An Interview with Dr. Dietrich Klinghardt

By Dr. Mercola

DM: Dr. Joseph Mercola
DK: Dr. Dietrich Klinghardt

Introduction:

DM: Welcome everyone. Today, we are honored to have with us Dr. Dietrich Klinghardt who I have known for many years. Actually, one of my earliest mentors in helping me understand some of the basic foundations of natural health and how one can apply it to facilitate and accelerate healing.

I have to first start off this interview with a warning though. If you have become a fan of Dr. Klinghardt the key thing to know is that things will change. He's always on the leading edge. Things are always different. I'm always amazed when I come back to him how much more he's learned. When you think he learned it all, you'll find out that there is an order of magnitude more to learn. That's what he's going to enlighten us on today on a very important topic which is Lyme disease.

Some experts feel that almost everyone has been exposed to Lyme disease and may have it in one way, shape, or form, or another. But clearly there are those who have it, who are severely disabled and crippled.

Dr. Klinghardt has actually suffered with this himself so as a result of this, he has a personal passion. He's really been on this journey that he's going to share with us and really tell us how he has evolved in treatment strategies and protocols and what he has learned from his many decades of clinical experience that he has found to be effective.

Welcome back Dr. Klinghardt.

DK: Thank you Joe. It's good seeing you again.

DM: Yes, indeed. Likewise. We're here today to talk about the Lyme disease. Why don't you start because you're just a phenomenal lecturer. One of the other comments that I neglected to mention is that when you do attend one of your lectures, it seems like you can just go – I don't know anyone else who is more skilled at going on and on for hours and hours without any notes or PowerPoints. I mean you're just a wealth of knowledge. It's just shocking. Let's start wherever you feel is appropriate and then I'll dialog and interject with some questions as we go along.

DK: First, I want to say that we're here doing this Skype thing and I'm not quite used to it. I'm going to be a little bit impaired because I'm not used to have earphones on and all that. I may not be flowing as easily as I do when I'm in front of a big room.

The issue with Lyme disease that – the only thing that's new with Lyme disease is that many of us have realized that pretty much all chronic illnesses are in one way or another way, the outcome of chronic infections or at least contributed to by chronic infections.

Even 15 years ago, most of us thought that chronic illness is the outcome of environmental toxicity and everything related to that. But we got a little wiser and realized that the issues go far deeper. What has been astounding to us when we look at illnesses that are well established in the conventional medical field like Parkinson or multiple sclerosis or chronic fatigue are all turning out to be primarily chronic infections with this particular expression of it.

Right at the center of that is really the ongoing discovery of Lyme disease – when I say Lyme disease I like to use the new definition of the new Lyme disease that means it's an illness transferred by insects – please hear me here, we're not calling it anymore a tick-borne disease because we know that mosquitoes can carry Lyme disease and many other serious infections. You know that spiders, fleas, mites can carry these illnesses. So to limit it to tick-borne disease as it was until recently has been too narrow a focus.

I like to take a big look at this whole thing. In modern genetics, when we breakdown our genome we find entire long sequences in there that come out of the insect kingdom, that come out of the bacterial kingdom, out of the viral kingdom that actually have become part of the human genome. What that basically means that in the process of discovering a new theory of evolution that these chronic infections were always an attempt of evolution to mingle with our genes, to expand them, to change them and once in awhile something good comes off it.

I may have to mention that already in my last interview with you that impressive examples of that are some of the carriers of spirochete illness in the past starting with Nietzsche. Nietzsche was infected with syphilis. In the course of the illness, he had one of the most creative philosophical outbursts ever happened to humanity.

I could also mention Mozart. Mozart was treated with high doses of mercury in the late stage of his life because he had contracted syphilis and died of mercury poisoning. During the course of his illness and during the course of the treatment of the illness, he created some of the most beautiful music ever. Beethoven lost his hearing from the mercury treatment for syphilis.

These are just a few examples of people that had a well known spirochetal illness.

[----- 10:00 -----]

This illness was clearly contributing to the enormous creativity and maybe even clairvoyance and breaching the perception into the other worlds and to the invisible world around us.

I'm taking today a very different approach to Lyme disease. I look at it as nature mingling with our genes. They are trying to incorporate their genome into our genome with the possible outcome that something good may happen occasionally. Most of the time it goes wrong but sometimes it goes well. This is like the point I want to make upfront that I take this more evolutionary view of it.

And then on the darker side of things, we do have some government documents that were leaked to us that shows in the 1960s and 70s or maybe into the 80s there were some wild experimentation going on in U.S. military linked – government documents that show that the U.S. government and other governments in the world were very well experimenting with recombining different microbes in order to create stealthy microbes that make large populations ill so they lose their will to fight and to attack. Whether these things were ever used we don't know. We know they were experiments going on.

Unfortunately and increasingly likely that some forms of Lyme disease are actually a microbe that has some human elements in it. It's likely that they are God-made creatures that evolved on their own but that somebody helped along with it.

I'm always positive when I go over to Europe how different patients with Lyme disease look there. I worked half my life over there as a physician and half my life here. The people in the U.S. with chronic Lyme disease are far ill. They have far less energy. It just looks like there is a viral element in our Lyme disease that we see here that is not present in Europe and that cannot be explained on pure biological grounds.

These are just some thoughts upfront. We do have some anthropological evidence that spirochetes were around for a very long time – thousands of years. We know that Bartonella, one of the significant co-infections were found in the soldiers of Napoleon who died in Russia. It was called trench fever. It was Bartonella quintana, a very nasty bug. The Russians lost a lot less soldiers because the Russian general was a homeopath and he had all his tens of thousands of soldiers taking homeopathic dilutions of their own saliva which saved a lot of their lives.

We know that Lyme spirochetes were around for a long time but something happened maybe 30-40 years ago where the creatures became more aggressive, more penetrating, and more illness producing than they were before. Some of us suspect it's a man-made element. Some of us suspect that the global warming may play a role in it.

I am personally suspecting that the exposure to electromagnetic fields in the home and the microwave coming in from the cellphone radiation are driving the virulence of many of the microbes that are naturally in us and makes them aggressive and illness producing. There is probably evidence for all sides of the discussion.

What I'm trying to do when I see a patient, we try to assume when somebody shows up in our office with a chronic illness we're not just suspecting there may be a chronic infection in the background but we're looking for it. We're looking intentionally for it.

We're not asking could it be that this patient has a chronic infection. We are asking the question, okay, the patient has a chronic infection, what is it? And then we try to define it, to narrow it down, to find it, to prove that it's there and then find the most gentle but the most directed treatment to treat it.

DM: Thank you for that introduction to Lyme. How would you describe, for those listening, some of the more common symptoms and then from the symptoms go into the process of getting a proper diagnosis because one of the big challenges that anyone who is really familiar with Lyme disease has been it's notoriously difficult to I guess test with traditional blood testing. Maybe if you can address that.

Again, some people like Lida Mattman believes that everyone at least in this country, in the United States, has been infected with Lyme. There is a whole range of views on this. I'm wondering if you could share with us your views on it.

DK: That was Lida Mattman by the way. In terms of the presentation of the illness, first of all, there is a great variety depending on where people contracted the illness and then there is a great variation depending on what other infections or infestations the patient has.

The contribution that me and my co-workers here in the office made in the last couple of years is that we differentiate very clearly (indiscernible 16:58) Lyme and its co-infections. That means that these are infections transferred at the same moment with the same insect bite as these Lyme spirochetes.

There is a group of factors; seven or eight microbes that are common. The worst ones are Babesia microti and the different forms of Bartonella. There is a large variety again amongst those creatures. Underneath that often is an infection with Mycoplasma where we still don't know if it's really transferred with the same bite or if the people had it all along and become symptomatic when the immune system is suppressed by the spirochetes.

Other than the co-infections, there is what I call the opportunistic infections. The combined effect of the initial infection is an immune suppressive effect and then the patient becomes vulnerable to all sorts of other things. The most common thing that people contract early on in the course if the illness are different forms of parasites. There is protozoa. Babesia itself being one of them.

There is Giardia, amoeba, Trichomonas, malaria, and different forms of infections that aren't labeled yet. There is a new one. It's called FL1953. Stephen Frye has discovered that. That's a protozoan organism that's causing severe fatigue and illness in chronically ill people. It's almost always present in a patient with Lyme disease.

And then we find a lot of worms in people. They may be microscopic and they may be macroscopic. That means they may be visible in the stool or they may not be visible. We'll get to the treatment later but it's important that the initial onslaught of microbes

with the insect bite or several insect bites or in several locations, as most of us travel, and there is the opportunistic microbes that come on board after the initial event.

That colors a picture so differently in different people and then of course there is a backdrop of genetics in a person coloring the picture. There is the nutritional background, the emotional background, the exposure to electrosmog which all paint the picture. Because of that, there is a large spectrum of illnesses that when we see them we suspect that there maybe a Lyme disease at the bottom of it.

Let's start with the most simple presentation which is the orthopedic forms of Lyme disease. They usually live more superficial. People still feel well that they have knee pain or hip pain. Typically it's the large joints.

[----- 20:00 -----]

I have rescued many, many hips from the orthopedic surgeons by injecting ozone into the hip joint. Ozone is a hundred percent effective if the Lyme disease or Mycoplasma or Rickettsia whatever the microbe is, lives in the joint and is confined to the joint space. Simply putting ozone in the joint will kill the spirochetes and often with one, sometimes two treatments make the joint completely pain free. That's one form of the expression of Lyme.

The next one is a little bit more difficult. It's when the microbes and the associated immune reactions live in the connective tissue then the patients get vague dispersed pain syndromes which usually are sent to me under the label fibromyalgia but usually it turns out to be the proper fibromyalgia with the 18 or 20 typical trigger points but there is widely spread pain in the body. Again, when we do the appropriate lab work, we find often that these people are infected. This is a little bit about the orthopedic expression which are the easier ones to handle.

Then we have an immunological expression. That means a wide variety of immune system disorders usually with some aspect of autoimmunity. You probably remember, I did my thesis in 1976 on autoimmune diseases and how the autonomic nervous system interacts with the immune system.

We found then already that the determining factor of the outcome of an autoimmune disease was the presence of microbes that were catastrophically unresponsive to antibiotics. Any autoimmune disease including rheumatoid arthritis we're suspecting there is an underlying level of Lyme disease that needs to be handled and treated appropriately before the patient has a chance to snap out of the illness.

The third expression that is very common especially with Babesia is the gastroenterological presentation where people have constant stomach problems, recurring stomach ulcers, indigestion. They're constipated. They can't move their bowels. They can't absorb their food and so forth. Sometimes with the direct outcome of pancreatitis or hepatitis, the associated organs becoming ill. That is very frequent but

usually an outcome of the parasites that have come on board after the patient contracted the Lyme disease. In these cases, we very aggressively treat the parasites. I have to say very successfully.

Then the most startling form of the expression of Lyme disease is a wide variety of neurological illnesses. That is what we're specializing here in the office. We see a lot of cases with MS and unfortunately, also ALS but then everything in between the chronic fatigued patients, the patient with vague, undistinguishable neurological symptoms, the feeling of buzzing in the head, buzzing on the skin, crawling under the skin, symptoms that are described in the homeopathic literature 400 years ago. Hahnemann described the same symptoms and so we know spirochetes were around then during the same.

Insomnia may be one of the key symptoms that we see today in our Lyme patients as the neurological symptoms like headaches, all varieties, all sorts of pain syndromes. I lump this together under the neurological expression of Lyme disease.

The key to diagnosing – the listener, please keep in mind that most commercial tests that are available in medicine to detect chronic infections are based on appropriate immune reactions that the patient has to the invading microbe. So you're looking for IgG, IgM antibodies. This is the response of the body mounts, the white blood cells mount to kill the microbes that are there.

However, the equation changes once we know that one of the primary cells that get infected with Lyme spirochetes are the white cells themselves. If they are infected, they lose the ability to produce antibodies. I call this the first Lyme paradox that in order to diagnose Lyme disease properly with one of the accepted commercial tests, you have to first treat the Lyme disease enough for the patient to be able to mount an appropriate immune response and then we can use the laboratory to detect it.

An exception to that are the test based on direct microscopy where you're not depending on the immune responses for the patient. The problem with the direct microscopy is that the tests that are done commercially. For example, the FISH test for Babesia are done on the blood. However, the concern that we have for example with Babesia is its presence in the central nervous system and in the joints and in the connective tissue. We are not concerned about its minimal presence in the blood.

Babesia, for example, can be easily missed in the blood because it doesn't live there. It strays there occasionally in small amounts but it lives in the central nervous system or in the joints. We don't have an easy test where you could do a brain biopsy but it would be just as easy to miss there than to miss somewhere else.

The promise with the direct microscopy is that the tissue that we usually look at is the blood and that's the one tissue that Lyme disease tends to only stray into from time to time maybe on the full moon, maybe when the patient goes to a trauma but it doesn't

live there, not in high amounts. It's the same problem with the PCR test and other tests. This is just to introduce you to the testing conundrum.

I like to just say what we're doing here. We are very simplistic. We treat the Lyme disease for at least six weeks to two months. Then we tend to do a western blot test. That's the test that's based on IgG and IgM.

DM: Is your treatment initially based upon the clinical symptoms that you just described? So the high suspicion that this is Lyme disease and then you treat empirically without any – you probably do some more sophisticated energetic testing. I'm not sure if you want to review that now.

DK: I think I can be honest about that here. I'm trying not to hide anything that we do. We use a form of muscle testing that I have developed. It's called autonomic response testing that incorporates many features of regular neurological testing. That means we're testing for example the cranial nerves in the classical way. We test the reflexes, the ankle clonus. The Babinski. We test with skin sensitivity to vibration and touch. Before we get to the actual kinesiology part, the muscle testing part, we're arriving at the time of the diagnoses that we can then further refine with the muscle testing.

I developed a system called autonomic response testing that has grown really out of the need for a physician to penetrate deeper into the system. It's not related to the applied kinesiology system that's quite distinct, a stretch from it but it may look on the outside similar. We're looking for very specific reflexes that are connected to very specific illnesses. We arrive at a tentative diagnosis through history taking, through looking at some of the skin signs, to palpating the tissues, through testing the normal neurological reflexes, orthopedic tests and then adding the muscle testing as an additional tool.

When we arrive at the tentative diagnosis, then we start with my approach to Lyme disease which I'll get into later. And then six weeks into that, we do the blood test. We have a very, very high level of correlation when we do the blood test at the right time during the treatment. It usually turns out positive.

I have to say that we used very strictly IGeneX Lab in Palo Alto. I don't have a financial investment in it or relationship but it's the gold standard in our field. They use two different antigens. The commercial labs and hospitals and so forth, they use one antigen and are notorious in under-diagnosing Lyme disease. We recommend to rather not test it than get a false negative test which will sometimes lead the patient 20 years on the wrong track.

With the other co-infections the detection rate drops way down. Babesia is much harder to diagnose. We do the FISH test at IGeneX Lab. It's a direct microscopy test which has more false negatives than the western blot. That's for Borrelia.

[----- 30:00 -----]

We use various tests for Bartonella. The leading test for Bartonella that we use is Fry Labs in Arizona. Steven Fry, who does a wonderful direct microscopy test and often comes back positive with the diagnosis of hemobartonella. Hemo means simply blood – Bartonella in the blood. Remember, he's testing the blood where the Bartonella typically does not live. It lives in the nervous system. So if you find it in the blood in small amounts it generally is an indicator that there is a high amount in other tissues in the body.

The principle that we really should do tissue biopsies has not been practical. These are the three tests that we do for the bugs themselves. And then we do one indirect test that hasn't changed that Raphael Stricker from San Francisco has given us. It's the CD57 test. The CD-57 is one set group of natural killer cells that are particularly damaged by the Lyme spirochetes. If the numbers drop down to a certain level, it is an indirect indicator that a patient most likely has Lyme disease. There simply no other infections known other than Borrelia burgdorferi that suppress CD57.

So the general guideline is the value should be over a hundred. If it's under a hundred the patient has an infection with Borrelia. If it's under 60, the patient has an infection with Borrelia plus Mycoplasma plus most likely some other co-infections. We very commonly start at levels of seven or nine. We normally start with the patient and gradually over the year and a half or so that we typically treat people, the levels go up back over a hundred then we're all happy. Then usually stop treatment but keep monitoring the CD57 maybe every six months or so. If it drops back down again, you know it's time to treat again.

DM: Thank you for that explanation. It's sort of an update of the current status of the different tests that are available for Lyme. One of the other ones that you didn't mentioned and I learned about recently from another clinician, Dr. Cowden who treats Lyme somewhat similar to you. I'm wondering if you can comment on it because some people might have a question on it. That's the Spiro Stat. If you can give your impression on that and how that might fit into the scheme of things.

DK: I know that my friends in the Lyme community are increasingly using the Spiro Stat test. It tends to be offering less false negatives than the other tests. I have not used the Spiro Stat test because I'm waiting until there is enough common agreement on the validity of it. I know it's a good test. I talked to the lab. I trust them. I think it's a big breakthrough in our field.

My position is I'm trying to have our patients get reimbursed by their insurance companies and put their treatment on a stable ground. Where the insurance (indiscernible 34:37) that decide whether the patient is going to be paid for or not. It's usually a secretary that didn't finish public school in terms of her educational level who is making all the decisions for the patient. For this reason I have stayed so far with IGeneX Lab because we had a very good success rate. If it's positive in IGeneX Lab that the insurance then was willing to pay for the procedure.

I know Spiro Stat is very close to gaining the same status but from what I hear it's not quite there yet. It maybe the better test. Really, that's all I know at this point.

DM: Thanks for that. I'm wondering if you could also address Lida Mattman's premise or hypothesis that most everyone is infected with Lyme. What's your experience have been because she's really more of an academician, really a PhD and not really treating patients as much as you are in the trenches treating people with the disease.

DK: I have an interesting history with Lida Mattman. I was introduced to her in 1990 through a dentist who was also an osteopath like yourself – Chris Hussar. Chris Hussar had worked with a biologist, Phil Hoekstra who was a direct student of Lida Mattman. I was introduced to Lyme disease actually through the lineage of Lida Mattman's teaching.

Lida Mattman was the discoverer of the cell wall deficient forms. Before Lida Mattman, we knew microbes to swim around in the blood and do things there or even the connective tissue. We only thought of viruses actually penetrating in the cell infecting the cells until Chlamydia came around and gonorrhea which are really strictly intracellular microbes. People were wondering how are these bugs doing it that they're penetrating the cell wall, such large creatures.

Lida Mattman found that bacteria to infiltrate, to enter a cell, have to shed this. They have to give up the cell wall in order to be living in the intracellular environment. That was her great discovery. Of course we know now that today that there is an intracellular form of Lyme disease and there is an extracellular form. Outside of the cell the spirochete looks like a corkscrew. On the inside of the cell, it may look just like a blot.

Lida, I think she's got a Nobel Prize or at least was nominated for one. She was not a small light. She is internationally. Everybody in Germany and Switzerland or so when I mention Lida Mattman, the people want to bow to me. I have to say no. I met Lida a few times but she was not my primary teacher so I can't really brag about it. Lida Mattman has internationally a high level of trust.

In the late phase of her life, she felt based on the tests, the direct microscopy tests that she used with the particular stain that she developed to make Lyme spirochetes visible in the blood, she felt that the penetration in the U.S. population is nearing a hundred percent that means everybody has it but not everybody is sick with it.

I'm not subscribing to one theory or another but certainly amongst the patients that come through my office, sit in the waiting room and come into my room most of them turn out sooner or later to be positive testing for Borrelia burgdorferi and many of them for Babesia and many of them for Bartonella and Mycoplasma and everything else that comes with it.

I do believe that post mortem, Lida Mattman is going to be redeemed and is going to be found correct in her observation. However, I want to put that in context that I am

personally suspecting that the spirochetes were always with us from beginning of humanity, we're a couple of hundred thousand years old now since we climbed from the trees. I believe this history goes way, way back.

I know that in the Black Forest area in Germany where I come from, the women, especially the women, when they are like 40 years old they get this big kind of huge knees from arthritic activity in the knees. It was already known in the 1930s that the outcome of a Borrelia species that lives in the Black Forest. It's called Borrelia afzelii that didn't do much other harm other than just infecting the knee joints and they were moving more slowly but these women reach a normal healthy age of the 90s or early 100s before they died but with big fat knees and a certain amount of stiffness in their knees. It's still like that today. That was known in 1930 that they had spirochetes in their knee.

[---- 40:00 -----]

I'm just suspecting that these creatures were along with us for a very long time. The world really has changed. The influence of the external factors and that is the toxicity in us, in the air, in the food, amalgam fillings, root canals, the food residues. All the things you talk about in your website, the vaccines. That's one big aspect and one that we know for sure because there is research on it that shows that the electrosmog, just the ambient fields in the house, the 60 hertz field drives the growth and the virulence of the microbes that live naturally in us. We know that the amount of microwave, the exposure from the cellphone radiation is near doubling now every three years, the amount of the exposure is doubling and has reached clearly catastrophic amounts.

One of my primary treatments for Lyme disease and now we'll get into treatment is to put people in protective clothing that shields them from incoming microwave. We shield the bedside. We turn off the wireless internet at home. We put shielding paint on the houses. That has been a more successful strategy to treating Lyme disease and to get people neurologically well than any of the antibiotics or any of the antimicrobial compounds. It has been more successful as a single strategy.

I know it is wrong for us to overly emphasize on the microbes. We need to know what's driving the microbes nuts in us. They were historically living with us happily, symbiotically. They may have always caused mild damage. We don't know or premature aging. We don't know for sure. But this virulence that is appearing now is a new phenomenon and it could be explained only with two things; one a mutation of the spirochetes, or one of the yet invisible co-infections or opportunistic infections.

Stephen Fry suspects a protozoal organism FL1953. Other researchers (indiscernible 42:17) suspect the eczema virus. We don't know for sure. But we know for sure that the exposure to the electromagnetic fields that we are undergoing right now is insane and it's driving the growth of the bugs. Several Russian research (indiscernible 42:33) on that that shows that.

DM: Thank you for that explanation. It sounds like from your perspective that one of the most important things you can do and it makes sense and clearly the scientific community through the new publications and research is validating the position that we've held for many years, decades that these exposure to the electromagnetic fields are particularly harmful and they are causing serious problems down the road many of which were not seen.

You're certainly witnessing them now with this individuals who are struggling with the Lyme disease process but there are millions, tens of millions, maybe even more who are going to suffer similarly that many smokers do now to chronic exposure to smoke and come down with cancers down the road 10, 20, or 30 years later. I thank you for that perspective.

I'm wondering if you could put it into sort of priority as to how you base your treatment. Obviously nutrition is going to be an important component of it too but do you find from your results of the patients you're treating that paying more attention to the electromagnetic even supercedes the importance of paying attention to optimizing the diet and eliminating sugars and those types of aspects.

DK: Let me outline our treatment approach. The first thing that we do with the patient when we enter the treatment decisions is that we look at the external factors that act upon the body of the patient 24 hours a day, 24/7. So we try to clean up the home, their sleeping location, their work location. The very first thing we look at is molds. There is a very new important new book out by Ritchie Shoemaker, his new book on mold. It's called *Surviving Molds*. There is a website with the same name.

With every patient, we do mold testing at home. We do what's called the ERMI score. The ERMI score is semi-quantitative assessment of how much molds is in your home. There is sort of an experiential value, the number shouldn't be over 2. Most of our patients are around 15, 19, 20. And then the first question that needs to be solved, mold is a huge contributor to the same symptoms that we normally associate with Lyme disease.

We try to clean up the homes. The American homes are notoriously catastrophic for mold. The ventilation and the homes are basically big cardboard boxes with plastic wrapped around it if you really look at the structure. It's like a mold growing in a fermentation chamber. We try to get the mold people in there to mitigate whatever is possible cleaning up their air ducts, aerating the home for an hour everyday, vacuuming, if there are any moist walls.

DM: If I can interject here because I have had a problem with mold in my own home and researched this pretty carefully. The key issue is the moisture. I mean, so many people have hidden leaks in their roof or their plumbing or their foundation, a crack in their basement because you cannot have a mold free home if you have a moisture intrusion into the home. It's just impossible.

DK: The other thing is the floor space, you know, very often we find that the ventilation system in the house sucks in the air from a crawl space that is completely infested with mold and blows the mold into the house.

I think the framework of this interview goes too far to go into all the details but if the patient lives in a moldy home they do not have a chance in succeeding with the Lyme treatment. That's the basic. I recommend reading Ritchie's books. Ritchie is in our inside circles – the god of the mold mitigation and mold diagnostics. I think it's a must to become cognizant of that.

DM: What's Ritchie's full name and how do people find those books?

DK: Ritchie Shoemaker. The website is simply www.SurvivingMold.com. It's a very important resource. I don't agree with all the conclusions and all the therapeutic steps that Ritchie Shoemaker does but in terms of the foundational knowledge and the science that he offers, it's fantastic.

There is a couple of lab parameters that we used that he is recommending. One is called TGF Beta-1 (Transforming Growth Factor Beta-1). It is an inflammatory indicator that tends to be high when people are exposed to molds. The other one is called C4A. It's one of the compliments. Unfortunately, the testing needs to be done on one particular lab in the U.S. It's called the National Jewish Hospital in Denver. The C4A is up. It's also an indicator for mold-related inflammation. We do a few other things but those two are the two big ones that we do with the very first visit to see is there any indicators here for mold.

And then we do a visual test. It's called the visual contrast score. I know you are aware of that because you've been to those workshops that Ritchie Shoemaker has introduced to us. It's a test that measures the ability to see contrast, black and white contrast. It's a simple apparatus that we have in the office that anybody can learn in 10 minutes. It gives you a score. If it's a below a certain level you know the patient has an ongoing mold exposure.

Unfortunately, there is no clear simple mold testing where you do a blood test and come and say, you are mold exposed. There is over 600 pathogenic molds. It could be astronomical testing for it so we reduced it to this minimum of test that gives us good guidance and then we use muscle testing to confirm yes there is mold. We need to treat the mold in the patient and we need to treat it in the home. Treating in the home is most important.

Here comes the most important other thing and that's the electrosmog. We know that the mold in the home gets by a factor of hundreds of times more virulent if it is exposed to microwave from incoming cellphone radiation, from wireless internet, from baby monitors, from alarm systems in the house and from the cordless phone. The cordless phone broadcasts 24 hours a day a very devastating pulse frequency into the house.

[----- 50:00 ----]

We know that the elctrosmog grows mold in the house faster and more viciously than would otherwise. The next step that we do we measure the microwave in the homes. We have an instrument that we give to patients. They have to send it back but sometimes it goes wrong. Instead of keeping it for one day, they keep it for a month. It's a thousand dollar instrument from Gigahertz Solutions. That's right now the accepted gold standard for measuring incoming microwave from the house.

There are certain values scales, I'm not going to go into that here but we measure every home of any chronically ill patient who want to know how high is their score. If it's beyond a certain level the patient has to what we call mitigate. That means there is two ways of shielding your home from the incoming microwave. The best one is to put a special graphite paint called Y Shield on the outside of the house and to use curtains in the house with silver coated cloth. That's we did in the office and it's fantastic. It's like coming home – going to work because the office is shielded from the incoming microwave and everybody breathes deeper and feels at home even in an environment like this.

DM: The downside of that for those who are going to this is that you won't be able to get cellphone calls.

DK: Exactly. Sometimes compromises work well so people just shield the bedroom and leave the other rooms contaminated but then be able to receive cellphone calls or get a corded phone in addition and tell all your friends what your phone number is and that works very well. That's step number one.

Step number two, no cordless phones in the house. So they leave the phones (indiscernible 51:58) incoming phone lines need to be either corded. Siemens and Motorola both make phones that only broadcast the microwave, the connective frequency when there is a phone call coming in or the other phones, the ones that most of the listeners will have at home are broadcasting a signal 24 hours a day.

DM: If I can give a refinement on that. This is from Vicky Warren who we both respect, who is a former director of the Bau-Biologie Group in the United States. The base station is really the offender there. It's not so much the receiver. So if you can put the base station like more than three or four rooms from where you're sleeping or spend most of the time in the day then the radiation goes out over so much and it's not an issue. And it really is only an issue when you're talking on the phone because that's the only time it transmits.

DK: Joes, I have to remind that the only person I know that has three or four rooms (indiscernible 52:56) is talking to me right now. Most of us live in small apartments.

DM: Then it becomes a moot issue. But the other alternative and they are difficult but you can go to EBay or Craigslist and you can find the older generation 900 MHz phones

and then those only transmit when they're on. But all the others transmit 24/7 just like you said.

DK: Do you have those instructions on your website? Can people find it?

DM: We do. We have a whole EMF site. It's EMF.mercola.com and she goes into that but Vicky is really just a brilliant electrical engineer, who has committed her life to understanding these processes and she's taught us a lot.

DK: The third thing that we do is that every patient has to turn off all the fuses at night until they're well. They can get a demand switch and do other things later on but while patients are under my care, they have to mitigate the incoming microwave or to get rid of the cordless phones and they have to switch off the fuses at night. This is preconditioned when we have further Lyme treatment. We have the mold mitigation and the electrosmog mitigation. Then we roll our sleeves up and treat the patient.

I just to want to say this as this is not like a special idea anymore or in a nice world we would be doing these things or maybe we consider those things sometimes. No. Every single patient who walks in my door gets these instructions at the beginning and we follow after that.

DM: Let me emphasize that's a golden pearl. For those of you who are listening I mean you really need to listen to this because you spent decades figuring this out and you've learned from hard trial and error and people spending thousands or tens of thousands of dollars in unsuccessful treatment that unless they're doing these two things you recommend, the treatment is going to fail.

That's a good strategy for everyone listening whether or not you have Lyme disease because there is no way mold exposure is going to make you healthy and the same thing for EMF. They're both toxins that should be limited. It's wise for everyone. But if you have Lyme don't even think about getting treated successfully unless you're addressing these issues.

DK: We see there are two groups of patients, the ones that we get well. Those tend to be the one that have done those two things and the ones that struggle. It's a slow uphill struggle if they don't do those two things. So I just want put that at the beginning before we launch into the actual treatment that everybody expects, okay, what other things that you do to treat the patient. Those are the first two things that I do.

Fairly early on in the treatment, we get the trauma and history of the patient and the family history and we look if there is any major trauma and any major losses; the death of a loved one, trauma in the family, the father was in Vietnam and lost a leg. Major traumas, we want to know about.

I do my PK work on the patient early on if we find that. If the issue is almost settled, I'll wait until the patient has made a degree of recovery when they are more able to sustain

a deep look inside. When they are able to introspect and look at their stuff. Usually it's later…

DM: Let me just interject here for those who don't know your work; that PK is psychokinesiology. That's a more advanced form of – similar to EFT but far more advanced and incorporates your decades of understanding and teaching.

DK: We use all the principles of EFT which I learned largely from you. The psychological treatment – really, I want to say it very clearly, if there is a major trauma in the patient's history you have to deal with that early on. If you have to refer somebody to a trauma therapist fine. We do that in the office. I love doing that work, not everybody does. I don't take it with a sense of shame but if there is a major trauma, your treatments are not going to work that you do later. We do that early on in the treatment.

But the family conflicts and love issues, relationship issues, we part that because of the time the psychological well being of the patient is totally dependent on the absence of the microbes in the brain. If you have microbes in the brain you cannot do any higher psychological work even though the presentation of the patient may look psychological or the underlying cause of it often is the inflammation in the brain and the toxicity caused by the illness.

Let's launch from here. These are the three steps; the molds, the electrosmog, the psychology. From here on, I launch (indiscernible 57:42) into the Lyme treatment that we are exploring and have been very successful with.

Just a little bit on the history of that. When I started out with Lyme in the early 90s, we used antibiotics. I was largely surprised initially how well antibiotics work in chronically ill patients that you really see some progress but then also saw that we fairly rapidly reached a plateau with the patients that we treated that way where it was really, really hard to move on from there.

I have a large background as you know in alternative medical treatments. I was trained a classical homeopath and then I did a lot of herbal training and doing the whole integrative medical staff and the hormone replacement therapy – all those things that many of the listeners also have learned. I very quickly decided I will try to figure out a non-antibiotic way of treating this illness.

So the first big breakthrough, my own personal life, what healed me from Lyme disease was bee venom therapy. Bee venom is the poison the bee uses to scare away attacking invaders. All of you have had a bee sting at one point or another. Most Americans mistake wasp stings with bee stings. Bees are smaller, sweeter. Bees make honey. Wasps are singular animals. They eat meat. Bees eat pollen. Bee venom is completely clean. A wasp venom is completely contaminated with other things also with viruses also suspected of carrying Lyme disease.

Bee venom contains a peptide called melittin which has been found to be an extremely effective antibiotic for Lyme disease but recently also has been found to be a very effective antiviral for many of these hidden stealthy viruses that come with it. My first line of treatment and this in the early 90s was bee venom therapy. We were very successful with that but the compliance in America is low as it has an uncomfortable treatment for the first months and then the reactions stop and then becomes very easy.

[---- 1:00:00 -----]

We still use bee venom therapy for a lot of patients but it's no longer the first line of treatment that we use. We explore the large variety of herbs. I'll just give you the conclusion now. We treat Lyme disease with what I call the Klinghardt antimicrobial cocktail. You can look the details up on my website. It's www.KlinghardtAcademy.com or the email address at info@KlinghardtAcademy.com. We have a wide range of protocol that gives you the details of my cocktail.

(indiscernible 1:00:40) artemisinin. Let me explain that. Wormwood has been used for treatment of infections since over a thousands years. It's documented. One extract of wormwood called artemisinin has been found to be extremely effective for malaria. It's still today the most effective malarial remedy beyond all the medicals. It's more effective, less resistant. (indiscernible 1:01:08) wormwood. You know, (indiscernible 1:01:11) doesn't like actual things (indiscernible 1:01:13) instead using wormwood which is completely natural. So there is a lot of misinformation also in the field.

Anyway, one of the microbes that I talked about Babesia (indiscernible 1:01:29) sends to artemisinin and then we realized that the malaria (indiscernible 1:01:36) live in the blood. It mostly lives in the central nervous system so we have to take artemisinin and carry it in tissues and the one cell that does it that we documented is the liposomes. To make a liposome means you're wrapping a little bubble around a water soluble molecule and in that form as the outer looks like (indiscernible 1:02:00). So this (indiscernible 1:02:01) crosses easily cell walls, crosses easily the blood brain barrier and the liver (indiscernible 1:02:07). There is a special way of (indiscernible 1:02:12). It's not actually available. The literature says artemisinin is a fantastic agent also against cancer, against all sorts of infections. So (indiscernible 1:02:21) as we blend the phospholipids together with artemisinin in the blender for a couple of minutes and then put it into ultrasonic (indiscernible 1:02:29) to the blender (indiscernible 1:02:30) at Sears

(indiscernible 1:02:33 to 1:02:38)

DM: What is the liposome that you're using? Is this egg yolk?

DK: No. We use a product from Bio Pure that's called (indiscernible 1:02:45 to 1:02:50) you can use lecithin and it makes (indiscernible 1:02:53) a capsule in liposomal form and that took a bit of research. I'm developing a product that does that.

DM: It would seem to me like you could use that broad type of supplement because that is really the key thing but (indiscernible 1:03:06)

DK: (indiscernible 1:03:07) than regular vitamin C. So we're putting vitamin C and then we have (indiscernible 1:03:17) wrote a beautiful book (indiscernible 1:03:18) leading herbalist in the world. I knew him from (indiscernible 1:03:23) a long discussion forth and back. (indiscernible 1:03:25) most effective herbs for Lyme disease put it in an herbal tincture. It's called quintessence. Quint, you know, like five. The quintessence goes into the cocktail.

That part we make as a liposome with the blender and then we use this ultrasonic unit and then we put it back in the blender and then we're adding in all other vitamins and things that can possibly, we take them orally. So we open capsules and put everything else in there that the patient needs to take for the day. And then at the end, we're adding some apple. I like to put an apple in there because of the apple pectin. It has wonderful healing properties and binding toxins in the gut and also giving the fiber to the gut to give this whole cocktail the structure that is slowly delivered. We don't want it all to be absorbed within a few minutes. We want it slowly delivered.

We go through a number of steps in adding some other ingredients to it that are more particular to that particular patient. The core piece is artemisinin, the quintessence, the five herbs and the vitamin C together with the phospholipids. That has just been a dynamite incredible thing. Mostly patients that I see are people that have been often three, four, five years on continuous antibiotics that keep them alive. They had probably improved on it at some point but they are still in a devastatingly low level of dose. Other people are typically, they get well or a lot better with our cocktail with the sequence of treatment.

The new thing that basically – yes, we can make anything liposomal, you can take any herb that's effective. I said in the beginning, usually in the beginning of the treatment many of our patients test positive for parasites. We tried all the anti-parasitic drugs that are out there.

There is one particular nasty parasite I want to mention. It's called the lungworm in dogs. It's called the lungworm. As it made the transition into humans, it's one of the roundworms that's called Varestrongylus klapowi. Larry Klapow was the biologist who discovered that one. It's in over 80% of the chronic fatigue patients that's present. When you successfully eliminate the parasite, the fatigue is gone. There is a direct relationship.

I've been working with that now for four years and I'm actually convinced that this parasite is present in most people with chronic Lyme disease and should be treated first. The way we're treating is two-fold, one we create a liposomal worm cocktail. We use an herb that unfortunately, the last time I even mentioned it only at one of my courses, the entire stock in the U.S. is bought up and no longer available because the

sources have immediately dried up because there is not enough production. So I'm not going to mention it to you Joe.

There is a medical drug that comes close to it. It's a cocktail of ivermectin. It's the key ingredient for the lungworm. We use a high dose of 12 mg two to four times a day. We put that in the cocktail and then make it liposomal. With that, it would have a huge effect on the lungworm. In addition that we let patients inhale SSKI, that's potassium iodide. It kills the parasite on the surface. That is important. It has become a hugely important first step to eliminate the lungworm from the patients.

With that everything changes. People feel better. They have more energy. Their brain gets clearer long before we even get to treating the Lyme disease. So we do the parasite thing first and then we do the cocktail for the Lyme spirochetes and Babesia, and Bartonella.

DM: That is interesting. I just read an article today or yesterday that noticed an observation that in Africa when they put patients – I think it was some type of parasitic infection. I think they called it river blindness in Africa. They treat them once or twice a year. I think once a year and they're trying it for twice but they noticed that the communities where the individuals were treated that they radically reduced the incidence of malaria.

DK: Absolutely. It's the same here, you know, the relationship between parasites and Babesia is the same as the parasites in Africa and malaria. People that have parasites don't have defenses against malaria get malaria. They eliminate the parasites and the malaria has no chance of finding fertile ground in the patient.

I can tell you Joe how effective this strategy has been. On my website you'll find my most sophisticated medical parasite protocol, the different drugs that we're using for it. It's good to know once we secure like the one herb that works so fantastic, once we secure like a pipeline that comes from the Himalayas and there is a limited growth but once it's there, it's going to be much easier to treat a lot of people in the natural way which is my goal with this. It has to be natural.

The last step that we do is the treatment of the viruses. We dealt with the parasites. We addressed that. We try to get positive lab tests. It's very difficult in the U.S. Maybe I'll say something to that also – why doesn't everybody know that they have parasites? I ran a parasite lab in India for two years. I worked with one of the top parasitologist in India together and I was running the lab.

It is a ground rule in parasitology if you want to find a parasite you have 20 minutes from the moment the patient has a bowel movement to finding it in the stool. After 20 minutes, most parasites use a process called autolysis. They release an enzyme that completely makes them disappear in the poop. What do we do in the U.S.? We collect the poop. It sits around in a shelf then it gets send by mail to the lab. Three days later, a lab technician looks at it. It's a joke. Whatever we're still finding is a miracle.

[----- 1:10:00 ----]

We don't have parasitology in the U.S. We have no available reliable test. I know MetaMetrics is trying to do a DNA based test that has a little bit of a higher detection rate but the false negatives are so bad. The way we diagnose parasites, we put people on the treatment and then look visually in the poop. That's my diagnostic test. Most of the time we can document the parasites.

A last word to that, many of the parasites are not microscopic. They are embedded in the same biofilm that the Lyme spirochetes are embedded in and they are harder and harder to detect with the eye. They're constantly mutating the outer surface proteins. They're very, very hard to detect in any lab test. We pretty much very often have to assume the patient has parasites, treat them and then judge by the clinical success that that's what it was and it's huge.

We start with the parasites then we launch into the Lyme cocktail as I call it, the liposomal mix of things. And then the last thing that we do is addressing the viruses. It's important to know there is some good evidence that artemisinin in liposomal form is very effective against eczema (indiscernible 1:11:22) the new suspected cause for chronic fatigue.

Many of the herbs that we're using are antiviral and we have a viral tincture that BioPure makes for me. It's called Viressence where we put the key herbs together. There is a Native American herb in there that's very, very for most of the fatiguing viruses that we're dealing with.

The basic principle with viruses is you cannot treat a virus with viral killing agents. We have to treat viruses indirectly. This is now where the diet comes in. This is where sometimes the methyl-B12 injections come in. This is where other strategies come in. We have to treat insulin resistance which we use Jonathan Wright's new protocol for insulin resistance which is fantastic. He dug up the literature on it.

We give people one gram of niacinamide three times a day and berberine that's basically Oregon grape root. We have that in tincture. It's called Viressence. It's two drops of it three times a day. That's over four months, one hundred percent successful in treating insulin resistance.

Just one word to that, you know, Joe Borescano published it a few years ago that virtually the main known cause for insulin resistance that we find has nothing to do with the things that Mercola with Lyme disease. Lyme disease induces insulin resistance. How do we know that? When we treat Lyme disease successfully the insulin resistance is gone.

Now, Jonathan Wright came up with this beautiful simple protocol that he dug up in the literature. So far it's been a hundred percent successful. What I want to say here pretty

much towards to the end of the interview is like if you have a Lyme disease patient and you treat the insulin resistance every else is going to go easier.

DM: Would that mean the clinical conditions typically associated with the insulin resistance which would be obesity, diabetes, high cholesterol, hypertension?

DK: The amazing thing in the Lyme group is there is a subgroup that has severe insulin resistance with high insulin levels in the morning and all the things and the skinny vegetarians they try to exercise as much as they can. They do all the right things and they still have the insulin resistance. They have a completely different expression of the things we normally associate with it.

So insulin resistance, I mean, I know it's a whole other topic or so but it's a huge part of the treatment of Lyme disease is handling insulin resistance. With that usually all the arthritic symptoms go away and the fatigue greatly improves and the sleep improves. Things that we normally don't associate with the insulin resistance improve dramatically. Jonathan Wright showed us clear evidence in the literature that osteoarthritis is an outcome of insulin resistance which I didn't know.

Thanks to Jonathan this has been a beautiful treatment addition. I found Italian literature – I mentioned that in one of my talks with you years ago that niacin has been found to be a very, very effective antibiotic against Lyme disease so there is a link. Niacinamide has the same antimicrobial activity as niacin has.

DM: But they're different, niacin and niacinamide because the niacin will give you the flush and niacinamide won't.

DK: Yeah. But the antimicrobial effect has been shown to be identical whether you use niacin or niacinamide. Nobody knows really how that works but they did culture experiments and both have the same…

Maybe I'll say something to this. There was a cluster of outbreaks of beriberi disease in Italy which was treated with vitamin B3 (niacin) and the illness went away. So it was concluded that it was a niacin deficiency because it goes away with niacin it must be a niacin deficiency. Years later, researcher came in and said, you can't really do science like this. Let's look what these people really have in these clusters in Italy that have the vitamin B3 deficiency symptoms. They did tissue biopsies and found all of them were infected with spirochetes.

So they realized that the high dose niacin with a gram three times a day was a very, very effective treatment for Lyme disease and then we looked up in the literature and found that niacinamide has the same anti-microbial activity. So treating insulin resistance it's interesting with Jonathan Wright's new cocktail also covers the Lyme spirochetes to a large degree. It's a beautiful thing to add in. There are no side effects from it. It's been a wonderful additional (indiscernible 1:16:26).

DM: How long have you been using it?

DK: I taught a seminar, A Deep Look Beyond Lyme Disease which I recommend by the way everybody gets the DVDs or the course handout because all my tricks are in there and that's the first time I introduce it. That was maybe four months ago.

DM: So it's relatively new?

DK: I used it for about a year but it took about eight months for me to really speak about it with authority.

DM: You're always on the leading edge. It's great to have this information but if we come again next year and talk about Lyme disease, you're going to have three or four new updates that are really pretty groundbreaking. Let me just state to that effect that it's not making it more complex. I mean the beauty and the elegance of your approach is that it's all about simplification using natural methods. So it becomes simpler and easier not more complex and harder which is the traditional path that most physicians go towards.

DK: There is another side to it. I have been at this now for 36 years but the more narrow the Lyme treatment is in the last couple of years. It is clear that with this approach we are also addressing Parkinson's and MS and chronic fatigue and illnesses that are not on the surface associated with Lyme disease. We treat a lot of children. Half of my practice is now autistic children. We put them with the same treatments and with fantastic results and they get their life back.

It just became my sort of my window into medicine or into life to approach medicine from that way. Believe me, once people get better, they get put on the exercise program and they get put on your website to learn how to properly exercise and how the different dietary things that you so wonderfully explore. That's sort of all over the world. I have a following in Germany, in England, Switzerland. I direct them to the website.

Once they're through the initial eye of the needle, narrow of treatment of infections, we release them basically into your hands to take them from there and to the greater levels of health. That has been wonderful rewarding journey.

DM: It is and it's interesting that – there is a similar analogy in traditional medicine where they'll – just take diabetes for example and they got these oral hypoglycemics, these agents that are designed to lower blood sugar which is only a symptom but in now way, shape, or form the cause of the disease. Because you're not addressing the cause, they get other diseases. They get heart disease. They get cancer because they never looked at the underlying treatment.

Similarly with you, you're not treating symptoms and unlike other physicians who are essentially treating symptoms by giving them antibiotics and it does give them partial

improvement but it's not addressing the cause so when you address the cause, you're not only treating Lyme but you treat all these other diseases that you mentioned.

DK: Maybe one of the last words, I do not want to put the antibiotic approach. There have been times with our patient where we used antibiotics maybe for four or six weeks not for six years. I do feel that ILADS, the group that promotes the very vigorous treatment of Lyme disease.

[----- 1:20:00 -----]

ILADS (International Lyme and Associated Disease Society) is by far the most responsible and best group where really I've learned a lot. I do recommend people go on that website www.ILADS.org and learn everything about Lyme disease that's known. Depending on where you live in the U.S. consider the treatment that is offered to you through a Lyme literate physician. Most of them have been through the training at ILADS and I do recommend that. But there is a level beyond that which I'm hoping I'm introducing here. If you just do antibiotics, okay, you just do antibiotics.

But if you think more holistically you do the things that I recommend and then you no longer need to resort to antibiotics because you cover the system on so many other fronts and with that you're not only treating Lyme disease but you're preventing cancer, you're preventing diabetes, you're preventing Alzheimer's disease, you're preventing pretty much all the other things that we didn't know were associated with Lyme.

So by treating the mold, by getting electrosmog under control, by treating the infections, by treating insulin resistance, we are preparing the patient for much happy and healthier longer life and more productive life which is of course what I'm hoping for that everyone who has been ill becomes an advocate for our environment and for sane living which we need desperately right now.

DM: Also just to benefit from your experience it seems very foolish even if you're embracing the antibiotic concept which many people who listen to this will to ignore the years of experience you've had that unless you address the mold and the electrosmog issue, you're just not going to get better whether it's your therapy or anyone's therapy. You got to address those first. You're just wasting your time, effort, and energy and resources unless you follow that advice and it's going to be good even if what you say is wrong which I don't believe is the case but even if it was, it's still going to help you in another way. There is no negative to it.

DK: Let me say one thing here. I had a fantastic teacher in classical homeopathy while I was going to medical school. At the end of one session, he introduced like the 50th remedy with all the details and I said, Dr. (indiscernible 1:22:25) all these remedies look the same to me. Like they all have the same kind of picture, little different shades here and there. They were all the same. He looked at me and he said, you know, if you give the patient one wrong homeopathic after another, after another, the input to the immune

system, the challenge to the system will be such that the patient gets well with all the wrong remedies.

I took that pretty much into my life as a physician that even if they things that I'm doing are in the moment maybe the wrong thing for the patient it still will lead him to higher ground on the long run and it has been absolutely true.

Of course we're not God. We're not trying to be God. We're doing the best that we can. Very often, we do thing that maybe unnecessary for the patient or maybe the wrong timing for this particular treatment and the patient still get well. The system is very forgiving.

DM: I think the reason it is so forgiving is because you're focusing almost exclusively on natural therapies. If you're using the conventional approach – and the antibiotics are certainly a part of them especially Cipro and these fluoroquinolones that are toxic and can kill people.

We over 100,000 people every year, that's a large number, who die for appropriately used prescription drugs, not abused, not overdosed, just given at the right doses, they die from them. That's the risk when you go with that model. When you go with your model, yeah, it may not work but at least you're not going to die and most likely you're going to be catalyzed on the path of healing.

DK: There was a time – I mean, I have to say (indiscernible 1:24:13) there was a time when I thought I would kill everybody by putting them on long term antibiotics and I was amazed if antibiotics are used correctly like ILADS is teaching. How actually relatively safe it is. But it's not aesthetic. It's not elegant. It's not in keeping with the Earth. It's not fulfilling the yearning of the Earth that we work with the Earth together with the things that are offered to us by the Earth.

I think my approach certainly comes from that, you know, wanting to be part of the Earth and not like the superimposed parasite that lives off the Earth but doesn't give anything back. We're looking at more like how can we live in harmony with the Earth where the Earth benefits from us and we benefit from the Earth. The approach that I lay out in the recorded meeting, "A Look Beyond Lyme" is certainly, it's in keeping with that.

DM: My major to using antibiotics is my new deep found appreciation for the gut ecology. I have certainly known about that for a long time. It's just being kind of even more importantly obvious to me that once you disrupt that flora, you're really exposing yourself for a whole risk of potential pathology.

The newest appreciation is this risk exposure to autism. Dr. Natasha Campbell McBride has done some of the work. She's Russian neurologist who has an autistic child. She found in her experience that it was this disturbed gut flora in combination with other predisposing factors like vaccines that really contributed to it.

If you've got these people who are on antibiotics for months, even though they are on a safe protocol, there is no question you're disrupting their gut flora. So you have to address that in some way. I suspect that's part of their protocol. I haven't looked at it but it's still a problem.

DK: Absolutely. Maybe one thing to that, I know that you have a new probiotic that I'm excited about. It's amazing when you think we have 400 different species of microbes in the gut and the best probiotic that we can buy has maybe two of them in it. How about the other 398?

In Germany we have a couple of products that have some healthy E. coli in it. That's three species. We got acidophilus. We got bifidus. We got a couple of healthy yeasts and we got coli. We got maybe five species of the 400 that we can actually calmly give to the patient with your product. Maybe there is another five.

I think one thing that we're really struggling with in our medicine is that the probiotic science sort of in a way, I'm sure you agree with me is at the very beginning. We can do the best there is right now.

DM: Probiotics are supplement. I mean, ideally you use a fermented food that has been used for ages in many cultures. There is a whole variety of different ones. That's really the first approach. And then not putting weed killers into your system like the sugars which kill them or antibiotics or these other factors, birth control pills that really disrupt that.

I think part of the reason, even if you go to supplements is they tend to work is that when you combine them with the dietary approaches you limit the growth of these bad populations so that eventually they don't suppress – it's sort of a competitive inhibition, the process that's going on. The other ones, even though they haven't been disrupted completely they give an opportunity to grow. If you remove most of the weeds then the good guys can grow.

DK: As you know, I was raised in sauerkraut.

DM: That's phenomenal. That is like one of the best fermented foods. I'm actually culturing some right now in my garage.

DK: You got to watch out you may start dreaming in German.

DM: It is a very powerful food. It's relatively inexpensive to make. It self cultures.

DK: I got to come visit you again Joe. I have no idea how to make sauerkraut but I grew up on it. It was the poor people's food. That's what poor people fed their children if they didn't have anything else. We could always get sauerkraut.

DM: One of the things I have learned that the Dr. McBride teaches is to use some of the sauerkraut or the juice from the sauerkraut right before you eat. It's a very powerful way to enhance gastric acid secretion. It's a massive problem for most people, is stomach distress that's why they're taking so many antacids and anti-ulcer drugs. So a powerful way to do it. It's simple. It just re-balances that gut flora but it also improves the whole function of the gut. It's massively important.

DK: I agree with you. I heard you say this but I think it's true. We pretty much know everything that's going on inside the cell. We have no idea what's going on inside the gut.

DM: It is so key. That is just phenomenal. I'm particularly intrigued with this new liposomal system that you've got going and the implications, my mind is spinning because it's massive. The potential is so massive for what it can do in so many of the different areas. We know one of the hottest things from the nutritional side right now is this liposomal C.

DK: You can make it in a blender for a fraction of the price it costs you elsewhere.

DM: The liposomal C is so useful even at the higher price because it's still better than the intravenous vitamin C that most of the alternative medicine physicians have used. We both use it in large quantities and that takes a long time and you've got to go to the trouble and hassle of getting an injection and go to the physician's office. It's not comfortable. But the liposomal can be every bit as effective or potentially even more effective.

[----- 1:30:00 ----]

DK: There is a lipsomal explosion going on as we are speaking that it is so easy make that was a big breakthrough for us. That we can take anything that shows up in our field that works for Lyme disease. We can make it work 20 times better for making a liposomal in a blender next to the kitchen sink.

DM: How did you develop that? Was that something you learned from someone else or you just figured it out by trial and error or muscle testing?

DK: I figured that one out by listening to the vitamin reps at the different conferences, putting different sentences together from different researchers how they're doing it. I realized there is no special science in that. It needs a blender and it needs an ultrasound unit to vibrate it at the sound frequencies that makes smaller and smaller bubbles. That is a not 5000-dollar piece of equipment that's needed for that.

I don't want to put the liposomal products down that are done somewhere in a pharmaceutical place or so. They may be a fraction more effective than the self-made ones but the cost-benefit ratio is so dramatic. Bio-Pure has a liposomal C that's

excellent but I like to make my own in the kitchen sink. I like to take a teaspoon of vitamin C and put it with the liposomes and have a huge effect on it.

Like flues are non-existent since we know this. You take a teaspoon of vitamin C and a tablespoon of the lipohealth powder, put it in a blender, put it through the process and two hours later, the flu is history.

DM: What type of vitamin C are you using? There is a whole argument. Do you use ascorbic acid or the calcium ascorbate or the salts of the vitamin C that any more beneficial than others?

DK: I use a product that has a lot of the natural co-factors in it. I don't want to actually say the name because it's a commercial available product that's used for people suffering from allergies. It has some quercetin in it and some of the typical flavonoids and other things from (indiscernible 1:32:23) and from some of the natural…I do strongly feel that the co-factors of vitamin C are just as important as the vitamin C. However this is for the long run. For the acute run, just straight ascorbic acid works.

DM: Will work.

DK: Will absolutely work. For the acute flu, there is nothing like it, you know, just a teaspoon of vitamin C. You get an effect of 10 to 20 times more. So 5 grams of vitamin C which you typically have on a teaspoon turn to 50 to 100 grams of vitamin C in terms of the effect. That's the effect of a really strong IV or more.

DM: Yeah because an IV is typically 25 grams at least in one ampule. I mean you can certainly put more but if you're taking 50 or 100 grams, it's going to take you four hours to run that IV.

DK: It takes forever.

DM: The other element that I'm sure you can affirm is that when you do the – one of the side effects of oral vitamin C is diarrhea once you get to a threshold dose. When you have a liposomal function because of the absorption it bypasses that. It goes right into the blood stream and you don't have any diarrhea.

DK: It's long absorbed before it can cause diarrhea.

DM: If it's causing diarrhea then you don't have a liposome because it's not working.

DK: Exactly. That's how you can test it.

DM: It's great. I guess from a person who is a typical candidate you're seeing or people you have seen that are applying these strategies in a diligent fashion where they're really taking to heart what you're saying and really being good about applying

the principles. What type of percentage of people are you seeing improve? You see probably the worse of the worst.

DK: Typically when we start somebody on a protocol we expect the first two months to be a little bit rough. They go through different die off of parasites and spirochetes and other things. We expect already after four months to be the patient on higher grounds sometimes it takes – usually I only see patients only once every four months so on the second visit I expect them to be on higher ground. In between the second visit and the third visit, four months later, two weeks, much higher ground.

Now, of course I'm specializing in the failures of everybody else so I have my friends in the Lyme field send me there, difficult patients. Difficult patients are also difficult for me. I'm not going mince words with that. The difficult usually arises because the patients are financially at the bottom and they don't have any help anymore. Their husband has long left and when I send them back and say they need to mitigate the mold, they don't have the means either psychologically or mentally, the strength, the will to translate that into action.

The typically chronic devastated Lyme case that we see is often not able to mitigate the mold and mitigate the electrosmog. So my preconditions are not meant. With these people, we struggle at first. We have to get them biochemically better in spite of the continuing offending influences at home. We have to get them biochemically better to where their mind functions to a degree where they developed the will again to put the things in motion that they to have a healthy home and they do continue to improve.

That really is our main obstacle. It's the practicality of it. The changes that people are asked to do in the beginning are massive and absolutely necessary. It's not like me being willful to the patient, unless you do what I say, I'm not going to see you. Actually, it's necessary for the chronically ill patient. Mitigating the electrosmog is an absolute must, mitigating the mold is an absolute must. If the patient doesn't have the support system around them to put that in place, those are the patients which struggle.

Occasional, of course, patients will do everything right and we still don't get them well. It's rare. That's of course life. These are usually my teachers. Patients are there to teach me something I don't know yet. I'm open to that and I don't take that personal anymore. My ego has long been gone, has long been destroyed. I don't take those things personal but I recognize some of my patients as my teachers, you know, the difficult ones that need a unique rout, that at the end looking back probably would have taught me something new and that's how new things come about.

DM: Because I have had a personal struggle with mold in my home I have done research and interviewed a number of experts in this field including Dr. Doris Rapp. Some of those articles would be appearing shortly. There are some resources that we'll have for people in addition to the Ritchie Shoemaker one you mentioned earlier who I'm actually going to contact and see if we can interview him.

What I just wanted to mention is that you're right there is no question that that mitigation process can be quite expensive. In my own you spend like $30,000 to do that maybe a little more. It doesn't have to be that expensive if the problem isn't that big but typically it can be and in many cases, really the home has to be demolished because you can't just remediate it. And the person might have to go and rent or do something. It can be a big issue.

We're going to provide some more practical strategies and hopefully – because everyone really needs to address this, to look at these hidden factors because this mold can be insidious and if you catch it in an early stage, it's just like prevention, it's going to be easier and far less expensive to treat but if it goes on for awhile it just grows and it just damages and it destroys. Before you know it, you have to rip out half your house.

DK: We taught by the way a couple of years ago with a seminar creating a healthy home and we have excellent mold experts in there. Also for the listeners here they may want to review the whole seminar, the whole three day seminar. It's going lecture after lecture on the aspects of toxicity in homes focusing on the mold and what to do about it where we have some of the leading experts in the there.

It's just the thing where we all need to become cognizant and informed about. Basically, the core problem in America is, okay, we 400 have million people now and you may only have room for like 50 – half a million in terms of healthy homes. There isn't 400 million healthy homes in the U.S. available for 400 million people. There isn't because most of the homes in the U.S. are built in a way they have become moldy after a few years. It's a devastating thing. It's something that brings America down on its knees.

In Europe, in Germany we have red brick buildings. It's a stone that breathes. For buildings to become moldy is an exception. Here it is a rule. It goes back to the Roosevelt years. Roosevelt wanted to create a building code that every American can have their own home.

[----- 1:40:00 -----]

It came from a very noble and good place. However, we have to count electrosmog environment. It makes each home a mold growing apparatus. It's a tragic development that you need to find a solution for. It isn't out there yet, the simple solution that everybody can afford. Maybe one thing, we use a propolis vaporizer.

There is an Italian study that (indiscernible 1:40:28) when you vaporize propolis at 82 degrees Celsius. It creates a mono-atomic vapor that bonds to mold spores that makes them heavy and they fall to the ground and can be vacuumed off.

DM: So this is not something people would swallow or inhale. This is something that was a treatment for the house.

DK: It's a treatment for the house. There is a website where we can get this stuff. It would be nice if you get it on your website.

DM: Sure. But the key thing I just want to emphasize is that unless you identify and remediate against the source of water intrusion into your home whatever killing mechanism you have, however good it is, ozone or whatever, it's just not going to work in the long term. You cannot kill all spores. It's like trying to clean and sterilize a root canal. It's like physically impossible. There is going to be some residual ones in there and as soon as the moisture hits it's going to start growing and you'll have a garden in there before you know it.

DK: The mold like I said is growing now at a much faster rate than it ever did in the history of the planet because of the electrosmog. There is a synergistic effect between the two.

DM: The catalysts. I just am really grateful that you are so committed and always expanding the window of knowledge in this area because there is really not a lot of people like you. You're a teacher too. You are a very eloquent communicator. You've really created a body of knowledge that is available for others to learn.

Unlike many people, you're out there regularly teaching. We'll have a link to the seminars that you have. In case, for whatever reason it's impractical for people to attend you've also record those seminars and there is DVDs and there is books and lectures that you have. If anyone is interested in what this discussion has been about and you want to learn more – because we can go on for 8, 10, 12 hours. Because we have only covered – I mean we touched the surface. And if you think you know it, as I said, you come back in a year or two you're going to have loads more to share. That's really the fun of having dialogues with you because you're always coming up with new information.

Let me encourage anyone listening and who are watching this to access the resources for further information because there is really a lot more out there that we have not covered. It's just impossible to do it because there is just so much information. That's my closing words. Do you have any closing words you would like to comment on?

DK: Just that for those people out there that are ill, please don't give up. We're so close to finding really good and practical solutions for all these things. Hang in there. I give all my recipes on my website www.KlinghardtAcademy.com.

Joe, you have been a phenomenal resource for the whole, really by now, with the information you give people. There are so many others out there now that are on the leading edge and just kind of know sort of we can't wait right now for studies to come out. The illnesses are moving faster ahead in the universities and the conventional science community can follow. There is a few of us that try to translate as quick as possible what we see, what we know, what science has learned into practical action and just keep your ears perked and keep open.

The physicians are now out there. We are in a blessed country in a way here in the U.S. I live here by choice. You live here probably by necessity but I live here by choice. It's a fantastic country and the level of communication, you and I. That wouldn't happen in Germany or somewhere else. We would kind of be model enemies sort of talking bad about each other because we are in the same business.

Here in the U.S. we have a synergy of practitioners and healers (indiscernible 1:44:23) and scientists that work closely with each other. I do think we're going to find solutions quicker than the problems arise. Thanks to the internet and to the communication media. I think there is hope for all of us.

DM: Let's hope so. Thank you again. Again, if you're interested in further information, we'll have those resources for you in the links.

DK: Goodbye.