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SPEAKER A

It's big protein, and there is a tunnel in the protein, like the Death Star, where Luke Skywalker needs to place his bomb to make the Death Star explode. And that's really the same with a vitamin D receptor tunnel. With our hundreds of RRS patients, we normally would have seen hundreds of relapses every year, but in four and a half years, I've seen not more than six. And so it's like you eradicate the disease.

SPEAKER B

Okay, good morning. You guys can hear me? Okay, we have Doctor Lemke, I believe, is. I hope I'm pronouncing that correct. Good morning. Or gunaben, I guess, perhaps, maybe, depending on where you're at. Are you?

SPEAKER A

Yes, it's close to evening. Yes, you're right.

SPEAKER B

And I appreciate you being here. This should be a fascinating topic. So you are in Germany, is that correct?

SPEAKER A

Yes, I'm in the south of Germany. It's called a city. It's called Heidelberg.

SPEAKER B

I've been to Heidelberg. Yeah, it's a very pretty, pretty place. The world's largest wine cask there, as I recall.

SPEAKER A

Yeah, it's a nice city. And many, many guests from overseas traveling to our town.

SPEAKER B

Yeah, I was born in Germany. I was born in, actually Hof in Bavaria, near kind of the. At the board of the Czech Republic now. But long, long time ago I had my german. Unfortunately, your english is going to be far better than my German, so I suggest we conduct this in English.

SPEAKER A

Okay? Of course.

SPEAKER B

So you are someone that has utilized something called the Comibra protocol. I think I'm pronouncing that correctly, which is a high vitamin D, high dose vitamin D protocol to treat various conditions, and I think one of which is multiple sclerosis. Is that correct?

SPEAKER A

Yes, it's very correct. We one of few doctors here in Germany and Switzerland and Austria

who are treating patients with this high dose vitamin D protocol. You're correct, yes.

SPEAKER B

And just, I guess for the sake of completeness, would you mind just telling us a little bit about your background?

SPEAKER A

Yes, of course I could do that. I was originally trained as a physical therapist and manual therapist and studied a few years athletic and sports in the University of Dorben and Bochum in Germany. And after working as a physical therapist, I decided to study again and to become a medical doctor. And I studied in Heidelberg, and I stayed there and married and have some kids. And after becoming a medical doctor, I started my training in neurology for a couple of years and a little training in internal medicine, but mostly it was neurology and mostly in neurology rehab centers of the University of Heidelberg. Besides that, my activities are in. We founded this medical society in Germany, and maybe you remember that we invented you to come to Wurzburg in 2020.

SPEAKER B

Oh, that's right, yeah. And then it got canceled because of.

SPEAKER A

COVID Yes, Covid canceled everything. And Reiner Kliman, which you already interviewed, and me and a few other guys invented this society and we do care for evolutional medicine and treatments and all these big things that glues everything together. So I'm very interested in nutrition as well. And this is part of my work here as a doctor, and I'm very interested in sport and athletic, of course, which should always be part of therapy. And besides our vitamin D protocol, we mainly work as an average functional medicine practice, I guess that's you call it in America. In us, we don't have such a word here themselves. Functional medicine, we consider it more like systemic or alternative or medicine in this manner. So we work with chelation therapy to get out your metals of your body. And we do work with intermittent hyper and hypo oxygen therapy and all these things functional medicine clinics do normally with patients.

SPEAKER B

It's interesting because when I was learning, you know, when I did my rotation through neurology as a medical student and then as a neurosurgeon as a surgeon, the field unfortunately didn't have a lot of good solutions. It seemed like, you know, it was hard to really impact disease, you know, in a significant way. It was kind of depressing, to be honest, and I don't know, you know. So how did you get interested in functional medicine from. From neurology? And I just. I want to talk certainly more about the successes you've been having with the different protocols, the Comibra, some of these other ones. So how did you go from neurology to having an interest in functional medicine? Was it because you already had a background in physical therapy?

SPEAKER A

Yes, and I guess that's the reason why I was, from the beginning of my medical education,

I was interested in all the things besides traditional medicine, because traditional medicine, it's mainly pharmaceutical interventions. And if you are trained as a physical therapist, you made the experience from the beginning on that with your hands. And with other interventio ns like sport and stretching and all the stuff and meditating, you could influence many, man y diseases far beyond pharmaceutical interventions. And with this perspective, I got into uni versity and I was 32 years old, so I was a little older than my colleagues and my co student s. And so maybe I was a little bit more experienced in life. And I questioned everything mor e than them. And from the beginning on, in my neuro training, I still ask questions. And the chief medical, he allowed me to work with my patients in nutritional way, because Rainer a nd me, we wrote a little paper of the paleo nutrition. I could convince my boss that it's scien ce, what I'm doing. And to treat neurological patients means they not only have neuro issue s, they also have metabolic issues. And so there's no reason why you could not change a d iet, a neuropatient, in the. In a way that he does not need his hypertension medication any more, for example. So I always tried little interventions. Well, you know, neurological is very conservative, so I couldn't do so many things, but a few I could do and I did them and I alw ays was interested besides them and my doctor, Fraser, I've wrote my doctoral thesis abou t lifestyle interventions in multiple sclerosis. So I got a very, very deep review of the literatur e in what could you do in kind of meditation, eating, doing sport and other interventions and doing that, I got more and more interested in vitamin D. And then I started in the clinic of n eurology to treat patients at least with a few thousand units of vitamin D a day. I guess that was the beginning of my interest of vitamin D. Yeah, I.

SPEAKER B

Guess we'll just kind of segue into the vitamin D stuff. So this Comibra protocol is, you kno w, not a few thousand, but it can be up to 100, 200,000 ius of vitamin D a day. And that's. T hat's a huge dose. And people be concerned about calcium metabolism and some of these other things.

SPEAKER A

So.

SPEAKER B

So could you talk, maybe talk us through that a little bit and how's it being utilized for things like **MS** and if there's any other conditions that you seem to have success with, as.

SPEAKER A

Of course I could, I appreciate to talk about this theme because it's very, very important to get the message out that vitamin D has a use far beyond the average doses. Well, it all star ts with a phone call of my doctor father, Professor Spitz. He's very famous here in German y. He brought all the us scientists, vitamin D scientist, to Germany, to Berlin in 2011 to plac e there the first conference of vitamin D in Germany. And so he's very, very into this theme. And once upon a time, he called me and said, well, there's this crazy guy in Brazil, he's cal led Comibra, and he's working with doses far beyond what we are doing here. It's 50,000, 100,100, 50,000. And I said, stop. That's way too much. I thought at that point that I knew s

o much about vitamin D, that giving a patient doses in these high is crazy and very, very se vere, dangerous for patients. I stopped him and said, well, Yurak, you could fly to Brazil. Yo u have the money, you have the time, you could check out the guy. But I'm out because I c onsider such high doses, as you said before, as very, very dangerous in the manner of calc ium metabolism. So that was my first reaction. So I reject it totally. But after three weeks, h e came back and he said, well, I have seen really miracle things. I've seen fabulous things. I've seen patients recover total from their MS, or at least make some very, very serious pro gress. And so we need to place these therapy in Germany. And as someone who's very, ve ry good in connecting people, he put all. It was at least three medical doctors who already t reat with these high dose protocols, and he brought them together with a few other doctors who are interested. And so we got our first training in the Comibra protocol by these first t hree doctors who already treated since 2016 in Germany. And that was an amazing time to get my first contact with these kind of therapy. And it was a three day training. And it was s o convincing to me that I decided that I have to visit one of them to see if this is really worki ng, what they're telling me. And that was my next step. After I got this little education, I trav eled to Beatrix Schweiger, and she's now my employee and good friend and colleague. An d I stayed in her clinic for a couple of days and see, treating her patients. So every day I se e patients, and it was so convincing what patients were telling me, like, serious symptoms li ke ataxia. There was a young guy who had such strong coordinative skills in his mouth that he bites himself while eating. And it was so severe that he was bleeding with every meal. And after a few months with vitamin D, for the first time for many years, he was able to eat without help, without something very straw where you pull in it, and he could swallow and e at like a normal guy. And he was so relieved. And I've never seen such a progress with me dication in seven years of neurology. I stayed in, and these days were such a game chang er for me, that on the end of this staying, I went back to my clinic and I spoke to my boss, to this chief medical, and I said, I quit. I couldn't stay even one more day in the hospital. At th e end, it was three more months, but I quit and started getting trained by Beatrix Schweiger with the Copenhagen protocol, because I've seen so many **MS**
patients in our clinic deteriorating under the medications, and suddenly we had a treatment. And so I couldn't agree to myself to work anymore with the medications. I needed to try it myself, and I never regret the step. And now, for four and a half years now I work with Beat rix and with my own patients in different autoimmune conditions, but mainly miss, and I'm making the same experience then years ago with Beatrix, with my patients. And it's a wond erful work. If you see young and older patients, get some or very much relief of those symp toms, as you could expect.

SPEAKER B

So just, just to delve more deeply into this vitamin D supplementation. So is it vitamin D thr ee? Is there a particular formulation? A lot of the vitamin D supplement formulas you can g et are soybean oil. Does it matter? How do you sort of approach this?

SPEAKER A

Yes, I could go into detail. I would like to give some little introduction why vitamin D is so po tential, if you wish, of course.

SPEAKER B

Yes.

SPEAKER A

I wrote a book chapter about vitamin D in the field of neurology and psychotry, and my coll eagues were very critical because for them it's **too omnipotent, they say it can't be that one substance**. And even the vitamin is able to influence such many different strengths of branches of metabolism. And so to understand, and for them, it's very, very important to giv e them an explanation why vitamin D is so potent, because it's unbelievable for a normal, a verage doctor that vitamin D could do that. And so the explanation is, well, vitamin D and al l the isoforms like colicaliferol, which is, as you know, the first form of vitamin D built from U VB in the skin, and then it's metabolized with the hydroxylases in the liver to 25. Vitamin D, we call it calcidiol. And then it's also metabolized with another hydroxylase in the kidneys or in the target tissues in every cell to calcitriol. And all these forms of vitamin D are so old. T he first form, the colocal syphil, we believe that at 800 million years old, it's so from the begi nning on when life got complex, like in the, I guess the english word. If you need to correct me if I pronounce it wrong, it's lichen, you know what I mean?

SPEAKER B

Yeah. I might say lichen, but yeah.

SPEAKER A

Or lichen. Yeah, we could see in lichen that cold cultivarol is already there. And then the di ol and the trial is 500 million years old, and that's such a long time. And so from the beginni ng on, when everything got complex, vitamin D played a role in these living organisms. And like the adaptive immune system, for example, we believe that it's 400 million years old. S o before we create our adaptive, or was created or creates itself 100 million years ago, diol and trial were already there in these little living substances. And another explanation why it' s so omnipotent, it's a steroid hormone, or we call it a psycho steroid hormone because the ring is broken, but that really does not matter. So it belongs to a class of hormones, which i s the high class of hormones who regulate us. So it could easily pass as membranes witho ut a calculation on the membrane if there is a need for it or not. Like any membrane, protei ns could get easily blocked by feedback mechanisms or something else, but not the steroid s that could pass membranes very, very easily. And vitamin D is one of those. It's one. It's. It belongs to the class of steroids who could pass a membrane. So it could be very potent b ecause it could pass nearly everything. And the third explanation why it's omnipotent in our metabolism is it's so cheap. It's built by energy, by sun energy on the skin. And if you put all these things together, it's very, very old. It's potent because it belongs to a high class horm ones and it's very, very cheap. And that's a one explanation why it got into so many differe nt branches of metabolism. Yes, that's a triass. Yes. And if you explain it these ways to our colleagues or to everyone there, I get a little bit more feeling that it's much more like a vita

min. And I could explain a little bit more in detail, but you asked me what form of vitamin D we take. Of course, we take the colic. It's the most easiest way to take in, and it's very, very good and easily controlled. We have in our body the feedback mechanisms in history. There are many, many interventions with calcitriol. But to use calcitriol, it's a little bit too dangerous because you could overdose very, very easily, but not with the colic, alciferol, if you consider some safety, some safety salts by using it. So we take mainly cholecalcible.

SPEAKER B

And just to clarify for people, cholecalciferol is considered the vitamin D three version, correct?

SPEAKER A

Yes, yes, of course. It's the D3 version, not the D2 Yes. It's the animal form and not the plant. Based form of vitamin D. Yes, of course, yes.

SPEAKER B

And, you know, with, with vitamin D being so well conserved and so old, um, you know, I mean, I. One of the concerns, like what we talked about was calcium metabolism, and I've read the Comibra protocol, at least, you know, the summary of it. And I know one of the things that's done is to measure a parathyroid hormone function. And there's this concept of vitamin D resistance that many people with autoimmune people so talk about, if you don't mind, I. There is a concept that people with autoimmune diseases have vitamin D resistance. Is that true?

SPEAKER A

Yeah, that's mainly the hypothesis Comibra made from a clinical perspective. Now, only 18 or 20 years ago, he was wondering why vitamin D, from the literature, if you see the mechanistic behind vitamin D, and he thought himself, why isn't it more successful in treating infectious diseases or autoimmune diseases? If you consider that vitamin D is expressed, or the vitamin D receptor at least is expressed in nearly every cell. There is only a few cells, really only a few, but mainly in nearly every immune cell, the vitamin D receptor is expressed. So why is that? And why is vitamin D involved in nearly any action or every action of the autoimmune system? And so why is it that if you treat people with vitamin D, why isn't it more successful? That was his thought from a clinical perspective. And he was so right, as we later found out, like **Carlberg** et al, that there is form of acquired vitamin D receptor resistance, or vitamin D receptor, or vitamin D resistance. There are potential ways to block the vitamin D system, like for example, the hydroxylases could be altered, or the vitamin D binding protein could have some genetic mutation. But we think that the most potent, and it's the vitamin D receptor itself which could be responsible for these resistance. And **Carlberg** is a german scientist who used to live in Finland, and they have these very, very long finnish winters, and they have serious problems without vitamin D. And Saudi was very, very deep in born, in doing science in this theme, and he was the first who could show that if you give a group of people the same amount of vitamin D, which is considered as a normal dose, lucky they gave them 3200 units of vitamin D. And he could show with his colleagues that giv

ing people such amount of vitamin D, the response is totally different. There are high responses, and he could show that by altering the very known proteins will normally be altered by vitamin D. And they have high responses, middle responses, and 25% of the group of students, and later on in the second trial, there were pre diabetic people, 25% did not respond to this amount of vitamin D on a gene level and on a protein level. And that was the first time in 2015 that they could show that there's kind of vitamin D resistance, like Professor Combra hypothesized years ago from a clinical perspective. And that was a very, very interesting feeling, because if you think about all the trials made with vitamin D, for example, in the multiple sclerosis, there were many intervention trials, and from the blood serum levels, it looks like they treated them well, but the results were very, very mixed. And if you now consider the fact shown by **Carlberg** et al that you have these 25% of non responses in the trial who do not respond to an average, sufficient dose of vitamin D, then if you consider that, then the results would be totally different in a way that if you consider that fact, then you normally, then you would have much, much better results in these trials.

SPEAKER B

I want to interject something here because you mentioned __pre diabetics__ not responding as well. There's interesting, I don't know if you're familiar, there's data from early 1920s metabolic study on Greenland Inuit Eskimos. And they looked at vitamin D levels in the development of rickets, which you know is a deficiency of vitamin D. And they found that the Inuits that were eating their natural native diet, even though they had relatively reduced vitamin D levels, did not exhibit signs of rickets. But if they were now eating a diet that contained a sugar and flour and canned goods, even with the same vitamin D levels, serum wise, they would develop signs of ricketts. So there could be this background. Im just wondering, what do you think gives us vitamin D resistance? Is it, does there, are there environmental or nutritional things that may be leading to this? Potentially?

SPEAKER A

Yes, of course. Of course. There must be very, very reasons beneath the surface on a genetic level and on an epigenetic level, who could explain that? Our paper we wrote is mainly on the acquired form of vitamin D resistance and we explain that later on in the paper. What we mean by acquired and what are the potential agents who could block the vitamin D system? And if you consider the vitamin D receptor, what is it and what does it does? What does it. The vitamin D receptor is a very, very old protein, hundred of million years old, and he is located in the nucleus of a cell and in the cytosol. 20% of it is in the cytosol and 80% in the, in the nucleus. And when the calcitriol is entering the cell and like. And then it binds to the vitamin D receptor. Then the vitamin D receptor is activated and goes into the nucleus and do some magic things. Magic sinks. What does it do in the nucleus? It regulates nearly 2000 genes as a transcription factor. And that's a very huge amount of genes. And it's a protein known for the most genes regulating. So the vitamin D receptor, it's a very, very interesting protein because when it enters the nucleus, it binds to genes which are stored very, very deep in the nucleus. And when I talk to my patients, I explain it. Like, for example, if yo

u have. Well, let me explain. The genes are chromatin. Yes. Chromatin strength. Yes. And we have 46 of those and they're up to five centimeter long. So in this very, very nucleus we have 46 five centimeter little strings called chromatin. And on these chromatin are our gen es. So there's absolutely no space in this nucleus. So only on the surface are the genes we need every day. And underneath are those stored for later things or for things you could n ot imagine in the. Yeah, yeah. So when, for example, we have a change in temperature fro m summer to winter, then you need many, many other genes. Or if you have suddenly a di sease, you need many, many other genes. Yeah. And you need something, a protein. Who could find those genes? For example, if you think chromatin as a spaghetti, if you have a b ig plate of spaghetti and you have on your spaghetti telephone numbers and very, very little written on your spaghetti, and beneath there is one number of a very, very old friend from school and you want to call him, then how could you find these numbers? You need arrows and you need glasses and you need light and tools to find on these spaghetti the telephon e number. And that's the job the vitamin D receptor does for us. He finds the genes in the n ucleus, bring them to the surface and make them readable. And so the regulation could kic k in. Without such a transcription factor, cells are not able to make their genes readable. An d the VDR is doing it for 2000 genes. And what are these genes? They're genes about nutri tion uptake. Yes, genes about the integrity of your intestinal barriers, like leaky gut. Without vitamin D, the cells could not glue together, for example. And very unknown fact is vitamin D is involved in detoxification via the bile acids. That's a very, very old mechanism to get rid of toxins. And without vitamin D, it does not function very well. And of course there is this i mmune system where vitamin D plays its action. And in case of an autoimmune illness. Yo u need to know that **Carlberg** showed with his work that the HLA cluster in immune cells. A nd to explain to the audience on the HLA clusters is the information for the immune cell to r ecognize our own tissue and to differentiate it from foreign invaders from antigens. These HLA clusters and every immune cell needs to have this book open and readable without th eir blind, and they do not know which or who to attack. Vitamin D opens the HLA clusters a nd there are a few clusters, and vitamin D is the only substance known to open these HLI c lusters. So without vitamin D, it is possible that your immune system is totally blind and cou ld not recognize your own tissue and mixed it like it's normal for an autoimmune immunity o r autoimmune disease. So that's why the vitamin D receptor is so potent and I so serious in autoimmune diseases. And what we show in our paper is the evidence in the literature that these vitamin D receptor could be blocked, easily blocked. And from an evolutional perspe ctive, it's very, very reasonable that it could be blocked because it's more five of four or 500 million years old, the vitamin D receptor. So in evolution, microbes need to find a way to ev ade our immune system. And why not take such a potent receptor like the vitamin D recept or? And if you look at the 3d structure of the vitamin D receptor, it's, it's big protein and ther e is a tunnel in the protein, a very, very small long tunnel. And it's a little bit like the death S tar, where you have this little tunnel where Luke Skywalker need to place his bomb to mak e the death Star explode. And that's really the same with a vitamin D receptor tunnel to bin d Kalzy trial must enter this tunnel and get deep down into the vitamin D receptor. And if yo

u have this tunnel, you could easily imagine that microbes could block such tunnel. And the y do. It is shown, for example, for the borrelia. Borrelia brockdophary **Lyme disease.**

SPEAKER B

Yeah, I'm sorry, Lyme disease, yeah, correct.

SPEAKER A

Yeah, the Lyme disease, yes. And if you. There's a very, very, there's a documentary on YouTube, it's called under our skin and it shows chronic Lyme disease patients with neurological issues, children and grownups, and it's such a severe disease. And maybe blocking the vitamin D receptor is one of the explanations why these microbes are so severe for our health, by blocking the most important, most important protein in regulating the immune system. And it's shown that it's blocked by that, the __deregulation of the vitamin D receptor is 50 times lower with borrelia Bharat. 50 times__. And so you put out the biggest player in the immune system with one microbe. And these are the things we discuss in our paper when we talk about an acquired vitamin D resistance. Yes.

SPEAKER B

So let me just ask you about some treatment. So you say you seen, you know, you were, you were amazed when you went to Brazil and you saw some of these amazing transformations with Ms. What have you seen personally, yourself, with utilizing vitamin D and any other things you might use? Because people are asking, do I need to take vitamin K with my vitamin D? How do you know? Are you seeing other, outside of MSG things? I saw someone talking about, they were a type one diabetic that was on Comibra protocol combined with even a carnivore diet. And they saw what they were claiming was resolution, which a lot of people would be skeptical about. But what are you seeing yourself?

SPEAKER A

Well, in our clinic, we treat over 1000 autoimmune patients, and we have a group above 700 **MS**

patients, 700, maybe 750. So we see many, many patients with autoimmune disease. And on YouTube, I published our statistics for the relapse remitting MS. As you know, we have different forms of MS. We have the relapse remitting and the primary progression and the secondary progression. And on YouTube, I presented the numbers for all three of these groups. It's really hard to believe if you have not seen it. We have here every second week, a colleague is visiting us to see how it works, what the reactions of the patients are, and they can't close their mouth. When you see a patient after three months of treatments, and after three months, 80% of the symptoms are gone. In patients, it's relapse remedy. In the secondary progression, it's a little bit more difficult as it is in the primary progression MS. But for the young patients and the rrms, the real life remitting is normally very often attacking young grownups. It's the most debilitating disease for young grown ups, for people from 20 to 40, and if they get into the vitamin D treatment, they almost relapse free. In four and a half years, I have seen now six relapses in a group of hundreds of RRMS patients. And if you consider, on average, 1.3 to 1.8 relapse a year, an RRMS patient has. So with our hundreds of

RRS patients, we normally would have seen hundreds of relapses every year. But in four a nd a half years, I've seen not more than six. **And so it's like you eradicate the disease**. Y eah, yeah. And yes.

SPEAKER B

No, I was going to say, you know, because you start these folks on this very high dose vita min D, you check their parathyroid hormones, I think you put them on a low calcium diet. I don't know if there's any other dietary restraints or any other supplements that you include, but are they on this now for life, or do they, do they come down on the dosage after time? How does it typically play out?

SPEAKER A

Well, we have both situations. We've seen, after a couple of years, we've seen that they go t a little bit more sensitive to vitamin D, and so we could reduce the dose. But let me explai n. We have on this planet different doses of vitamin D in the Comibra protocol. Comibra himself started in Brazil, and as it looks to us now, he needs higher doses than we need in Brazil. The average dose is 1.5 or two point of the body weight. So if an 80 kilogram person needs 160,000 units of vitamin D every day, that's in Brazil. And we think that is too epigen etic reasons. If you see, like mankind evolved on the planet, South America is epigenetic. V ery, very far from here, from Europe, middle Europe. So here in Europe, as we have for tho usands of years now, contact to milk, and milk has a very, very severe influence on calcium metabolism. We need such lower, need, lower doses than in Bristol. Here, on average, we have 1000 units for 1 body weight. __So an 80 kilo person starts with 80,000__. And after a couple of years, a minimum of one third, we could lower the dose up to 40 or 30,000. We could not promise, but we've seen it many, many times that they got more and more sensiti ve to vitamin D. And as low as a dose is, the less severe could be the side effects of vitami n D supplementation, and the less calcium fear or danger is there. And another difference t o the Brazil way of treating with high doses is that our patients need, very often need calciu m, while in Brazil, they need a very, very strict calcium diet. And we did that with our patient s for a couple of years, and then we noticed that they have a severe calcium deficit. So we treat with 1000 units of vitamin D and very often together with calcium. So it's totally differe nt from the Brazil way of the Comibra protocol. If we speak about side effects, the most fe ar of any educated doctor is kidney and hypercalcemia. But if we are right with our hypothe sis that there is acquired form of vitamin D receptor, then it should be that a high dose of vit amin D is not more dangerous than an average vitamin D dose for a non resistant person. And that's what we see in our population. We have not one in the last four years of any kid ney failure. We haven't seen it. We have seen a few hypercalcemia, only in the lab work, n ot in clinic symptoms. And what we could publish, a friend of us could publish this in nutritio n. He could show that we do no harm to the kidneys. It's the opposite. After a couple of yea rs in the vitamin D protocol, the kidney get better. So it's the total opposite of what our colle agues think. And the kidney data is already published. We published the hypothesis, and o ur kidney data is very close to publish, because we have the same statistics as professor A

mon in Germany with his patients. We think we are right. We think that the resistance is rea l, and that's why the high dose is not dangerous for patients. We need to monitor them. Tha t's totally clear. We need every three months in the first year, we need lab work, we need ki dney parameters, we need PTH, of course. Yeah. And we take a lot of, lot of stuff every thr ee months, and we take a 24 hours urine sample to see how the kidney works, how many c alcium is in the urine, how many phosphate, and how many protein, and receives very, ver y cautious monitoring. We could guarantee our patients that we do not harm with the protoc ol. It's totally the opposite.

SPEAKER B

When you're monitoring, you know, the parathyroid hormones, the renal function, calcium l evels and so on and so forth. Are you, do you, if you ever see a problem, how do you, how do you adapt to that? What do you do? Back off the vitamin D dose? Do you, do you chang e something else?

SPEAKER A

You mean if we see problems, right? Yes. Okay. Like I mentioned, kidney is normally not th e problem. Yeah. What we see temporarily is, like I said before, vitamin D is responsible for detoxification in the bile acid system. So if we treat or start giving the organism the needed dose of vitamin D, detoxification kicks in. And some patients notice that there have some s kin issues, like a teenager being in puberty. And what we see in the kidney tissue is that th ere's a little, little rise of creatine, creatinine, but it's temporarily for a couple of months, and then it goes down, and very often better than before. So we think that this is detoxification progress in the kidney tissue. And when it's finished, the kidney is better to filter than befor e. And for some people, and especially for those who are having **MS**
for 20 or 30 years, this detoxification is too strong. For example, if you rebuild a house, yes, you haven't. You buy an old house and you put out the windows and the heater and the flo or and everything together, and you still live in the house. You could do that if you're young, you could sleep and have a little stuff and you don't need heat because you're young. But t he old could not. So if a detoxification kicks in to. For nearly every organ system, that's too much for them. For those guys, we need much, much, much lower doses. But after a coupl e of years working this field, we are very experienced, sense what we offer, what starting d ose to a patient. And the rule is clear. As younger, as higher, we could get in, and as older, and as long as they have the disease, and the more severe the disease is, the lower the do se is. And very often in these very, very ill patients, we start with something like 20,000 ius a day, for example, outside.

SPEAKER B

Of Ms, because you mentioned that. And I'm just kind of curious as to, you know, if you're s eeing remyelination, you know, if you're seeing plaques going away. But what other autoim mune conditions are you seeing success with? Could it. Would it be safe to say that all, all autoimmune conditions could potentially benefit from this?

SPEAKER A

We hope that in the beginning, that would be insane. And we tried nearly everything. We do not reject any patients. So any freaking auto immune disease, which you see once in a lifetime, we say, well, let's try it. And so now we filter a few ones where it's very, very good treatable. And these are, for example, the chronic intestine diseases like morbid Crohn and colitis ulcerosa. Colitis ulcerosa are good, treatable with vitamin D, the rhymosoid illnesses, polyester, and the thoromosoid lupus erythematodis, for example, is good treatable. Psoriasis could be very easy treatable, but the biggest success is an MS. __So for every other autoimmune disease, it's less than in MS__. For example, this is a guess because I didn't do a statistic on psoriasis, it's between 50 and 60% success rate. For the intestinal diseases, it's between 60 and 70% of success rate. But with this very, very low rate of side effects, we could offer the treatment to any autoimmune patient. And let's look. Maybe you respond to it. For example, the type one diabetics, I have a couple of type one diabetics, children who had their diagnosis a couple of weeks before they come in our. And for those kids, yeah, we are successful to treat them with high dose vitamin D and a carbohydrate restriction and to make these insulin free interval bigger than it normally would be. One of the kids, after two or three years, still don't need insulin, and other kids need a little bit more doses of insulin, but compared to the average type one diabetics, is less. And besides the success rate in treating the autoimmune disease, you need to understand, or the patients need to understand that if you have an untreated vitamin D resistance, which you could see in this high elevated PTH. Yeah. With sufficient vitamin D doses, that's our claim. If you have PTH elevated and you have a normal range of vitamin D, then you are susceptible of vitamin D resistance. And if you do not treat it and you have an autoimmune disease, then the chance that you get a second autoimmune disease is very, very high, or even a third or fourth. And this is what literature shows, an average autoimmune patient has not only one, has two or three autoimmune diseases, and that's what we could protect. So if you do not could treat the autoimmune disease, we could at least protect them from getting a second one.

SPEAKER B

Is there a, you know, outside of the vitamin D protocol, is there anything else we're doing? Are you modifying their diethyde anyway? I mean, does diet have to play a role here? Does sleep, does exercise, sun exposure, any of those things? Haven't have it have a role in this stuff?

SPEAKER A

Yes, of course. When a patient comes to our clinic, they mainly come for the vitamin D protocol, the Comibra protocol. And so when we first met, we normally speak about vitamin D and for treatment because it's very, very strong in many patients, even the young ones, they don't need to do any additional therapy than to take the vitamin D and get rid of their multiple sclerosis. But as long as we know, the more we know our patients and the more we speak to them, we confrontate them with nutrition ideas, of course, and we confrontate them with physical exercise ideas. In our clinic, we have a very good friend of mine from the University of Heidelberg. He's a university teacher for physical therapy and thought therapy. And

so we recommend our patients to contact him to get a training protocol for MS, because training and MS, it's very, very strong combination. And of course, after a couple of meetings, we start talking about diet. And as you know, I come from the Paleo section and the keto section. I know your diet, which is very, very interesting and I recommend it. Those who are open to it, to eat only carnivore diet and **MS**
patients are very, very open to those ideas. It's very interesting. And so of course we offer it, and then I offer sleep management and many ideas how to correct sleep. And one very, very important thing is body temperature. You know that vitamin D resistance, our idea of the acquired form is due to microbes or to heavy metals. So of course we talk about chelation, but the microbes, why do the microbes could develop themselves in our organism? And one idea is that the internal milieu has changed and we could measure this by body temperature. And very, very often autoimmune patients are not very well temperated. So we see in Celsius, I don't know the Fahrenheit degrees. In Celsius, you should have 36, seven degree of Celsius, and patients have 35, 360. So they are one degree or even one point degree or even two degrees colder than normally there should be. And so then we start treating with thyroid hormone. Yeah, the t three form, not the t four, the t three form, to level up the temperature. And then the regulation kicks in, because thyroid hormone is as strong as vitamin D is, it's also have a nuclear receptor. And then suddenly both work together. And of course, we do measure sexual hormones in our patients. And then we have a third group of steroid hormones, and you have a little bit more synergism of these hormones, but not from the beginning on, like I explained. Yeah. People come to us with the idea of the Comibra protocol, and as they trust us more and more and see that it works, then they're open to other ideas of treatment, and then they get into a functional, holistic way of treating them.

SPEAKER B

There was one, somebody had a question about, you know, if you don't have **MS**
and you wanted to take higher doses of vitamin D for another issue, there's no. I mean, you can measure to make sure there's no danger with that. Can the average, if the average person that doesn't have vitamin D resistance, could they get in trouble with high doses of vitamin D?

SPEAKER A

I suppose, yes, it could. And it depends really on the PTH from the beginning on if you have an average vitamin D level of, let's say, 40 nanograms, a milliliter, and your PTH is above the middle of the Lorathe, as we explained. In our paper, then there is some hint of vitamin D resistance and then the experience kick in. We know that **MS**
patients have a very severe vitamin D resistance, so they need higher doses. And if you are not belonging to this group, then you start with a high dose of 1000 units per kilogram. You could easily suppress PTHev below the reference range. And in that moment, PTH is beneath the reference range, then you in danger of hypercalcemia. And that's why we monitor our patients so well for MS. We know we could easily work with these high doses every other condition, even conditions we do not know very well, we start from the lower end with 10

,000 or 15,000 a day, and then see after three months, what is PTH doing and how do they respond? Because a suppressed PTH brings you in danger of hypercalcia. And that's what we do not want in our clinic and we do not see, as I explained, because we are very carefu lly monitor our patients. There are two more signs of being overdosed. If you creatinine sud denly rises on the factor of 0.2. For example, if you have a creatinine of 0.8 and suddenly y ou have 0.1 or 0.11, which is defined as acute kidney failure, and suddenly your calcium ris es, then you are for sure overdosing your vitamin D. Yeah, yeah. So that's my really what I will say every patient. Yeah. Don't experiment with these high doses. Always start from the lower end and level and monitor yourself. If you don't have the money to work with therapis t. Yeah. Then start from the lower end, never from the top.

SPEAKER B

Yeah. So if someone, because there will be people that probably watch this, will try to do th is, and I want this to be cautious. So what you're saying is, you know, you start with a relati vely modest dose, 10,000 ius or something like that, look at your parathyroid hormone and you want it to be in the lower one third of the normal reference range. That indicates good hype, that indicates good vitamin D receptor sensitivity. You're not overdosing, your parath yroid is good, you're not going to get in trouble with hypercalceria and kidney stones and w hatnot. Correct?

SPEAKER A

Correct. Yes. Most valuable diagnosis, two for us is the 24 hours urine. It's the one where y ou could detect hyper or hypocalcemia very, very early on in the blood. Calcium is very well controlled. That's why PTH is there and other feedback hormones in the urine. You could s ee very, very early. If you have a problem with calcium. And here in our gene pool in our mi ddle european, which is very close to your gene pool in the United States, we see that mos t of the patients have two less calcium in their urine. And if you have two less calcium in yo ur urine over a long period, then your body starts to react, and then he's taking the calcium from your bones. And then suddenly you have too much calcium in your urine, then sudden ly you have hypercalciarhemia. Uremia. That's a difficult word for me. And that's why we ne ed the 24 hours urine sample as the most important too, because calcium in the zero in the blood is too good, controlled. Yeah, yeah.

SPEAKER B

I've almost never seen an abnormal range. Serum calcium, it's never very, very serious.

SPEAKER A

Serious signal for the body. And so we have these feedback mechanisms, but not for the ur ine. And there is where the danger starts. And that's why now. Yeah. I've never heard abou t the 24 hours urine sample in my clinical work, but since now I'm a Comibra protocol doct or, that's my tool, the urine doctor Lemke.

SPEAKER B

Unfortunately, we're running out of time for. I have to go do a consultation right now. But if someone is interested in learning more about this or even becoming a patient, I don't know

if you see people remotely, but certainly in Germany, how do they find out more about the Comibra protocol or learn more about this stuff?

SPEAKER A

To my knowledge, there are not so many Comibra protocol docs in the United States, and that's maybe due to your system here in Germany, we are a little bit more free to treat like we want as long as we do not harm our patients. And I think in the United States, the press ure is a little bit bigger for treating beyond the normal scope. And that's maybe the reason why there's not so many doctors in the US. And that's why a friend of mine phoned him a fe w days ago and said, I need an english website, and he's programming it to me. It's doc le mke.com. yes, it is. Yes, of course. Could you show it in your show notes, this website?

SPEAKER B

Yeah, I think if you send it to us, we can do that.

SPEAKER A

Yeah, it's docmindslamke.com. and so maybe I could spend some time in educating americ an patients in the treatment and to offer some help to this terra incognita.

SPEAKER B

Well, thank you so much for taking the time to share your knowledge with us. And I look, yo u know, and it's great you've been publishing some of this stuff. So continue the good work, and we'll chat again down the road. I mean, if I get to Germany, hopefully. I'd love to go ba ck sometime. So, anyway, it's great the invitation still stands.

SPEAKER A

So in that moment, we. We start acting like a normal society again. We need to be with us, Sean. Yeah.

SPEAKER B

Yeah, I'd love to.

SPEAKER A

Awesome. Okay. Awesome that you invite me. Thank you very. Yeah.

SPEAKER B

Okay. Thank you. Have a good evening. And Dakashane and Gutenabin and all that good stuff. Thanks, everybody. We'll see you guys tomorrow. Take care, everybody. Bye bye, no w.

SPEAKER A

Bye.