Success in treating resistant pathogens and infections which do not respond to clinical treatment with BICOM resonance

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CASE STUDIES

Patient with Staphylococcus aureus MRSA[1] following hip operation in 2002

I should like to present to you a 66-year old female patient who first came to my practice in May 2003 after serious and complicated hip surgery.

The patient history revealed that a total prosthetic replacement of the right hip joint was carried out in December 2002. During the subsequent recuperation period, a fist-sized abscess developed at the site of the operation. This advanced so progressively that it was necessary to readmit the patient to the hospital where she had been operated on. An ultrasound examination carried out on readmittance revealed a considerable accumulation of fluid in the right hip joint which extended to the joint.

A swab which was taken revealed group B+++ haemolytic Streptococci. As a result of this finding, the prosthetic replacement was removed surgically, a high dose of antibiotics prescribed and the entire operation site through-drained. In March 2003 the condition of the wound was such that a cemented total prosthetic hip replacement was reimplanted. Once again a high dose of antibiotic treatment was prescribed following the operation. In April 2003 the patient was discharged for post-hospital treatment still with a discrete serous secretion locally from the middle section of the wound.

The patient came to my practice one month later in severe pain, with markedly restricted movement and resulting psychosomatic stress. Physical examination revealed a heavy discharge of serous fluid at the site of the operation and a soft fluid cavity, about the size of a fist, was palpable. The secretion meant the dressing had to be changed five times each day. The patient's overall state of health was markedly reduced. The patient rejected the approach, favoured by conventional medicine, of removal of the prosthesis again and subsequent arthrodesis of the hip, requiring a spell in a wheelchair following surgery.

It emerged from swabs taken in the course of our treatment that the infection was methicillin-resistant Staphylococcus aureus (MRSA). As I am sure you know from the traditional medical literature, these infections are feared throughout the world, are hard to treat due to their multiresistance and have a marked tendency to spread epidemically in clinical institutions. In patients with low resistance, such as in our case, both Staphylococcus aureus and MRSA can cause severe infections of the wound, pneumonia or even fatal sepsis, with the distinction that MRSA is much harder to treat being resistant to antibiotics.

Owing to the patient's rejection of the proposed operation, our aim was to improve her overall state of health, stimulate her own powers of resistance, control her pain, remove her psychosomatic stress and, if possible, do everything by way of treatment to overcome the adverse effects of MRSA. To this extent we discussed conducting bioresonance therapy with the patient, making clear the possible consequences.

The following was recorded on the patient's bioresonance therapy card: the patient first presented at my practice on 28.05.2003. She wanted to receive bioresonance therapy following surgery. I took over the patient following surgery on the right hip in December 2002 with subsequent complications lasting until April 2003 (see medical account earlier in the article). My initial examination revealed: poor overall state of health, suppu-

[1] MRSA = methicillin-resistant Staphylococcus aureus

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rating reddened tissue covering an area around 30 cm in diameter on the hip. Severe concomitant pain. The results of the lab test on the stool showed 1,000,000 Candida albicans plus Candida species.

The extremely poor diagnosis and my initial suspicion that I might be dealing with Staphylococcus aureus and, following tensor testing, even with MRSA, caused me first to direct the patient back to conventional medical treatment. Since I did not, at this stage, have any reports from the hospital which had been treating her, this appeared to me to be the safest route.

The patient followed my advice and went back to the original hospital for treatment as an outpatient for a while. However, she discharged herself from conventional medical treatment at the end of June 2003. The reason for this was that the doctors informed her that, due to the continuing suppurating inflammation, the hip would need removing surgically, the inflammation must heal properly and she would no longer have the use of the hip. Following arthrodesis of the affected area she would have to use a wheelchair.

The patient refused this treatment. Her religious convictions gave her an almost iron determination.

She returned to my practice on 04.07.2003. Following a detailed discussion explaining that our treatment would perhaps not bring the desired result and she might even die of sepsis, the patient persisted with the express wish for me to give her bioresonance therapy. As a matter of form, we also discussed this with her son and daughter-in-law in her presence and had her confirm her wish in writing.

Our first step was to send a wound swab to the lab. It confirmed our testing with the result "substantial levels of Staphylococcus aureus", There was no evidence yet of MRSA (although I had already tested with the tensor and obtained a positive result).

As the patient had been taking antibiotics for a number of months, this bacterium was resistant to virtually all antibiotics. Moreover, she refused further antibiotic treatment due to severe stomach upset.

Bioresonance therapy was begun immediately but initially proved very difficult as the patient was not particularly resilient. Following the standard procedure, the scars, including those on the left hip, had to be treated thoroughly. They were the first priority as regards therapy blocks. The eliminating organs also had to be opened. I supported the liver with Lycopodium D30.

This was followed by the first treatment to eradicate the bacteria with subsequent elimination. I naturally made use of endogenous secretions. Both took an inordinately long time. I stabilised the patient with the "5 element human" test kit and added compensating therapy. Bioresonance drops and a chip were prepared during therapy.

One of my most important considerations was how can I control the germ without using antibiotics and, at the same time, reduce the major fungal attack on the intestine. So I decided to use Propolis 50 % 1 to 1. (Propolis is a natural antibiotic, around 2000 years old, obtained from beehives). Daily intake 6 x 10 drops, also apply 3 times a day to the inflamed area. I gave the patient Aloe First Natural Soothing Spray to disinfect the inflamed area.

Tests also revealed the patient was seriously affected by heavy metals, post-vaccinal complications, toxic stress from the industrial and home environment, pesticides, cortisone, general anaesthetics, formaldehyde, parasites, amalgam, allergies and geopathy. I prescribed Heidelberg Chlorella algae. I tested the dosage thoroughly. Intake 2 capsules 3 times a day.

Although the "allergy" test tube responded positively, I could not at first locate the allergy.

The patient was told to come to my practice at 2-day intervals.

In the next 6 sessions I only treated the priorities such as therapy blocks, opening the eliminating organs. I eliminated fungal toxins specifically and fought the bacterium. Depending on the patient's resilience, I added programs for stabilising the immune system and treated to relieve the pain. I also prescribed Samento plus in high doses of 3 capsules 3 times a day for the next 9 days. Then continuing with 2 capsules 3 times a day for 6 days and then 1 capsule 3 times a day for an indeterminate period.

The patient's state did not alter, positively or negatively. Yet she had an incredibly strong determination to get better. In my opinion, her faith also played a large part in this.

In the 8th session I finally discovered the one thing to which the patient had developed an allergy. It was, in contrast to conventional medical opinion, the titanium in her hip.

Treating the allergy proved extremely difficult. In all, 16 sessions were needed. Then, though, the

allergy no longer responded in any of the familiar amplifications.

By now the results of the patient's swab submitted on 19.08.2003 were available. As initially feared, I was now actually dealing with MRSA. It was a good job that I had observed strict hygiene right from the first day of treatment.

The patient had now been treated by me 23 times and yet I could see no definite improvement. I consoled the patient with the fact that her condition had not deteriorated either.

Further testing revealed that we were now also dealing with 17 bacteria in various amplifications. Yet Streptococcus and Providencia rettgeri tested most strongly.

An additional problem was that the area of skin around the hip was badly affected by the Propolis embrocations. I regenerated this area with various skin creams and limited myself for now to prescribing Propolis orally.

I treated the patient for a further 11 sessions according to the old scheme. I was able to successfully treat an additional problem with the gallbladder. For this Opium C200 was oscillated directly over the gallbladder.

The wound swab submitted on 10.09.2003 again revealed MRSA Staphylococcus aureus. It was still MRSA. The stool sample showed however that Candida albicans had dropped from 1,000,000 to 10,000. This confirmed my suspicion that intestinal fungi really can be controlled by taking Propolis.

I tested the patient a fortnight later with the following result:

There were no blocks present, scar interference fields had been successfully treated, no further allergies were present, heavy metal contamination was markedly reduced, no further evidence of toxic stress from the home and industrial environment, general anaesthetics and stress from antibiotics no longer tested either. Geopathic stress still needed another one or two sessions' treatment. Amalgam and post-vaccinal complications still tested, as did Staphylococcus aureus. There was no longer any fungal infestation.

I now prepared elimination drops for the amalgam contamination and vaccine elimination drops. The patient now takes these each day.

I continued to eliminate the toxins in subsequent sessions.

Once the opening of the wound had reduced in size and the discharge of pus had receded, I arranged another lab test. To my surprise this had not changed. The result for 09.10.2003 was "substantial levels of Staphylococcus aureus MRSA" as before and that is after 44 sessions over a period of some 14 weeks. The patient's tremendous determination and her astonishingly good general state of health continued to give me the motivation not to give up.

So I treated the patient a further eight times, never losing sight of the goal of eliminating the bacterium. It was noticeable at this stage that the discharge of pus was declining each week. Now I was able to apply Propolis to the wound again. This time I decided on alcohol-free Propolis. As the patient had been taking Propolis orally for many weeks, the mucous membranes of her mouth were also badly affected. Unfortunately I was unable to prescribe Propolis honey as the patient is diabetic. And Propolis in globule form was insufficient. So the patient also had to endure this certainly very unpleasant situation.

On 29.10.2003 I submitted another swab to the lab for testing. You can imagine how happy my patient and our practice were when the result came back showing no aerobic or anaerobic bacterial growth.

We immediately tested the patient thoroughly with the bioresonance device and also the tensor. There really was no evidence of bacteria. In subsequent sessions the bacteria no longer responded, yet I did not speed up the scar's healing either. The tissue had to be able to grow again, putting as little strain on the patient as possible. My main task was now to build up the patient and enable the wound to heal cleanly.

No further wound swabs were possible as the wound was completely closed on 18.10.2003. The patient is free of pain and can now be handed over to an experienced physiotherapist.

My recommendation to the patient is to continue taking Samento plus for a further 4 weeks or so and to discontinue the Propolis for now.

Once the oral mucosa have completely regenerated, Propolis can be taken again in lower doses as a preventative measure against a range of illnesses.

In total, the patient was treated 53 times. I'm sure you will be thinking about the cost of such a treatment! Sometimes it makes sense to class an extreme case as "scientific research".

The patient currently comes for a check-up at 3 weekly intervals.

This case should encourage you, dear colleagues, to treat even apparently hopeless cases

and never lose sight of the goal of helping patients recover. I believe that bioresonance therapy will give hope to many patients seeking help in future.

Female patient with recurrent Herpes simplex for around 20 years

I shall now present to you a 40-year old female patient from my practice whose recurrent Herpes simplex, the size of a tennis ball, on the right cheek, I have treated with conventional medicine since April 1998. In her history the patient reported she had suffered from the same condition for over 20 years, always in the same form and size. She could no longer remember previous therapies due to the number of occurrences and the resulting range of types of treatment she had received.

In the period between April 1998 and October 2003 when I treated her, the patient presented 10 times at intervals of 3 to 4 months always with identical symptoms. This condition was always accompanied by marked lymphadenitis of the right cervical region. In addition, the patient exhibited severe psychosomatic symptoms culminating in extreme weeping spasms, due to the infection of the right half of the face and the recurrent nature of the condition.

Conventional methods of medical treatment, always administered in the same form, brought about a remission of the symptoms after some 4 to 6 weeks. During these periods the condition was treated systemically by administering Acyclovir and locally with Gentamycin in crème form as prophylaxis against infection. Due to the frequency with which the condition recurred, in one treatment period we conducted systemic Acyclovir therapy in high doses over a 4 week period, even after the condition had healed.

On 16.10.2003 the patient, whose pictures I would like to present to you later, came back to me. This time I could see no real benefit in conventional medical treatment as it had been carried out so frequently. Bioresonance therapy was discussed with the patient, if only for psychosomatic reasons. Once again, to make it quite clear, all conventional medical practices were abandoned.

The following was recorded on the patient's bioresonance therapy card: long-term patient since 1984 with marked Herpes simplex, tending to affect the right half of the face, conventional medical care as described above including with Doxycycline, Gentamycin, Zostex, Famvir 125 mg, etc.

Initial results: blood pressure 130/80, BS on empty stomach 82, blood right-spin, urine and stool completely left-spin, blood smear normal.

As this was a patient with acute symptoms, we restricted ourselves to treating the therapy blocks, in this case a tissue block. In addition we opened the eliminating organ, which showed priority at the time. In this case it was the liver which we treated thoroughly with the depth probe after testing out the time precisely. At the same time Lycopodium D30 was applied. The Herpes viruses were now thoroughly tested using the combined test technique (KTT) and treated with an Ai program. In addition, the roller electrode was used on the right half of the face. Then the "antivirus" ampoule was applied with an A program. To round off the treatment, we stabilised the patient with the testing ampoules from the "5 element human" test kit. As the patient was in considerable pain, we treated her with the "dragging neuralgia" programs incorporating the individually tested times. To conclude the first therapy, we added a compensating therapy. Program 900 was not indicated as the patient's blood pressure was 150/95. We prepared bioresonance oil and a chip for the patient to support the first therapy. Our tests indicated the chip could only be applied to the tested site 2 days later (in this case on the liver). The oil was to be applied thinly to the affected Herpes zones and around the navel the following day. We also gave the patient Propolis 50 % 1 to 1 to take 6 drops 5 times a day.

The therapy proved successful after the very first session.

We treated the patient three more times at 4-day intervals with a similar sequence of programs.

We then extended the breaks between therapy following thorough testing and also treated geopathic stress, scar interference fields and ensured toxins were thoroughly eliminated.

6 therapy sessions were needed in all, whereby after the 4th session none of the Herpes viruses could be tested (not even through provocation). The viruses could no longer be tested in the check-ups either.

The patient felt fine and we prescribed Bach flower remedies tested individually to stabilise the patient's psychosomatic state.

The success of this treatment relying solely on bioresonance therapy shows its effectiveness with recurrent symptoms, even without the intervention of conventional medicine. The patient will be coming to us at regular intervals for testing so that

we can record the reliability of our therapy. The patient's excellent psychosomatic condition and the rapid progress of her recovery through this therapy were particularly noteworthy.