

Due to the possibility of an overwhelming number of direct inquiries, the doctor (D.O.) who presented this discussion has requested that his name be withheld. At this time he works as a medical director of a multi-specialty clinic with ongoing clinical research projects in cellular regeneration. He is the former chair of the department of Osteopathic Medicine at a highly recognized medical school. He has taught at other medical schools throughout the United States. He has also authored a book on the immune system, as well as articles published in a major medical journal.

SESSION 1: Discussion on Organo Mineral Complexes (Ionyte)

Taped presentation Sept. 5 & 6, 2003

I want to share with you some of the clinical things I have been doing in my clinic because **I deal a lot with minerals**. Minerals usually make a big difference in so called chronic pain situations. That's why I have such success, because we help 9 out of 10 patients who walk through the door with chronic pain. Very few of my colleagues can say that, especially my MD colleagues, because they rely upon narcotics often times in these kinds of situations. I can't even tell you how many times I have written a prescription for narcotics so far this year, but I know that it would not fill up one hand worth of prescriptions.

So nutritionally, many, many things can be corrected in the body and what is grossly unappreciated is the impact that minerals can have. Osteoarthritis and arthritis are two different things. **Arthritis** simply means that you have an **inflammation of a joint** capsule. I get teenagers in who have football injuries from high school and so forth and they have arthritis because they have hurt a shoulder or have hurt a knee or something like that. You can call it also a sprain or strain, but there is an inflammation of the joint capsule. **Osteoarthritis** means that we actually have a situation where the bone has undergone some degenerative changes. So, whether we talk about arthritis or we talk about osteoarthritis, **all of them respond positively** when you correct the mineral content of the body and you change the internal pH—how much acid and alkali there is. Joints do not change unless there is a change in the pH into the acid range—and the acid range is acidic. So we can **alkalize the tissue**, a lot of the swelling will automatically disappear. If we can **provide the tissue then with the correct minerals, it will self correct**. The **osteoarthritis will stop** in terms of progression. If the osteoarthritis started in a younger person, in their lifetime they will see some remodeling where they will lose some of the knobiness to the joints, but in older individuals of course, if you are say 75 years old, chances are you are not going to live to 110 years and say that, “Oh, now I don't have knobby knuckles anymore.” It takes the body time to remodel these things. But if I have a patient who is in his 40's or 50's, who has that kind of arthritis already and he has hebreeding nodes and things like that—if he will make simple modifications in his diet, (I give patients often times acid and alkaline food lists) and take their mineral supplementations—no more arthritis.

Different minerals exert different effects. For example, if someone has creaky joints when you are actually holding the patients hand or feeling the joints and the joints are going, “eh, eh, eh, eh” it means that they are low on calcium fluoride. Yesterday I talked about the fact that there are many, many different kinds of calcium. Calcium fluoride is a very unique mineral in the body, in my mind. Where do we find it? We find it in the dentine of teeth, which is the hardest substance in the human body. Teeth will bite right through bone and we find that it is part of the matrix of elastin protein. What is elastin protein? Well if I lift up my skin and hold it up, it pulls up where I am pulling it and I let go—it bounces right back to where it was, doesn't it? That is controlled by elastin

protein. Calcium fluoride is part of the matrix of that protein. So if I am low on that form of calcium, that tissue begins to change and it manifests as a lack of deformation/ reformation and you can perceive it as creakiness in the tissues, especially around the joints where you have lots of motion. So all I have to do is, add to their regimen a small amount, a very tiny amount, because—what did we learn yesterday—**less means more**. So I don't want to suddenly blast them with a bunch of calcium fluoride, because that would be very, very distressful to their liver. All of a sudden, they will come back on their next visit, a week or 10 days later and they'll say, "You know what? You're right. I feel more flexible, it's easier to move."

Well, when we look at certain products for example—a product that is an **organo-mineral complex (Ionyte)**—what is really interesting about this product is that we can take many different kinds of clinical scenarios and the product will dramatically help the patient. You will say, "But how can it help a patient with diabetes, and a patient with osteoarthritis, and a patient with rheumatoid arthritis, and a patient with irritable bowel syndrome, and a patient with chronic fatigue syndrome?" You say, "How is that possible?" Let's talk about **diabetes** for a moment. Why would it help a diabetic? Why is it that I can give an organo-mineral complex (**Ionyte**) to a diabetic patient and I know that after a certain period of time, as I monitor their blood sugar and their urine sugar, I know that I can start to decrease their insulin? If I keep them on it, I may even get them off insulin or if they are on one of the oral glyceic agents (they are easiest to get rid of). If the pharmaceutical companies that make those drugs knew how often I am taking patients off, they would probably send a hit man. Because I get every patient that comes to see me, who's on oral glyceic agent, I get them all off. Why? Because if you understand how the physiological mechanisms work, all we have to do is, modify how the cell membrane is behaving through the foods they are selecting, the supplements they are taking, and the cells respond. What happens in diabetes is that we develop insulin resistance. What does that mean? It means that as the pancreas makes insulin to control your blood sugar level, the insulin can't find a site to plug into on the cell membrane to get the sugar out of the bloodstream into the cell. Because if we get the sugar out of the bloodstream into the cell, only one thing happens to that sugar—it's converted into ATP—your little energy packet—to drive whatever the enzymes are wanting to do; to do whatever the cell wants to do in terms of helping itself, helping its neighbors within its community of fellow liver cells, fellow pancreatic cells, fellow cardiac cells. The cells live in communities. If I can modify the cell membrane and provide it the different minerals that drive the enzymatic reactions, insulin works just fine. So what I have to do is, I have to put patients on high doses of omega 3 fatty acids. Why? At least in the United States the American diet is way too high in the omega 6 fatty acids. Why? Because back in the 40's and 50's they found that the quantity of lard consumption and tallow consumption was having an impact on coronary artery disease. So they said, let's go to vegetable oils, because they function differently in the body—which is true. The problem is that omega 6 fatty acids, like corn oil (that's one of the most common ones used in the U.S., because we have a corn belt which produces a lot of corn), is like building a house with no windows and no doors as cell membranes are constructed of that fatty acid. It is hard to get things in and out. So we have really tough membranes, and we have very difficult exchange reactions. When we are talking about diabetes, glue bodies or the little things that the insulin plugs into. They are synthesized where? Where are they constructed? At the level of the nucleus of the cell—that means they have to be transported to the underside of the membrane, inserted through the membrane so that the insulin from the outside produced by the pancreas, can come along and plug into that molecule, open up the channel, and glucose flows from the blood into the cell so it can change into ATP. That's the process—very simple. But if I have no windows and no doors, how am I supposed to fit the glue body through, so the insulin can plug into it, so we can

bring all those pizzas and pies inside the house of the cell? Now in addition to that there are certain minerals that are associated with this process. Chromium is a very important mineral in this process. In organo-mineral complex (**Ionyte**), these are several forms of chromium. Vanadium is another mineral that is involved with this process. In the OMC (**Ionyte**), we have different vanadium complexes. Plus, yesterday I said that with the OMC (**Ionyte**), the carbonatious ones, we have how many ways for those to get into the cell? **Six!** And with the oxy ones—how many do we have? **Seven!** And with most things, like a mineral salt, we have? **One!** Do you begin to understand the dynamics of **how powerful this kind of product is?**

So as a consequence, I start a patient on high doses of omega 3 fatty acids and I start them on OMC (**Ionyte**) and it doesn't take long before—if you don't modify their insulin level—they start to have hypoglycemic reactions. Why? Because the cells start to take the glucose in, and now they have too much insulin, so now you have to drop it. As they continue to take it and more and more cells begin to recuperate and say, “Wow, finally I can get this dog-gone glue body out there, so that we can get this glucose in here. Before I kept sending signals to the brain that says we're starving, would you please go and find some food?” And yet, your blood sugar levels are 300, so what does the body do? The body, after you eat, gives you 3 or 4 hours to do something with that food. After 3 or 4 hours, the brain says, “Blood sugar, sugar levels are too high, obviously we were mistaken, the cells aren't calling for that much food”, so it initiates the conversion process and the sugar is turned into triglycerides. Triglycerides are fat—so the body stores it as fat. If we can get the glucose from the blood stream into the cell, it is never converted to fat. Never! **Only to energy!** So that's one way I've been using the OMC (**Ionyte**).

Now in south Florida, we're called the Sunshine State. You can tell from my Celtic background and my northern European background that the sun and I don't interact a great deal. We came to an understanding about that a long time ago. But I see a lot of people from the north. In the town I live in, there are between 50'000 and 60,000 Canadians that show up here in November, and they hang around for a number of months. I have a fair number of Canadians in my practice, mostly from Eastern Canada, Ontario and Quebec. They get sun burnt, and **sunburns** can be to the point where they develop blisters. With the OMC (**Ionyte**), all I have to do is apply it topically and have them repeat that—the sunburn does not go to blistering, it will disappear. They will still often times have some skin flaking, but you cannot see any obvious damage to the tissue. Versus anything else that I have ever used, there is sun damage, which is called “actinic” damage. I've had a couple of female patients who have come in, that have had **burns** on their hands from the oven or the stove that had already started to blister and so forth. The moment that we start to use the OMC (**Ionyte**), the blister will recede, so that usually by the next day you see **no blistering**. So those are two different kinds of burns and they respond very well.

I have used it with patients who have **psoriasis** because I've gained a bit of a reputation for that. I've taken some really severely horrible cases of psoriasis. I have some other equipment in my office that I have specifically developed. I have something called a “harmonic laser” that is very good at helping to signal cells to what to do to help repair themselves. You see, cells communicate in many different ways. I tried to convey that to you yesterday. There are many different ways that cells communicate. Light is one, vibration or sound is another, and electromagnetic fields are another. I use these in my practice to help cells understand what they need to do to cooperate with one another to correct things. So I've taken patients who have psoriasis so badly, that the joints in their fingers (where the folds are) are cracking with the movement and weeping lymphatic or clear fluid—the skin is raw and feels like sand paper. They've gone through cold tar baths. They're using topical and oral steroids, oral chemotherapy agents and ultra-violent light treatment and they're not

making any progress. I start them on OMC (**Ionyte**) **topically, orally and by injection**. I'll do some intravenous. Within a week, they can move their hands. There is no more cracking. They require about 10 treatments. I had one patient, an elderly Chinese gentleman, who was really in bad shape, come to me from the University of Miami, where they worked with him for two months and he was not making any progress. He took 11 treatments. His skin was still bright pink, but as far as his family was concerned, I had cured him. I don't use the "C" word myself, but that's what they said. So it works really great for that. Now, with the psoriasis patients, what most people don't understand because it's not in the medical textbook, and some of my gastro neurology friends might ask, "How do I know this?" Well, I know because I do physical examinations of my patients, and I find where things are malfunctioning. Every psoriasis patient has a gut problem. They are absorbing toxins they should not be absorbing. They are absorbing molecules of size they should not be absorbing, and the skin is trying to get rid of these toxins and the skin reacts. We only have four ways to get rid of toxins or garbage from the body. Perspiration, respiration, urination, defecation, and that's it. There is a fifth one that the body does, and that's called surgery.

I've also used the OMC (**Ionyte**)—just to make sure you understand: **it stops arthritis**. I've used it with patients who have had an injury to an area. They may have re-injured that area and what happens is, the cells lose their internal content of trace minerals in the repair process. Whenever we have a trauma to an area; whether it is from a motor vehicle accident, or being clipped by someone on the football field, or someone coming down from a shot while playing basketball and their elbow smacked their opponent, or here in Canada, they got beat up in the hockey rink. When tissues are traumatized this way, they have to go into overdrive to start to repair things from scratch, so to speak. So as a consequence, they use up all their internal resources for mineral content in the construction of whole new enzyme systems. So the tissues are repaired now. It looks like they got it back, but then they go back and they will injure the same area. And you say, "Why? Was it bad luck?" NO. Usually it is because that tissue is still weaker. It still did not fully recover, and yet they went out to play as if nothing was wrong. That is why there is a lot of re-injury to these things. Then they are side lined for X number of months, and the body is just not repairing itself. Why? The minerals are not there for the enzyme systems to work. If I don't have the minerals there, enzymes are like a hot-air balloon. They're there, they're moving, and they are doing something slowly. If I add in a co-factor, which is a mineral, which is usually a trace mineral, then all of a sudden I am in an airplane. Now we are definitely getting somewhere. When I use an OMC (**Ionyte**), the enzyme activity increases an incredible amount. It is difficult sometimes to imagine that kind of increase. How much money would you say you have in your purse or pocket, \$40? And you need \$97, O.K. The reason I am asking is, that with \$40—your enzyme system can accomplish a certain amount in a, 24 hour, period of time. With \$97, you can accomplish twice the amount of work in the same amount of time. When I use the OMC (**Ionyte**), $\$40 + \$97 = \$137$. So if I took what that cell has and what this cell has and put them together and let them just die, now, because I have \$137, I certainly can do things better than those two cells. With the OMC (**Ionyte**) we increase enzyme activity a billion times. Do we have a billion dollars in this room? No. Can you imagine if you could suddenly bring in a billion dollars in this room? What could all of you as cells do with your lives? So when I look at tissue repair rates, I use the OMC (**Ionyte**) in post-operative patients. In south Florida, we have a fair number of plastic surgeons, and I know ahead of time that some of my patients are going in for **surgery**. So, I start them on an OMC (**Ionyte**) supplementation. And I say to them when the plastic surgeon finishes the surgery, he and his staff will be **astounded and amazed** at how quickly you are going to recover, and they will come back to me and say, "You're right, they can't believe how fast I am repairing. They can't believe how quickly everything is

looking so great. I am their wonder patient.” Why? Because, **minerals are what we need for our enzymes to work efficiently!** When I have certain combinations of minerals: not just a single mineral but a **combination of minerals**, what happens is amazing. Whether we look at diabetes or we look at **congestive heart failure**, heart disease—what is the root cause of **heart disease**? I say this to some of my cardiology colleagues, and they look at me as if I was from outer space—and yet in the clinical literature, it is crystal clear from research that has been done in Europe and in Russia and in China, heart disease starts with a copper, zinc imbalance in the body, because they work as a pair. And I can have okay zinc levels, but I not have okay copper levels and the heart tissue deteriorates—I can have okay copper levels, and not have okay zinc levels and the cardiac tissue deteriorates. I only have one cardiologist colleague in south Florida, who has a minor cardiac infarction—they had a cardiac myopathy, they had a cardio megaly, they had a left sided congestive heart failure, they had a right sided congestive heart failure—can you make a suggestion to them in terms of what they can do to help themselves? YES! Now, does it mean they should also modify their diet? YES! But you would witness **miraculous changes** in that individual compared to anybody else you would like to look at as a patient population, if you **re-mineralize** that patient or re-mineralize that individual. So I cannot emphasize that enough.

Question: Can a patient, who has had a **heart attack** and has **coronary artery disease** just take OMC (**Ionyte**) and is that all he needs or does he need something else as well?

Answer: Let us talk about **coronary artery disease**. There are certain scenarios where it would help very quickly, and there are certain scenarios where it would help slowly, and if we did something else in addition, it would make it just as quickly as the other. So now we need to look at specific examples. Coronary artery disease is not a single ideology, not a single reason. For patients should have increased homocystine production. Homocystine is an amino acid complex that will crystallize. Now, why will it crystallize? Do you remember what I said yesterday? That amino acids are the building blocks of protein and every protein in the body, whether we look at human beings or we look at an earthworm, every protein is a crystalline substance. So homocystine will crystallize, but the crystals that form have sharp edges. If they happen to impact other cells or walls or membranes in the body, they can create little tears or rips. Well, where is this most likely to happen? Wherever things are under high pressure in the body and moving. Where do we have high pressure moving systems? In the arteries! Especially the cardiac arteries! Our heart hoes 7 days a week, 24 hours a day, non-stop. So it has the most opportunity to have crystals, like little pieces of glass striking the surfaces of these vessels. Does that make sense? The OMC (**Ionyte**) **will stop that**. But that is only one ideology for coronary artery disease. Another ideology is that there is a type of organism called micro bacteria or micro bacterium. These are very tiny bacteria. Sometimes even biologists refer to them as bacterio-aides—meaning they resemble bacteria. But are they really bacteria or are they simply large viruses? So are they small bacteria or large viruses? Who cares! It is an organism, that when it attaches to a wall and a vessel area, preferentially starts to attract and grab out of the system—**cholesterol**. Why? Because it builds a nest for itself literally in the cholesterol, so you get sequential layering just like you’re building up coral from the ocean. What’s underneath becomes dead, but we have several layers of bacteria that are building their little walls until pretty soon, you have this concretion coming in and suddenly you have no circulation through that artery. So in that case, first of all, we need something that will keep the cholesterol suspended in circulation if we are starting to dissolve it, and we can do that with chelators—and we need something that will kill the bacteria so it does not happen again. There are different ways we can go about this. But tetracycline molecule is the single best choice. The micro bacterium will die with

that in the circulation. So you can then use a chelating agent to help dissolve the plaque. It takes something like the omega 3 fatty acids which come from salmon or fish oils—it also comes from borage oil—I make sure that the plaqueing can't occur. Also, if you have plaqueing that you are afraid is going to break off and maybe go up and hit the brain and have a stroke—the combine the omega 3 fatty acids prevent that kind of sloughing. So they do many different things. If I combine: the omega 3 fatty acid with the OMC (**Ionyte**), I have covered all my bases. How simple is that? We are talking about two things.

Question: What is an ideal time of day to take the OMC (**Ionyte**)?

Answer: I could give you different examples or rationale why I would take it in the morning, or on an empty stomach for certain situations. The reality is if I hold it sublingually for 30 seconds—now 30 seconds is actually a lot longer than you think it is—if you hold it sublingually for 30 seconds, a large quantity of that will actually absorb into the lymphatic system. Once it is in the system, it doesn't matter. It's in—it is going to absorb. If I had certain situations where I know the person is not going to be holding it in the mouth to allow for that kind of absorption (they are going to swallow it), then if you want to maximize or speed up the absorption process—taking it on an empty stomach is obviously going to make sense. By the same token, if they happen to take it with food, does it make a big difference? No, it does not make a big difference. If they are taking it every day, they are absorbing those substances. They are absorbing them.

I have to say one more thing, which I forgot when I was talking about sports injuries. When I put just 3 drops (**Ionyte**) into a syringe along with B12 (because muscles use a lot of B12), and “Procaine” (which also helps muscles in different ways neurologically), and inject this into a myofascial trigger point or into a muscle that is not healing—because part of the issue with the body is, that we have to deliver it to the site where the injury is or we have to deliver it to where it is needed—I'll **inject the muscle**—no more trigger point. That muscle starts to heal. Now sometimes the muscle will feel warm. Why? Enzyme activity is going through the roof. The tissues are going nuts. The cells are going, “Wow, let's do this—hey we can also do that and let's do that.” I have used it intravenously with one of my elderly patients who has an autoimmune type of disorder and it is incredible how much better she is feeling.

SESSION 2

Amongst the various questions I received in between the sessions, there was one young lady who asked me about a response that her doctor gave her about the **absorbability** of the product. So I would like to share with you and maybe expand your ability to answer that kind of question. Because she talked about the rate of absorption in terms of 100% absorption of the product, (but she was speaking in terms of coral calcium as being the primary ingredient that is being absorbed), so of course, the doctor's response was a very literal one, thinking: “well if it is 100% absorption, the calcium balance would be thrown out of kilter. So of course, not being a chemist, in terms of her background, she did not know what to say to that specifically. Although you could have a really high rate of absorption from a liquid calcium type extract or an OMC (**Ionyte**), but we are not just talking about calcium. Now, if I looked at a chemical analysis and said that calcium was the #1 element present in terms of quantity—FINE. Because if we looked at the human body, what is the #1 element found in the human body? Calcium is by far. I think potassium comes in there, if not second, then third. So certain elements we have in large quantities in the body. Again, it depends on the species of calcium. Calcium citrate responds differently than calcium oxide would. Because

calcium citrate is blood calcium, if I suddenly had a large absorption of blood calcium, would I expect it to have an impact of how the blood is behaving? Certainly! But the OMC (**Ionyte**) is not calcium citrate. We have a whole variety of calcium there. We have a variety of magnesium there. We have a variety of iron there. We have some nickel, some cobalt, some zinc—we could just start going down the list. So how it behaves then, also changes, because when we mix minerals together, they work in groups and families. So how would you answer your doctor? “This is mineral complex.” When you look at a delivery mechanism, we look at a liquid, a capsule, a tablet or a spray. Tablets have the least absorption—the best you can get from a tablet is 40% absorption into the body. With a capsule you can go up to 50% absorption. With most sublingual medicine, for example “sublingual nitro-glycerine”, that’s like 90%. OMC (**Ionyte**) given sublingual, if you just hold it there under your tongue, **100% of it will absorb**. You don’t even have to swallow it. Now you get some stimulation of the saliva production because it is there. So fluid may keep flowing into the mouth—but if you hold it there long enough, you will absorb all of it right there—right into the mouth—right into the mucous membranes. Some of the ways I have used it with patients in my office, patients who have had an erosive event inside of their nose, so they are **bleeding**—either from a virus or from something that they are reacting to—or one young man who got a little carried away with some recreational substances—I take OMC (**Ionyte**) in a dropper bottle, they tip their head backwards and I squirt it with a dropper into the turbulence of the nose. It absorbs right through the mucous membrane—right there. If somebody is really tender around the nose, because of a cold or something like that, it will absorb through any mucous membrane. I’ve also have had to take foreign bodies out of a patient’s eye, or they were down at the beach and someone kicked up the sand and they got the sand particles out, but it scraped the surface of the eye. Now the surface of the eye hurts—it is called corneal abrasion. I will put a drop or two of OMC (**Ionyte**) right in the eye and by the next morning the corneal abrasion is healed up. How can you beat that? Versus going down to the drug store and buying “cortisporin”, ophthalmic solution for \$28, or if you have a drug plan, you can probably get it for \$10. It will also work, but it will take a week, that’s all.

For **seasonal allergies**, I would take the OMC (**Ionyte**) in a spritzer bottle and I would spritz it up into the nose. It will accomplish two things simultaneously. Firstly, it will wash the surface of the nose—an allergy can only come if an irritating substance has protein in it—because in order for you to have an immune response, you have developed an IGE—allergy response. In order to get those eosinophil white blood cells to respond, there’s got to be protein in that little pollen particle. You wash that off the surface of the nose and, secondly at the same time you provide those minerals there—the self-correcting mechanisms, you ramp them up in terms of their ability to suddenly deal with all that histamine—so you don’t need anti-histamine. You have just increased the efficiency of what your cells can do—dramatically. At the same time you have physically washed off whatever the irritating thing was that your immune system was starting to respond to. So you simply wash your nose the same way you wash your face or brush your teeth—every night. As soon as the season is gone and you are not re-exposing yourself to those things, you don’t need to continue. But in the meantime, you also have now developed soft tissue addiction to some kind of anti-histamine substance like “Robotussin” or something like that, the moment you stop, whether you are exposed to the allergens, or not, you blow up, because the tissues have become dependent upon it. That is one thing they don’t tell you—the fact that as you continue to use things like “Flonas” you become dependent upon it, so the moment you stop—boom! You got it and you think, “Oh, I still have my allergies”, and you say to yourself, “I’ve got to spray some more ‘Flonas’. I’ve got to spend another \$30 for that product so I can use it every month.” Well, guess what? We could put you into a plastic

bubble and be feeding you filtered air, you stop the “Flonas” and you will blow up. Where is the allergy? There is no allergy! You have just become addicted to the drug.

Question: Physicians have indicated the fact that too much calcium can give a negative impact in the body. Is that true?

Answer: I indicated yesterday, when I was going through different species of calcium and the fact that calcium oxide is a very inert type of compound—very un-reactive. You know where it is used the most in our society, besides as filler? In paint, because it is a wonderful paint pigment base, it is a nice soft white color and doesn't fade with sunshine. So if I paint the outside of my house with that, because I want a nice white picket fence and the calcium oxide that is in there, it stays white—winter, spring, summer, and fall. So it is wonderful for that. It's like titanium dioxide—the whitest pigment that somebody can use. So the whitest, brightest paint has a lot of titanium dioxide in it. Why? It is so un-reactive. It stays white forever. But if I take that form of calcium, what will it do for me? Well, it will make the coating of my gut nice and white until it moves on out through. It will make my stool lighter colored. That's all it will do. I do not absorb it into my body. I do not produce enough stomach acid to dissolve it no matter what age I am. So what is so wonderful about the OMC (**Ionyte**) is it has **several different forms of calcium in there**. Each different kind of calcium supports cellular function to some extent. One form will help a lot more in a human cell than this form over here, but that form is still usable. The body can convert it easily because it is already bound to a carbon matrix. So it is very easy for the body to transform that. The liver uses one kind of calcium, the endo-bone uses a different kind of calcium, the long staff of the bone uses its kind of calcium, and the heart uses a different kind of calcium. I named a bunch of them yesterday. One of the reasons the advanced cardiac life support protocols keep shifting all the time is because at first they realized that the heart really needed calcium when it was in major distress or too swollen. So they started adding calcium chloride. Well, calcium chloride does work with the heart, but it's awfully rough. So here is the heart struggling and all of a sudden it gets slapped with the calcium chloride. Sometimes it was just too much. It would overwhelm the heart. So they started to play around with the dosage that the emergency medical textbook would use. In reality, if they used the OMC (**Ionyte**) mixed with a little copper, the heart would actually just shrink right there. They would save a lot more lives, but you would have to have a bunch of articles published on that. You would have to have animal studies done and so forth before the establishment would shift to something like that. But from a strictly logical point of view, that would make a heck of a lot of sense and be more life saving.

Question: How fragile is the OMC (**Ionyte**) in terms of losing its charge or its ability to do something?

Answer: It's not that fragile. So if people have braces, they don't have to worry. The only thing is, because there are a number of different metals in this complex, could they react with some of the metals in the mouth? Because we have saliva, we have a certain amount of acidity or alkalinity in the saliva. We also have amylase, which is an enzyme that helps us digest carbohydrates. If all these substances are there, plus we also have bacteria in our mouth, and I suddenly add these things in, could I do something that might change the surface oxidation of chromium-plated braces? Yes, I could see that happening. Would I be concerned that it would actually manage to dissolve some of the chromium off the braces? No. Chromium actually helps you with glucose metabolism, so I wouldn't be too worried about that. If it looks like it would become too unsightly, you could always go to putting it into apple juice or cranberry juice. Then just brush your teeth. Then you don't have

to worry about any discoloration of braces, if that was one of your concerns. Putting in a metal spoon, does that change its charge? No! How could it be that fragile? If it is able to do all these other things, if it is able to penetrate like it can into the cells, how can it be that fragile? **It is not that fragile.** What I would not do with an OMC (**Ionyte**) is I would not put it into a glass that had lead-based glazes on it, because it could certainly pull some of that lead out. But they tell you not to cook with that anyways. The OMC (**Ionyte**) could be more reactive with that type of surface in terms of actually leaching things out of there. So I wouldn't use that as my storage container.

Question: Can you treat asthma with OMC (**Ionyte**) and if so how much?

Answer: **Asthma** is a multi-factorial process, which means that many different things are coming together to create the response. Certainly, not one of the small issues of that is the person's own thought process and their relationship with other members of their family. So I can give you as an example, one of my patients, a young woman, who has fairly advanced **bronchitic asthma**—it is considered a **chronic obstructive pulmonary disease**. Her father brought her to the clinic. They live out in the country area. They passed by a field where they are growing some things that he knows she is extremely allergic to. But she is asleep in the car. They drive past the field and the father sees it. His anxiety goes up, his heart starts beating fast, he thinks, "Oh my she is going to go into an asthmatic attack". Nothing happened. They come to the clinic and I check her out. She looks like she is doing very well. I said I'll see her in about two months and sent them on their way. Going home—for whatever reason, he drove the same road back home (I would have driven a different route). They are going by the field, but now she is awake. She sees the plants. Boom! An acute asthmatic attack—started to gasp! The father starts to panic and brings the car to a stop. Comes racing back to the clinic. They rush her in—she is turning blue. We give her some "susperin" and so forth. We start to open up the airways, but what I am trying to point out to you is that part of it is psychological in terms of the individuals themselves. Will the OMC (**Ionyte**) make a direct impact on that? No. Unless there is a psychological imprint that says, "If I take this medicine, I know I am going to get better". That also works. That is why when arriving to the emergency room they usually start to calm down. Arriving in the doctor's office, they calm down. When I walk into the room, they calm down even more. If they don't, then you shake them a little bit. That aspect is part of asthma. There is a definite correlation in terms of the dynamics of interaction between the child and the parents—more often the mother than the father. Sometimes what those children need is a "parent-ectomy". Let's go back to a physiologic model. Let's just talk about physiology. If it is going to help with an allergic reaction and a histamine response, as I talked about earlier, will it then help with a histamine response in the lungs? Yes, it will. Will it help with the mucous production response, which starts to actually close off the airwaves? Yes, it will help. But the other factors will have to be taken into account, because people can bring on their own asthmatic attack.

Question: Can you use the OMC (**Ionyte**) in your eyes if your eyes have become irritated by photo-electronic irritation, like working in front of the computer screen all day?

Answer: Yes, you can. You will see the **swelling will go down and the redness will disappear.**

Question: If a patient is on a calcium channel blocker, can they use the OMC (**Ionyte**)?

Answer: Yes, they can. Remember, I said earlier, different forms of calcium have different impacts in different parts of the body. Calcium citrate and calcium chloride would annoy the heart if they were taking a calcium channel blocker. How much calcium chloride is in OMC (**Ionyte**)? Zero! So

will it irritate the heart? No! How much calcium citrate is there? Zero! So will that irritate the heart? No! That's again knowing or understanding what kind of species of substance we are talking about. Are we talking about calcium salt? Are we talking about OMC (**Ionyte**)?

Question: What about **Crohn's disease**?

Answer: That is an excellent question. I am going to broaden the question. What about **ulcerative colitis**? What about **irritable bowel syndrome**? What about **leaky gut syndrome**? For leaky gut syndrome, irritable bowel syndrome, and ulcerative colitis—this is wonderful. **Wonderful!** Now, you have to drink it in larger quantities. How much? If I wanted to start treating someone with ulcerative colitis, I would have the person drink 1/3 of a bottle a day for a week—orally. They can take it straight—but if they object to the taste they can take it in a little bit of juice. As long as you can see through the juice, you can mix it. If you can't see through the juice, don't use it. I would avoid grapefruit juice or orange juice, because it will bind with some of the ingredients in some brands and then—you are wasting it. I would want to take it orally. Why? I want to get it to the site of the issue. What we need to also do is, we have to introduce it rectally. They must have an enema set up or a turkey baster—they must use a bit more than 3 tablespoons in the enema. After they have installed it rectally, and they have done this for a week, there will be enough healing that has taken place. Now they can have a colonic done or if they do not have access to a place that does colonics, they can take something like milk of magnesia that will purposely clean them out. You can also use magnesium citrate—it would really clean them out. Then I would have them drink an entire bottle of OMC (**Ionyte**)—this is for ulcerative colitis. Now, with Crohn's disease—there is a genetic component to that. I cannot say that the OMC (**Ionyte**) will correct the genetic component, but I can tell you that if they make sure their internal bacteria is good—so if they are doing something like “pro-biotic” and they are using the OMC (**Ionyte**), at least you can predict that the number of attacks that they will have will decrease noticeably in terms of frequency, severity, duration and so forth. Those individuals will have to be very careful with their diet and what is going into their gut. They will have to make sure that they have plenty of good bacteria in there to support them, so that bad bacteria cannot help change the parameters of the gut, so that something breaks down.

Question: How much do they take after drinking to bottle?

Answer: Then they go on the standard dose. What you will see is that by that time all the ulcerations will be gone.

Fred Kaufman interjects: One word of caution—if the person has never been on the product and they take a large quantity, they may detoxify and have flu like symptoms. They should perhaps start out with 3 or 4 half droppers to make sure they don't go into detox.