

To Be or Not To Be Subclinical Pellagra

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"To be, or not to be, that is the question." These words of Shakespeare can be applied to subclinical pellagra. Is it a disease? Is it a syndrome? Is it a deficiency? Is it an allergy? Questions like these are frequently asked by the public, the patient, and doctors too. I believe subclinical pellagra is part of the continuum of mental ill health. It starts with complaints of a minor nature, maybe some behavioral disturbances, and may extend on to the frank psychoses. It is a sounder diagnosis than adolescent behavior syndrome, minimal brain damage, and the like.

Definition

Subclinical pellagra is a syndrome characterized by perceptual changes involving all senses, special and/or proprioceptive. There is also an unusual sensitivity to refined carbohydrates. This combination leads to a variety of symptoms which blanket the field of medical complaints. The administration of niacin causes prompt disappearance of special sense dysfunctions, while proprioceptive sense changes are more slowly corrected with dietary and other measures.

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The name Subclinical Pellagra was important in the early years after I discovered and named it in 1969. I learned from Dr. Hoffer about special sense dysperception. I tried to pin the diagnosis "schizophrenia" on a nice little six-year-old blond boy. He saw little people, was quite paranoid, and heard voices. The mother left in a huff after this because he had come in complaining of abdominal pains. I later had a note from my partner of that time never to use the word schizophrenia on clinic patients again. Obviously schizophrenia was not the diagnosis to be made, yet the patient was hallucinating, was paranoid and not functioning well. The late Dr. Bella

Kowalson coined the term "metabolic dysperception." It was at once descriptive, accurate, and difficult. Neither the patients, my confreres, nor the computer would accept it as a diagnosis. Economics had to act as the Mother of Invention. In a facetious mood I called the disease Prince Albert Pellagra. I wrote a short report which I gave to Dr. Mike Galambos. He read it to the meeting of the Canadian Schizophrenia Foundation in Vancouver, in 1970. Naturally that name was too descriptive and too limited because I felt it was a worldwide problem. I thought then it was

due to an excess of refined carbohydrate and not enough protein, because my Indian patients filled this bill exactly., I recalled subclinical jaundice, therefore why not subclinical pellagra? From that time on the name has stuck. This was a name for a disease which did not frighten the patient. It was a vitamin deficiency and therefore perfectly respectable for the patient, his parents, and their friends. Here was a name which doctors could not refute, without actually learning something about the disease, then trying the megavitamin treatment. As yet they have done neither some eight years later. More importantly the name was accepted at that time by the record office of the hospital and the computer in Regina. This happy state did not last very long.

Background

By 1968 I was fed up with the way I was practicing medicine. I would go to the Penitentiary nearly every morning, then to the hospitals for rounds and to do anesthesia, or surgery. The afternoons were filled with patients whose complaints varied from day to day, from week to week. Neurotics seemed to be my lot. Just as I relieved a set of symptoms, another set popped up. Medicine was like a rotating squirrel cage, and I was the squirrel. The harder I worked the more there was to do, all to little avail. The same patients kept returning endlessly, searching for answers, and I gave them more of the same medicine. My wife had been very ill in 1967 with Guillain-Barre syndrome, and her recovery was slow. One of my daughters had trouble with school work which was most unusual. She was depressed and cranky at home all the time. I, too, was depressed, but did not make the diagnosis, nor did anyone else. I read ads in the **Financial Post** looking for something I could do at which I could earn as much money as I did in medicine. Seven children and a fine big house are very expensive. I did not take long to discover that only medicine could fulfill my requirements. Over the years I had taken short postgraduate courses at

various hospitals, learning more about anesthesia, surgery, and paediatrics. I thought dermatology might be interesting, then podiatry, and did some work in these fields. I did a short course in psychiatry in '68, but could not apply it to my practice.

About this time, Dr. Hoffer's Work was written up in **Macleans**, a national magazine. His brand of psychiatry appealed to me. I arranged an apprenticeship with him in October of 1968. This was the turning point for me in medicine, in my life. He taught me to ask about perceptual changes. He taught me to ask questions about hearing voices and visual changes. He taught me to ask questions regarding special sense changes because such a patient rarely volunteers such information. The patient was quite happy to answer if questioned because these were his real symptoms. If such a patient volunteered these illusory symptoms it may have meant committal to a mental institution. I realized only then I was seeing the same type of patient in my office as Hoffer was seeing in his. They had basically the same complaints. They had headaches, backaches, abdominal pain, fatigue. They were called "neurotic" when extensive investigations would fail to reveal a cause for their complaints. Frequently their HOD scores were high and Hoffer would call them schizophrenic. This diagnosis was accepted with equanimity by his patients, but not mine, however. When a patient has complained for years without getting definitive answers, he is delighted to accept a positive diagnosis. I started asking the right questions of patients who came to me with physical complaints though no positive physical findings. To my surprise and delight they frequently showed perceptual changes. Some were even able to demonstrate these changes for my records. Anne Marie was such a child. In 1969 Anne was failing Grade 4 after having been at the top of her class. She saw words backwards. They moved around so much she couldn't catch them, or make sense anymore. This is how she perceived her

name.

Anne Marie^A

The above was written by me and I asked A.M.T. to depict it as it appeared to her on April 1, 1969.

n i e n r a M A

This is what A.M.T. felt her name looked like. It is little wonder she had trouble reading.

After 30 days on nicotinic acid her perceptual changes cleared up and she passed her grade without trouble. A 12-year-old child found letters and numbers lost their shape, so she could neither read nor calculate. She too was cleared in 30 days. The discovery of complaints of this nature used to raise the hair on the back of my neck. Medicine suddenly had become new and exciting again.

After 2,000 deliveries there is no excitement left unless something goes wrong. That kind of excitement isn't desirable. After giving 18,000 anesthetics and doing a thousand operations you begin to wonder why. Perceptual dysfunction was an uncharted sea of complaints which had never, to my knowledge, been elucidated in general practice. These were normal children coming to my office with a sore throat, earache, abdominal pains, or leg pains, or headache. These were the same children I'd been seeing since 1948. Now I asked if they saw double, if the ground moved, if they heard their names called, if their faces changed shape in the mirror. More often than not these things did happen, and megavitamins cured them. Through 1969 and 1970 I worked on a set of questions for perceptual dysfunction. I knew this wasn't schizophrenia, but a new entity which I had named subclinical pellagra. I wrote a paper, "Subclinical Pellagra: Its Diagnosis and Treatment," which was published

by **Schizophrenia** in 1970, Vol. 2, Numbers 2 and 3. At our hospital clinical meetings I tried to get my colleagues to ask questions about perception, to do the Hoffer-Osmond Diagnostic Test which would save themselves time and effort. I wanted to share my findings with the other doctors. I felt subclinical pellagra was as important a discovery as was penicillin and would revolutionize the practice of medicine. I thought within three years my concept would be used by all. Each time, without exception, my advice was rejected and my assistance refused. Not only were the doctors not interested, they were actually opposed to any change in their way of practice. I eventually learned, the hard way, to keep my mouth shut.

Development

My progress and that of development of subclinical pellagra went hand in hand. The more I learned of perceptual changes, the more aware I became of their extent in the field of medicine. Complaints which heretofore could not be explained, I realized, were due to perceptual dysfunction. This happened in young and old, male and female, rich and poor. The common factor about them all was lack of an acceptable explanation for their physical complaints. Frequently I could demonstrate visual, auditory, and other special sense distortions in many such complaining patients. By using vitamins in large doses, their complaints tended to disappear. In some, however, there was only partial clearing, so I had to search farther for the reason. Excessive use of highly refined carbohydrates was a very common finding. These people had a sweet tooth. A large percentage admitted to excessive use of coffee, cigarettes, alcohol, tea, or pop. Excessive *use* of almost any food could be a clue. Not infrequently there was a history of alcoholism in the patient, or his immediate relatives.

It was about this time that my own allergy tolerance was exhausted. I began to suffer increasing fatigue and irrit-

ability. Instead of playing 18 holes of golf I had to quit after 11 because I just couldn't swing the club. I needed more and more sleep, yet I was still tired. Eventually a glucose curve was done. To my amazement, my curve went from 100 up to 212 in 30 minutes, then dropped rapidly to 80, then returned to the fasting level. Naturally I read everything available on the subject. Traditional medical books and journals dismissed the subject of low blood sugar out of hand. If the sugar level was more than 50, there was no hypoglycemia. This led me to Tintera's writings and to medical meetings where doctors, who thought differently, would congregate. I started on the low blood sugar diet, then began to look for and find my symptoms in my patients. They, too, were sensitive to refined carbohydrates and had hypoglycemia. Throughout Tintera's writings he frequently referred to allergy. I didn't twig to the importance of this until much later. I began to do five-hour sugar-tolerance curves on many of my patients. The value of the curve was questioned by many. The same set of numbers would be interpreted differently by different doctors, yet the patient would experience symptoms of hypoglycemia during the test. I used the hypoglycemic diet plus megadoses of vitamins C and B3 to clear symptoms. Many patients, myself included, did well for a time.

In 1973 I attended a meeting in San Francisco at which Dr. Theron G. Randolph spoke about food allergy. I asked about hypoglycemia. He denied its existence. He claimed that hypoglycemia was merely an expression of food allergy and the symptoms could be brought on by foods other than refined carbohydrates. By now I was getting up at night to eat peanuts and cheese, or drink milk. Randolph laughed and said, "Exactly, and what do you think that is—food allergy." I had to listen because my symptoms were coming back with a vengeance in spite of the low blood sugar diet.

Now the jigsaw of many symptoms and complaints began to fit together. In 1971 in Dallas I heard Mandell, Newbold, and Phipjott

give papers on cerebral allergy. Mandell told me at that meeting that we were saying the same thing. Subclinical pellagra treated by me with vitamins, and cerebral allergy patients treated by him with elimination of foods, were one and the same disease. I had no reason to believe him at the time, either. Nearly every case of subclinical pellagra had symptoms of low blood sugar. It was becoming apparent that seemingly un-explainable symptoms in my patients could only be due to allergy. This was too much to accept all at once.

In 1974 I took the Williams course in Rinkel allergy testing at Cheyenne, Wyoming. Ted Randolph was one of the speakers, and he reiterated his views of the previous year, with case reports to back him up. He told us of fasting a patient four days, then giving one food at a time. This would provoke the most outlandish symptomatology, but always something about which the patient had complained. Randolph could eliminate symptoms by fasting, then reproduce symptoms with foods and chemicals. He would do this on demand! This was definitely allergy, and allergy would cause backache, headache, earache, or any other ache. Allergy could cause and did cause depression, mania, hyperactivity, or schizophrenia. Allergy could cause fatigue, lethargy, and hypoglycemia. This was to me a revelation, only because now I was ready to accept it at face value. The hypoglycemia diet had failed me and others. Vitamins had failed on some patients. Shock treatment never was too successful in this type of patient. Now I can understand why medical men have trouble accepting new concepts. Here I was, working in the field since 1968, refusing to believe Mandell in 1971, or Randolph in 1973. Only when the facts were demonstrated by personal experience did I permit myself to believe. It seems we all must learn the hard way. By now I was convinced of allergy as being the basic reason for many of the ills of man and took up Rinkel testing. Dr. Ivor Glaisher of Regina, Saskatchewan, showed me the practical side of the testing. I set up a lab with my wife in

charge. In 1974 I spent a week with Dr. William H. Philpott. He was fasting and food testing, also using vitamins and many psychological techniques on his patients. In 1975 I visited Randolph's hospital for several days. All during this time I was expanding the use of the four-day rotary diversified diet and megavitamin therapy, particularly intravenous vitamins. I have fasted many patients using Randolph's technique and found his work to be factual, reproducible, and effective. By recognizing allergic symptoms as being due to allergens whatever their nature, one is able to do much for patients. Best of all, you know the cause of the patient's symptoms. A headache can be due to coffee, perfume, or a musty basement. Once a patient *sees* this relationship and more importantly is willing to correct it, he is well on the road to recovery.

Parallel to my progress in allergy and megavitamins was increasing disenchantment of my confreres. I was slow to recognize this for what it was. I am not stupid though I would not or could not believe what some were trying to tell me. In January, 1973, the chairman of the Medical Advisory Council wrote to me. This letter should have been enough to smarten me up. He said among other things "the M.A.C. does not accept the concept of megavitamin therapy, until such time as it is accepted by the psychiatric community and the medical profession in this country." They accused me of admitting patients with an incorrect primary diagnosis, then treating with megavitamins for psychiatric illness. Three full years later I am now even more convinced of the correctness of my view and my diagnoses.

In 1973 I was still chairman of the admission and discharge committee. I am prone to take the direct route, which may be unfortunate, and spoke to this august body. The matter seemed so simple and clear-cut to me, I never thought of seeking legal advice, or even the opinion of a medical colleague. I did delay the attack, only to have it break out a year later with a change of officers of the Medical Advisory Committee.

Here is an excerpt of a letter from the chairman in

June, 1974. M.A.C. had previously requested that the medical audit committee study all my charts for a six-month period. "The study shows the nature of your therapeutics to be so unorthodox, as to question whether you could reasonably expect the support of the medical staff or the hospital, which provides the facilities for your practice." I was given a period of three months to correct my ways. When this did not occur I was told to appear for a disciplinary hearing. In a further letter they cited 41 charts for unacceptable (megavitamin) therapy and for language unacceptable to the audit committee. My lawyer quickly disposed of the unacceptable therapy business. He told them in effect that they had to prove that vitamins did not work. This is quite different than me trying to prove they did. My use of the Queen's English was another matter, so I promised to be a good boy. I agreed to use medical terminology instead of English. By May, 1975, the M.A.C. agreed I could stay on staff, and advised me that the hospital is not a center for experimentation, and that unorthodox methods still leave the hospital and me open to criticism. The only thing unorthodox about a fast, which has been used as a treatment as long as man has been around, is that other doctors won't use it.

More problems were surfacing at our other hospital. Until I started using intravenous vitamins to treat disturbed patients, including alcoholics, their admission to hospital was a major problem. Sitters, on a 24-hour basis, were required at the patients' expense. The only way to avoid this was by written permission of the chief of psychiatry, the chief of staff, and the chief of medicine. This led to interminable conflicts, waiting, and bad feelings. Our 60-bed psychiatric service refuses to admit patients with delirium tremens. These patients are quite common in my practice, so I devised a routine of treatment. The patient is put to sleep with chlorpromazine in 100 mg doses, every 10 minutes if necessary, then given gram doses of vitamins B3, C,

B1, B6, and a few mg of B-12- Patients so treated needed no sitters, no nursing, and were ready for discharge in 24 hours, often less.

When I first experimented with this treatment I gave each vitamin separately. As the vitamins proved their worth, I used them all together. Soon I put them in 500 cc normal saline and had the nurses give the repeat doses. Everything went well until the pharmacy committee thought they should worry about drug incompatibilities. The next step was for a nurse to refuse to add the vitamins in the I.V. solution. I was expected to drop whatever I was doing to start an intravenous on a hospitalized patient. This annoyed me greatly and was only corrected by my refusing to accept a drunk from the outpatient department. I advised them to call the chief of medicine, who oddly enough was on the pharmacy committee. He refused to take over the patient, but allowed the nurses to start the I.V. then add one vitamin at a time using a special drip chamber. Instead of a single procedure and one I.V. setup, we now had a very expensive and time-consuming one, but face had been saved. Cost means nothing in such a situation. The nurses still must add vitamins one by one, some three years later. Any staff nurse familiar with the technique will admit my regime is the best of any for delirium tremens so far as they are concerned. As yet no other doctor is using it, although these patients are admitted as pancreatitis, or what have you.

I'll not describe my efforts to get admitting privileges to the psychiatric wing of the hospital. I applied in 1969, permission was granted in 1972. My experience in the wing has not been a happy one. I rarely if ever admit patients there now. My use of shock therapy has diminished to almost nil, as other methods of treatment almost preclude its use, except in severe bipolar depression in the elderly.

The economics of my practice has changed a great deal since my induction into the Orthomolecular field. In 1967 I admitted, between the two hospitals in Prince Albert, 530 patients with a total patient days of 4,599. At that time the per diem cost was \$36.43 so I generated \$167,541.57 in hospital costs alone. Along with this I would average eight patients every day in the nursing home at a cost of \$12 a day. This would generate another \$31,200 direct costs to government. Presuming I worked 325 days, at three dollars a day per patient, I could earn \$21,591 on hospital and nursing home visits alone. In 1975 I admitted 135 patients for 851

days. The fee schedule allows me \$4 a day which would mean \$3,404 from the government coffers to me. It also meant I generated only \$73,603 of cost to the hospital plan in 1975 at \$86.49 or 2.37 times the 1967 rate.

I was a member of a group practice for 12 years, indeed I formed the group in 1960. My reason for so doing was to get free time for myself to be with my family. From 1964 to 1971 I was responsible for the care of inmates in the Prince Albert Penitentiary. I tried to implement changes in the prisoners' diets and in their vitamin intake, to help them get better. Inmates refuse to make any personal effort whatsoever to improve their health. A petition was circulated asking for my dismissal. My partners agreed with the prisoners, even though I told them I would resign from the partnership. In March, 1972, I was again in solo practice. I have never for an instant regretted that decision. My income dropped markedly and still is not back where it was four years ago. One can never be really free when temporal things are put before spiritual values. I did this to be free. Had I continued with the group, I would not have had to sell my home, nor would my wife have gone to work. The only way we could afford to practice the way I knew I had to, was to make sacrifices. Being right, in medicine or any other endeavor, is no guarantee of kudos or money. This is especially true for me, since there are so very few physicians who march to the same drummer. The Medicare people kept pulling the rug out from under me. They used to pay me for psychological testing,

then stopped, on the advice of the College of Physicians and Surgeons. My peers felt I had no special training or accomplishments in this field. Indian Medical Services used to pay for intravenous vitamins and bacterial vaccines. When these became quite substantial items they stopped again, on advice from our College. Over the past four years I have given away, or stopped doing, many bread and butter items of medical practice. I no longer do anesthetics, or assist at operations. I only perform enough operations myself, to keep my hand in, and to retain my privileges. This year I am letting it go almost completely. I refer most surgical and all complicated medical and obstetrical cases. My confreres accept these referrals with charm and grace. I am still waiting for my first referral or consultation from them.

It is now eight years since my discovery of subclinical pellagra. This led me into psychiatric problems, then the hypoglycemia area, and now allergy. The patients I now see are "failed patients." They have seen everyone and been everywhere, yet still have their complaints. Many do want to try to get better. Through practical experience over the years, I am able to apply thinking from all the specialties to my patients' problems, from my own particular perspective. Whether it's called allergy, or clinical ecology, or faith healing matters little if the patient gets the desired relief. I call myself a Health Nut. I practice preventive and nutritional medicine. It is the patient who must do most of the work. All I

can do is show them how. "For the way of truth is simple." I make my own fee schedule. I work longer hours now than I ever did before. I think my medicine is better now than ever before. If they judge by my dollar cost to the government, I am not very successful compared with previous years. If they judge by patient acceptance and patient referral I am more than holding my own. Perhaps the income tax people are unhappy; they get half what they used to, and I get twice the satisfaction, a factor of four. Instead of wanting to quit medicine as I did in 1968, I look forward to new problems each day, and new solutions. We only make advances if we have difficulties to overcome. When all is smooth sailing, life is a bore. When patients are at the end of the medical investigations road, we must develop new techniques to meet their problems. One patient of mine could eat only one food without symptoms, another patient only four. I developed new ways to neutralize, their symptoms so they can survive long enough for Nature to rebuild their shattered defense mechanisms. These patients had been diagnosed as having multiple sclerosis, hysteria, asthma, neurosis, or psychosis. They are none of these things. They are food and chemical sensitive patients who are now responding to new modes of treatment. These modes are developed from necessity, the Mother of Invention. If I had my life to live over again I would change nothing.