Human Papilloma Viruses (HPV)

Treatment of Diseases involving HPV with SANUM Remedies under Orthodox Medical Monitoring

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Summary

1. Introduction

New research, as well as the recent possibility of being vaccinated against papilloma viruses, has altered the way in which we deal with this topic, even in Natural Health practice.

More and more of our female patients and their daughters expect a clear opinion from us regarding this problem, and an alternative to conventional treatment and vaccination. They are afraid of missing out on something if their daughters are not vaccinated, and this is reinforced by the aggressive treatment of the subject by the media. This means that we have been really challenged in our practice to apply SANUM treatments in this area too. Apart from enquiries regarding the possibility of vaccination, the patients who come to us are the ones who already have a disease caused by the papilloma virus.

It was the possibility of initiating a healing process here in cooperation with the gynæcologist responsible for each case (follow-up swabs, etc.) that gave me the idea of preparing a longer-term progress report.

For this observation exercise on the use of these remedies I accepted exclusively female patients with disease of the portio and/or cervical area at various stages.

Some of these women had already received invasive treatment (see Table 1: cytological picture and clinical evaluation of smear) and were suffering a relapse; in other cases a first diagnosis had been made, with the option of having a conisation or abrasion following a further smear after three months. In some cases a hysterectomy had also been advised.

2. Diagnostic possibilities

There are various laboratory diagnostic procedures to demonstrate the presence of papilloma viruses. The Pap smear test (cytological) has been well-known for years and makes it possible to evaluate neoplastic changes. As well as this, there are various procedures (e.g. Digene Hybrid Capture 2 = hc2 Test), to determine the phylogenetic class of

Pap Stages	Cytological picture	Clinical evaluation;Therapeutic action
Pap I	Proper cytological picture	negative; no action
Pap II	Normal cytological picture (additions of leucocytes and micro-organisms); degenerative and regenerative changes.	negative; checks recommended, poss. treatment for inflammatory process.
Pap III	Unclear, dubious cytological picture; inflammatory, atrophic or degenerative changes already present.	suspicious; to be followed up within 3 months after appropriate treatment; if endometrial cells present after menopause: abrasion.
Pap III D	Low to medium-grade dysplasia.	suspicious; neoplasm stage; if it persists beyond 1 year or progresses: conisation and abrasion.
Pap IV a	Pathological cells (severe dysplasia, cellular atypia);suspected carcinoma in situ.	positive; histology (biopsy); conisation/abrasion, and then possible hysterectomy.
Pap IV b	Suspected micro-carcinoma; possible incipient invasion.	positive; conisation and abrasion to confirm diagnosis.
Pap V	Large quantities of clearly malignant tumour cells.	positive; histology; surgery (hysterectomy, removal of ovaries/local lymph nodes), or radiotherapy and possibly chemotherapy.

Table 1: Cytological picture and clinical evaluation of smear

the virus in the form of a HPV-DNA test.

In the interests of general understanding, I shall describe below the Pap smear test and the latest research into the papilloma virus.

PAP Smear Test
In this cytodiagnostic test, devised by Papanicolaou, a cervical smear is fixed in 96% ethyl- or 99% isopropyl alcohol and then stained (nuclear staining with hæmatoxylin and combined plasma staining with Orange G6 and polychromic dye). On the one hand this makes it possible to evaluate the nuclear structures (size, shape and chromatin content), so as to determine the caryopyknosis index (nuclear ripening) and cancer diagnosis. On the other hand, the plasma staining permits determination of the degree of maturity of the cytoplasm (eosinophilia index), on the basis of the colour change from bluish green to red.

3. Papilloma Viruses - Phylogenetic Classification of the Viruses
Human papilloma viruses (HPV) form a group of DNA viruses, which has come to embrace more than 150 various types. These are non-enveloped, double-stranded DNA viruses (dsDNA), which are classified as belonging to the papilloma virus family.

These groups of dsDNA are regarded as slow viruses: they can be present for months or years and yet remain unnoticed, thus initiating a slowly progressing disease.

This group is made up of a wide variety of viral families (…viridæ) with various subfamilies (…viranæ).

Here are a few selected classes:

1. Herpesviridæ
   (a) Alpha-herpesviranæ:
   Herpes simplex (HHV1 and 2)
   (b) Beta-herpesviranæ:
   Cytomegalovirus (HHV6)
   (c) Gamma-herpesviranæ:
   Epstein-Barr virus (HHV4)

2. Adenoviridæ:
   Human adenoviruses

3. Papillomaviridæ:
   Human papilloma viruses (HPV)

HPVs attack epithelial cells of the skin or various mucosæ and, in the infected cells, they trigger an unbridled growth similar to that of a tumour. These tumours are benign in the main and result in warty growths at the dermal or mucosal site in question. Should the infection occur in the genital or anal region (usually as a result of sexual intercourse), this results in the formation of genital warts (e.g. figwarts).

However, a few types of HPV can also give rise to malignant changes, particularly cervical cancer in women. They are also suspected of having a considerable part to play in the development of vaginal, penile and anal carcinoma. The gene products of these viruses, particularly the E6 and E7 genes, prevent the programmed death of cells (apoptosis) and make any repair of the cell's DNA double strand impossible.

Viral groups of HPV
So far 118 types of HPV have been completely described. Of these, about 30 infect almost exclusively the skin and mucosa in the ano-genital region.

The genital types of HPV can generally be divided into two groups: the low-risk and high-risk types. This distinction is made on the basis of the type of risk: A few of these pathogens occur in extremely large quantities in association with carcinoma.

The types are:

a) High-risk viruses
These particularly include HPV 16, 18, 31 and 33, but also 35, 39, 45, 51, 52, 56, 58, 59, 68, 73 and 82. In 99.7% of all cases of cervical cancer HPVs of the high-risk group have been identified, with the majority of these cancers being triggered by high-risk types 16 and 18, followed by genotypes 31 and 33. A few cancerous diseases in the oral region (oral sex) are considered to be associated with HPV. In 2005 the WHO officially classified genotypes 16, 18, 31, 33, 35, 39, 45, 51, 52, 58, 59 and 66 as carcinogenic.

b) Low-risk viruses
This group includes HPV 6 and 11 since, as the main causes of warts in the genital area

(Condylomata acuminata), they are not potentially dangerous to life.
Other low-risk types are 40, 42, 43, 44, 54, 61, 70, 72 and 81. The low-risk types are almost never directly involved in the development of cervical cancer. However, in the case of multiple infections (infections with more than one HPV genotype) their presence can also be demonstrated in cervical cancer, although this is always together with a clinically relevant type of high-risk virus.

4. Pathways of Transmission

Principally infection occurs via skin contact, and in certain types of virus primarily via unprotected sexual intercourse (genital, anal or oral). Thus infection with HPV is one of the commonest to be passed on through sexual intercourse; however, the infection often remains undetected, sometimes for years.

Condoms only offer protection up to a point. Admittedly the germ can only gain entry via direct sexual contact (from pathological skin changes or body fluids with microbial content), however it is also possible by smear infection. The proof of this was provided by Dr. Andreas Clad, director of the Department of Gynæcological Infectiology at the Freiburg University Gynæcological Clinic, in a study („Nucleic acid Amplification Tests for Trachomatous Chlamydia and HPV").

There are no general figures for the rates of infection in men. The reason for this lack of data is the absence of regular medical check-ups for men in this area. If one partner is infected with an HPV, then it is highly probable that the other is also affected. Up to 70% of male partners of a woman who tests positive in HPV screening also have an infection, although this often causes only minuscule lesions on the penis. HPV can also remain undetected in the skin of the penis for a long time. In rare cases malignant changes, even carcinoma, may occur on the penis.

Since penile carcinoma is extremely rare in circumcised men, retained smegma and repeated inflammations of the foreskin and glans (chronic balanitis) are presented as decisive factors in uncircumcised men.

5. Treatment

At present, from the orthodox medical point of view, there is no specific treatment for people with the papilloma virus. Where lesions are present, essentially it is surgical intervention that is considered. Beyond that, there are also local cauterisations; however, following these there is a relatively high incidence of relapse. Systemic or local treatments, such as interferons and other cytokines, have so far not been crowned with overwhelming success. For this reason a great deal of money is being spent on promoting vaccination and stepping up the publicity for safer sex.

So far as vaccination is concerned, I do not intend to make any statement in this article, since I would like to give pride of place to Natural Medicine by presenting a patient's treatment history.

I wish to make it expressly clear that those patients who were treated over a period of up to two years and whose progress was written up in detail, were also closely monitored and tested by their gynæcologist at the same time. The patients were informed by me that, in the event of their condition deteriorating or degenerating, they should certainly give serious consideration to the possibility of invasive methods (conisation, abrasion, hysterectomy).

Case Example

Mrs. A. from Hamburg, b. 1980, working, stable relationship, wanted children.

Evidence of HPV (06.04.2005):
high-risk strains pos. (HPV 16, 18, 31, 33, 52, 58),
low-risk strains neg.
Pap follow-up test after three months.

Pap smear (28.7.2005):
Group III D, proliferation grade 3-4,
Pap follow-up test advised after three months.

Pap smear (07.11.2005):
Group III D, proliferation grade 3-4,
anti-viral medication prescribed, whose name the patient had forgotten, since she discontinued it after a week because it dis-

agreed with her (nausea, vomiting).

Evidence of HPV (17.05.2006):
high-risk strains pos.
(HPV as at 06.04.2005),
low-risk strains neg.
Pap follow-up test.

Pap smear (22.05.2006):
Group IV a,
A CO_2 laser vaporisation of the ectocervix was proposed, or cervical abrasion.

Surgical appointment (23.08.2006):
Colposcopy:
Portio macroscopic with small, circular ectopy; following vinegar test, at the cervical canal (6-10 o' clock) vinegar-white areas with dots show up. A CO_2 laser vaporisation was carried out. Findings: inconspicuous cervical mucosa, endometrium inactive to slightly proliferated, no indication of dysplasia.

Evidence of HPV (19.09.2006):
high-risk strains pos.
(HPV as at 06.04.2005),
low-risk strains neg.
Pap follow-up test.

Treatment with Natural Therapies
Dark-field diagnosis: apart from a slight displacement of the milieu, slight anæmia and only slightly active granulocytes, no further suggestion of higher-valency stages.

Medication from a clinical point of view:
September 2006

Prescription I:
SANUVIS drops. 50 drops to 1l water,
QUENTAKEHL 3X suppositories, vaginally, in the evenings
FORTAKEHL 3X suppositories, anally, in the evenings
- alternating between anal and vaginal (then QUENTAKEHL anally and FORTAKEHL vaginally, and so on)
- during menstruation only anally.

Prescription II (28 days later):
SANUVIS drops, continued
CITROKEHL tablets, one twice a day mornings and evenings additionally
QUENTAKEHL 3X suppositories continued
FORTAKEHL 3X suppositories continued
SANKOMBI 5X, 5 drops twice a day, in the morning on an empty stomach and in the evening undiluted before retiring.

Prescription III (a further 28 days later):
continuing as per Prescription II, but….
Suppositories only every other day,
RECARCIN 6X capsules, one once a day, alternating with UTILIN 6X capsules, one once a day, on Saturdays on an empty stomach!

Prescription IV (a further 28 days later):
Continue with milieu remedies SANUVIS and CITROKEHL; suppositories only Mon., Wed., Fri. in alternation; immunomodulation (RECARCIN 6X and UTILIN 6X), in weekly alternation until end of treatment.
SANKOMBI 5X, 5 drops once a day in te mornings on an empty stomach, SANUKEHL Pseu 6X, 5 drops once a day in the evenings before retiring.

Duration of Treatment:
4 months altogether, but this is always decided according to the individual case, depending on gynæcological findings.

Maintenance dose until two further negative smears:
Citrokehl, 1 tablet once a day; every other day:
1x FORTAKEHL suppository, vaginally
1x QUENTAKEHL suppository, vaginally,
except during periods.

Gynæcological Check-ups

Pap smear (15.02.2007): Pap II

Gynæcologist's final findings:
"In 2006, the above-named patient was found to have altered cells at the os cervix, resulting from a HPV infection of the high-risk type.

Additionally, the patient is known to have suffered from recurring attacks of colpitis.

On the basis of these casetaking data, and to avoid any renewed HPV infection of the genital tract, I urgently recommend a prophylactic vaccination against HPV using Gardasil®."

Final examination at the Natural Health practice

Pap smears carried out by the gynæcologist in 2007/early 2008 remained at Pap II. Mrs. A did not have the Gardasil® vaccination, and initially remained on half-yearly check-ups.

This therapeutic example is representative of about 20 patients, whom I have now had under observation for three years. Most patients still kindly provide me with copies of their test reports, even if they are not currently being treated for other problems.

Four of these women who, like my sample patient, wanted to have children, have become pregnant in the meantime, or have already given birth.

In my opinion, however, it is not the SANUM remedies that are responsible for the pregnancies, but rather the peace and quiet that one requires in order to get into a new way of life. Constantly being dogged by anxiety is a burden which often precludes that.

From my point of view as a therapist, there are two matters which are worth mentioning in conclusion, from an objective point of view: firstly, in the dark-field image I found no actual clues as to this local process in the region of the portio and/or the cervical channel. Secondly, I was able to see how the four steps of treatment with SANUM remedies brought about a regulatory change in their action.

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