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*The Blending of Conventional and Alternative Philosophies*

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Re: [ILADS] paper on treating borreolosis with Candida

Candida is a real, and overlooked, and undertreated, and misunderstood, and maligned as Lyme disease. I recall when I started to practice in CT< and ran head-on into the epidemic of Lyme (54% of families in Wilton!) I was getting info from the local docs, and I asked one of the prominent Lyme specialists what he did about Candida. He responded that he never saw it! Over the next few years, I saw several of his patients, and two had vaginitis as a major complaint, for which he had prescribed the standard OTC creams – but he never saw it as a systemic problem, and as far as I know he still doesn't.

We were taught in Med school that systemic candida was a fatal complication of immune suppression, as with cancer and chemotherapy, and eventually with AIDS. Otherwise it was a “normal” intestinal flora. Just as the IDSA hasn't budged on Lyme they haven't learned that the relationship with candida has changed drastically since the advent of the high sugar diet, the antibiotics, the Birth control pills and the steroids, which together have created a monster. Orion Truss, MD wrote a great little book in 1976: *The Missing Diagnosis* in which he correctly identified the colon as the source of the overgrowth, and with Nystatin and probiotics and a low carb, low yeast diet he could clear not only the GI problems, but also the vaginitis and a host of other symptoms such as fatigue, rashes, migraines and other chronic headaches, myalgia, arthralgia, etc, etc. However, it didn't take long to discover that the worst cases had negative stool cultures and negative antibodies, so many doctors discarded the baby with the bath water. I believe that the negative cultures come about after the colony of yeast reaches a critical mass and a consciousness for self preservation (Read a new book – *The Biology of Belief* by Bruce Lipton, PhD, a cell biologist who supports that notion scientifically) and it sends “roots” into the gut wall to anchor itself against the eventuality of a purge that would leave the colony “out in the cold.” That provides a more reliable source of nutrition, and the colony gradually becomes converted into an “underground” system of fungal filaments with a negative cultures of stool. The negative antibodies are characteristic of immune suppression, just as in Lyme. That is a “systemic,” non-fatal candida infection. Dark field microscopy, now outlawed by CLIA, frequently showed mycelial forms in the blood, which cleared when the absorbable antifungal drugs were used, but not Nystatin, which “cant get to the roots” like a lawnmower removing the dandelions temporarily. (it is still very useful to prevent overgrowth, or in early cases, and is very safe because it is not absorbed.

How to diagnose? Rectal brushings can be stained for the fungal elements. (In a study that I reported in 1985, 55% of patients that I had clinically diagnosed as having candida were found to have parasites on the same specimens! That was in NYC – I am not finding it that high in Phoenix.) In patients who do make antibodies, the presence of antigen/antibody complexes is diagnostic of invasion. Some patients even have + PCR. (I don't know why others do not, but absence of evidence is not evidence of absence.) The reaction to candida antigen by skin test is both diagnostic and useful therapeutically to treat the enormous allergy that most of these patients develop, and which frequently leads to spreading allergies to foods and chemicals. One of the big breakthroughs in indirect diagnosis is by finding yeast metabolites in the urine – Tartaric Acid and Arabinose are pathognomonic. (Dr. William Shaw at Great Plains Labs discovered this while doing his Organic Acid test. Other dysbiotic organisms can also be recognized by their specific products, which are not part of human metabolism.) Diflucan, Sporonox, Nizoral, and Lamisil were all effective, but Diflucan has been castrated by the FDA's ill-advised decision to allow treatment of chronic vaginitis by a one day course of therapy, which has allowed the rapid emergence of resistant strains – most patients need a month of intensive diet, probiotics and system antifungals. Occasionally IV Amphotericin has been necessary. Some newer agents are not out long enough to be safe despite FDA approval, in my opinion.

Since the recent reports from Germany, I have been using Diflucan again, from the gitgo, as part of an intensive program to restore healthy colonic flora, while waiting for the results of Lyme workup. It will cause a Herx from heavy candida alone, so it can't be relied on as being indicative of the Lyme Herx.

If you have read this far, I thank you for your perseverance.  
Warren M. Levin, MD.