Understanding Arthritis—The Clinical Way Forward

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The Clinical Way Forward

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and

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Preface

Not so long ago, in the medical world, the word 'flux' (diarrhoea) was considered to be a diagnosis. The patient had a flux, the remedy was so-and-so. Nowadays, of course, doctors recognise many different causes of diarrhoea, and cannot be satisfied with that simple descriptive label because the different varieties of diarrhoea demand quite different treatments. Diarrhoea caused by ulcerative colitis might very well be treated with steroid enemas, whereas the same treatment for an infection of the bowel would be catastrophic. The science of microbiology—the outstanding example of how examination of the environment can revolutionise the management of real-life illness in humans—has taught us to distinguish carefully between the different causes of a symptom and to make what is called an **aetiological diagnosis**, that is, a diagnosis that includes an identification of the cause.

Once upon a time physicians recognised an entity called consumption, or phthisis. It was a recognisable group of symptoms and signs that occurred again and again in different patients, that is, a **syndrome**. It was an entity, a disease, an attacker on the body. Along came Robert Koch, a brilliant nineteenth-century scientist, and in an epic adventure of science taking up many years he tracked down 'the cause'—a germ called *Mycobacterium tuberculosis*. Koch discovered a simple method for finding the germ in patients' sputum, or in the tissues, and virtually overnight physicians stopped talking about consumption and phthisis. Today's medical students have never heard the words. Instead, medicine had a brand-new disease called tuberculosis, which eventually led to new methods of treatment which have virtually eradicated the disease from the Western world.

However, today's doctors still fail, very often, to learn the lesson of nineteenth-century microbiology. We still too often talk about 'asthma', 'migraine' and 'arthritis' as if these words were diagnoses. They are not. They are descriptive labels, just like flux and phthisis. They are the first stage towards making a diagnosis, the identification of a syndrome. The words do not tell us the causes. The body has only a limited repertoire of symptoms and signs. The skin can produce a rash called eczema, for

example, which can be caused by dozens of different things. The same is true of asthma, migraine and arthritis. The word 'arthritis' means no more than 'inflammation of the joint(s)', and even that is often a misnomer, as we shall see below.

I have known Dr. Bill Fox since 1979, and respect him as a fellow scientist. Many others fail to realise how much a scientist he is because he is unfamiliar with modern conventional scientists' rhetoric. He was trained as a doctor nearly 60 years ago, and his style of expression and writing is that of the doctors of those days. Many professional scientists of today will read his portion of this book with disdain because of the style in which it is couched, but scientist he is. He looks at patients and listens carefully to what they say. He finds much of what they say inexplicable, and sets out to search for more satisfying explanations of what he sees. He erects hypotheses, and then tests them against the realities of clinical life. His experiments have led him to a conclusion—although he recognises, as all good scientists do, that there is no such thing as the ultimate 'truth' in science, that there is always much more to be understood—that much of the chronic ill health seen in general practice, adorned with a multitude of symptoms and descriptive medical epithets, is caused by the slow, chronic, rheumatic process that he describes. His view may or may not be correct, or it may turn out to be partially correct. Like all good medical hypotheses, it is testable and it leads on to predictions as to the types of treatment that might be most (and least) appropriate. Bill Fox is now nearing the end of his active life; it is up to other scientists and doctors to take up the baton that he is holding out.

It should be understood that the claims he makes about the treatment, based on this hypothesis, are in no way exaggerated. I personally have seen about 50 of his patients over the last nine years. Because of the accumulated evidence of his excellent success rate, I have recently started to use his methods in my own practice, with equally satisfactory results.

No medical innovator is thanked by his peers—totally new insights in medicine are uncomfortable to doctors as they carry the implication that up until this point we were all doing things wrong. Medical innovators are always greeted with hostility by their fellow medics. This has been Bill Fox's experience also, but he may take comfort from two reflections:

1. Although unpopular, his work has always followed the principles of the greatest teachers of mainstream orthodox medicine.
2. He is neither the first nor the last medical innovator to be scorned by his peers during his lifetime.

However, if there is any truth at all in his beliefs, if he has come even a

little closer to the ultimate truth than others have done, he will receive his recognition one day, and will have brought untold and untellable benefit to suffering human beings.

This book is Bill Fox's account of the rheumatic patch, which is an important contributory factor in the chronic rheumatic diseases but which is ignored by most medical textbooks. He reports how he discovered rheumatic patches, and learned their importance and how to treat them effectively, with results so good and so fast that most doctors who witness the treatment have difficulty in believing their eyes. He also tells of his parallel discoveries: the importance of commensal diphtheroids in the throat, and the usefulness of antihistamines. My part, as an academic immunologist and also Bill Fox's pupil in clinical rheumatology, is to provide (as far as possible) a scientific interpretation of his clinical findings.

Rheumatic disease causes an enormous load of human misery, as well as a quite shocking death rate [1], both from the disease itself and from the drugs used to alleviate its effects [2]. History will not readily forgive the medical profession, if in our caution or our conservatism we fail to examine carefully every possibility of effective drugless treatments, even though the ideas might be novel.

University of Salford, 1989

D.L.J.F.

Prologue

I qualified as a doctor in 1929. After two years in hospital and locum work I entered general practice. Within a further two years it became abundantly clear that my ability to diagnose, treat or refer patients (excluding the infectious diseases) was restricted to about 20 cases per annum. These represented the major diseases which filled the textbooks and the patients who occupied the beds in the teaching hospitals.

The vast majority of the patients in general practice complained of vague aches and pains or discomfort designated according to their location, such as headaches, migraine, stiff necks, brachial neuralgia, pleurodynia, lumbago, sciatica coxalgia, slipped disc, cramp in the hands or feet, undiagnosable pains or discomfort in the chest or abdomen. Sore throats and 'colds', loss of energy and depression frequently accompanied many of these symptoms. Finally there were the cases of proven (by X-ray) osteo- and rheumatoid arthritis.

The great value of our hospital training was not so much the diagnosis of the major diseases, but the insistence on a meticulous attention to every detail of the patient's history and symptoms and the absolute requirement of a thorough physical examination of the patient. It was in this way that our great clinical masters of the past were able to present to us complete detailed analyses of diseases which provided the sure foundations of understanding and diagnosis on which modern scientific medicine could be applied to find a cure for so many complaints. This was the dilemma which confronted me in the 1930s.

A diagnosis could be achieved in only a limited number of cases. The remainder were conglomerations of symptoms which had no meaning, no understanding and could therefore be treated symptomatically only, which is about as unscientific as one can get. I therefore resolved to pay meticulous attention to all of these cases. Slowly and arduously I began to perceive a hazy relationship between all those symptoms listed earlier—they seemed to be interwoven into a rheumatic pattern. So I decided that I must study the chronic rheumatic diseases.

To this end I moved to London, took on a small general practice and became a clinical assistant at the Charterhouse Rheumatism Clinic and

also, because I had studied some osteopathy, clinical assistant to Mr. W. E. Tucker in the Orthopaedic Department of the Royal London Homeopathic Hospital.

Treatment at the Charterhouse consisted of a vaccine made from a number of organisms isolated from the throats of rheumatic patients by its founder, Dr. Warren-Crowe. Physical medicine and later gold were introduced. Within a year or so, I formed the opinion that the value of the treatment was questionable. I began to wonder what I was doing there and thought of resigning. In a moment of blinding lucidity I realised that this was the heaven-sent opportunity I wanted—to study the natural history of the chronic rheumatic diseases.

During the war the Honorary President of the Charterhouse Clinic, the Duchess of Kent, opened the new clinic in Weymouth Street and just prior to that I became a Consultant.

What I chronicled during the next 12 years was published in 1950 [3] and formed the basis of all my researches since then. Re-reading what was written there, I see its deficiencies in the light of modern attitudes, but its essential clinical truth survives and holds its place in the basic diagnostic criteria required in the understanding of the chronic rheumatic diseases. Four years after publication of this paper there was no point in remaining at the Charterhouse.

I later made contact with Mr. Tucker who had spent many years in the army. He suffered from osteoarthritis of both hips and I suggested he might like to try the effects of injecting some rheumatic patches. He readily agreed and was so impressed with the result that he asked me to return as Clinical Collaborator in the Orthopaedic Department at the Royal London Homeopathic Hospital. Following this my study of osteoarthritis of the hip was published.

Unfortunately Bill Tucker retired and so my association with the hospital was terminated. He suggested I went to America with him to open a clinic, but I declined because I did not feel that the problems were properly solved, and there was more research needed. However, in 1983, a doctor whom I trained became a visiting consultant at the hospital in Bermuda, which was part of the Tucker territory.

My studies at the Charterhouse Clinic showed quite clearly that patients slowly but surely deteriorated, with occasional remission of their symptoms which could last from a few weeks to up to two years. Relapses were sudden with an acute exacerbation of one area, or an entirely new part of the body, and they were frequently heralded by a feeling of malaise and a mild sore throat.

In a clinic of 50 patients, if one presented with this story you could be quite sure there would be at least five others by the end of the session. This was a clinical reinforcement of the possibility of a viral infection.

Furthermore, it was obvious that patients got used to a lower

standard of health and function and a greater tolerance of pain, so that any judgement of minor improvement in the reduction of swelling or pain, or slight increase of function attributed to drugs or physical medicine, must remain suspect. The only drug that would produce a clear impression of improvement is a steroid but this is a drug which flatters to deceive, and one which I would never use.

The essential basis of the treatment is to inject the appropriate rheumatic patches with 0.5% solution of sodium salicylate. This will produce an almost immediate response in diminution of pain and increased movement. For example, in osteoarthritis of the hip the patient will be able to raise himself from a chair more easily, followed by increased ability in walking and weight bearing, especially to be noted in dealing with staircases. In the same way, loss of movement and power in rheumatoid arthritis can be improved with a resultant stronger and less painful grip.

For all these reasons, I insist that my treatment must produce an unequivocal improvement within two or three minutes, that it is repeatable and does not require any anti-rheumatic drugs or pain killers except a limited use of aspirin. That is why I claim immediate improvement in at least 80% of all cases treated—a figure which is corroborated by a rheumatologist in Bulgaria where similar treatment is available in every district hospital for osteoarthrosis [4].

Some five years ago I conducted a private seminar at the house of Professor Eli Davis in Jerusalem. In his concluding remarks he said how very impressed he was with my presentation, but found great difficulty in believing me because my claim for improvements was so high—if it had been around 50% he would have accepted it!

My reply was rhetorical: 'Do you want me to tell lies so that you should believe me?' Read this book and decide for yourself.

London, September 1989

W.W.F.