Rheumatoid Arthritis

Hello this is Dr. Mercola. Today, I would like to talk to you about arthritis. This is a condition that you know that affects tens of millions of people. It can be quite disabling and crippling.

There are basically two different types of arthritis.

One is called osteo- or degenerative arthritis that you typically acquire as you get older. The second is rheumatoid arthritis, which is actually an autoimmune disease.

To discuss more of those, I've actually created a separate video, which is below this one. So if you're interested in the differences, then certainly watch and review that video.

What I want to review in this video is really a treatment protocol and a plan to treat rheumatoid arthritis, which is by far the more serious condition.

Rheumatoid arthritis would include not only rheumatoid but also other rheumatoid-like conditions such as lupus or SLE, ankylosing spondylitis, polymyositis, dermatomyositis and scleroderma.

They are some of the other types of conditions that would be categorized under the umbrella of rheumatoid arthritis. Traditionally, patients with these types of illnesses are seen by a specialty called rheumatology.

As many of you know, I'm not a great proponent of conventional medicine but nearly every single specialty I can think of has some valid appropriate use, and some more than others, such as surgeons or emergency room physicians. I thank God we have them. They really have a very powerful and effective tool and skill that can really address some major challenges that we have primarily from acute traumas and such.

But, one of the disciplines, and perhaps really the only one that I don't believe actually even needs to exist, is rheumatology. Other than diagnosing patients, which is an important component, but other than the diagnosis, they really have, in my experience, virtually no benefit for patients because they really rely on toxic approaches that primarily just treat the symptoms.

These remedies and therapies and drugs that they're using are some of the most toxic in medicine.

About the only other specialty that uses more toxic medication would be oncology; to treat patients with cancer. Even in rheumatology, they use some anti-cancer treatments such as methotrexate.

What I want you to understand are principles I'm going to review, and a rheumatologist
isn’t an appropriate part of that regimen. Certainly, using them carefully and weaning yourself off of the drugs that are typically prescribed is the biggest challenge.

Let me just state that there are alternative views.

I first became interested in the alternative views of treating rheumatoid arthritis when I saw a 20/20 segment in 1989 that interviewed Dr. Thomas McPherson Brown who at that time was really close to the end of his life. I hadn’t realized it, but he had been treating patients with rheumatoid arthritis and rheumatoid-like conditions for five decades or so.

Dr. Brown was a Board-certified rheumatologist. He was actually a graduate of Johns Hopkins University. He really was a pioneer. He vigorously objected to the primary treatments that were being done in those days, that primarily rely on the use of prednisone.

His theory was that rheumatoid arthritis was actually an infectious disease caused by a mycoplasma or an L-form of bacteria. He essentially used antibiotics to treat patients. He had over his years, treated over 10,000 patients and most of them have gotten tremendously improved.

I was just at the beginning of my journey in treating patients and had adopted it and started treating patients with his protocol. I was actually surprised to see quite dramatic improvement in most of the ones that I was taking care of. I used this approach for nearly 20 years.

Dr. Brown did die in 1989. So he wasn’t able to contribute further to the therapy but there were a number of us who treated. I myself ended up treating about 3000 patients. I think probably collectively there have been over 100,000 people who have tried this. So it has been used by many people.

This is not a new experimental innovative therapy. It’s been around for quite sometime.

There is actually quite a bit of peer-reviewed, double blinded placebo control trials that document its effectiveness. However most of the trials tend to focus on the use of an antibiotic. What I learned early on is that, although Dr. Brown had really a very powerful and innovative way to attack this disease that was strategically far more foundational effective than using immune-suppressing drugs, it still needed a lot of tweaking.

One of the side effects of his approach is that most everyone underwent a reaction called Herxheimer reaction. That is a scenario where your symptoms actually worsen once you start the treatment.

That worsening could be anywhere from several weeks but typically several months or even longer. And then people started to notice an improvement to the point where they would gradually go into remission. These conditions and these symptoms that people
had are really quite amazing.

Many of you have probably seen someone with rheumatoid arthritis. There is typically a joint deformity. That’s one of the ways that you diagnose it. It is very difficult to have the diagnosis if the hands aren’t involved. Typically, you can see by these pictures, some of the amazing changes that occur within the joints.

Unfortunately, when you are receiving treatment for this, the treatment that I’m describing, although it’s effective at stopping the progress of the disease, it will not, let me emphasize it, it will not reverse the joint deformities that have already occurred. The best that we can hope to do is stop the disease in its tracks and prevent any further deterioration.

Most of the time, the pain is so severe in these conditions that it is quite a dramatic benefit from nearly everyone because the pain is so crippling and disabling that they just are nearly suicidal in many cases. So it’s a major benefit.

Anyway, Dr. Brown had used this approach that involved the Herxheimer reaction. I gradually started adopting it to my own practice. I realized that there were ways to improve it. Interestingly, when I started using this was at the beginning of my medical practice. Over the years, my modifications and revisions to the protocol paralleled my adoptions of new information I was learning on how to optimize people’s health.

There were a number of different strategies that I learned over the time that made some quite dramatic benefits. They typically occurred in the mid to late 90’s. Some of the major ones were nutritional typing.

In other words, the concept that we are not all designed to eat the same foods; that a food that would cause one person to thrive and grow and do extremely well and benefit tremendously would cause another person to actually flounder in their health.

We basically divide people into three types, a protein type, a carb type and a mixed type. If you’re interested in this program, (we actually, for many years, have had the nutritional typing test. We charged people for it. Actually, tens of thousands of people took this test and paid for it).

But now we’ve covered our cost to produce it and we now provide this test free of charge.

So if you’re interested in that, I would definitely encourage you to use it as a tool to help you understand some of the basic foundations of what fuel you are designed to eat. It is not only useful for rheumatoid arthritis but pretty much any clinical conditions.

As an extension of that, I developed a nutritional plan which is continually evolving over time. I’ll have a link to that plan lower on the page. That plan is also on the right side of my homepage. There is a link to it. That’s a 40- to 50-page document that really goes
into all the specific details of how to optimize your diet in addition to the nutritional typing.

Basically, understanding the foods that you need to eat is really an important central component of the improvement. And when I did this, when I integrated that into the program, we noticed a tremendous improvement in the way people are responding.

Some of the other really crucial components that we added were things like omega-3 fatty acids. By omega-3, I’m talking about animal based such EPA and DHA which are really profoundly important at changing some of the important elements of inflammation because these fatty acids will actually modulate information through prostaglandins.

When I first started out, I was recommending fish oil because it was my impression and understanding that that was really the best way to get that. Because even back then, we knew that most of the fish in the sea were contaminated with mercury and dioxins. We certainly don’t want these contaminants in your food.

Fish oil, my understanding at that time, was one way to provide a clean product. But since then I’ve learned that there is even better ways to receive the benefits of omega-3 fats. Let me just explain this briefly because I think it’s an important point.

What I didn’t understand when I first started recommending fish oils is that fish oil has the fatty acids EPA and DHA but these don’t exist as free floating fats. They are actually attached to a triglyceride molecule and tri- means “three” of course. So it’s a glyceride molecule with three fats attached to it. The fats could be EPA or DHA or other fats but primarily those two.

Your body cannot absorb those fats in that form. It’s impossible to absorb that. So when you swallow fish oil, your body has to physically break that down. It has to remove that attachment from those fatty acids to the triglyceride molecule.

So that’s only the first step and because of that first step, about 80%; somewhere between 80% and 90% of the actual fish oil is not used. Much of it winds up in your gut. That’s what causes about 50% of the people not to be able to tolerate fish oil because they have this burp-back. This belching with the fish oil because that’s the undigested fats in your gut that do not get absorbed.

So even once you break it down and the fats actually get into your blood stream then they’re free floating and they don’t work in that form yet. They actually cause some harm and they have to be broken down.

The only way that you can use it, is that these fats, the DHA and EPA flow in your blood to your liver where your liver attaches a phosphate to it; typically a phosphatidylcholine or phosphatidylserine. Typically, phosphatidyl choline. In that form, when the DHA and EPA are attached to that phosphate, then, finally, your body can use it.
So you’re literally getting a really small fraction of the fish oil that you’re swallowing.

But interestingly, I found out that krill oil already has the phosphate attached to it. So all of the DHA and EPA is attached in a way that you’re body is physically going to use it. So it works much better; you need far lower doses. In fact, the recommendation is typically a thousand milligrams.

We’re carefully examining the new literature that suggests that maybe all you need is as little as 500 mg.

Sometimes it can be combined with GLA (gamma linolenic acid) to provide some other powerful anti-inflammatory effects.

The other component that is an important element of the fish oil versus krill is that the krill oil has a powerful antioxidant called astaxanthin, because these DHA and EPA fatty acids are highly perishable to oxidation. They can go rancid real quickly. In fish oil that is exactly what happens.

It has been our experience from review of the literature that most of the fish oils out there are rancid even before you open up the bottle. The krill has this astaxanthin, which is a powerful antioxidant that prevents the oxidation from occurring.

In addition to that, some of the newest findings is that this astaxanthin can be actually extracted from algae and taken as a supplement in doses of about 4 mg. That may have a very powerful benefit at further reducing the incident [of arthritis].

They also have other benefits: such as radically decreasing the likelihood of developing cataracts or age-related macular degeneration, which is the most common form of blindness in people.

After you’ve been on it for a few weeks, it almost prevents the ability to get sunburn.

So, lots of good benefits. It’s actually a supplement I take everyday and one that we hope to provide at some point in the future for people. That’s another component.

The other thing is that we learned is the emotional components. Almost all autoimmune diseases; rheumatoid arthritis, Crohn’s disease, inflammatory bowel disease, multiple sclerosis, they have at their core a dysfunction of the immune system, bodies beating up on itself.

We believe that the trigger for that dysfunction may lie in an event, an emotional trauma that occurred before the age five or six when the conscious mind was being formed. You can go in there with effective tools to obliterate that pattern so that assault on the immune system can diminish, and then healing can occur. So it’s been our experience: that in almost every case this is present.
In addition to that, what is pervasive in the population but clearly in people with autoimmune disease is a vitamin D deficiency.

Ideally our vitamin D levels should be over 50; 50 at a minimum. I think for optimal health it might be even closer to 80 or 90 nannograms per milliliter of vitamin D in your blood. So when you get your levels up to that level it will have a powerful influence at increasing your body’s ability to fight infection.

I do believe Dr. Brown was right that rheumatoid type diseases ultimately involve a dysfunction of the immune system, the autoimmune process but there is an infectious component. So if you can use vitamin D to regulate your immune system, to have your body optimize the production of 200 to 300 antimicrobial peptides that are far more powerful than most of the antibiotics, then you have a great chance at defeating this.

I believe it’s medical malpractice to treat someone with rheumatoid arthritis and not regularly monitor their vitamin D levels, their 25-hydroxy levels to make sure they’re at these levels.

Whatever it takes, at least 5000 units for an adult. That may have to go up to 10,000, 20,000 even 30,000 or 40,000 units but to be monitored very carefully and make sure that levels get into therapeutic range. Ideally, of course, you would be able to get this from the sun. I personally am able to get my levels up to 90,000 without any oral vitamin D. But most people don’t have the opportunity to expose their skin to that much sun.

The other component is exercise. It’s a bit complicated with rheumatoid arthritis because many times, the joint deformities are such, and the pain, that it’s difficult to participate in exercise. But really, it’s going to be a foundational element.

One of the keys I’ve learned with exercise with rheumatoid is that if you have pain longer than an hour or two hours after the exercise in the joints, then there probably was too much damage to the joints, so you have to modify it [the exercise routine] at some point in the future.

Ideally, you want to adopt a program. Something like the Peak exercise fitness program that we’ve been talking about. Even, if you can, the Peak 8, which is a high intensity element that causes you to go to really high levels of exercise for about 30 seconds and then going to recover phase, and repeat that about eight times to the point where you’re really pushing yourself to the maximum heart rate to have massive increased improvements in growth hormone and decrease in your percentage of body fat, and really improving your overall health.

These are some powerful improvements that I have noted. When we apply these strategies, we were actually able to eliminate the Herxheimer reaction in most everyone of these patients with rheumatoid arthritis. As I said, I treated about 3000 patients with this protocol and about 15% or so were lost to follow up for whatever reason, but our experience is that well over two-thirds, probably closer to 80% or more of the people
received pretty dramatic improvement with this protocol.

The typical strategies that conventional medicine is going to offer for you for this debilitating, devastating disease are pretty limited. They maybe able to provide pain relief but that’s about it.

So if you or someone you know or love has this condition I would encourage you to carefully review the update I did below.

The last time I did this update was about 10 years ago. So I’ve modified it again and really carefully edited the recommendations to provide the best and the current thinking of how to improve this devastating disease.

The key is to find a clinician to work with; an educated healthcare professionals who can help you wean off these toxic medications because it’s very, very rare for someone to come in with rheumatoid arthritis who is not taking loads of devastating drugs -- some of the most toxic drugs that are used in medicine. They cannot be stopped blindly.

That needs to be done with someone who understands how to use these medications. So, ideally, it’s going to be a licensed physician who is trained in pharmacology who knows how to wean people off of those appropriately. There are other great clinicians who can help you, but you have to be really careful with those medications and really do that wisely so that you don’t go into a big flare up.

Hopefully, this is useful information. RA is such a devastating disease that we really need an effective strategy to address this illness.