Herpes in different guises: successfully treating viral stresses caused by HPV, Epstein-Barr and Varicella zoster

Irene Kolbe, Naturopath, Hanover, Germany

Welcome

First of all I would like to extend my thanks for the invitation to speak at this international congress, which has now become something of a tradition. Thank you for your trust in us as therapists. In bioresonance we have an important therapeutic tool with which to test and treat. Our patients are the real teachers here, because they continue to present us with new challenges. This is what drives me on to look into many of the more complex topic areas in order to gain a greater understanding of the underlying issues from a pathophysiological perspective. This is why my chosen theme today is viruses.

Viruses, a 'borrowed life' (they cannot synthesise their own proteins and have no enzymes for energy production).

Classification

- DNA or RNA viruses

  In terms of morphology, these are:
  - double or single-stranded DNA or RNA viruses (e.g. ssRNA)
  - enveloped or naked (CWD: cell wall-deficient microorganisms)
- Classification
  - Historically based on clinical criteria Nowadays based on factors such as their structure and the **composition of the nucleic acid sequence**
- **Type of duplication and impact**

  This varies and depends on how the virus behaves within the cell, as well as the anticipated consequences.

  a) **Viral replication:** Blocks synthesis in the host cell and ends with cell necrosis.

  b) Oncogene expression: The viral genome leads to uninhibited host cell division. This form is therefore highly pathogenic, since from the outset it promotes malignant transformation.

  c) Temperate infection: the viral genome is installed in the host cell genome without any initial pathological impact and is then transmitted to daughter cells. Even if this does not primarily have a pathogenic impact, there may be a subsequent oncogenic impact because apoptosis is switched off.

  This form of temperate infection probably results from a slow virus infection.

Specific examples

HPV naked dsDNA (human papilloma virus)

HPV, researched by among others Nobel Prize winner Prof Dr Harald zur Hausen (2008), who previously researched EBV and described this behaviour on a number of occasions.

HPV virus groups

118 HPV types have previously been described in full. Around 30 of these almost exclusively infect the skin and mucous membrane in the anogenital region.

Genital HPV types are generally classified into two groups: low-risk and high-risk types. The classification is based on risk type: a small number of pathogens are extremely common in connection with carcinomas (carcinoma in situ of the portio and/or cervix).

The same applies to the **EBV** group: enveloped Herpesviridae

(Lymphocryptovirus), whose nomenclature and history were described in a paper given by Dr Jurgen Hennecke at the 52nd Congress.

Varicella zoster: enveloped Herpesviridae dsDNA (varicella virus).

(Caution for naturopaths: since 2013 the Federal Law on the Prevention of Infectious Diseases (IfSG), sec. 24 Ban on Treatment, enshrined in sec. 6 Microorganisms elevated in status by virtue of sec. 15 (= adapting the notification requirement to the epidemic situation).

Clinical symptoms and their laboratory parameters for selected case studies of each virus type presented

HPV (Human Papilloma Virus)

There are almost no clinical symptoms. Normally the virus is identified during gynaecological screening.

There are two important laboratory diagnostic procedures which provide evidence of papilloma viruses. The **pap smear** (cytology test), in widespread use for a number of years, enables an assessment to be made of any neoplastic changes. In addition, there are various evidence-based procedures (e.g. **Digene Hybrid Capture 2 = hc2 test)** in order to determine the strain of the virus in the form of an HPV DNA test.

There is currently no specific treatment for the papilloma virus in conventional medicine. Any existing lesions generally require surgery. Local cauterisations are also carried out, although these result in a relatively high recurrence rate. Systemic or local therapies, with interferons and other cytokines, have failed to produce any major success to date.

CASE STUDIES

Case 1 HPV

Ms A., born 1980, employed, steady partner, would like to start a family

HPV evidence:

High-risk strains pos.
(HPV 16, 18, 31, 33, 52, 58)
low-risk strains neg.
Pap test after three months

Pap smear:

Group III D degree of proliferation 3-4.
Pap test after three months advised

This patient then presented at my practice.

Naturopathic diagnosis revealed:

Dark field diagnostics: Except for a slight milieu shift, slight anaemia and few active granulocytes, there was no other indication of higher valence. This control option was therefore eliminated.

Testing via bioresonance:
Liver stress, lymphatic drainage problems and a viral stress.

Treatment

Treatment was carried out using the BICOM optima (used for the other case studies too).

1. Basic therapy:
   In this case:
   Patient with normal energy levels
2. Liver programs:
   retested at every session
   Liver detoxication 1st program 430.2 or
   Liver detoxication 2nd program 431.3
   Low deep frequency: liver detoxication 3063.0
3. Virus programs:
   Strain, exposure to pathogens (viruses, fungi, bacteria) 978.1
   I would once again like to refer you to the work of Dr Hennecke and his wife Simone Maquinay who has discovered an additional low deep frequency for

virus therapy of **5.2 Hz.** This too should be included in treatment.

4. In the honeycomb (channel 2): Quentakehl, Lymphomyosot alternately with Fortakehl, Grifokehl and Nigersan

In this case six therapy sessions were held four weeks apart. At each session testing was carried out again and the programs tested were tailored to the patient's needs.

The patient was supplied with a chip during the sessions, which was worn either near the buttocks or on the left/right lower abdomen, and she took 1 x 4 drops of Quentakehl orally each morning before eating, as well as 1 x 4 drops of Grifokehl in the evening before going to sleep.

Final check-up

Pap smears after six months and then every half-year by the gynaecologist remained at pap grade II, plus a follow-up test using bioresonance.

Case 2 EBV

Ms K., born 1955, currently still officially unable to work (teacher)

Symptoms:

- Chronic fatigue syndrome
- Dizziness

Resulting in following conditions:

- Autoimmune disease —> Development of type 1 diabetes mellitus, proving difficult to stabilise
- Perioral dermatitis

Ostensibly the patient did not present with any symptoms of fulminant disease. Everything that came to light was attributed to the diabetes.

While discussing her case history we started to talk about the EBV and its symptoms. The patient listed a number of minor symptoms which she had also mentioned to the various diabetologists treating her and for which she was always given the reassurance that 'once we have managed to control your diabetes, which is proving difficult to stabilise, then...'

Since the patient had brought a number of different lab results with her, I first of all attempted to gain a clear understanding of the situation to see whether this would perhaps provide any confirmation. As we all know, viral stresses, as we see them in bioresonance, do not always conform with titre test results. (Caution: this is why we all too frequently overlook them!)

Particularly noticeable were:

Leukopenia, which worsened in proportion to any deterioration in blood sugar levels.

HbA1 c lab test results became progressively worse over the course of a year, rising from an initial 7.2% to 9.0%.

In addition to this, despite intensive insulin adjustment and readjustment, severe hypoglycaemia or even hyperglycaemia occurred every day, occasionally resulting in loss of consciousness and associated falls. Retinopathy also developed rapidly as well as nephropathy, expressed in a change in retention values (fall in GFR and higher creatinine values).

As part of the initial case history I carried out various bioresonance tests using the tensor and noticed during the priority test that the entry portal for an improvement in type I diabetes would only be reached by reducing the viral stress. The dark field diagnosis provided further confirmation when considering the monocytes and the change in them, as well as the stressed lymphocytes and an almost complete lack of symprotits (CRP value in conventional medicine).

Treatment

1. Basic therapy: exhausted patient
2. Elimination programs:

   Renal function impairment: 481.0 or 481.2

   Liver detoxication 1st program 430.2 or

   Liver detoxication 2nd program 431.3

   Low deep frequency: liver detoxication 3063.0

3. Virus programs:

   Strain, exposure to pathogens (viruses, fungi, bacteria) 978.1 alternately with 996.0

4. In the honeycomb (channel 2): Quentakehl and Grifokehl, Syzygium jambolanum

Final check-up

After six sessions held four weeks apart (treated in each case in the intervening period with a chip), the patient claims to be feeling well.

Leukopenia laboratory values have returned to the normal range with HbA1 c standing at 6.9%, and no extreme fluctuations within a 24-hour period.

Retention values are improving continually. The most recent retinoscopy also showed a clear improvement.

On the issue of further treatment of autoimmune diseases I look forward to the presentation following mine, which is given by Dr Schmieden-Lindner.

Case 3 Varicella zoster ophthalmicus

Ms L., born 1958, school secretary. Contact with sick child suffering from chickenpox.

At this time the patient was already suffering from sinusitis.

Herpes zoster ophthalmicus affected the left side and the cornea particularly badly. In terms of the appearance of the skin, there was a barely visible, but extremely acute exanthema. Pain when blinking, impaired vision and a feeling of soreness as seen in the cases of Sjogren's syndrome, with additional itching.

Following an appointment with the patient 14 days previously, the ophthalmologist had started treatment with Dexagel ophtal, which after a further 14 days was replaced by Virgan AT and Isopto-Dex.

An attempt by the ophthalmologist to break off treatment came to nothing.

At this point the patient came to my practice, because she had been informed about scar formation on her cornea.

Testing the appropriate programs via kinesiology and using the tensor revealed a viral stress with additional elimination problems in the liver and intestine.

Treatment

1. Basic therapy: exhausted patient
2. Elimination programs:

   Low deep frequency: liver detoxication 3063.0

   Regulate bowel action 565.0, 460.5
3. Virus programs:

   Strain, exposure to pathogens (viruses, fungi, bacteria) 978.1
4. Internal scars (cornea!): Scar elimination 900.2 and 910.5 (possibly also 910.3, 927.3 or 341.4)
5. In the honeycomb (channel 2): Quentakehl and Grifokehl, Mucokehl Atox

Eye electrodes are ideally suitable for this form of treatment.

Subjectively, the patient felt a clear improvement in her symptoms after three sessions.

Ophthalmological findings indicated an objective improvement. After nine months no scars are now visible on the cornea.

It was possible to reduce the proscribed medication after the second treatment session.

In the transitional phase after taking eye drops from the ophthalmologist I prescribed 2 x 1 drops of Mucokehl eye drops, then 1 x 1 drop at night for ca. six weeks.

The patient now no longer needs eye drops.

Follow-up testing on the viral stress revealed that it was no longer present and therefore no further treatments were necessary.

Finally, <u>despite the different</u> guises, <u>it always comes back to viruses and their borrowed lives</u>

I would once again like to refer to the presentation given by Dr Hennecke back in 2012. In his paper the different general and also specific symptoms were addressed.

As with my own case studies, there are cases demonstrating clear symptoms and others which reveal almost none or very few clear clinical symptoms.

For this type of stressed patient, using a different form of testing is the only way forward.

Let's factor this simple, yet effective type of testing into our thoughts and actions. It may need more tailored programs (the way I work at least), but that is what makes diagnosis and treatment with bioresonance so unique and always exciting.

Not in every case will we find parallel evidence in other diagnostic procedures, but the end result is that the patient finally feels well again and that is ultimately what matters.

Thank you for listening and I hope that you take encouragement and motivation from this valuable Congress.

A special thanks goes to all involved in organising the Congress so well and in particular to the Brugemann family.

Irene Kolbe