Table I: Collagen Tissue Diseases (Rheumatoid Diseases), and Associated Rheumatic Disease Conditions

Collagen Tissue is the main organic constituent of connective tissue and of the organic substance of bones. As such, it is pervasive throughout the human body.

Clinical Name of Disease                                      Symptoms, Onset and Body Locations

Acute Cholecystitis                                          See Table II.
Acute Meningitis                                             See Headache, Table I and Table II.
Acute Pancreatitis                                            See Pancreatitis, Table I.
Adenoid Hyperplasia                                          See Amyloidosis, Table I.

Adenoid Hyperplasia is enlargement of adenoidal tissue due to lymphoid excessive proliferation of normal cells in a normal arrangement (hyperplasia). This condition occurs in children and may be physiologic or secondary to infection or allergy. Obstruction of the eustachian tubes may result in recurrent acute, chronic, or secretory (serous) otitis media. Obstruction of the passageway between the nose and pharynx (choana) may cause mouth breathing, a hyponasal voice and pus forming or running in the nostril (purulent rhinorrhea).

See Hypersensitivity Penumonitis, Table I.

Alopecia                                                     Partial or complete loss of hair resulting from genetic factors, aging, or local or systemic disease, such as seborrheic dermatitis and Psoriasis. See Psoriasis, Table I.

See Amyotrophic Lateral Sclerosis, Table I.
See Amyloidosis, Table I.

Amyloid resembles starch, and is a white insoluble protein substance found as an abnormal deposit in various organs. Homeogeneous, translucent and colorless, it consists of protein-carbohydrate fibrous or filamentous (fibrillar) amyloid in amounts sufficient to impair normal function of the tissues or organs. The appearance of Amyloidosis may or may not be associated with a specific disease. It can be found associated with chronic diseases such as tuberculosis, Alzheimer's disease, dilatation of the bronchial tubes (bronchiectasis), inflammation of the bone and marrow (osteomyelitis), leprosy, marrow plasma cell tumors (multiple myeloma), lymph system cancer (Hodgkin's disease) and other tumors, or inflammatory Rheumatoid Arthritis. In primary Amyloidosis -- without associated disease -- the heart, lung, skin, tongue, thyroid gland and intestinal tract may be involved. Localized amyloid "tumors" may be found in the respiratory tract or other sites. The liver, spleen, kidney and vascular system are frequently involved. In secondary Amyloidosis -- with associated disease -- there is a predilection for the spleen, liver, kidney, adrenal glands and lymph nodes. However, no organ is spared and vascular involvement may be widespread. The liver and spleen are enlarged, firm and rubbery. Kidneys are usually enlarged. Sections of the spleen show large, translucent, waxy areas. Amyloid associated with certain tumors (multiple myeloma) may be widespread and may show unique sites of involvement, or the Amyloid may be a local occurrence associated with some malignancies. Symptoms are non-specific and will often originate in the organ or system affected by the Amyloid tissues. There are, therefore, different, distinct pathologic signs and symptoms depending upon the organ or system affected. Some forms may resemble cardiac failure, or nerve dysfunction (peripheral neuropathy), skin disease, or Hashimoto's or Reidel's Struma. Amyloid Arthropathy may mimic Rheumatoid Arthritis in some cases of multiple myeloma (Cancer). Secondary Amyloidosis recovery depends on successful treatment of the underlying disease. If successful, then, Amyloidosis can be arrested. See Muscular Atrophies, Table I.
See Allergic Purpura, Table II.
See Anemia, Pernicious, Table I. Also see Splenomegaly, Table I.

A gradually increasing increase in size of red corpuscles (macrocytic) and lowered color index of blood (hypochromic) anemia with usually deficient supply of hydrochloric acid (achlorhydria) and a deficiency of a specific factor with enzyme-like properties present in normal gastric juice, called "intrinsic factor," or "Castle's Intrinsic." This factor interacts with food to produce the antiperinicious anemia principle which is required to transport B12 across the intestinal mucosa. Anemia develops in most patients insidiously and progressively as large liver (hepatic) stores are depleted. Gasterectomy, Chronic Atrophic Gastritis, Table I, and Myxedema, Table I, may also cause deficiency. Competition for B12 may also occur from invasive organisms. Absorptive sites in the ileum may be destroyed by inflammatory Regional Enteritis, surgical resection, or because the producing cells are congenitally absent. There are other causes, such as malabsorption syndromes, chronic pancreatitis and use of various drugs. Enlargement of the spleen (Splenomegaly, Table I) and liver (Hepatomegaly, Table I) may sometimes be seen. Various gastrointestinal manifestations may be present, including loss of appetite (anorexia), intermittent constipation and diarrhea, poorly localized abdominal pain, a sensation of burning of the tongue (glossitis), and weight loss. A transient burning or prickling sensation (paresthesia) may be felt in the upper extremities, or other peripheral nerve sensations (periph-
Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment. General data include: mild hypothyroidism, and moderate hyperthyroidism with goitre or without goitre, Table I. 

**Asthma**

Reversible airways obstruction which can occur secondarily to a variety of stimuli. A person may suffer from subclinical symptoms. Stress may precipitate an overt attack. These stimuli may include viral respiratory infections; exercise, emotional upset, changes in barometric pressure or temperature, inhalation of cold air or such irritants as gasoline fumes, fresh paint and other noxious odors, or cigarette smoke, and exposure to specific allergens, as well as psychological factors. About 10 to 20% of the adult population suffer from "extrinsic asthma," exposure to airborne pollens and molds, house dust, and animal danders. Perhaps 30 to 50% of adult asthmatics have episodes triggered by nonallergenic factors (infection, irritants, emotional factors), or "intrinsic asthma." Presents with coughing, rapidity of respiration (Tachypnea), shortness of breath which is sometimes painful (dyspnea), tightness of pressure in the chest, and wheezing.

**Atrophic Gastritis** (with iron deficiency)

Acute or chronic inflammation of the gastric mucosa. Wasting away or diminution in the size of cell, tissue, organ or part of the gastric cells, often with inflammation. Patients complain of nausea and pain, also in the upper middle portion of the abdomen, over or in front of the stomach (epigastric distress). There is lack of hydrochloric acid (hypochlorhydria) at least in sections of the gastric mucosa. Fatigue, weight loss, mild anemia, and muscle stiffness may occur in severe disease. Inflammation of the eye (Iritis, Table I) (less than 25% of cases) and involvement of the heart (cardiac) (less than 10% of cases), including cardiac abnormalities (arrhythmias) or aortic insufficiency. See **Ulcereative Colitis**, Table I.

**Anterior Uveitis**

See **Uveitis**, Table I.

**Arthralgia**

Pain in a nerve, or radiating along a nerve (Neuralgia) or pain in a joint.

**Atrophic Gastritis** (with pernicious anemia)

See **Atrophic Gastritis** (with iron deficiency), Table I.

**Basedow's Disease**

See **Hyperthyroidism**, Table I.

**Bell's Palsy**

Sudden onset of facial paralysis, presumed to be a swelling of the nerve due to immune or viral disease, whence compression on the facial nerve creates the disturbance. Pain behind the ear may precede the facial weakness, which can develop to complete paralysis in a matter of hours. The involved side is flat and expressionless, and patients may complain about the seemingly twisted intact side rather than the side involved. In severe cases the patient cannot close the eye. A lesion near one of the nerves (proximal) may affect salivation, taste and tears (lacrimation) and may also result in an abnormally acute sense of hearing, or a painful sensitiveness to sounds (hyperacusis). Also see **Lyme Arthritis Disease**, Table II. See **Arthritis**, Table I.

**Bronchial Asthma**

See **Lymphoma**, Table I.

**Bursitis**

Acute or chronic inflammation of a bursa, the saclike cavity with fluid that surrounds the location where tendons pass over bony prominences. **Bursitis** may be caused by trauma, acute or chronic infection, inflammatory **Arthritis**, Gout or Rheumatoid Arthritis. Acute **Bursitis** is characterized by pain, local tenderness, and limitation of motion. Swelling and redness is frequently present if the bursa is superficial. Chronic **Bursitis** may follow prior attacks, or repeated trauma or foci of infection. The bursal wall is thickened, with degeneration of the tissue surrounding the bone (endothelial lining). The bursa may eventually contain adhesions, threadlike processes from the synovial membrane (villi), calcium (calcareous) deposits and muscle atrophy. Pain, swelling, tenderness, muscle weakness and limitation of motion vary.
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Attacks may last from a few days to several weeks, with multiple recurrences. Tendon or muscle tears must be ruled out, as well as inflammation of the bone marrow (osteomyelitis), tuberculosis, and cellulitis.

Candidiasis
See Candidiasis, Table II, and Regional Enteritis, Table I.

Carcinoma
A tumor occurring in the covering of the skin and mucous membranes (epithelium) which tends to spread to other organs (metastasize) throughout the body.

Cardiac
See Rheumatic Fever, Table II. Also involves heart Dysrhythmias, Table I, Myocardial Disease, Table I, and Pericardial Disease, Table I.

Cardiomyopathy
See Myocardia, Table I.

Carpal Tunnel Syndrome
One of a number of single or multiple nerve conditions involving sensory, motor, reflex, or blood vessel contraction and expansion (vasomotor) functions, is called Peripheral Neuropathy, Table I. In this classification is found Carpal Tunnel Syndrome, which is an entrapment of a middle (median) nerve compressed between the wrist (longitudinal carpal ligament) and hand muscles and a ligament that is perpendicular, passing across the wrist (transverse carpal ligament.). With Carpal Tunnel Syndrome there is wrist pain, an abnormal, burning or pricking sensation (paresthesia and sensory deficit) radiating from the palm of the hand (radial-palmar) and weakness of thumb opposition. Although infectious agents may be responsible, this condition is considered a symptom complex rather than a disease entity. Diabetes, mechanical trauma, surgery for tumors or ruptured intervertebral discs can also cause the problem. Arthritis, Table I, Fibrositis, Table I, and Dermatomyositis, Table I, may also simulate the condition. Carpal Tunnel Syndrome usually recovers rapidly with treatment, but may recur if the cause is not avoided. Recovery may be incomplete, with sensory, motor, or blood vessel motor nerve (vasomotor) residual symptoms, and in severe cases there can be chronic muscular atrophy as well.

Celiac Disease
A chronic intestinal disorder caused by intolerance to gluten. Cereals, for example, will bring about an insidious onset of symptoms after ingestion. Age of onset is typically 6 to 18 months, though symptoms may appear or reappear from age 20 to 50. There is depression, abdominal distention and muscle wasting. Stools are usually soft, pale and malodorous. May have attacks of vomiting, and tests may show iron deficiency.

Celiac Sprue
"Charleyhorses" sand Leg Aches
Chlorosis
Chronic Discoid Lupus Erythematosus
Chronic Hepatitis

Chronic Lymphocytic Thyroiditis

Chronic Pyelonephritis
Celiac Disease
Cogan's Syndrome
Collagen Tissue Disease

Conjunctivitis
Corpus Luteum Cyst
Cranial Arteritis
Crohn's Disease
Cutaneous Lupus Erythematosus

A disease of the main organic constituent of connective tissue and of the organic substance of the bones. Inflammation of the delicate membrane that lines the eyelids.

Spontaneous Myxoedema -- without goitre, Table I.)

See Acute Pyelonephritis, Table I.

See Celiac Disease, Table I.

See Polyarteritis., Table I.

A chronic and recurring condition affecting the skin, and characterized by discolored spots or stains and plaques displaying a skin redness due to congestion of capillaries (erythema), hair follicle plugging, scales, dilatation of small capillaries and minute arteries which form small tumors (angioma), and atrophy. This condition is often divided into lesions above the skin, and those lesions affecting the rest of the body. Exposure to sunlight frequently precedes the initial appearance of lesions. The disease is more
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**Cyclitis**

**Cysts**

**Cytopenia**

**Dermatomyositis**

**Diabetes Insipidus**

**Diabetes Mellitus**

A syndrome characterized by abnormal insulin secretion and various metabolic and vascular manifestations as shown by inappropriately higher blood glucose levels, thickened capillaries, accelerating atherosclerosis and nerve disease (neuropathy). Numerous laboratory measurements have been made of various physiological factors, but, it seems, no definitive early warning test has yet been found. **Diabetes Mellitus** consists of a set of symptoms that vary from insulin shock to a coma produced by incomplete metabolism of fatty acids (ketosis). Symptoms for Ketosis, or Ketacidotic Coma are: Insulin is insufficient, the onset is gradual by days, there may be preceding illness or stress. Physical examination will present appearance as extremely ill, skin as dry and flushed, there may be infection and fever. Gastrointestinal symptoms may present with a mouth that is dry, thirst intense, hunger that is absent, common vomiting, and frequent abdominal pain. Respiration may be exaggerated, air hungry. The breath will have an acetone odor, and blood pressure will be low, pulse weak and rapid, eyeballs soft. In insulin shock, food intake may be insufficient, insulin excessive, and onset more gradual. Illness may be absent. Physical appearance will present as very weak appearance, moist and pale skin, absent infection, but hypothermia may be present. Gastrointestinal symptoms present as a drooling mouth, absent thirst, occasional hunger, rare vomiting, and no abdominal pain. Respiration will be normal or shallow, blood pressure normal, and acetone odor of breath very rare. Blood pressure will be normal, pulse as full and bounding, and eyeballs normal. The earliest symptom of elevated blood glucose is an excessive secretion and discharge of urine containing increased solids (polyuria). Continued excessive sugar in the blood (hyperglycemia) and urine (glucosuria) may lead to thirst, hunger and weight loss. Excess sugar in the urine may lead to fungal infection of the vagina and itching. Accelerated fat catabolism in certain patients produces loss of appetite (anorexia), nausea, vomiting, air hunger, and, if untreated, coma and death. Onset tends to be abrupt in children and insidious in older patients. Additional factors complicate this condition, such as large vessel atherosclerosis and microvascular disease. Diabetic disease of the retina (retinopathy) is usually detected 5 years or more after diagnosis of **Diabetes Mellitus**, but is present to some degree by 10 years in 50% of patients. Nerve involvement may be characterized by lancing pain, and there can be other presenting or laboratory symptoms.

**See Hypersensitivity Penumonitis**, Table I.

**See Hashimoto's Thyroiditis**, Table I. (Also similar to **Primary Myxoedema**, Table I; or **Spontaneous Myxoedema**—without goitre, Table I.)

**See Herniated Nucleus Pulposus**, Table I.

**See Cutaneous Lupus Erythematosus**, Table I.

**See Multiple Sclerosis**, Table I.

**Abnormality of heart rhythm. Also see Myocardia, Table I, Pericardia, Table I, and Rheumatic Fever**, Table II.

**See Ulcerative Colitis**, Table II.

**See Sarcoidosis**, Table I; also **Ulcerative Colitis**, Table II; also **Allergic Purupura**, Section II.

Esophageal webs may develop in patients with iron deficiency anemia, or without an overt anemia. They are usually located in the upper esophagus and produce difficulty in swallowing (dysphagia) solid foods. The webs disappear with treatment of the anemia.
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**Extrinsic Allergic Alveolitis**  
See **Hypersensitivity Pneumonitis**, Table I.

**Fetal and Ovum Abnormalities**  
See **Ovum and Fetal Abnormalities**, Table I.

**Fibromyalgia**

A group of common illnesses, non-specific in nature, characterized by pain in the muscles. Also see **Fibrositis**, Table I and **Fibromyositis**, Table I.

**Fibromyositis**

A group of common illnesses, non-specific in nature, characterized by pain, tenderness, and stiffness of joints, muscles, joint capsules and adjacent structures and inflammation of the muscle tissues. See **Fibromyalgia** and **Fibrositis**.

See **Uterine Fibroids**, Table I.

**Fibromyalgia**

Similar to **Fibromyositis**, Table I with inflammation of the fibrous connective tissue components of muscles, joints, tendons, ligaments, and other "white" connective tissues. Various combinations of **Fibromyalgia**, **Fibrositis** and **Fibromyositis** may occur together as "simple rheumatism," known as **Palindromic (recurring) Rheumatism**, Table I. Any fibromuscular tissue may be involved, but the most frequently are low back (**Lumbago**, Table I), neck (**Torticollis**, Table I), shoulders, thorax (**Pleurodynia**, Table I), and thighs (**Leg Aches**, Table I, and "Charleyhorses"). **Torticollis** is tonic or intermittent spasm of the neck muscles causing rotation and tilting of the head. **Fibrositis** pains can be brought on or intensified by trauma, exposure to dampness and cold, and by rheumatic problems. A virus or toxemia -- the effect of absorption of bacterial toxins or products formed at a local source of infection -- is felt to be causative sources. Environmental or emotional stresses may play a role. Onset of pain is often sudden, and aggravated by movement. Tenderness may be present, perhaps localized. Muscle spasm may exist. Occasionally considered in retrospect as an early onset for **Rheumatoid Arthritis**, Table I, **Polymyositis**, Table I, **Polymyalgia Rheumatica**, Table I, or other connective tissue diseases. **Fibrositis** may appear spontaneously within a few days or weeks, or may become chronic, or even recur at frequent intervals.

See **Ovarian Cyst**, Table I.

**Food Allergies and Chemical Sensitivities**

People can become addicted to most any food, which then constitutes a **Food Allergy**. **Chemical Sensitivities**, however, develop from the body's response to toxins or poisons that are not adequately handled by the person's unique biochemistry. As both **Food Allergies** and **Chemical Sensitivities** can affect biochemistry in similar fashion, the two are often confused and wrongly used interchangeably. The foods that are best liked, and eaten most frequently, tend to be those to which an individual is allergic. The biochemical rules for addiction are the same as those for **Food Allergies**. A person will feel better after having eaten the food to which they are allergic, and then, with withdrawal symptoms, will want to replenish the item that made them feel better. Complete withdrawal can often lead to bizarre phenomena and behavior, as when withdrawing from alcohol or tobacco, or more damaging drugs. There are many different symptoms that can be displayed because of either **Food Allergies** or **Chemical Sensitivities**, as every organ or system in the body can be affected. As the most important shock organ can be the brain, the result can be changes in circulation, localized swelling, increased pressure in the skull, headaches, fatigue, uncontrollable sleepiness, inability to concentrate, memory lapse, incoordination, hallucination, changes in perception from any of the five senses, loss of consciousness and convulsions. Allergic symptoms can mimic exactly the symptoms that have been attributed to nervous breakdown, neurosis or psychosis. **Food Allergies** and **Chemical Sensitivities** can also mimic many other diseases, including **Rheumatoid Diseases**. Also see **Regional Enteritis**, Table I, and **Candidiasis**, Table II.

See **Polymyalgia Rheumatica**, Table I, and **Polyarteritis**, Table I.

**Giant Cell Arteritis**

**Gluten Enteropathy**

**Granulomatous Colitis**

**Granulomatous Illeitis**

**Graves' Disease**

**Hashimoto's Thyroiditis**

**Hypersensitivity Pneumonitis**

**Hyperthyroidism**

**Hypothyroidism**

**Polymyalgia Rheumatica**

**Polyarteritis**

**Regional Enteritis**

**Polyarteritis**

**Regional Enteritis**

**Regional Enteritis**

**Chemical Sensitivities**

Chronic inflammation of the thyroid. Occurs in all groups of people, but particularly in ages 30s or 40s, and more frequently in women. Common complaints are fullness in the throat. The gland is painless, firm, and marked or covered with rounded eminences, as on the surface of a bone or of a tumor. About 1/3 have an under production of thyroid (**Hypothyroidism**, Table I). Lifelong treatment with thyroid hormone is necessary. May be with or without **Hypothyroidism** or **Thyrotoxicosis**, Table I.
Headache

Headaches are usually common manifestations of acute systemic or intracranial infection, intracranial tumor, head injuries, severe hypertension, lack of oxygen to the brain (cerebral hypoxia) and many diseases of the eye, nose, throat, teeth and ear. The remainder of the headaches result from muscle tension or head pain for which no structural cause can be found. As there is a wide variety of source cautions for headaches, stemming from various diseases and bodily parts, only those involving the brain covering, the meninges, Paget's Disease, Table I, Meningomas, Table I, and Iritis, Table I, are reported here. With Meningeal Irritation, Table I, or Acute Meningitis, Table I, the patient is usually acutely ill, and may be expected to be confused, irrational, excited. The patient may have a stiff neck, or in the sitting posture or when lying with the thigh flexed upon the abdomen the leg cannot be completely extended (Kernig's Sign). Symptoms are recent, severe, generalized headache which is constant, radiates down the neck, with malaise, fever, vomiting. Precedes sore throat or respiratory infection. In Paget's Disease, the headache is mild, burning, intermittent or constant, localized or generalized. There is a history of increasing size of skull, and pain in back and limbs. The skull is tender, with evidence of compression of brain and cranial nerves. With Iritis, there are changes in appearance of the iris, increased intraocular tension and errors of refraction. The headaches are frontal or supraorbital, moderate or severe pain, frequently worse after use of eyes, and pain in the eyes. In Meningomas, there may be visual field changes, aphasia, paralysis and mental changes. The headaches will be mild to severe, localized, generalized, or intermittent. Slow progressive weakness may develop on one side, with convulsions and vomiting. There are also headaches that may accompany an assortment of vascular diseases that should be mentioned here. Also see Headaches, Table II.

Hepatosplenomegaly

Hepatosplenomegaly is enlargement of liver and spleen. The liver is the most complex organ in the body, with a remarkable ability to regenerate in response to injury. The liver must detoxify lymphatic drainage from all of the body's cellular wastes. Various disorders in which components of the blood that are abnormal are associated with the spleen, resulting in hemoglobin (anemia), and leukocytes (leukopenia) decrease, and decrease in the number of platelets (thrombocytopenia), or any combination of the foregoing. There are numerous clinical signs, as this condition may be a primary or secondary liver/spleen disease. Diagnosticians determines size and hardness or tenderness of liver. See Splenomegaly, Table I.

Herniated Disc

Degenerative changes or trauma may rupture the fibrous ring (annulus fibrosa) of the vertebral discs. Most commonly this affects the lower back (lumbosacral) and neck (cervical) areas. Symptoms result when the herniated nucleus compresses a nerve root, either within the spinal canal or at the openings where the nerves leave the spinal column (intervertebral foramen). Pain may begin suddenly and severely, or insidiously. It is worse on movement and may be increased by coughing, laughing, straining at stool, etc. Numbness in the sensory impressions (parathesia) may occur. Lower back (lumbosacral herniation) will have pain when straight legs are raised. With herniated cervical discs, neck movements (flexions) are similarly painful. Muscles that are supplied by the impaired nerve eventually become weak, wasted and flaccid and may show spontaneous firing of motor nerves (fasciculation). Cervical cord compression may cause spastic partial paralysis (paraparesis) of the lower limbs and also either urine retention or incontinence from loss of control of a ring-like muscle (spincter) that controls the flow of urine. When these conditions -- partial paralysis and loss of control of urine -- occur, urgent care and close supervision is required. Compression of a nerve root, thus pain, may also be caused by a spinal tumor, vertebrae tumor or a tumor on the nerve root itself. Bone spurs (osteophytes) may also intrude on the nerve openings, or the inappropriate movement of one vertebra upon another (subluxation): Spondylolisthesis may create similar pain. See Spondylolisthesis, Table III.

Hodgkin's Disease

A condition characterized by the abnormal multiplication or increase in the number of normal cells in normal arrangement in the tissue (hyperplasia), creating excessive secretion of its hormones, and increased metabolic rate. The disease is characterized by nervousness, weakness, heat sensitivity, sweating, restless overactivity, weight loss (usually with increased appetite), tremor, palpitation, stare, and lid lag. Abnormal protrusion of the eyeball (exophthalmos) may
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be prominent. An overactive heart may be enlarged, and accompanied by high pulse pressure (tachycardia), hypertension, and high heart rate is the rule. Older persons may have an apathetic form with heart failure, general ill health and malnutrition (cachexia), muscle atrophy, or diarrhea. The thyroid is usually enlarged two to three times, and sound or murmur (bruit) may be heard on listening. There may be reddish nodules on the anterior of the legs (pretibial Myxedema, Table I) and occasionally clubbing of the fingers (thryoid acropachy).

Hypersensitivity Pneumonitis

A lung disease caused by an allergic response to one of a variety of agents. Extrinsic agents that can be the source of inflammation are often from moldy hay (Micropolyspora faeni or Thermoactinomyces vulgaris); parakeets, pigeons and hens (serum protein and droppings); sugar cane waste (Micropolyspora faeni or Thermoactinomyces vulgaris); mushroom post-spawning compost (Micropolyspora faeni or Thermoactinomyces vulgaris); moldy cork dust; infected maple bark (Cryptostroma corticale); moldy barley, malt (Aspergillus fumigatus or Aspergillus clavatus); moldy sawdust from redwoods (Pseudaria pullulans or Graphium species); moldy cheese (Penicillium species); infected wheat flour (Sitophilus granarius); bovine and porcine serum protein and pituitary antigens; fish meal; coffee bean dust; humidifiers and air conditioners (Micropolyspora faeni or Thermoactinomyces vulgaris); animal pelts, hair or dander; straw and reeds used in roofing. Precipitating antibodies to these and other (intrinsic) foreign antigens suggest an immune-complex-mediated (Type III) reaction, as with Systemic Lupus Erythematosus, Table I. Type IV reactions are cell-mediated or delayed reactions, as with an infectious disease such as tuberculosis resulting in the release of substances (lymphokines) which affect cells and lead to tissue damage by sensitized lymphocytes following contact with antigens. (There are also Type I and Type II reactions which are not discussed here.) In acute disease, episodes of fever, chills, cough and difficult or labored breathing (dyspnea) occur to a previously sensitized individual. This typically occurs 4 to 8 hours after reexposure to the antigen. Loss of appetite (anorexia), nausea and vomiting may also be present. Abnormal respiratory sounds may be heard, but wheezing is unusual. In the chronic form of the disease, progressive exertional labored breathing, productive cough, fatigue, and weight loss may occur.

Hypopituitarism (Adult)

Hypopituitarism in the adult may result from space-occupying infiltrative lesions, or from coagulated dead tissue (infarction) of the pituitary usually associated with childbirth hemorrhage or shock (Sheehan's syndrome) Lesions may also be associated with hypothalamus, and from other sources. The degree of deficiency depends on the nature of the underlying pathologic process and the stage in the historical progression of the disease. The function of all target glands will decrease when all hormones are deficient (Panhypopituitarism, Table I). Thyroid Stimulating Hormone (TSH) deficiency leads to Hypothyroidism, Table I; Adrenocorticotropic Hormone Corticotropic (ACTH) deficiency leads to hypofunction of the adrenal cortex with corresponding hypotension and intolerance to stress and infection. Lack of Follicle Stimulating Hormone (FSH) and Luteinizing Hormone (LH) in the female leads to infertility, absent or abnormal menstrual cycles (amenorrhea) and decreased secondary sexual characteristics. Lack of Follicle Stimulating Hormone (FSH) and Luteinizing Hormone (LH) in the male leads to testicular atrophy, decreased sperm (spermato-genesis) with consequent infertility, and a decrease in secondary sexual characteristics. Deficiency in Human Growth Hormone (HGH), perhaps in conjunction with lack of cortisol, may lead to hypoglycemia. Human Growth Hormone (HGH) also influences the growth of collagen tissue.

Hypothyroidism

See Hashimoto's Thyroiditis, Table I.

Illeitis

See Regional Enteritis, Table I.

See Regional Enteritis, Table I.

Iritis

See Uveitis.

See Uveitis, Table I. Also see Headache, Table I and Table II.

See Regional Enteritis, Table I.

Juvenile Arthritis (Still's Disease)

Uncommon before six months of age; common at ages 1-3; can occur any time, especially about time of menopause in women. Tends to affect larger joints, resulting in interference with growth and development. Unusual or undue smallness of the lower jaw (micrognathia), due to impaired growth of the mandible. Rash, fever, inflammation of eye (Iritis, Table I), enlargement of spleen (Splenomegaly, Table I), and generalized disease of the lymph glands (lymphadenopathy) are frequently present. Rheumatoid Factor (RF) -- a non-specific blood test found in many diseases -- is usually absent. Complete remissions occur in 75 to 80 % of patients. Also see Splenomegaly, Table I.. See Rheumatoid Arthritis, Table I.

Thigh pain. See Fibrositis, Table I.

A Lymphoma is a tumor (neoplasm) arising in the reticuloendothelial and lymphatic system. Two major types are Hodgkin's Disease, Table I and Non-Hodgkin's Disease, Table I.

Leg Aches and “Charleyhorse”

Leukopenia

Lou Gherig's Disease

Lumbago

Lupus

Lymphoma

Leg Aches and “Charleyhorse”

See Amyotrophic Lateral Sclerosis, Table I.

Low back pain. See Fibrositis, Table I.

See Splenomegaly.

See Systemic Lupus Erythematosus, Table I.
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Rarer forms include Burkitt's Lymphoma, Table I, and, even rarer, Mycosis Fungoides, Table I. Annually there are 5 to 6 thousand new cases of Hodgkin's Disease diagnosed in the U.S. The male-to-female ratio is 1.4 to 1. It is rare among children under 10 years of age, and occurs with equal frequency among young and old adults. Hodgkin's Disease resembles a low-grade grafted-versus-host reaction. A number of infectious agents, including viruses, have been postulated as a cause, but an infectious origin is unproved. The rate of progress varies greatly from relatively slow to an aggressive process. Intense itching (pruritus) may occur early. Lymph Node Enlargement, fever, night sweats and weight loss occur frequently. Internal lymph nodes (retroperitoneal), liver (viscera) or bone marrow are involved. Occasionally there are a few days of high fever regularly alternating with a few days to several weeks of normal or subnormal temperature. There is immediate pain after drinking alcoholic beverages. Bone involvement may produce pain, diminution of bone density or bone destruction and, rarely, fracture. Other complications can arise from nerve compression, bile duct obstruction, Cryptococcosis of the Central Nervous System, Herpes Zoster infection, tuberculosis and others. In Non-Hodgkin's Disease, there is a close relationship to lymphocytic leukemias, in that up to half of children and about 20% of adults develop a leukemia-like set of symptoms. Non-Hodgkin's Lymphoma occurs more frequently than Hodgkin's Disease. Each year 7 to 8 thousand new cases are diagnosed in the U.S. It occurs in all age groups, but the incidence increases with age. The cause is unknown, although there is substantial experimental evidence for a viral source. Lymph nodes are rubbery and discrete and later become matted. The tonsils are a common site. Lymph swelling may cause pressure symptoms on various organs. Gastric involvement can simulate gastrointestinal carcinoma, and intestinal lymphoma may cause a malabsorption syndrome. The skin and bones are initially involved in 15% of patients with a condition that breaks down the tissues (histiocytic lymphoma) and 7% of patients with a condition that involves lymphocytes (lymphocytic lymphoma). Anemia is present initially in about half of the patients and eventually develops in most. Burkitt's Lymphoma, Table I, involves lymphocyte producing cells, and has a geographic distribution which is rare in the U.S., appearing to be determined by climatic factors suggesting an insect vector, and is found in Central Africa. There is strong evidence that the herpeslike Epstein-Barr virus may be the cause. Mycosis Fungoides, Table I, is an uncommon chronic lymphoma that primarily affects the skin but occasionally involves internal organs. The disease is rare and is insidious in onset. It may appear as a chronic, severely itching intermittent rash that cannot be diagnosed for a long time. Initially plaquelike, it gradually spreads to involve most of the body, becomes more extensive and nodular, and eventually disseminates. Lesions may become ulcerated. Most patients are over 40 by the time the disease is diagnosed, and from then to death is about 7 to 10 years. Also see Splenomegaly, Table I.

**Marie-Strumpell Disease**
See Ankylosing Spondylitis, Table I.

**Martorell's Disease**
See Takayasu's Disease, Table I.

**Meningeal Irritation**
See Headache, Table I and Table II.

**Mikulicz's disease**
See Headache, Table I and Table II.

**Motor Neuron Disease**
See Sjogren's Syndrome, Table I.

**Multiple Sclerosis**
See Muscular Atrophies, Table I.

A slowly progressive Central Nervous System (CNS) disease characterized by disseminated patches of missing nerve tissue fatty (lipid) sheath (demyelination) in the brain and spinal cord, resulting in multiple and varied neurologic symptoms and signs, usually with remissions and exacerbations. There is a suggestion of genetic susceptibility. Women are affected somewhat more often than men. The disease is more common in temperate climates than in tropics, but relocation after 15 does not alter risk. Onset is usually insidious. In most cases, patients present between age 20 and 40 with one or more symptoms, their nature depending upon the site of missing nerve sheath. Most early common symptoms are: An abnormal or missing sensation (paresthesias) in one or more extremities, the trunk, or on one side of the face; weakness or clumsiness of a leg or a hand; visual disturbances, such as partial blindness and pain in one eye (retrobulbar optic neuritis), seeing double (diplopia), dimness of vision or partially blind area (scotoma). Other common early symptoms are a fleeting ocular palsy, transient weakness, slight stiffness or unusual fatigability of a limb, minor gait disturbances, difficulties with bladder control, vertigo, or mild emotional disturbances. These often occur months or years before the disease is recognized. There are numerous other mental, cranial nerve, motor, sensory, and autonomic symptoms, depending upon the nerves affected. The course of the disease is highly varied and unpredictable. It often remits, and at first, months or years of remission may separate episodes, but then the intervals will grow shorter until eventually permanent and progressive disablement occurs. Life span is probably not shortened. Average duration of illness probably exceeds 25 years, but there is great variability. Some remissions have lasted longer than 25 years, while other patients are incapacitated rapidly. The course is progressively and unremittingly downhill, and occasionally fatal within a year.

**Muscular Atrophies**
Muscular Atrophies is a disease characterized by progressive degeneration of Central Nervous System (CNS) cells, certain brain cells, and certain nerve cells that carry signals away from the cells related to the brain and CNS (bulbar efferent neurons). Symptoms vary considerably.
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Myalgia
Mycosis Fungoides
Myocardia

Myocardial Infarction
Myositis
Myxedema
Necrotizing Angitis
Neurotic Illness

Non-Hodgkin's Disease
Non-Hodgkin's Lymphoma
Non-tropical Sprue
Organic Brain Syndromes
Organic Dust Pneumonconiosis
Osteitis Deformans

Ovarian Cancer
Ovarian Cysts

Ovum and Fetal Abnormalities

Paget's Disease
Palindromic (Recurring) Rheumatism
Pancreatitis

Neurotic Illness are disorders in which psychologic and associated physiologic responses to ordinary stress present in exaggerated form. Neuroses differ from normal conduct mainly in quantitative, rather than qualitative form. Contact with reality is undisturbed, and neurotic patients retain insight into the morbid character of their impulses and actions. There is a relationship between a Neurosis and the stress that preceded it. A severe obsessional or phobic state may be precipitated by bad news but is rarely relieved if the information proves to have been erroneous. Organic disease and Psychosis may initially present with neurotic features. Neurotic patients usually have a history of difficulty in adapting and also have emotional disturbances, but they do not usually encroach upon the individual's everyday life. Childhood Neurotic symptoms usually present as a cluster of symptoms including nightmares, temper tantrums, minor phobias, extreme shyness and speech difficulties. They may have difficulty in relating to other children or authoritative figures in school, as well as later problems in sexual adaptation such as dysfunction of arousal and orgasm or sexual deviation.

A slowly progressive bone disorder characterized by an initial loss of bone calcium (osteolysis) usually followed by bone growth (osteoblastic) phase. This results in abnormal skin structural patterns and gross deformity. About 3% of people over 40 have Paget's Disease (Osteitis Deformans), and the incidence increases to about 10% of those over 80s, although more men are affected than women. The disease appears to be more common in parts of Europe, England, Australia and New Zealand, and is rare in Scandinavia, Africa, Japan, India and South America. Onset is frequently insidious, often showing up during routine blood chemistry studies that show an elevated alkaline phosphatase, or when X-rays are obtained for other reasons. Although any bone can be involved, the most commonly affected bones, in order, are the pelvis, femur, skull, tibia, vertebrae, clavicle and humerus. The course is slowly progressive. Deformities may develop from bowing of the bones or involvement of adjacent joints. Pathologic fractures of the femur or tibia may occur. Spinal cord compression occurs in patients with lumbar spine involvement. There may also be severe pelvic disease, with extrusion of the acetabular bone. The acetabulum is the cup-shaped cavity where the femur bone articulates. See Headache, Table I and Table II.
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Pancreatitis is inflammation of the pancreas. Bile tract (biliary) disease is the usual underlying cause in about 50% of patients. Attacks can be related to the passage of gallstones into the duodenum. Trauma or local deficiency of blood (ischemia), after surgery, may precipitate the inflammation. Severe abdominal pain is the outstanding symptom. Usually generalized or in the upper quadrants and often radiating to the back, it steadily increases, reaches a maximum in a few minutes or hours and then usually remains severe and steady, occasionally colicky, until it diminishes gradually over days or weeks as the inflammation subsides. Movement and sometimes respiration aggravate the pain; sitting up or flexion at the waist relieves it. Nausea and vomiting are common. Fever of 38° to 39° C (100° to 102° F) develops during the first few days. Shock may occur in severe attacks; the blood pressure is reduced, the pulse rate elevated, and the skin clammy. Abdominal guarding and rigidity are present in only 30% of patients and rebound tenderness in 15%. Diminished or absent bowel sounds and abdominal distention occur in 15% of patients. Common bile duct stones, or compression of the common bile duct by the swollen and inflamed pancreas may cause jaundice which diminishes as the inflammation subsides. A faint discoloration of skin (ecchymoses) may be observed in the flanks or about the umbilicus.

There may be massive upper Gastrointestinal (GI) bleeding, cardiovascular shock, hypocalcemia or other signs. Pain persisting for more than 5 days along with chills, fever, and an elevated White Blood Count (WBC) suggests further complications.

Pelvic Inflammatory Disease (PID)
Periarteritis Nodosa
Pericardial Disease

The membranous sac surrounding the heart, the pericardium, may be involved with inflammation, trauma, or neoplasms. Inflammation may be from bacterial, viral, or fungal infection, or may stem from a systemic disease, such as Rheumatoid Arthritis, Table I, Systemic Lupus Erythematosus, Table I, Uremia, Table II, or Acute Myocardial Infarction, Table I. It may occur without an identifiable cause (idiopathic or benign) (Pericarditis, Table I), after surgery (pericardiectomy) or as a consequence of coagulation of dead tissue resulting from obstruction of circulation (Myocardial Infarction, Table I). Wounds that penetrate the chest or due to the swallowing of foreign bodies may rupture the Pericardium. Cancerous tumors (Carcinomas, Table I, Sarcomas, Table I and Lymphomas, Table I) may also create bleeding (hemorrhagic effusion) into the pericardium. Pericarditis is characterized by localized or widespread light or heavy deposits of a whitish, insoluble protein formed by the action of materials that form blood clots (fibrinogen). It may result from infection, trauma, bleeding or may accompany Collagen Tissue Disease, Table I. It may begin abruptly or insidiously, and is preceded by dull or sharp pain over the heart or stomach (epigastrium and lower part of thorax) or chest (substernal) pain radiating to the neck, trapezius, or shoulders. Pain may vary from mild to severe and may also be aggravated by thoracic motion, cough and respiration (pleuropericarditis). It is relieved by sitting up and leaning forward. Non-painful (indolent) Pericarditis, Table I may result from tuberculosis or Uremia, Table I. Excessive respiration (tachypnea) and a cough may be present, with fever, chills, weakness and anxiety. An unusual pulse (pulsus paradoxus) may be present. Also see Dysrhythmias, Table I, Myocardial, Disease, Table I, and Rheumatoid Fever, Table II.

Arthritis that is situated in joints.
See Sarcoidosis, Table I.

See Carpal Tunnel Syndrome, Table I.

See Ulcerative Colitis, Table II.

Thorax pain. See Fibrositis, Table I.

See Hyperthyroidism, Table I.

See Esophageal Webs, Table I.

Death of liver cells.

Charactcrized by inflammation of small and medium arteries having segmented dying cells (necrosis), with secondary deficiency in blood supply normally supplied by the affected blood vessels. Probably has a multiple pathogenic origin. Inflammation of the kidneys (glomerulonephritis) is frequently present. Various drugs, vaccines, bacterial and viral infections have been associated with the onset of this disease. Onset is usually between ages 25 and 50, but has been reported in patients aged 1 month to 78 years of age. The disease is three times more common.
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<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progressive Bulbar Palsy</td>
<td>Symptoms are determined largely by the location and severity of the arteritis, and by the extent of secondary circulation impairment, and may affect virtually any organ system, or combination thereof. The most common initial symptoms include fever, abdominal pain, weakness, weight loss, related peripheral neuropathy, asthma, hypertension, swelling (edema), urination at long intervals (oliguria), the presence of urinary constituents in the blood (uremia), widespread or localized abdominal pain, nausea, vomiting, and bloody diarrhea. Acute cellular death (ischemia) may occur in the intestines leading to perforation of the membrane that lines the abdominal wall (secondary peritonitis). Affecting the central nervous system, symptoms will be headaches, convulsions and psychosis. Muscle (myalgias) and joint (arthralgias) inflammation is common.</td>
</tr>
</tbody>
</table>
Psoriatic Arthritis
Psychotic Illness

Psychotic illness is usually defined as dementia praecox and manic-depressive states. Manic-depression is a benign feeling or mental state chiefly marked by emotional instability, striking mood swings, and a tendency to recurrence. Dementia praecox is a term for a large group of psychoses of psychogenic or biochemical origin, often recognized during or shortly after adolescence but not infrequently in later maturity. The chief characteristics are disorientation, loss of contact with reality, and splitting of the personality (schizophrenia). The dementia praecox types include paranoia and other forms such as hebephrenia and catatonia. Drugs, cerebral tumors, temporal lobe epilepsy, Multiple Sclerosis, Table I, vitamin B₁₂ deficiency, head injury, and fat embolism are the most common organic causes of psychosis. Paranoid schizophrenia is the most common psychotic syndrome appearing in cerebral diseases. Schizophrenic states due to excessive consumption of amphetamines, alcohol, or less often bromides are frequently misdiagnosed as primary schizophrenic illnesses. Paralysis (paresis) mimics psychosis. Depressive states often follow influenza, typhoid, infectious hepatitis, or childbirth or may be associated with medications such as antihypertensive drugs. Senile demenitia is due to a degenerative process with a large loss of cells from the cerebral cortex and other brain areas. The brain shows marked atrophy. Senile plaques and neurofibrillary tangles are present. See Amyloidosis, Table I. The condition is more common in women and appears usually in the 8th decade or later. Dementia usually progresses steadily, becoming well advanced after 2 to 3 years.

Psychotic Senility
Pulseless Disease
Pyoderma Gangrenosum
Raynaud’s phenomenon

A condition caused by an abnormal degree of spasm of the blood vessels of the extremities, especially in response to cold temperature and which would not affect a normal person. Emotional stress may cause the symptoms, while heat relieves the symptoms. Rare in males.

Regional Enteritis

Small particle tissues (granulomatous) -- tumors or neoplasms -- create nonspecific inflammatory diseases usually affecting the lower ileum but often involving the colon and occasionally other parts of the gastro-intestinal (GI) tract. This disease occurs equally among men and women, most cases beginning before age of 40, with a peak incidence in the 20s. The tiny tumors or neoplasms (granulomas) seem to derive from the lymph nodes and intestinal tissue, suggesting that a transmissible agent might be responsible for the characteristic cellular lesions. The inflammatory process involves all layers of the intestinal wall, which becomes greatly thickened. Changes are quite marked in the submucosa with cell thickening, lymphocytic infiltration and extensive fibrosis occurring. Patchy ulceration develops on the mucosa, with mucosal swelling (edema) and ulcers, creating a "cobblestone" appearance. Similar characteristics occur to adjacent tissues with enlargement of certain lymph nodes. Inflammation, deep ulceration, swelling (edema), and creation of fibrous tissue (fibrosis) are responsible for obstruction, and deep hollows (sinus tracts) -- ulceration, and abscesses which are the major local complications. Segments of diseased bowel are characteristically sharply demarcated from adjacent normal bowel, prompting this Enteritis to be given the name of "Regional." Many segmented lesions may be separated by normal areas. Inflammation of the ileum alone (ileitis, Table I) is involved with 50% of the cases. Both ileum and colon (ileocolitis, Table I) occur in about 40%
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Rheumatoid Arthritis is probably initiated by multiple factors; one percent of the population is affected, women 2 to 3 times more commonly than men. Rheumatoid Arthritis is a chronic syndrome characterized by nonspecific, usually symmetric inflammation of the tissues surrounding the joints (articular), potentially resulting in progressive destruction of the joints (articular) and surrounding tissues (periarticular) structures. Other generalized manifestations may also be present. Onset may occur at any age, but usually occurs between 35 and 45. Diagnostic criteria requires a number of characteristic observations, such as pain and morning stiffness. On use of the joints, there is tenderness in at least 1 joint, swelling in at least 1 joint, symmetric joint swelling, subcutaneous nodules over bony prominences, and other related clinical factors. Usually identified by use of a clinical assessment check-list and blood tests, as well as other factors. No single definitive test known. Also see Trigeminal Neuralgia, Table I. See Juvenile Arthritis, Table I. See Rheumatic Fever, Table II. See Juvenile Arthritis, Table I. See Ulcerative Colitis, Table II.

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Sarcoidosis is a multisystem condition of skin and mucous membranes (epithelium) consisting of nodules (tubercles) that involve various organs or tissues, with symptoms that depend on the site and degree of involvement. Sarcoidosis, Table I, occurs predominantly between ages 20 and 40 and is most common among northern Europeans and American Negroes. The incidence in some developed countries exceeds that of tuberculosis. Symptoms may be absent, slight, or severe and depend on the site of involvement. Loss of function of specific organs may be due to the active granulated tissue (granulomas) or to development of secondary fibers (fibrosis). Fever, weight loss, and Arthralgias, Table I, may be initial manifestations. Persistent fever is usually accompanied with liver (hepatic) involvement. A disease of the lymph glands (Peripheral Lymphadenopathy, Table I) may be involved. The lungs (pulmonary infiltration) may be involved. Skin lesions (plaques, papules, and subcutaneous nodules) are frequently present in severe Sarcoidosis. A redness of skin, with nodules (Erythema Nodosum, Table I), with fever and Arthralgias is common in Europe, but not the United States. Liver granules (hepatic granulomas) are found in 70% of the patients. Enlargement of the liver (hepatomegaly) is noted in less than 20% of patients. The Uveitis, Table I, (granulomatous uveitis) affects in 15% of the cases, along with loss of vision from secondary glaucoma, if untreated. The heart may be involved, with angina, congestive failure, or fatal abnormalities (conduction). Acute Polyarthritis, Table I, with swelling and tenderness, may be prominent. The Central Nervous System (CNS) may be affected in many ways, but cranial nerve palsies, especially facial palsy, is most common. Diabetes (Diabetes Insipidus, Table I) may occur. Renal failure, (hypercalcemia and hypercalciuria) may occur, due to renal stones (calculi). Spontaneous improvement is common, with symptoms disappearing for months or years. Complete clearing of the disease occurs in one-third of the patients, recovery with minor residual symptoms in another
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**Sarcoma**
A tumor made up of a substance like the embryonic connective tissue. Mortality is 5 to 8%.

**Scaling Papular Diseases**
See Psoriasis, Table I.

**Schonlein's Purpura**
See Allergic Purpura, Table II.

**Scleroderma**
Widespread formation of fibrous tissue (fibroids) and vascular abnormalities in the skin, joint structures and internal organs (esophagus, intestinal tract, lung, heart and kidney, especially).

- May be mild or cause early death due to heart failure, kidney disease, lung complications, or intestinal malabsorption and a profound state of constitutional disorder (cachexia).
- Initial complaints include Raynaud's phenomenon, Table I, and swelling of the extremeties of the fingers. Polyarthralgia, Table I, may occur early. Polymyositis (Sclerodermatomyositis), Table I, symptoms may occur. With disease progression, the skin becomes taut, shiny and hyperpigmented. The face becomes masklike. Changes may include intestinal organs (visceral), lungs (pulmonary), destruction of bile and other liver cells (biliary cirrhosis of the liver). Joints may be painful because of friction, Tendonitis, Table I and that the large saclike cavities are filled with viscid fluid that lower friction around the joints (bursae sacs). There is blood-clotting, insoluble protein (fibrin) deposits on synovial tissue. Many other effects can occur in other parts of the body. (See Systemic Lupus Erythematosus, Table I)

**Sclerodermatomyositis**
See Scleroderma, Table I.

**Shaking Palsy**
See Parkinsonism, Table I.

**Sicca Syndrome**
See Sjogren's Syndrome, Table I.

**Sideropenic Dysphagia**
See Esophageal Webs, Table I.

**Sjogren's Syndrome (Mikulicz's disease)**
A marked dryness of all mucous membranes, resulting from deficient secretion of the glands, particularly the throat (laryngeal) and salivary glands, those of the upper respiratory tract, the sweat glands and the glands of the stomach. Also see Trigeminal Neuralgia, Table I. Neck Pain. See Fibrositis, Table I.

**Spasmodic Torticollis**

**Splenomegaly**
Splenomegaly is enlargement of the Spleen. Various disorders are associated with Splenomegaly. The spleen consists of two organs, an immune one, the "white pulp," consisting of lymphocytes and a reticuloendothelial one, the "red pulp," consisting of phagocytic macrophages and granulocytes lining vascular spaces (the cords and sinusoids). The white pulp generates antibodies to circulating antigens, and on occasion, inappropriate autoantibodies to circulating blood elements. White pulp also produces a leukocyte modulating hormone (tufsin), which increases neutrophil phagocytosis and chemotaxis. It's absence is associated with increased susceptibility to infection. The red pulp removes unwanted particulate matter such as bacteria or aging blood elements. It provides a reservoir function for blood elements, such as leukocytes and platelets that can be released to the circulation. In stressed animals "autotransfusions" of red blood cells may occur from the spleen. The spleen may serve to replace bone marrow as a blood forming organ, among other functions. Various disorders are associated with Splenomegaly. Deficiency of cellular elements of the blood (Cytopenia, Table I), a reduction of one or more blood elements, resulting in diminution of hemoglobin (Anemia), deficiency in leukocytes (Leukopenia, Table I), decrease in number of platelets (Thrombocytopenia, Table I), or any combination thereof in association with abnormal increase in normal cells in normal tissues (Hyperplasia, Table I) of the respective marrow precursors of the deficient cell type. Most of the presenting symptoms are those of the underlying disease. Besides noting an enlarged spleen, the following may be encountered: Left upper quadrant abdominal pain associated with splenic friction rubs which indicate splenic area of cellular death (necrosis) or coagulation (infarction), epigastric and splenic sounds (bruits) which may presage bleeding, early feeding satiety, and friction rubs which indicate splenic area of cellular death (necrosis) or coagulation (infarction), or any combination thereof in association with abnormal increase in normal cells in normal tissues (Hyperplasia, Table I) of the respective marrow precursors of the deficient cell type. Most of the presenting symptoms are those of the underlying disease. Besides noting an enlarged spleen, the following may be encountered: Left upper quadrant abdominal pain associated with splenic friction rubs which indicate splenic area of cellular death (necrosis) or coagulation (infarction), epigastric and splenic sounds (bruits) which may presage bleeding, early feeding satiety, and manifestations of mucosal bleeding. See Amyloidosis, Table I, Anemia, Table I, Chronic Hepatitis, Table I, Hepatosplenomegaly, Table I, Juvenile Arthritis (Still's Disease), Table I, Lymphoma, Table I, Polycythemia, Table I, Polymyositis, Table I, and others. See Hashimoto's Thyroiditis, Table I. See Juvenile Arthritis, Table I.

**Spontaneous Myxoeaema**

**Still's Disease**

**Systemic Lupus Erythematosus**
An inflammatory connective tissue disorder of unknown etiology occurring predominantly in young women, but also in children and older adults. A form of cellular death in which the tissue is changed into a dry, amorphous mass resembling cheese (fibrinoid necrosis) and where cellular bodies of altered nuclear material may be found in the tissues of any organ. May begin abruptly with fever, simulating acute infection, or may develop insidiously over months or years with only episodes of fever and general discomfort (malaise). Up to 90% of patients complain of joint (articular) symptoms. Several skin (cutaneous) lesions may occur, including the characteristic cheek (malar) "butterfly" redness of skin due to congestion of capillaries (erythema). Other parts of the body may also be affected, and, the condition may spread so that the sympathetic appearance of the skin becomes confluent with others, including tissue swelling (edematous). Generalized loss of hair (alopecia) is frequent. Kidney (renal) involvement occurs in the majority of patients, and may become fatal. (See Scleroderma, Table I.)

**Takayasu's Disease**
A syndrome resulting from destruction of one or more of the large branches of the aortic arch.
Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment. Usually the result of arteriosclerosis and its complications, but syphilitic weakening of the artery walls (aneurysms) may also cause it. There are a group of patients, about 5%, in whom the condition results from a peculiar form of proliferative inflammation of the arteries (arteritis) usually occurring in young Oriental women 15 to 30 years of age, and is commonly referred to as Takayasu's disease, but it can also be found in woman and men of all ages. (Also see Polymyalgia Rheumatica, Table I.)

**Temporal Arteritis**

Tendinitis

Inflammation of the lining of the tendon sheath (tenosynovium) and also quite frequently the enclosed tendon. The synovial-lined tendon sheath usually is the site of maximum inflammation, but the inflammatory response may involve the tendon itself. As a result of calcium deposits, for example, the tendon may be the site of primary irritation and inflammation surrounding the tendon sheath. Tendon sheaths may be affected by systemic diseases, such as Rheumatoid Arthritis, Table I; Progressive Systemic Sclerosis, Table I; Gout, Table III, Reiter's Syndrome, Table I and Amyloidosis, Table I, and also associated with elevated blood cholesterol levels (hyperlipoproteinemia, Type II). Extreme or repeated trauma, strain, or excessive exercise may also be causative. Most common sites of inflammation are the shoulder capsule and associated tendons, wrists, fingers, hip capsule and associated tendons, leg hamstring and the heel tendon (Achilles). Involved tendon sheaths may be visibly swollen due to fluid accumulation and inflammation, or they may be dry but irregularly contoured, causing friction which is felt on movement of the tendon in its sheath. Local tenderness may be present, and it may be severe or associated with disabling pain on movement. Calcium deposition may occur in the tendon sheath, and may be seen by X-ray as calcific tendinitis. Recovery may take from 2 to 3 weeks to several months, in most cases.

**Tenosynovitis**

Thrombocytopenia

Thryroidtoxicosis

See Hashimoto's Thyroiditis, Table I. (Also similar to Primary Myxoedema, Table I; or Spontaneous Myxoedema -- without goitre, Table I. Also see Hyperthyroidism, Table I). See Trigeminal Neuralgia.

**Tie Douloureaux**

Trigeminal Neuralgia

**Torticollis**

Toxic Diffuse Goitre

Toxic Nodular Goiter

Tubal Pregnancy

Ulcereeative Colitis.

Ulcereeative Proctitis

Uremia

The presence of urinary constituents in the blood, and the toxic condition it produces. It is marked by nausea, vomiting headache, vertigo, dimness of visionicient secretion of the urine from any cause.

**Urinary Calculi**

Urinary Calculi (stones) may occur anywhere in the urinary tract and are common causes of pain, obstruction and secondary infection. About 1 in every 100 adults are hospitalized annually in the USA because of urinary stones. They are related to factors that increase the urine concentration of stone crystalloids, and other factors that favor their formation in normal urine concentrations. Calculi vary in size from microscopic to several centimeters. In adults, in the USA, about 90% of stones contain calcium and 65% oxalate, 5% are predominantly urate and 2 to 3% are cystine. Magnesium ammonium phosphate stones parallels that of urea-splitting bacterial infections accompanied by elevated urine pH. Typical symptoms include excruciating intermittent pain, usually originating in the flank or kidney area and radiating across the abdomen along the course of the ureter, frequently into the region of the genitalia and inner side of the thigh. Gastrointestinal symptoms of nausea, vomiting, and abdominal distention may obscure the urinary origin. Chills, fever, discharge of bloody urea (hematuria) and frequency of urination are common, particularly as a calculus passes down the ureter. The affected kidney may become nonfunctioning temporarily.

**Urticaria**

Uterine Fibroids

These are noncancerous tumors composed of fibrous muscle or fully developed connective tissue. Fibromyomas, Table I, cause postmenopausal bleeding, but other causes should be ruled out, such as cancer (endometrial) or the abnormal multiplication of cells (hyperplasia). Fibroids, Table I, develop following the onset of menstruation, enlarge during pregnancy, and
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Table II: Arthritis (Rheumatic Diseases) and Related Diseases Caused or Suspected of Being Caused by Bacterial, Mycoplasmic or Viral Infections

Villous Pigmented Synovitis

Tumorous, hard, small particles that create inflammatory response in joints, predominately occurring in young men. The knee is most commonly affected, then the hip, ankle, wrist and elbow. There is pain and swelling with joint motion. Discomfort is usually mild and intermittent, but may be persistent if the joint tends to lock or if swelling and fluid leakage (effusion) are prominent. Joint erosion may occur, and cysts form, most commonly in the hips, hands, and feet, less commonly in the knee. May be confused with a possible malignancy.

Young Oriental Female Disease

A rare disease that begins as having local tumor or neoplasm inflammation of upper and lower respiratory mucosa, usually progressing into generalized, dead and tumorous vascular cells (neutrophils) or granulomatous vasculitis and also inflammation of certain kidney cells (glomerulonephritis). The disease resembles an infectious process. Men are affected about twice as often as women. Disease can occur at any age. Onset my be insidious or acute. Presenting symptoms include severe discharge of a thin nasal mucus (rhinorrhea), inflammation of the sinuses (paranasal sinusitis), nasal mucosal ulcerations, with consequent secondary bacterial infection, running ear (serous or purulent otitis media) with hearing loss, cough, spitting of blood (hemoptysis) and inflammation of the lining of the lung (pleuritis.). At first, Wegener's Granulomatosis is often mistaken for chronic sinusitis. After a few weeks, inflammatory skin lesions and pulmonary lesions, along with vasculitis and kidney symptoms appear. Fever, malaise, loss of appetite, (anorexia), weight loss, migratory joint aches (Polyarthropathy), skin lesions and eye symptoms may present. Eventually the disease will progress to functional kidney (renal) impairment, without treatment. (Also see Polyarteritis, Table I.)

Wryneck

An uncommon illness which occurs mostly with males ages 30 to 60. It is characterized by a deficiency in blood (anemia), increased skin pigmentation, joint symptoms (Arthralgia, Table I, and Arthritis, Table I), weight loss, diarrhea, and severe intestinal malabsorption. This disease affects many organs, such as the heart, lung, brain, Gastro-Intestinal tract, joints, eye, and serous cavities, but the small intestine is always severely involved. Symptoms are those of malabsorption, Arthralgia and Arthritis of the knees, wrists and back, coughing, abdominal pain and chest pain. Recovery is excellent, with proper treatment. Untreated, patients suffer the consequences of malabsorption, and death.

Table I: Arthritis (Rheumatic Diseases) and Related Diseases Caused or Suspected of Being Caused by Bacterial, Mycoplasmic or Viral Infections

The following organisms are either known, or suspected infectious organisms in creating Arthralgias:

1. Bacterial: Gonococcus, Meingococcus, Pneumococcus, Streptococcus, Staphylococcus, Salmonella, Brucella, Streptobacillus moniliformis (Haverhill fever), Mycobacterium tuberculosis, Treponema pallidum (syphilis), Treponema pertenue (yaws), and others.
2. Rickettsial
3. Viral: Rubella, Mumps, Viral hepatitis, and others.
Acute Bacterial Arthritis

An acute Arthritis resulting from an infection in the synovial tissues surrounding the joints, by pus forming (pyogenic) bacteria. Although any pathogenic bacteria may infect the joint, in young children the most common is the staphylococci Haemophilus influenzae. Older children and adults are usually infected by gonococci, staphylococci, streptococci or pneumococci. The usual route for bacteria reaching the joint is through the blood, however, direct inoculations may occur in the joint during surgery or drug injection. Patients with Rheumatoid Arthritis are particularly susceptible to Acute Bacterial Arthritis. In infants who have a fever and are irritable, a careful examination may reveal failure to move a limb spontaneously, and tenderness, or pain with passive motion of the involved joint. Older children and adults complain of acute joint pain and stiffness, which, on examination, is warm, tender and swollen, with evidence of swelling and the escape of fluid into the tissue (effusion). Other signs of infection -- fever, chills, or an increase in the number of leukocytes in the blood (leukocytosis) -- are usually present. Patients who receive anti-inflammatory drugs may show very little response. A history of recent inflammation of the urethea (urethritis), inflammation of the fallopian tube (salpingitis) or bleeding from vessels of skin lesions (hemorrhagic vesicular skin lesions) suggests gonococcal arthritis.

Acute Cholecystitis

Acute Cholecystitis is in most instances caused by a gallstone which blocks up the outlet of the gallbladder or cystic duct. Inflammation of the gallbladder can occur with stones, bacterial infection by chemical irritation and the digestive activities of certain enzymes. Pain often occurs at night or in the early morning. Usually the pain is well localized to the right upper quadrant of the abdomen. epigastric pain and radiating pain to the back is frequent. Whether the onset is sudden or gradual, the pain reaches a plateau which it maintains with little fluctuation. Nausea, vomiting, and flatulence are frequent. Temperature elevation is slight. The right upper quadrant musculature is often found to be rigid with pronounced, localized tenderness. The liver edge is tender. Complications of infection involve Escherichia coli, Bacillus aerogenes, enterococci, Klebsiella, Proteus vulgaris, Staphylococcus and Clostridium.

Acute Infective Tubulointerstitial Nephritis

Acute Pyelonephritis

Acute Pyelonephritis is an acute, diffuse, often bilateral pus producing (pyogenic) infection of the kidneys. Infections usually occur by the ascending urethral passage (meatus). Obstructions can be strictures, calculi, tumors, prostatic hypertrophy, or neurogenic bladder, all of which can predispose to infection. Pyelonephritis especially likely in females in childhood or during pregnancy, in diabetics, and after urethral catheterization, but is uncommon in males free from urinary tract abnormalities. Almost any pus-forming (pyogenic) bacteria may cause the problem, but Escherichia coli is the most common, accounting for 85% of uncomplicated infections. Staphylococcal bacteria may cause systemic kidney infection. Candidiasis, Table II, may also infect the kidney. Patients with indwelling instrumentation, or catheters, or suffering from diabetes mellitus, or those being treated with corticosteroids or immunosuppressive drugs are particularly likely to colonize with unusual organisms such as Serratia, Mima-Herellea and Candida. Typically the onset is rapid and characterized by chills, fever, flank pain, nausea, and vomiting. Bladder irritation from infected urine may result in frequency and urgency. Sometimes a physical examination will show abdominal rigidity which must be distinguished from that produced by intraperitoneal disease. An enlarged kidney may be felt. There may be tenderness on the infected side. Chronic Pyelonephritis is may result in kidney failure from various causes, due to progressive failure.

Adenoid Hyperplasia

Allergic Purpura

An acute or chronic inflammation of the vascular system (Vasculitis), affecting the skin, joints, and the gastrointestinal tract, as well as renal systems. The process often follows a streptococcal infection which damages the vessels (vascular endothelium). Blood and plasma leaks (effusion) into the skin, mucous, and adjacent portions of the cells (subcutaneous, submucous, and subserous surfaces). Skin lesions appear, varying in appearance, but Purpura is usually associated with a redness of the skin (Erythema) and a rash or hives (Urticaria). Fever and malaise are often present, and leakage into joints (effusions) or viscera may produce joint pain -- Arthralgias (Schonlein's Purpura), or bouts of abdominal pain (Henoch's Purpura). Severe conditions may lead to death. Often, however, the disease is self-limiting and carries a good prognosis.

Appendicitis

Appendicitis is inflammation of the vermiform appendix. Acute Appendicitis is usually caused by Escherichia coli and other normal bowel flora. It is often preceded by an obstruction (in the appendiceal lumen) by kinking, swelling of the lymphoid tissue in the wall or a foreign body from the fecal stream. The condition is most common in adolescents and young adults, peaking between ages of 15 and 24, and the most frequent reason for surgery in infants and children. Inflammation causes swelling (edema) and cellular death (ischemia) in all layers of the appendix and can progress to gangrene and perforation. A perforated appendix can result in inflammation of the membrane that lines the abdominal walls, resulting in abdominal pain and tenderness, constipation, vomiting and moderate fever. Pain typically begins in the
Asthma

Brucellosis

This infectious disease, which is characterized by an acute feverish stage, has few or no local or regional signs. In the chronic phase there are relapses with fever, weakness, sweats and vague aches and pains. The causative microorganisms are Brucella abortus (cattle) Brucella suis (hogs), Brucella melitensis (sheep and goats), Brucella canis (dogs), and Brucella rangaferi (Alaskan and Siberian caribou). Brucellosis is acquired by contact with secretions and excretions of infected animals, by ingesting their products (milk, butter, etc.) which contain live organisms. It is rarely transmitted from one person to another. It is most prevalent in rural areas, and is an occupational disease of meat-packers, veterinarians, farmers, and livestock producers. Children are less susceptible. The incubation period varies from 5 days to several months, with an average of 2 weeks. Symptoms may vary in the early stages. Onset may be sudden and acute with chills and fever, severe headache, pains, malaise, and occasional diarrhea. Or onset may be insidious with mild malaise, muscular pain, headache, and pain in the back of the neck, followed by a rise in evening temperature. Complications may include inflammation of the covering of the brain (meningitis), of the brain (encephalitis), of the nerves (neuritis), of the gall bladder (cholecystitis), pus in the liver (hepatitis), and pus in the joints (arthritis), and in the spine (Spondylitis; See Table II). Fevers may persist for 1 to 5 weeks, then go into remission for 2 to 14 day periods, and this may be repeated over years. Constipation is usually pronounced, with loss of appetite (anorexia), weight loss, abdominal pain, joint pain, headache, backache, weakness, irritability, insomnia, mental depression, and emotional instability. Enlargement of the spleen (Splenomegaly) may appear and lymph nodes may be slightly or moderately enlarged. Patients with acute, but uncomplicated Brucellosis usually recover in 2 to 3 weeks. The chronic disease may result in prolonged ill health, but is rarely fatal. Also see Splenomegaly.

Bursitis

Candidiasis

Candida albicans, which is found most everywhere, invades various parts of bodily tissues, resulting in localized infections. Common sites of infection are the mouth as in infant Thrush, gastrointestinal tract, vagina, urinary tract, prostate gland and skin and fingernails and toenails. Under normal conditions our bodies are able to resist this invasion, as it does other germs. However, whenever various substances weaken the immunological system, the yeast/fungus organism begins to spread, and in the spreading creates virtual havoc throughout the body parts and systems. The yeast/fungus invasion may cripple the immune system so that it can no longer repel invaders. It can create allergies to chemicals and foods. It is believed that it invades the intestinal wall where toxins from microorganisms and protein molecules from food enter the bloodstream, being there recognized as foreign invaders. Because proteins are derived from common DNA (gene molecule) structure, each time a new protein enters directly into the bloodstream, it, too, can become recognized as a foreign invader, and thus a "cross-reactivity" occurs, causing one to have increasingly more Food Allergies, Table I. Yeast feeds on sugars and carbohydrates that easily convert to sugars. In turn, yeasts produce a series of chemical products as waste among which are acetaldehyde and ethanol. Ethanol is alcohol, and there are cases of people on record who have never drunk a drop of alcohol yet are daily inebriated. Acetaldehyde is produced as the alcohol breaks down and is about six times more toxic to brain tissue than ethanol. These two chemicals are probably responsible for the following effects. 1. Cell membrane defects, damage to red and white blood cells and other problems; 2. Enzyme destruction. Enzymes are the key to breaking down foods in the body so that they can be utilized as nourishment; 3. Abnormal hormone response. Hormones regulate bodily functions. Some of the symptoms caused by Candida albicans are these: 1. Allergic reactions; 2. Gastrointestinal problems: bloating and gas, diarrhea, abdominal pain, gastritis, gastric ulcers, constipation, and many others; 3. Respiratory system: sore throat, sore mouth, contribution to sinus infections, bronchial infections and pneumonia; 4. Cardiovascular system: palpitations, rapid pulse rate, pounding heart; 5. Genitourinary system: vaginitis, frequent urination, lack of bladder control, itchy rashes, etc.; 6. Musculoskeletal system: muscle weakness, leg pains, muscle stiffness, slow coordination, and so on; 7. Central Nervous system: Headaches, poor brain function, poor short-term memory, fuzzy thinking and so on; 8. Fatigue is extremely common as impaired metabolism doesn’t enable the body to get enough fuel and impaired enzyme functioning inhibits energy production; 9. Weight gain is common. As can be observed by reviewing the above characteristic symptoms (which are not complete) many similar symptoms may “present” with Rheumatoid Disease, Table I. It is often difficult to discriminate between one cause and another as diseases operate on the same tissues, the same organs, producing similar symptoms, in similar ways. Rheumatoid Disease spreads with a weakening of the immunological system. Candida albicans spreads with a weakening of the immunological system. Rheumatoid Disease as well as Candidiasis seems to lead to Food Allergies and Chemical Sensitivities, Table I, over
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Both diseases produce similar symptoms in many bodily tissues. Both diseases are systemic in nature. A Candidiasis victim does not necessarily have Rheumatoid Disease, but a Rheumatoid Disease victim almost certainly suffers from Candidiasis. Candidiasis spreads with the use of almost any kind of surgery where antibiotics were used, or if given antibiotics orally for any purpose, s/he probably suffers from some degree of Candidiasis, because antibiotics kill off the “good-guys” bacteria required in the intestinal tract for good nutrition, the yeast/fungus spreads, taking the “good-guys” place, and sends rootlets into the intestinal mucosa, helping to age the total system. These “good guys,” such as Lactobacillus acidophilus, need to be replaced.

Cholangitis

Cholangitis is inflammation of the bile ducts. Bacteria, most often Escherichia coli, enter the bile ducts via the lymphatic system or bloodstream or by regurgitation of intestinal contents. Usually the bile ducts are obstructed by stones or a tumor. Upper right abdominal pain, jaundice and fever with chills are characteristics. Pain is intermittent and colicky and can be severe. Patient is usually very ill and has only moderate tenderness to touch in the right upper quadrant of the abdomen.

Hepatitis B virus causes a minority of cases. See Table I.

See Rhinitis.

Ectopic Pregnancy

Ectopic Pregnancy occurs outside the mucous membrane that lines the uterus (endometrium) and endometrial cavity; that is, in the cervix, uterine tube, ovary, or the abdominal or pelvic cavity. The most common site is in the uterine tube, and about 50% are caused by a previous tubal infection. Spotting, and cramping pain usually begin shortly after the first missed menstrual period. Symptoms are similar to a threatened abortion. Gradual hemorrhage causes pain and pressure, but rapid hemorrhage results in hypotension or shock. Often, uterine bleeding precedes these events and there is irritation in the abdominal lining (peritoneal). The uterus is enlarged, the cervix is tender to motion and a tender mass may be felt in one fornix. The cul-de-sac may bulge (Culdocentesis), and yields non-clotting blood. At about 6 to 8 weeks of pregnancy a marked, sudden, lower abdominal pain may occur, followed by fainting. This usually indicates rupture of the tube with intra-abdominal hemorrhage. See Adnoid Hyperplasia, Table I, or any condition related to lymphatics.

Eustacian Salpingitis

Eustacian Salpingitis is inflammation of the eustachian tube. A patient with middle ear disorder may present with one or more of the following complaints: a feeling of fullness or pressure in the ear; constant or intermittent, mild excruciating pain; diminished hearing; tinnitus; and vertigo. These are all related to Otitis Media. In Acute Otitis Media fever and other systemic symptoms may present, such as loss of appetite, vomiting, lethargy, and so on. The various symptoms result from infection, trauma, and disturbed pressure relationships secondary to eustachian tube obstruction. The causes may involve discharge of mucous (rhinorrhea), sore throat, allergic reactions, headache or other evidence of involvement of the covering of the brain (meningeal), or other systemic symptoms.

See Brucellosis.

Possible virus or bacterial toxins may be the source. See Table I.

See Brucellosis.

Syphilis, Tuberculosis and Cryptococcosis may create signs of Meningeal Irritation which is less marked than in the acute form. There may be cranial nerve palsies, delirium or confusion, dull to severe headaches, which are generalized over the crown. There may be a history of syphilis or tuberculosis. Also see Headache, Table I.

See Allergic Purpura.

See Lymphoma, Table I.

See Lyme Arthritis Disease.

An Arthritis by infection caused by the spiral-shaped bacterium Borrelia burgdorferi, carried by at least one species of tick, Ixodes scapularis. Of those infected about 60% will notice a round rash (erythema chornicum migrans); then, after three days to a month later, there will be a redness at or near the site of the tick bite. The reddened area does not itch or hurt, but will expand over time until it may measure several inches across. There is a clearing that begins in the center, as the rash enlarges, resembling a bulls-eye. Some may acquire the rash, but fail to see these characteristics because of the location. The rash may disappear within weeks or even days. Days or weeks later, a variety of other early symptoms affecting many areas of the body appears, and these symptoms are thought to be from the spread of the spirochete to many different tissues through the blood stream. Symptoms will include flu-like, such as chills, fever, fatigue, joint and muscle pains and loss of appetite. Sometimes neurological problems also appear, in about 20 percent of untreated patients, including Bell’s Palsy. (See Bell’s Palsy, Section I.) Other neurological afflictions include sensitivity to light, stiff neck, headache (meningitis), sleepiness, mood changes, memory loss (encephalitis), and irritation at the roots of the nerves stemming from the spinal cord causing painful tingling and numbness.
Medical data is for informational purposes only. You should always consult your family physician, or one of our referral physicians prior to treatment. Cardiac problems occur with 5 to 10 percent of those infected, if left untreated. Early symptoms may also include mild musculoskeletal disturbances where patients complain of vague, migrating pain without swelling in muscles, tendons or joints. Ten percent of those who reach the "arthritic" point will go on to suffer Lyme Arthritis. These patients will find joints swelling for months at a time, or certain joints will become enlarged and achy for a year or more. A joint that aches on one side will not necessarily lead to a matching (symmetrical) joint on the other side, as with Rheumatoid Arthritis. Although the skin, heart, joint and nervous system are usually targeted, Borrelia burgdorferi bacteria can invade any system in the body, and every organ or system can also produce its own variation of symptoms, similar to the syphilis spirochete.

See Brucellosis.

Psychotic Illness
Possible viral or toxin source. See Table I.

Non-Hodgkin's Disease
See Lymphoma, Table I.

Nonviral Inflammatory Conditions of the Liver
There are a large number of micro-organisms that can affect the liver, including bacterial, fungi, and protozoa. Bacteria may include tuberculosis, leprosy, salmonellosis, brucellosis and other infections. The commonest organism is Escherichia coli found in 65% of the cases. Staphylococci are also common, and numerous other organisms have also been reported. The patient is toxic, wasted, and obviously seriously ill. There may be dull right upper quadrant discomfort with tender enlargement of the liver and pain with percussion over the lower rib cage. Jaundice may occur late. Infections caused by mycoses may produce focal or spreading (metastatic) lesions. Actinomycosis is caused principally by the anaerobic Actinomyces israelii. The patient is usually toxic and severely ill. Histoplasmosis is acquired by inhalation of airborne spores of Histoplasma capsulatum. Cryptococcosis is established as a primary infection in the lung following inhalation of Cryptococcus neoformans. Individuals with malignant disorders of the reticuloendothelial system are particularly susceptible. Most of the mycoses can cause liver lesions. Coccidioides immitis, Candida albicans and Aspergillus fumigatus are among those more commonly reported. The protozoan can cause Amebiasis. The highly infectious cysts of Entamoeba histolytica are ingested and change into the vegetative trophozoite form in the colon. The amebas then invade the colonic mucosa and are carried by the portal venous system. An amebic abscess in the liver is usually large. The onset is usually gradual with intermittent or no fever, and jaundice, if present, is mild, even though the patient looks ill. Right upper quadrant pain, aggravated by alcohol or certain positions, is greatest when the lesion is expanding rapidly. Tender, enlarged liver is virtually constant. Complications include secondary infection, and rupture of the abscess into the lungs, and other body parts. Additionally, malarial infection affects the liver as may Helminths and Spirochetes. See Chronic Hepatitis, Table I.

Pericardial Disease
Possible viral or toxin source. See Table I.

Polyarteritis
See Table I.

Regional Enteritis
Possible microorganism source. See Table I.

Reiter's Syndrome
An arthritis of adult males, often associated with inflammation of the delicate membrane that lines the eyelids and covers the eyeball in front (conjunctivitis), inflammation of the fibromuscular tube which conveys the urine from the kidney to the bladder (urethritis), and infrequently with discharge of mucus from the horny layer of the skin (keratoderma blennorrhagica). Considerable evidence suggests that the cause is a myxovirus or mycoplasma. Onset may be acute or subacute. Usually it is asymmetric and one or many joints (mon- or polyarticular), with a preference for feet, ankles, knees and sacroiliac joints. Often there is history of recent sexual exposure. Diarrhea (dysentery) may precede the onset of joint symptoms followed in a few days to 2 weeks by inflammation of the urethra (urethritis) and a low-grade fever, and within another 2 to 4 weeks by conjunctivities. Symptoms, however, may occur in a different order. Lesions may occur on the soles and palms, starting out as multiple, small, yellowish vesicles that break, become confluent, and form superficial ulcers. On the soles, lesions start as pustules and become encrusted. Arthritis tends to persist after the eye and urethra inflammation die down, but persistent Arthritis may continue in the sacroiliac joints or to inflammation of a vertebra (spondylitis). Recurrence of Arthritis is common with about one-half the patients, with subacute joint symptoms appearing intermittently for 10 years or longer. Recurrences may appear as a single symptom or in the form of the complete triad.

Rheumatic Fever
An acute inflammatory reaction to streptococcal infections that appears in the joints (Arthritis), brain (Chorea), heart (Carditis), subcutaneous tissues (nODULES) and the skin (Erythema marginatum). Rheumatic Fever is the most common heart disease among school children, being found in 1 to 2%. It is responsible for about half of the rejections from military service for cardiovascular reasons. Manifesting Arthralgia is often mistaken for Juvenile Arthritis. Except for inflammation of the heart (Carditis), and the effects on it, joint pain and fever often subside within 2 weeks, sometimes more rapidly. New manifestations of heart inflammation (Carditis) will seldom occur after 2 to 3 weeks, except murmurs do not disappear. Usually
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Acute evidence of inflammation returns to normal within 5 months. Scars left by damage may contract and change, and secondary difficulties may develop in the muscles of the heart (myocardium) without inflammation. Long-term outcome depends on the severity of the initial attack. Patients with severe attacks during the acute episode are usually left with residual heart disease that is worsened by the rheumatic disturbances to which they are particularly susceptible.

**Rhinitis**

Rhinitis is the most frequent of the acute upper respiratory infections, characterized by edema of the nasal mucous membrane, nasal discharge and obstruction. It is the usual manifestation of a common cold, but it may also be caused by streptococcal, pneumococcal or staphylococcal infections. Chronic Rhinitis may occur in syphilis, tuberculosis, rhinosclerosis, rhinosporidiosis, leishmaniasis, blastomycosis, histoplasmosis, and leprosy, all conditions characterized by a tumor or neoplasm made up of granulation tissue (granuloma) and destruction of soft tissue, cartilage, and bone.

**Salpingitis**

Salpingitis is inflammation of the fallopian tubes or eustachian tubes (Eustachian Salpingitis). The term Pelvic Inflammatory Disease (PID) is used to include infection of the cervix (cervicitis), the uterus (endometritis), or the ovaries (oophoritis). Salpingitis of the fallopina tubes occurs predominately during the late teens or early 20s in young, sexually active women and is the result of an infection transmitted mostly by intercourse, less often by childbirth (puerperal fever) or by abortion. Patients with intrauterine devices (IUDs) are vulnerable Salpingitis rarely occurs before menarche, after menopause, or during pregnancy. The principal pathogen is Neisseria gonorrhoeae, but other gram-negative bacteria and gram positive cocci, as well as Mycoplasma and viruses are often implicated. Tuberculosis salpingitis is uncommon, especially in the absence of systemic tuberculosis. Infection begins intravaginally in most cases. The endocervical glands provide an optimum environment for organisms to flourish before spreading upward to produce a superficial inflammation of the lining of the uterus (endometritis) and inflammation of the lining of the ovarian duct (endosalpingitis). Although symptoms and signs may predominate on one side, both tubes are probably affected. The tubal infection produces a profuse exudate and leads to cellular clumping (agglutination) of mucosal folds, adhesions and tubal occlusion. Peritonitis is common. The ovaries tend to resist infection, but also may become invaded. With gonorrheal infection, a profuse purulent cervical discharge may appear within 3 to 5 days of intercourse, accompanied by malaise and low-grade fever and often associated with a purulent urethral discharge. These symptoms may subside or be mild or absent, but will reoccur, usually just after menses. Occasionally the symptoms do not occur until several months after infection. There will be severe lower abdominal pain, tenderness, fever, a purulent cervical discharge, signs of inflammation of the lining of the abdominal walls (peritoneum) and adjacent parts. Palpating the cervix or adjacent parts produces severe pain. There will be tenderness and muscle guarding. For nose and throat, see Eustachian Salpingitis.

Schonlein’s Purpura

See Allergic Purpura.

Thrush

See Candidiasis, Table II.

Undulant Fever

See Brucellosis.

Ulcerative Colitis

A chronic, inflammatory disease of the colon accompanied by ulcerations, and characterized by bloody diarrhea. Any age may be affected, but most frequently found between the ages of 15 and 40. The disease usually begins in the lower part of the colon extending to the rectum (rectosigmoid region), eventually involving the entire colon; or it may attack most of the large bowel at one time. Ulcerative Proctitis, a more benign form, usually remains localized to the rectum. As the disease progresses, the mucosa breaks down into a red, spongy surface dotted with a myriad of tiny blood- and pus-oozing ulcerations. Usual manifestations are a series of attacks of bloody diarrhea varying in intensity and duration, and these attacks may be acute and sudden, with violent diarrhea, fever, inflammation of the membrane surrounding the abdomen (peritonitis), and symptoms of excessive toxins (toxemia). More often, however, symptoms begin insidiously, with an increased urgency to defecate, mild lower abdominal cramps, with an appearance of blood and mucus in the stools. Complications might include hemorrhaging, the most common, tiny perforations of the bowel with localized obstruction of the bowel (ileus) and inflammation of the lining surrounding the abdomen (Peritonitis). Without effective treatment death may result. Extra complications include: Arthritis (peripheral), Ankylosing Spondylitis, inflammation of the sacrum and ilium (Sacroilitis), inflammation of the eye, (Uveitis: posterior), redness with nodules on the skin, (Erythema Nodosum), pus and dead tissue on the skin (Pyoderma Gangrenosum), and inflammation of the white portion of the eye, (Episcleritis), and, in children, severely retarded growth and development. The Arthritis, eye-white and skin complications tend to fluctuate with the colitis, whereas the Spondylitis, Sacroilitis, and eye-posterior (Uveitis) usually follow an independent course. Most colitis patients with spinal or sacroiliac problems also have evidence of Uveitis, and vice versa. These conditions may precede the colitis by many years, and may occur without bowel disease in relatives of colitis patients. There seems to be a genetic overlap among those suffering from Ulcerative Colitis, Ankylosing Spondylitis, Uveitis, [B27 genotype]. The risk of colon
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Cancer is great. A rapidly progressive initial attack may be fatal in nearly 10% of patients. Complete recovery after a single attack may occur in another 10%. In most cases, the disease is chronic, with repeated increases and remissions. Onset is sudden. After surgery, the disorder may appear from 2 to 7 days. Colicky pain and nausea occur, rapidly followed by prostration, high fever, and usually profuse, watery, and sometimes bloody diarrhea with offensive, greenish-yellow stools and severe fluid loss. Pulse rate rises and blood pressure falls. Dehydration, abdominal distention, and collapse follow. Slight abdominal tenderness may be present; bowel sounds may be normal or over-active. The stool will show gram-positive cocci, or Staphylococcus aureus.

Proctitis See Ulcerative Colitis.

Uveitis may occur with syphilis, tuberculosis, and sarcoidosis. See Uveitis, Table I; also see Sarcoïdosis, Table I.

Table III: Osteoarthritis and Degenerative Joint Diseases

| Herniated Disc | See Low Back Pain. |
| Ligament Strain | See Low Back Pain. |
| Low Back Pain |

Low Back Pain (lumbar, lumbosacral, sacroiliac regions) is also often accompanied by pain down the legs along the distribution of the sciatic nerve (Sciatica), and this pain can be more severe than the backpain. Most Low Back Pain is thought to relate to degenerative disease. The condition increases with age, and with about 50% of those 60 years of age and older.

Low Back Pain also may be caused by a ruptured intervertebral disc (Ruptured Disc) where herniation has caused inflammation or direct mechanical nerve root pressure. Herniation may be an isolated injury, or related to intervertebral joint degeneration. Fracture, infection, or tumor which involves the back, pelvis or behind theserous membrane reflected over the viscera and lining the abdominal cavity (retroperitoneum), or traumatic ligament rupture or the tearing of muscles beside the spine (paraspinous) may cause Low Back Pain accompanied by radiated Sciatica pain. Mild congenital defects are common (spina bifida, occulta, abnormal intervertebral facets, sacralization of transverse processes of the lowest lumber vertebra) and may predispose to low back strain. Slipping forward of a vertebra upon the one below (Spondylothesis) may cause back strain and Low Back Pain. History is important and often crucial for diagnosis. Increased pain may follow coughing or sneezing (Valsalva's maneuver), or limitation of straight-leg raising, and limitation of back motion. Ligament Strain, Muscle Tear or Ruptured Disc is suggested by its sudden onset. Symptoms usually begin 2 to 24 hours after heavy lifting, or other strenuous physical exertion. Localized tenderness over a particular interverbral space is significant and suggests a process in the back itself rather than in the pelvis or behind the serous membrane reflected over the viscera which lines the abdominal cavity (retroperitoneum). Intrapelvic source, and behind the serous membrane reflected over the viscera and lining the abdominal cavity (retroperitoneum), may be suggested by the presence of associated symptoms and by the absence of localizing signs in the back, other than limitation of motion due to pain. A Ruptured Disc is diagnosed by the presence of objective signs of nerve root irritation, such as muscle/nerve (motor) weakness. Tumors and infections may mimic a Ruptured Disc. Chronic Arthritis and underlying skeletal defects, such as Spondylothesis, are also suggested by gradual onset of Low Back Pain. Fracture and fracture dislocation may be ruled out by the history and the nature of the trauma, as well as X-ray.

See Low Back Pain. Chronic Arthritis of noninflammatory character. See Osteoarthritis

Osteoarthritis is the most common form of Arthritis. It is characterized by loss of joint (articular) cartilage, death of cells beneath the cartilage (subchondral bony sclerosis) and cartilage and bone proliferation at the joint margins with subsequent bony growth formations (osteophytes). Synovial inflammation is common. Factors considered of importance are genetic, metabolic, endocrine, biomechanical and hydrolytic enzymes. Abnormal biomechanical stress can lead to cartilage cell (chondrocyte) damage, and the release of the protein digesting (proteolytic) enzymes then results in joint (articular) cartilage degeneration. When cartilage repair cannot keep pace with degeneration, Osteoarthritis develops. Osteoarthritis may also be secondary to chronic trauma or underlying joint disease. Onset is usually gradual and localized to one or a few joints. Pain, usually the earliest symptom, is greatest after exercise. Stiffness or fibrositis commonly follows inactivity but usually only lasts for 15 to 30 minutes. Joint motion can be limited in severe cases. Tenderness and grating of bone on bone (crepitus) are present. Joints become larger because of the proliferation of bony material beyond the edge of the joints. Swelling may occur from the escape of synovial fluid. Deformity and dislocation (subluxation) occur as the disease progresses. Other symptoms throughout the body, or outside of the joints, are not observed. There is a wide variation in observed clinical manifestations. Enlargement of the joints (Heberden's nodes) closest to the nails (terminal interphalangeal joints) is common. Painful gelatious cysts may also be present. Women are affected ten times more than men. Similar deformities (Bouchard's Nodes) may develop at the the next joint (proximal interphalangeal joint) also. When placed at the joints closest to the wrist (car-
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Chondrocalcinosis

Intermittent attacks of acute Arthritis and X-ray evidence of nodules of calcium salts under the skin, muscles, tendons and nerves (calcinosi) of the joints. Frequently associated with other conditions such as Osteoarthritis, diabetes mellitus, hyperparathyroidism, Gout, and a skin condition (hemochromatosis). The disease develops in maturity, and affects both sexes equally. Over 50 years of age, the incidence is appreciable. Unexplained acute or subacute attacks of Arthritis occur, usually in the peripheral joints. There is a suggestion that deposits of calcium pyrophosphate dihydrate in the cartilage is secondary to degenerative changes in the joint. Attacks follow the pattern of uric acid Gout, but are less severe, with complete freedom between attacks. At other times, distress persists, with low-grade symptoms similar to Rheumatoid Arthritis. Symptoms may persist intermittently for life.

Gout

A recurrent acute arthritis of the peripheral joints which results from deposits, in and about the joints and tendons, of crystals of monosodium urate from a supersaturated solution of uric acid in the blood (hyperuricemic). Gout may become chronic and deforming. Not everyone with supersaturated blood may develop gout, but the greater degree and duration of the supersaturation, the more probability of crystal deposition and of acute attacks of Gout. Men are most often affected. Usually an underlying abnormality in the metabolism of a chemical called "purines" is attributed to the Gouty condition, with excessive production of purines and diminished ability to clear uric acid as being the major factors. Associated with Gout can be a number of other diseases, including blood (hematopoietic) diseases, Psoriasis, thyroid (Myxedema), parathyroid (hypo- and hyperparathyroidism), hypertension, heart (myo-cardial infarction), kidney (advanced renal diseases), obesity, and several hereditary diseases (Down's syndrome and glycogen storage disease, Type I). There can be a sex-linked presence of uric acid in the urine (uricaciduria) with a deficiency of a certain enzyme (hypoxanthine-guanine phosphoribosyltransferase). This is associated with markedly excessive uric acid production, a tendency to develop uric acid kidney stones, and severe Gouty Arthritis and kidney disease (nephropathy) at an early age. Acute Gouty Arthritis may be the presenting symptom of another underlying metabolic disorder. An acute attack usually appears without warning, but may be precipitated by minor trauma, as from minor surgery or ill-fitting shoes, overindulgence in food or alcohol, fatigue, emotional problems, infections, or treatment with antibiotics, insulin or mercurial diuretics. One or more joints, usually at night, may signal the first onset. Pain becomes progressively more severe and is often described as a throbbing, crushing, or excruciating pain. Swelling, warmth, redness, and extreme sensitivity resemble an infection. The skin is tense, hot, shiny and dusky red or purplish in color. The big toe joint (metatarsophalangeal) is most frequently involved, but the instep, ankle, knee, wrist and elbow are also common sites. First attacks may show in only one joint, with later attacks involving more than one joint. Systemic reaction may include fever, heart rate increases (tachycardia), chills, malaise and an increase in leukocytes (leukocytosis) in the blood. First attacks may last but a few days. Later, untreated attacks may last for several weeks. Symptoms and signs may regress. Intervals between bouts vary considerably, but tend to become shorter as the disease progresses. Eventually, without treatment, several attacks will occur each year. With chronic Gout, hard or gritty (tophaceous) deposits appear in the joint and tendons. Chronic joint symptoms develop as permanent erosive joint deformity appears. There is limitation of motion, often involving multiple joints of the hands, feet, or both. Rarely is the shoulder, scapcoiliac or sternoclavicular joints involved. Sometimes the cervical spine may be involved. Monosodium urate deposits are common in the walls of the sacs surrounding joints (bursae) and within tendon sheaths. Usually
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The characteristics of Gout are so unique as to be easily diagnosed by patient history and examination. Therapy permits patients to live a full and productive life without serious disability, provided diagnosis is prompt and that the patient accepts the treatment. Some limited reconstitution of joint structure is possible. The hard, gritty deposits (tophi) can be resolved, joint function improved, and kidney dysfunction can be halted. Progressive, untreated kidney dysfunction leads to further gouty deposits, which accelerates the process, thus forming the greatest threat to life.

**Gouty Arthritis**

See Gout.

**Pseudogout**

See Chondrocalcinosis.

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**Table V: Other Rheumatic Diseases**

1. Traumatic and/or Neurogenic Disorders
2. Neoplasms
3. Allergy and Drug Reactions
4. Inherited and Congenital Disorders
5. Miscellaneous, unclassified.

**Charcot's Joints**

See Neurogenic Arthropathy.

**Dupuytren's Contracture**

Contracture of the palm's band of tissue which invests and connects the muscles resulting in flexion deformities and loss of function of the fingers. The incidence within families is more than 50%, and the incidence increases progressively after age of 40. It is higher in chronic invalids, alcoholics, epileptics and patients with pulmonary tuberculosis and diabetes mellitus. It may appear as a late sequel to the Shoulder-Hand Syndrome. One or both hands may be affected, the right hand most frequently. The ring finger is involved most often, followed by the little, middle and index finger. Diagnosis is by visual inspection and touching with the diagnostician's hand (palpation). Initially a small painless plaque or nodule develops in the fascia of the palm and eventually extends. The skin adheres to the fascia and becomes puckered. Contracture of the fingers gradually follows. Extension of the affected fingers is impossible when the wrist is flexed and, in advanced cases, in any position. When the Shoulder-Hand Syndrome is involved, the hands may resemble those affected by Scleroderma or Raynaud's Disease. The condition progresses at a variable and unpredictable rate.

**Neurogenic Arthropathy**

Destructive joints (arthropathy) where there is impaired pain perception or position sense. See Neurogenic Arthropathy.

**Neuropathic Arthropathy**

See Neurogenic Arthropathy.

**Tennis Elbow**

A strain of the forearm (lateral) muscles near their origin, caused by repetitive strenuous turning of the palm of the hand upward (supination), and against resistance, as in manual screwdriving, or by violent extension of the wrist as in tennis. Tennis Elbow can be disabling. Pain may be severe and radiate to the outer side of the arm and forearm. It is aggravated by continued use, especially with the same movements under resistance. Weakness of wrist may be pronounced.

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**References**


The Arthritis Trust of America®/Rheumatoid Disease Foundation, 7376 Walker Road, Fairview, TN 37062