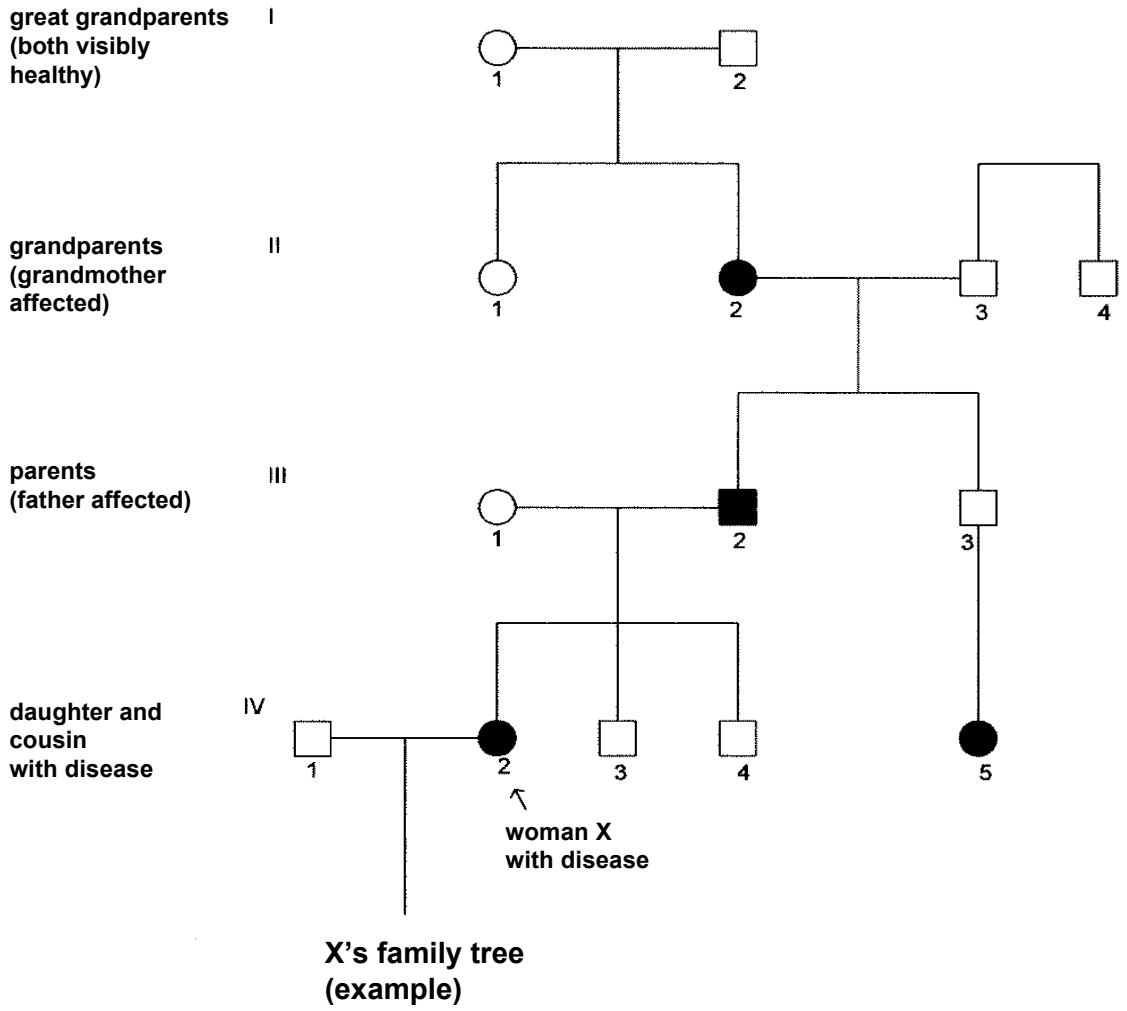

Fig. 1

gravate the disease if it is a severe form where the affected skin throughout the whole body is covered by irregular redness.

Angina: Angina and other infections are often the cause of the occurrence of psoriasis or its progression. An infection represents the strongest provocation for psoriasis. Psoriasis frequently occurs for the first time with angina or other acute inflammations. We cannot avoid these diseases completely. We can however make an effort to live healthily and keep our bodies in good condition which will make us resistant to almost all diseases.

Alcohol: In most cases alcohol aggravates psoriasis. Consequently sufferers should keep off alcohol altogether or only drink small quantities.

Medication: It is important to know that some medication can be harmful and trigger psoriasis. We must therefore always follow the doctor's directions and consult him if anything is unclear.

Being overweight: If a patient is overweight, this also has a negative effect on the progress of the psoriasis. Consequently patients should endeavour to lose weight gradually.

Pregnancy: this does not essentially aggravate the clinical picture.

Stress: You would expect that stressful situations in the sufferer's life would always aggravate the disease. But this is not so. There are instances of the clinical picture of psoriasis improving even with stress or other more serious diseases. This largely means minor unimportant stressful situations, the little everyday worries which people should not take too seriously. In most cases, however, psoriasis reacts negatively to stress. The important thing is for patients to learn to ignore the disease. They must get used to living with it.

PROCESSES ON THE SKIN

Human skin consists of the epidermis (top layer) and dermis (sclera). The cells of the top layer are continuously renewed from the so-called renewal layer, from where they are transported to the surface of the skin where the dead cells drop off.

In healthy skin this renewal process takes 28 days but with psoriasis it is reduced to 37 hours, i. e. less than two days.

So in psoriasis sufferers the cell division of the epidermis is significantly accelerated and consequently the skin is 4 to 6 times thicker. The cells which die through psoriasis form silvery-grey deposits. The reddish colour associated with this process is caused by dilated blood vessels in the affected area. They supply the rapidly dividing cells. A characteristic feature of the condition is the numerous inflamed cells at the affected points of the epidermis, in some cases visible as purulent plaques. Inflamed cells also accumulate around the blood vessels of the sclera.

These are the basic features of so-called psoriasis foci which appear as small reddish scaly skin lesions.

No discrepancies in carbohydrate, fat or protein metabolism have so far been found. Neither has hormonal imbalance or disturbance of the autonomic nervous system been detected. Moreover, it has not yet been possible to identify the specific IgE parameters for psoriasis.

Fundamental changes take place in the diseased area of the skin itself. In pathological biology, therefore, we make a distinction between the actual psoriatic changes. Each change has two typical features: inflammatory reddening and skin flaking. The reddening is the clinical indication of inflammations in the dermis, the flaking is indicative of accelerated cell division in the epidermis and disturbed hornification, as a result of cell death.

It has been possible to identify all these changes but medicine does not know the cause of this process. Recent research highlights dysfunction of the cyclic proteins (nucleotides) which regulate the division of the epidermal cells and their differentiation which is abnormal in psoriasis. It is assumed here that **transmission** occurs **through the genetic make-up** or that genes mutate in the disease.

In the 1980s, while medical director of the thermal baths in Portoroñ, I introduced thalassotherapy and became better acquainted with psoriasis patients as a result. Portoroñ is a spa town on the Slovenian coast close to Trieste. I had contractual agreements with Swedish and Norwegian psoriasis associations to treat psoriasis patients seasonally in the thermal baths. Patients with the worst forms of psoriasis came to us. The basic standard therapy involved sea-water baths, so salt water. This is water which remains in the salt-works until the salt crystallises. This water is very rich in minerals: sodium, chlorine, magnesium, bromine, iodine and sulphur. I noticed heightened reactions and skin reddening in individual patients who were given this bath each day. At that time I did not know the reason. If the salt concentration of the bath water was reduced, i. e. by adding more fresh water, the reactions were much milder. Other patients tolerated the normal salt-water concentration as spa therapy. If I look at the files now, I see that patients with large amalgam fillings did not tolerate the baths. And now I understand it all. Sea water and the oceans are huge reserves of mercury. This therapeutic procedure irritated the bodies of patients who react allergically to amalgam fillings, and who bathed in the salt-water and also ate seafood, and the mercury was also stimulated by the sea-water. It is not necessary to comment further. The same picture emerged with chlorine allergies.

COMMENTS AND THOUGHTS OF A BICOM PRACTITIONER

Firstly, it has been proven beyond doubt that electroacupuncture testing via the meridians is highly unreliable with psoriasis sufferers. The thickened skin and scaling do not permit this type of testing. The conductivity of the electropotential in the skin is disturbed.

Different test methods must be used with psoriasis patients. In my opinion the tensor method is the best.

If it emerges from this test that the patient is blocked, we must explain to him that there is a block and that his willingness to get better may be crucial to the success of the therapy. It is not surprising if the psoriasis sufferer's sense of self-esteem is seen to be damaged.

Consequently, exercises and discussions must be conducted with the patient to strengthen his self-esteem despite all his problems and to encourage him to get better. Moreover, the realisation that he is not the only one affected by this condition provides strong internal support. Group work and discussions, in which patients' own worth and self-confidence are reinforced, are very useful.

To treat tissue blocks we select program no. 991 and treat these once or twice. We place emergency drops (Bach flower remedies) in the input cup, both hands on the hand electrodes, incorporating the small intestine meridian[1].

Bioresonance therapy continues as for allergies by emphasising certain programs which will be mentioned later.

Children suffering from psoriasis, who are brought by their parents to the bioresonance therapy practice before starting cortisone therapy, are interesting. Dermatologists have already been consulted who also confirmed psoriasis with the inevitable prognosis that the disease is incurable.

I claim there is an 85 % chance of success in healing children with psoriasis. This means the same recovery rate as with other allergies. The basis for this claim is the realisation, when making the diagnosis, that the child with psoriasis is not affected psychologically, the cutaneous eruption does not have a negative effect on it. The child is not subject to the stress of diagnosis.

Children whose skin lesions are not yet very severe and who only show signs here and there and whose hands are not yet affected can also be tested with Voll's electroacupuncture technique. I have observed that allergy therapies proceed just as quickly with psoriasis children as with food allergy patients. I detected amalgam contamination in around 70 % of children.

My worst psoriasis patient has been suffering from the disease for over 15 years. The psychological strain has turned him into an alcoholic. Despite intensive and very precise daily adjustment I have been unable to achieve any improvement in his condition.

I had a 30 % success rate for healing psoriasis in women who were badly affected mentally yet who did not drink alcohol and in around 700 female patients who I looked after in my many years of practising when I did not yet know about BICOM therapy but used traditional Chinese acupuncture. I was able to achieve an improvement in the clinical picture of about 40 % of those affected. Today, using BICOM bioresonance therapy and some additional therapeutic methods, I can record a 60 % success rate in healing this group. The results are stored in the computer program of the company Maurus.

Based on recent findings from the literature, seminars and the Fulda congresses, we are achieving a recovery rate of around 65 % for psoriasis in our health resort with the emphasis on younger patients with a brief history of the disease. In addition, these patients have not been given particularly high doses of cortisone and only for a short period of time.

HOLISTIC THERAPY

Psoriasis treatment which did not incorporate the patient's overall physical and mental state would be incomplete and unsatisfactory. BICOM bioresonance therapy with the patient's own oscillations is the main focus, within holistic treatment, for harmonising, relieving and detoxifying all areas of the body. Consequently Dr. Schumacher's summary forms part of the holistic treatment of psoriasis:

- well-known homeopathic constitutional therapy
- elimination of any foci (geopathy, etc.)
- mucosal clean-up (intestinal symbiosis control)
- restoration of the natural intestinal flora (mycosal elimination is important)
- switch to wholefoods
- elimination of conflict situations, being overburdened – family, school and workplace, etc.

Mentioning restoration of the natural intestinal flora reminds me of Prof. Kogoj who stressed in his paper: "Let's compare the human body to a cooking pot. If we want it to look clean on the outside, we also have to clean it thoroughly on the inside." By this he wanted to stress that the human skin will look healthier if we restore the natural intestinal flora and remove any mycoses present. "Clean the pot from inside = restore the natural intestinal flora." In other words: use colon hydrotherapy.

It is my view that BICOM bioresonance therapy is not sufficient of itself to treat a difficult disease such as psoriasis. Here we must also draw on the accompanying therapies recommended by Herr Baklayan.

In first place we have so-called colon hydrotherapy.

[1] Opinions are divided over whether willingness to be cured plays a large part with psoriasis patients. Their whole life through they have heard their GP say that the disease is incurable and that they must learn to live with the condition to the end of their days. This block is deep-seated and, for therapy to be successful, this must first be tackled. Unwillingness to get better affects the body and tissue and can therefore also be tested using the kinesiological muscle reflex test, which will be familiar to you from various seminars.

Herr Baklayan's book explains very well when and how this therapy is conducted: "Parasiten – die verborgene Ursache vieler Erkrankungen" [Parasites – the hidden cause of many diseases] (page 178).

Secondly, I should like to highlight anti-parasite therapy which is also described in Herr Baklayan's book. This therapy is closely linked with strict observance of an anti-mycosis diet.

And thirdly accompanying therapy with the zapper for a shorter treatment period, as tested and proven in my practice.

The yeast, Geotrichum candidum, plays an important part in the treatment of mycoses. Cow's milk allergy is also an essential factor in the treatment of psoriasis. When studying and testing Geotrichum candidum, I came across a material which I removed from the areas of the skin affected by psoriasis with a scalpel. In the lower layers of the dead scales I found Geotrichum candidum. Laboratory cultures confirmed its presence and growth. The top layer of scales or abrasion did *not* yield a positive laboratory result. It should be emphasised that Geotrichum candidum can be found in cow's milk products. Geotrichum candidum is added to cheese to prevent the premature decomposition of the cheese substances. Yet, psoriasis sufferers are particularly fond of cheese (there may even be a dependency). For this reason they must be informed about the links. I think that Geotrichum candidum must be identified in cheese and in milk products with an accurate diagnosis and these products must then also be included in the Baklayan diet.

In my practice we also record mycosis infestation in the patient's stool: 60 % with psoriasis sufferers, 40 % with atopic dermatitis, around 45 % with the healthy control group. I found Geotrichum candidum infestation in the same patients. Of 40 patients, 28 % were positive. For atopic dermatitis the figure was 12 %. Obviously the laboratory equipment used plays a large part here. Consequently these percentages are different from those listed by Herr Baklayan. I feel that percentages are not so important. What is important is the evidence that mycosis infestations such as Geotrichum candidum are present in psoriasis patients.

We must achieve an improvement in patient health with holistic therapy. I have observed with psoriasis patients that psoriasis, when cleared, remains cured for an unlimited period. I have stored the progress of each patient's therapy on computer over my 10 years of working with BICOM bioresonance therapy and I can prove these results and confirm them morally and ethically.

However, I also maintain that, of all the allergic disorders, psoriasis is the most persistent form of allergy to treat.

I should like to emphasise once more that I would not have achieved these results in any of the cases with the cortisone therapy I used to employ.

To conclude, I should like to mention that in the last two years I have added oxygenated water or oxygen douches to my existing therapies. This form of therapy is a German discovery described in the book "Sauerstoff-Wasser – Ein Geheimnis des Lebens entdeckt!" [Oxygenated water – one of life's secrets revealed] (authors: Prof. Dr. med. Dr. rer. nat. Reinhard E. Wodick, Dr. med. Bernd Ullrich and Wolfgang Lüdke.)

By studying this literature thoroughly, I was able to establish that the water in the Olimje thermal baths in the village of Podèetrtek in Slovenia is slightly radioactive. One cubic metre (m^3) of water contains 17 becquerels radon. Under the influence of radon, this healing water, unique to Slovenia, splits the water molecules (H_2O) into radicals. The main radical in this water is therapeutic, the chemical formula is H_2O_2 – known as peroxide. This peroxide blows over the psoriasis scales with beneficial effect, removing them from the surface of the skin. In studying oxygenated water, I have tried to enrich this water with medicinal oxygen in a special mixer. In doing so I obtained better results than I had expected with water from the health resort. I have experimented for a very long time and can now claim that I am able to reduce the time needed to treat psoriatic lesions on the skin by 50 % by douching with oxygen-enriched spa water. Moreover, I established that chlorinated water enriched with oxygen had only a 20 % success rate.

The medicinal baths with oxygen or oxygen douches with water from the Olimje spa mentioned in the literature definitely prove that these douches slow down the skin's ageing process and stimulate skin regeneration. This water activates the microcirculation and aids the blood supply to the skin. It suppresses allergic skin reactions especially with neurodermatitis and psoriasis. The water removes the negative impact of histamine. It aids wound healing in chafed and broken skin. It supports detoxication and the elimination of toxins from the body. Consequently we recommend drinking

this water. I would emphasise again that these results are only achieved with slightly radioactive and unchlorinated spa water. We do not obtain these results with hard water containing chlorine, even though it is enriched with oxygen. Consequently I believe that these additional therapeutic methods to basic psoriasis therapy – to BICOM bioresonance therapy – are highly significant and help treat the patient better, in some cases help clear the condition quicker thus supporting the work of the therapist.

Treatment without BICOM therapy only led to a 12 % improvement in my practice.

THERAPY SYSTEM

I do not want to list every stage of therapy here as these are carried out with all patients anyway to activate the patient's regulatory system, according to Sissi Karz's system with which we are all familiar.

However, it is important to incorporate knowledge of the 5 element theory into therapy and to conduct supporting therapy using ampoules from the combined test technique.

I personally also test any possible stresses with the relevant combined test technique test set and treat any stresses found according to directions. I pay particular attention to mycotic and parasitic infestation which I clean up thoroughly.

Afterwards the patient is in a far better general state of health which makes it much easier to treat the allergies.

I treat the following indications intensively with the following programs:

Prog. 842, 922	improve histamine action
Prog. 428	thymus activation
Prog. 951	cell regeneration

- Therapy time and amplification are tested out individually with each program.
- DMI (Dynamic Multi-Impulse packets) is also tested. "Attenuation" is primarily needed with programs 842 and 922.

I hope I have been able to encourage you to be creative in your work.

CONCLUSION

Contracting psoriasis is generally the result of the internal organs dysfunctioning. As the organs are linked with all other parts of the body, psoriasis also appears on the surface of the body, primarily at the point at which the organ area "opens outwards", i. e. at the appropriate tissue or sense organ. Using these test connections we can establish the pathological changes by checking external changes to eyes, ears, nose, constitution and vitality, facial complexion, tongue and pulse, make an accurate diagnosis and arrange appropriate therapy.

Psoriasis therapy for children is straightforward. It should proceed as normally as allergy therapy highlighting stimulation of skin lesions.

Patients with a long history of the disease yet low doses of cortisone have a chance of being cured and the results achieved were good. In these cases the accompanying therapies mentioned in the paper are needed alongside BICOM therapy. Where the patient has a history of the disease stretching back over more than 10 years, the symptoms can be alleviated and the accompanying symptoms reduced, but a cure should not be expected.

Therapy principle

- strengthening the immune system, origin of the disease
- prescribing individual therapy which varies from patient to patient, according to their symptoms.

Therapy should not forget the mind either as psoriasis often has a serious effect on the patient's mental state. We also call in a psychologist to the therapy at the thermal resort who tries to relieve the accompanying symptoms, motivates the patient and thus tries to give them back their self-confidence. Alongside these therapies we also treat the patient with BICOM programs to restore their general state of health.

We hope that advances will be made in research to enable patients with a long history of the disease to be helped as well. I believe that, in future, chronic and incurable forms of psoriasis will no longer exist. Our way of life and recognition of the importance of prevention will mean that even small children with psoriasis will be treated with BICOM therapy. It alone enables us to successfully treat and cure a fundamental cause of psoriasis; allergies.

Orthodox medicine does not want to admit this success and continues to defend the theory of drug therapy such as antihistamines, anti-allergic agents, ultimately cortisone and life-long abstinence to

combat allergens. This attitude really has to change and I maintain that many cases of psoriasis are incurable precisely because of this refusal to understand the new BICOM therapy which, if applied at the correct time, can achieve excellent results.

Thank you for your patience and for the time you have taken to listen to my lecture.

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