

# Results and effects in the diagnosis and treatment of diseases received in medical practice from “Complex medical expert” (CME)

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## INTRODUCTION

In modern medicine, the reliability, ease of maintenance and quality of diagnostic devices are crucial factors in the production of medical diagnoses and the determination of strategies for prevention and treatment of disease. In the words of Dr. Mark Hallett at the 19th World Congress of Neurology in Bangkok 2009, in many situations the neurologists have to cope with treating patients without the availability of much equipment. MRI and even CT scanners may be sparse. A sole EEG machine cannot be helpful if it is broken or is out of paper; a new digital model may be too expensive. Neurologists require better and more reliable resources.

The use of CME navigates diagnostic and therapeutic thinking and offers the following possibilities:

- to obtain rapid and wide-ranging information of the health-state (morbidity) of some patients;
- to evaluate the pathological condition of different human body biological systems and organs in mutual connections and common causal and pathogenetic continuity;

- to assess the particular character of the dominant impairment and its location and details;
- to determine a plan, a chain of required ancillary investigations to establish the tactics for systemic treatment and healing, e.g. an elaborate long-lasting recovery program: urgent (rescue) causal treatment, primary and secondary prevention, prophylaxis, palliative treatment (Drobný *et al.* 2006a).

Along with the diagnostic process to apply the automatic regulated energy-emission therapy through the reverse commutator by means of recombinant spectral samples chosen from a database containing 3.7 million recombinant spectral samples with a full spectrum of phase-planes; the efficacy of the spectral therapy to follow and materialize by means of blood pressure, glycemia, EEG, temperature measures and other readily available simple obligatory ancillary investigation results, and finally by means of repeated registration of spectral emission portraits to demonstrate changes in pathologic issues positively influenced

by spectral reversed therapy (Drobný *et al.* 2006a; Drobný & Statelová 2006; Drobný *et al.* 2007; Drobný 2006a; Drobný 2006b; Drobný *et al.* 2006b; Drobný *et al.* 2006c).

## RESULTS

### Patients' series, investigation by CME and result assessment

All series included 18,217 patients (pts) with an average age of 44.75 years. The maximum age of patients was 84 years and the minimum was 1 year, of whom 7,773 men with an average age of 45.25 years, (range 1–84) and 10,444 women with an average age of 45.47 years (range 1–84). Total patient amounts were randomly divided into:

**a. test group (TG)** by CME + classic neurologic investigation:

**14,508 pts** – with an average age of 44.44 (range 1–84);

Men – **6,053 pts** – with an average age of 44.44 (range 1–84);

Women – **8,455 pts** – with an average age of 44.43 (range 1–84);

**b. Control group (CG)** investigated by means of classic neurologic protocol:

**3,709 pts** – with an average age 46, (range 3–83);

Men **1,720 pts** – with an average age of 45.99 (range 3–83);

Women **1,989 pts** – with an average age of 46.40 (range 3–83). The structure by sex and age in both observed and control series is depicted below (Figure 1).

The following facts were detected – age of the control group is infinitesimally higher than in observed group (Table 1).

Share of male (alternatively female also) can be considered the same in both groups

Both groups are by “age- and sex-matched“.

Results of the statistic tests “(1)” and “(2)” corroborate that both groups are homogeneous showing a balanced and representative selection from the point of view of age and sex. Hence the data (Figure 1) indicates comparable structure of both of the series according to age and sex.

The following number of pts. were categorized in particular diagnostic classes (DC) (Table 2).

Numbers of pts in diagnostic classes (groups) according to ICD-10 are displayed below (Figure 2).

It is possible to say, referring to the composite of diagnostic classes, the professional specialization of the consultant out-patient department determined the composition of patients according to diagnostic conclusion and it was only marginally influenced by other circumstances. After the spectral emissivity compensation, the pathology of patients in 87.6% of the cases demonstrated improvement of subjective indicators of adverse pathological symptoms and sensations of pathological conditions, and at the same objective a significant impact on the status of the disease is not expressed and manifested in just 32.4% of them.

CME helped to identify a significantly higher number of valid diagnostic conclusions during initial contact with the patient and significantly facilitated to broaden the horizon of knowledge about a pathologic condition, namely in the state of inflammatory, neoplastic and degenerative markers, but also recognition precursors in dreams and into future possible manifestations and affections.

The diagnostic productivity and utility of CME at initial contact with the patient in comparison with classic propedeutic examination approach is shown below (Figure 3).

The graphic illustration shows the wider diagnostic range in CME approach compared to the classic course of examination despite the same professional skills to think, to make solutions and decisions that are applied in both series. The bases of the lineal-graph illustrates a range of 2–4 diagnoses using the classic procedure, but 6–7 diagnostic conclusions utilizing the application of the CME-system.

Diagnostic usefulness and productivity of CME and classic neurologic examination are depicted and compared below (Figure 4).

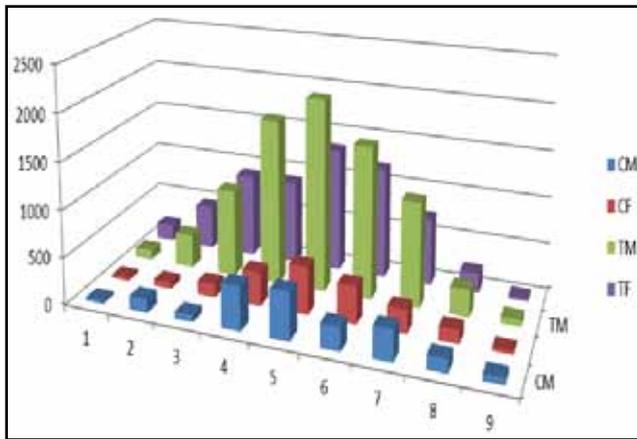
In the observed group of pts the gain of new diagnoses represents more than 350% while using the classic propedeutic neurologic procedure the addition of new diagnostic conclusions demonstrates a change of only 190% using the same skills in thinking, experience and level of education (Figure 4).

**Tab. 1.** Patients' series investigation by CME.

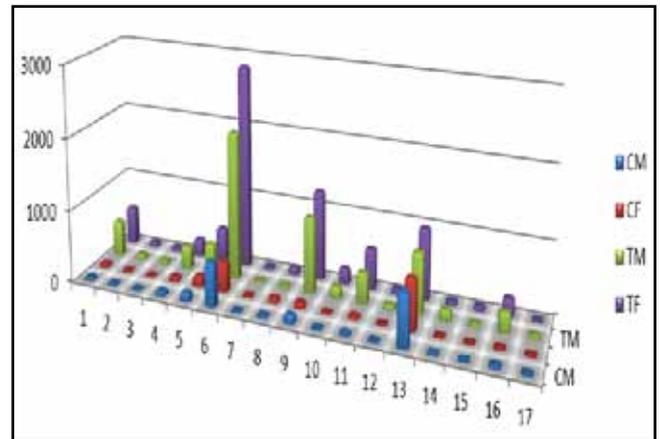
Two-Sample Assuming t-test with equal variances	Age in group CG	Age in group TG
Median	46	44
Variance	413.534	372.056
Observation	3,709	14,508
Common variance	378.819	
HYP. The difference of mean values	0	
Difference	1.7845	
t stat	2.186	
p (T<=t) (1)	0.024	
t crit (1)	1.688	
p (T<=t) (2)	0.042	
t crit (2)	2.114	
t crit (1)	1.645	
p (T<=t) (2)	0.039	
t crit (2)	1.866	

**Tab. 2.** Number of pts. categorized in particular diagnostic classes.

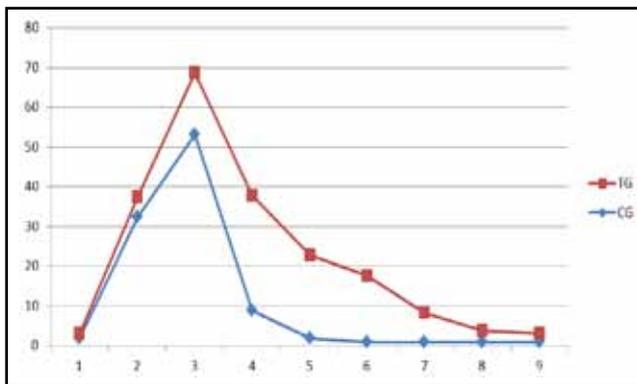
Diagnostic class (DC)	Observed disease	Total number of patients in DC	Number of patients in TG	Number of patients in CG
1	contagious and parasitic diseases	1,152	1,044	108
2	neoplasms	181	144	37
3	hemopoietic and blood tissue diseases	143	108	35
4	vegetative-endocrine system diseases	720	576	144
5	psychic disorders	1,188	900	288
6	nerve system diseases	5,935	4,896	1,039
7	eye diseases	96	72	24
8	ear diseases	252	144	108
9	blood circulation diseases	2,520	2,304	216
10	respiratory system diseases	414	396	18
11	gastrointestinal tract diseases	1,100	1,008	92
12	skin and subcutaneous tissue diseases	160	144	16
13	skeletal muscle and bone diseases	3,267	1,836	1,431
14	urinary system diseases	249	216	33
15	Inherent errors and deformations	120	108	12
16	group with signs and symptoms	612	540	72
17	injuries, intoxications and some other consequences of external causes	108	72	36



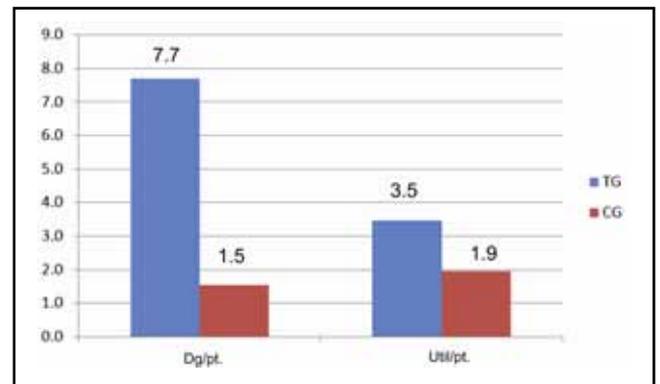
**Fig. 1.** Structure of both series by Age and Sex. CM = control group - male; CF = control group - female; TM = observed group - male; TF = observed group - female



**Fig. 2.** Diagnostic classes according to ICD-10. CM=control group of male; CF=control group of female; TM=observed group of male; TF=observed group of female.



**Fig. 3.** CME productivity. CME productivity is tapered since 4 diagnostic conclusions/one course till 8 (in TG), whereas in CG diagnostic productivity is tapered between 4 and 5 diagnostic conclusions/one diagnostic course; control group; TG = observed group



**Fig. 4.** Diagnostic usefulness and productivity of CME. Dg/pt = mean number of diagnostic conclusions; util/pt = index of diagnostic utility; TG = observed group; CG = control group

**Tab. 3.**

	Age in group CG	Age in group TG
Median	1.83	3.66
Variance	1.044	1.819
Observation	<b>3,709</b>	<b>14,508</b>
Common variance	0	
HYP. The difference of mean values	4216	
Difference	<b>-8.53</b>	
p (T<=t) (1)	<b>1.18353E-15</b>	
t crit. (1)	1.651	
p (T<=t) (2)	2.56706E-15	
t crit. (2)	1,971	

p-value of statistic test 1.18E-15 expressly gives evidence in favor of an alternative hypothesis. A significantly lower number of diagnoses were verified in the group CG in comparison with group TG.

## DISCUSSION

With reference to composite diagnostic classes, we can say that the professional specialization consulting outpatient department determined the composition of these patients according to diagnostic conclusion and it was only marginally influenced by other circumstances. The patients alleged improvement of adverse subjective persistence of pathologic symptoms and perception of pathologic conditions after spectral emission therapy in 87% of cases as was the case when illness was not also objectively influenced (in 38% of them) .

CME helps to realize a significantly higher number of valid diagnostic conclusions even at the initial contact with the patient and thus significantly widens our horizon in the pathologic condition of inflammatory, carcinogenic and degenerative markers, but also recognition precursors of dreams and into the future possible manifestations and affections.

Evidently, the semiotic, syndrome identification and diagnostic skill of the experienced neurologist at the primary investigation, according to the classic neurologic protocol, is excessively high. Although, at the same time, there are the etiologic or at least etio-pathogenetic diagnoses with eventual clarification of a sufficiently wide range of a pathogenetic chain of illness (its decisive part necessary for a sufficient range of effective treatment and a sufficient level of knowledge about the pathologic state), that have a substantial influence on the further management, medical and agreeable treatment results.

Currently, the practice of medicine in the 21<sup>st</sup> century involves the primary medical investigation where at first contact the doctor must spend a relatively extended time without an objective substrate of the

underlying condition, hence he/she has no certainty in diagnostics, he/she only presumes about it and his/her professional experience supports a very passing implicit certainty but does not abolish explicitly any uncertainty. At the initial application of CME they have "in real time" certitude, support and can verify the validity and objectivity of indexes, markers, precursors with lesser presumed values. Indexes correlating with subjective symptoms (subjective/objective history) and objective medical examination findings they believe valid and the substrate of the disease state since the onset of the first contact with the patient.

Therapeutic influence over indexes of acute, chronically ill conditions together with markers of inflammatory, degenerative or neoplastic processes (by means of reverse recombinant spectral emission markers) works positively upon the function of respective organs or systems (such as the stomach, heart, insular cells of the pancreas, kidney, adrenal glands as well as cardiovascular, gastrointestinal, vegetative, endocrine, immune systems and others) if significantly frequent and the influence lasts according to follow-up transiently for 1–7 weeks. There is a significant difference in the duration of the course of treatment with CME due to individual differences in the patients.

We consider the positive therapeutic effect of recombinant spectral emission samples to be the confirmation of diagnostic conclusion and correct or adequate therapeutic-pathogenetic influence to be effective in discovery of the pathogenetic chain (it is a therapeutic test confirming correctness of pathogenetic diagnostics – thus the test confirms the correctness of diagnostic conclusion). Effectiveness of the energetic emission treatment is measured "on line" by blood pressure, glycemia, heart rate, temperature, EEG, EMG, CT, MRI and repeated spectral portrait registration and its pathologic CME-indexes "0", "53..." which are changed to the normal indexes or transmitted from the red-acute field to the green (to become healthy), white (to be only a remnant or vestige – to get over an illness) or yellow fields (to be in a chronically ill state) which means a long lasting pathologic state with different functional restriction (failure).

We observed 92pts with acute viral influenza by means of repeated registration of spectral portraits before, during and after PK-Merz (amantadine sulphate). Transmission was made of the red viral influenza positive indexes during treatment with a constant daily dose of 2 × 1 table.

(tab. 75 mg) (Drobný 2006b). The positive influenza virus indexes transmitted from the red field – acute florid contagious disease – into either white – adjacent fields, which means overcoming current fever disease with resting markers of illness, or a green field denoting complete healing without interruption. Registered changes relating to positions of positive influenza virus indexes correlated with the clinical picture, in addition to the antiviral influence (attenuation of influenza

viruses) of recombinant reversal spectral samples accelerated the healing process of the contagious conditions and increased the number of transmitted positive viral influenza CME-indexes "0" or "53..." into the adjacent white marker zones, or green zone which means the complete restoration of the healing processes. In comparison with the group treated only by PK-Merz, the group treated by combined cure – PK-Merz + CME reverse spectral recombinant marker, the velocity and completeness of the healing process was better in the combined group of treatment. The "open clinical trial" – a pilot study showed a possible trend of CME application in clinical research.

CME helps most frequently to discover the following pathogenetic factors underlying in central nervous system (CNS) diseases and/or the peripheral nervous system (PNS) illnesses (Drobný *et al.* 2006c; Sániová *et al.* 2009):

In 38% hypertonic regulation of blood circulation – renal, adrenal, sympathetic, idiopathic, hypothalamic, hypertension.

In 32% of disorders of carbohydrate and/or lipid metabolism, with secondary encephalopathy, polyneuropathy, myelopathy.

In 46% chronic lesions of the upper respiratory tract (GRP) with a pronounced disorder of the immune system or without it.

64% of patients were found to be carriers of the activated viruses (namely, the herpes virus – herpes simplex 1 (HSV1), herpes simplex genitalis (HSV2), Epstein-Barr virus (EBV), rotavirus, Coxsackie virus, infectious mononucleosis virus (IMV), cytomegalovirus (CMV), influenza viruses.

Chronic disorders of the gastrointestinal tract in 72% (gastro, dyskinesia of the biliary tract – gallbladder, bile duct, cystic duct), inflammatory lesions of the gallbladder without concretions (stones), with hypotonic-atopic gallbladder, calculous cholecystitis, which occurs in women three times more often than in men, followed by neuropathic visceral nerves and plexuses, including the AV-bundle correlated with cardiac arrhythmias.

Acute lesions of gastro-duodenal complex – gastritis, duodenitis, acute gastric ulcer, duodenal ulcer and/or gastro-duodenal-esophageal reflux disease simulating vertebral pain between the shoulder blades, hence the area of projection based on the projections of visceral zones according to Haed's discoveries.

Hidden forms of pyelonephritis, pyelitis and cystopyelitis in 48% of patients, latent forms of glomerulonephritis in renal hypertension, which correlated with measurable indicators of albuminuria and hypertensive blood pressure, namely diastolic, along with vasomotor headache, lacunar brain infarcts, attacks of vertigo – dizziness and Parkinson's disease of the lower extremities.

Dysuric states with established underlying prostatic inflammation, urinary bladder inflammation or S3

segment myelopathy – a functional inability to control urination (24%).

Focal infection of teeth, nasal mucosa, pharynx, tonsils, chronic infectious lesions in 96.2% of patients.

Yeast and fungal urinary organs, muscles, skin, joints, spine in 52% of patients who received frequent treatment with antibiotics or corticoids together with antibiotics.

Polyneuropathies with the underlying muscle myelopathy, uremia, hepatopathy in 33%, encephalopathy in 28%, meningopathy in 25% and were significantly more frequent in migrenepodobnyh, pathological changes of cerebrospinal fluid in 15% of patients, confirmed by lumbar puncture (prospective or retrospective study of cerebrospinal fluid).

Slow virus encephalitis encephalopathy mimics multiple sclerosis (MS), acute disseminated encephalitis in 14% of patients in the observed group.

Given the results of the diagnosis, we can use treatments very well with the application of Western and Eastern medicine, so we can determine an optimal plan for additional research on the basis of the results obtained through CME.

The typical signs of acute illness (Figures "0" and "53..." in the red box) or long-term chronic changes (the same figures in the yellow box) that can alter or prevent the complex of the classical measures for primary prevention of disease or prevention of compensatory correction proposed by CME (Drobný *et al.* 2006a).

The data in the green box means a state of convalescence, and chronic changes emanating from the past (yellow box), more or less recovered or permanent functional defects, which we confirmed by additional laboratory tests or can be compared with their previous results from the medical records. Subjectively perceived symptoms described in the individual subjective or objective history of the disease also correlate with the findings of the CME (Orželskij 2005; Fedotkin, Orželskij 2003). In this sense, CME eliminates "polypragmasy" additional surveys, saves time as well as financial and human resources. CME also offers support for alternative methods of diagnosis and treatment – homeopathy, acupuncture – that are physically detectable on a spectral-energy basis and reproduced portraits, quantified by statistical methods. CME may help to determine, to objectify and to trace the effects of treatment (Fedotkin & Orželskij 2003).

## CONCLUSION

We are convinced that the method of CME in the diagnostic process at the initial contact with the patient provides an excellent guide as a physician's assistant in the diagnosis and planning of an effective treatment strategy for the patient. Data obtained using this method, the results of practical work in the so-called "open clinical trial" in a series of 14,508 patients and a control group with an appropriate age and sex

(n = 3,709 patients) have confirmed these findings. The computerized system, based on the medical application of which is controlled by an automated spectral compensatory correction method of spectral recombinant markers (each of which contains 3.7 million revolving phase planes), offers a new, modern, fast, effective, cost-effective system invaluable in terms of speed, range of application, flexibility, completeness and accuracy.

The system of CME also offers, in addition to the existing practical diagnostic and treatment approaches, the opportunity for research work in various fields of medicine using methods that are not invasive interventions in human organs and systems at the primary medical contact with the patient. These methods have so far not been used in clinical medical practice, and they can detect acute, chronic and protracted (latent) processes and markers of past treatment of pathological processes. The CME system supports a broader understanding of the disease in a particular case, and speeds up the definition of detention in the narrow therapeutic window for the application of the most effective therapeutic intervention. Treatment results obtained using the automated approach of the spectral correction of the patient, are also impressive.

We continue to evaluate the effectiveness of the spectral correction methods of re-registration of spectral portrait of the patient, demonstrating the increased use of effective alternatives for pharmacological methods of treatment. Control of inflammatory markers, tumor markers, markers of degeneration is one of the non-invasive approaches to diagnose different diseases, with authority to make long-term observation of changes of the markers in "real time", which is an advantage compared to the lengthy, uneconomical and hardware biochemical studies, which have been implemented for a long time.

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