

Comparison of the possibilities of using the methods of EPD and bioresonance therapy with family medicine standards in the United States for the examination and treatment of patients

D.D. Tikhomirov  
(FPC MR RUDN, Moscow, Russia)

The health care of the Russian Federation is gradually turning to the world practice of family medicine.

The main advantages of working as a family doctor are the ability to observe the patient in dynamics, maintain good health of all family members, correctly influence the formation of the psychological climate in the family, and carry out timely prevention and treatment.

This paper compares the possibilities of using the methods of electropunctural diagnostics and bioresonance therapy with the US family medicine standards in the examination and treatment of patients in such nosologies as malignant prostate disease and urolithiasis.

Epidemiology of prostate cancer: the most common neoplasm of the prostate, which secondarily leads to death from cancer in men from 250 thousand to 400 thousand annually. The number of deaths annually averages 45 thousand with a weak tendency to decrease in the last 5 years.

Table 1

	US Standards [1]	EPD and BRT
one	<p><b>RISK FACTORS</b> The most important factor is age, genetic by DNA and racial predisposition, nutritional characteristics, bad habits.</p> <p><b>SCREENING</b> - more common in the elderly people. It should be borne in mind that most of the elderly die from other medical problems in the early stages of prostate cancer, which is already detected at autopsy. Prostate cancer (PR) tends to grow slowly and many treated have significant complications. <b>DIRECT RECTAL EXAMINATION (DIR)</b> is the oldest diagnostic method, and the main problems associated with the tumor are determined already at later stages, although it should be noted that tumors are palpable in the posterior part of the prostate, and those that extend deep along the gland are not palpable.</p>	<p>Assessment of genetic predisposition DNA markers.</p> <p>Selection of diet, elimination of unhealthy foods, inclusion of useful ones.</p> <p>Bioresonance therapy for bad habits and addictions. Assessment of the role of the influence of external factors - radiation, electromagnetic, toxic, parasitic, etc. according to the scheme.</p>
2	<p><b>PROSTATE SPECIFIC ANTIGEN (PSA)</b> - really more sensitive, hormonal status with than a specific method for detecting prostate disorders. PSA increases in benign prostatic hyperplasia, RP and prostatitis from 4 nanograms per milliliter. Test regarding sensitive, but only 50% specific - has a much higher specificity (but low sensitivity) with an increased PSA level.</p>	<p>Blood autoantibody testing for with an assessment of the level testosterone and androgens.</p>

3	<p>SAMPLE USING FINASTERIDE (Proscara) confirms that a) Finasteride prevents most men RP at</p> <p>b) a sufficiently large group with normal PSA detects RP on biopsy, which leads to the conclusion that there is no rigid connection between normal PSA and RP.</p> <p>Means of increasing PSA accuracy: PSA density calculations involve dividing total PSA by prostate size: if the ratio is greater than 0.15, Cancer is suspected; if the ratio is less than 0.15, good-quality hyperplasia is suspected.</p> <p>PSA Rate - An increase in PSA of more than 1.5 nanograms per milliliter over 2 years suggests RP.</p> <p>Modern research has confirmed that men with the highest PSA growth rates are most likely to die from RP. Age specific PSA levels - PSA increases with age. So the PSA value of 4 nanograms per milliliter is not standard for 40-year-old men, but more tolerant for 60-year-olds.</p> <p>A free-to-total PSA ratio of less than 19% raises suspicions of RP. The smaller the ratio, the higher the likelihood of the presence of RP in the patient, which confirms the greater change in the structure of total PSA.</p> <p>Why PSA Screening Tests Do Not Reduce Mortality? This is due to the temporal aspects of PSA observations, as well as the real possibility of detecting RP when it is detected.</p> <p>clinically from the moment of diagnosis to the death of the patient, which requires early implementation of preventive diagnostics within the framework of the log-normal distribution of the incidence and detectability of RP.</p>	<p>Medical testing of finasteride (proscar) as a test indicator for benign hyperplasia or prostate cancer, as well as the need for its appointment.</p>
4	<p>DIAGNOSTICS. After positive detection of DRE and PSA values, transrectal ultrasonography is recommended. 33% of RP have low ECHO, 33% - high ECHO and the rest - not detected. This technique is not applicable without a biopsy, since USG for one user can brilliantly establish the state of the prostate and conduct a biopsy needle through the prostate, if the entire area is uniform according to ECHO, then more than 12 unambiguous biopsies to evaluate the prostate. However, it should be noted that</p>	<p>Diagnosis of tumors is carried out at the prenosological level, when there is no direct visual confirmation on ultrasound, computed tomography and a low probability of a correct biopsy.</p>

	<p>some tumors are so small that they will not be included in the biopsy area, so patients with a negative biopsy in some cases can have an RP.</p> <p>Other tests. Bone scan if PSA is greater than 10 nanograms per deciliter (to detect bone metastases).</p> <p>Computed tomography if PSA is greater than 20 nanograms per deciliter.</p>	
<p>five</p>	<p>TREATMENT APPROACHES - SURGERY, RADIATION, CLINICAL OBSERVATION.</p> <p>Radical prostatectomy - removed lymph nodes following the prostate. Usually the operation lasts 2-2.5 hours and is usually performed through the lower vertical incision. There are newest laparoscopic approaches to the procedure. The aim is to remove the prostate and preserve other vital structures that most affect potency and sexual function.</p> <p>Pelvic irradiation - This can be done externally using X-ray fluxes to the prostate area or by implanting a variety of radioactive sources into the prostate under general anesthesia (brachytherapy). Side effects include impotence, damage to the bladder, spinal structures, and possible other radiation complications. Clinical observation (waiting) Option of choice for elderly patients or patients with significant concomitant clinical burden. PSA, DRE, clinical trials every 6 months, and bone scans every 2 years for metastasis are done. If there is an obvious presence of metastases, androgen-lowering therapy. It should be noted that recent studies in Sweden on male enhancement life expectancy with RP at the observation stage showed acceptability, although other Scandinavian studies have shown a greater survival rate of operated patients compared with those who underwent conservative treatment in advanced stages of tumors.</p> <p>Cancer in its final stages. In these cases, the use of docetaxel (Taxotere) and other chemotherapeutic agents is of interest.</p> <p>Follow-up. Any</p>	<p>In advanced cases - preparation for surgery, regulation of the body's immune properties, minimization of the effects of chemotherapy and radiological exposure. IN postoperative period - carrying out rehabilitation measures.</p> <p>In case of detection of cancer in the last stage - accompanying the patient with minimization of chemical and radiological effects, concomitant etiological and symptomatic therapy.</p>

	<p>effective intervention, including prostatectomy, results in a decrease in PSA to 0. After irradiation, PSA is not equal to 0, but will be below 1 nanogram per deciliter. To suppress the recurrence of RP, the prostate bed is irradiated after surgical removal, reconstructive surgery, cryotherapy and androgen blocking.</p>	
6	<p><b>BENEFICIAL PROSTATE HYPERPLASIA</b></p> <p>Epidemiology - mainly affects men in adulthood and in some cases can be symptomatic.</p> <p>Anatomical aspects: As the prostate enlarges with age, the urethra forms a reduced angle, leading to symptoms of obstruction and irritation. It should be noted here that in 50% of men these manifestations progress, in 33% - remain stable, and in a small% - the condition improves. The most severe symptoms are acute urinary retention requiring transurethral dissection of the prostate and is an ancient form of therapy against the background of modern development of methods.</p> <p>Diagnostic work - begins with a study of the medical history and prescription of medications, the study of the structures of the urethra on cystoscopy. An international prostate symptom scoring system is used to determine the degree of symptoms, examination of the prostate, performing urofluometry and appropriate urine measurements.</p>	
7	<p><b>MANAGEMENT OF THE PATIENT</b></p> <p>If the symptoms are not severe, alpha-blockers are prescribed: tamsulocin (flo-max), alfuzocin (uroxatral), terazacin (chitrin). Flomax and Uroxatral do not require dilution, 5 alpha inhibitors reductases (finasteride, dutasteride, avodart). Surgical intervention is indicated mainly in severe cases. Absolute indications for intervention are: refractory hematuria, urinary retention, increasing creatinine levels, irritation symptoms of the most general nature.</p>	<p>Electropuncture diagnostics using urine autonosode, organopreparations of the prostate, urethra. Appointment of general and private bioresonance drugs with the connection of alpha blockers and 5-alpha reductase inhibitors to the device circuit. Compilation of a hormonal profile. Corrective therapy using electronic copies of hormones.</p>

Epidemiology of urinary tract stones: affect 5% of the population. Risk of passing stones 8-10%. The risk of renewal - 50%.

table

	US Standards [1]	EPD and BRT
one	<p><b>TYPES OF STONES</b>                      Radioplastic - observed on x-rays for the corresponding nosodes and / or imaged, subtypes include: calcium oxalate (most common), calcium phosphate (second most common), and struvite (infectious stones). Struvites - most easily detected in the kidneys, ureter, bladder on X-ray research.                      1) radio lungs, subtypes including uric acid (most common), cystine (rare), not found in the kidneys, ureter and bladder,                      2) indinovor stones</p>	<p>Electropuncture stone testing                      substances forming them</p>
2	<p><b>FACTORS LEADING TO CRYSTALIZATION</b>                      Nanobacteria leading to deposition and crystallization, urine volume, concentration factors, stone inhibitor levels (citratates inhibit stone formation), diet.   <b>METABOLIC RISK FACTORS</b> Hypercalciuria, hyperuricosuria, hyperoxaluria, hypocitraluria, low urine volume, and dehydration are the most common causes.</p>	<p>Assessment of the role of external and internal factors affecting the body - radiation, electromagnetic, toxic, parasitic, etc., genetic, cicatricial, etc. Assessment of metabolic parameters, excess or deficiency of hormones, minerals and microelements, vitamins</p>
3	<p><b>CLINICAL MANIFESTATIONS</b>                      70% of stones are symptomatic and 30% are asymptomatic. Symptoms: pain in sight colic, pain in the upper ureter, back or verification in the area opposite the passage of the stone, pain in the lower abdomen, in the testicles or genitals, or in the lateral side if the stone is in the middle or distal part ureter, nausea and vomiting, hematuria, as well as symptoms of inflammation if a genitourinary infection joins. <b>CLINICAL ASSESSMENT</b>                      Urinalysis (absence of hematuria is not means no stones), urine culture, blood and urine nitrogen, serum creatinine, and electrolytes. Routine x-rays of the pelvis, ureter, and kidneys for stones.                       Intravenous pyelography is indicated for suspected surgical intervention. Contraindicated studies are contraindicated in patients with renal insufficiency, then ultrasound of the kidneys is also used with an assessment of side effects. <b>DECISION-MAKING</b> is based on the state of obstruction, concomitant infection and fever, size and the location of the stone and other symptoms.</p>	<p>Assessment of biochemical parameters for blood and urine autonosodes. Diagnostics of the degree of the inflammatory process; of infectious agents, carrying out etiological and symptomatic-analgesic and bioresonance therapy, consultation with a surgeon</p>

	<p>INDICATIONS FOR HOSPITALIZATION - presence of infection or fever. Pain not relieved by analgesics, severe nausea and vomiting with previous use of oral analgesics.</p> <p>CHANCE TO PASSING STONES Less than 25% if the stone is more than 5 mm; from 20-45%, if the stone is 5 mm; 40-50% if the stone is less than 5 mm and is in the proximal ureter, 75% if it is in the distal ureter.</p> <p>MANAGEMENT OF PATIENTS. Analgesics are prescribed: acetaminophen, ketorolac, or tramadol.</p> <p>INDICATIONS FOR REMOVAL. Stones with obstruction and fever, stones over 5 mm, small ureteral stones that have not gone away within 4 weeks.</p> <p>SURGICAL INTERVENTIONS. Urethral stent, extracorporeal wave lithotripsy for stones in the upper urinary tract up to 1 cm,</p> <p>urethroscopy with laser lithotripsy for kidney stones, percutaneous nephrolithotomy for stones more than 1.5</p>	
<p>4</p>	<p>cm. MEDICAL SUPPORT.</p> <p>Uric acid stones - leaching. Potassium citrate is usually given to change the pH from 7 to 7.5. Usual Starting Dose 10 mg Drug Testing - equivalent per day with an increase of up to 20 mg eq of potassium in a day. Cystine stones: leaching up to 7.5 pH or more with the use of thiopronine (thiol), infectious stones are removed surgically, followed by the appointment of antibiotics. An increase in fluid intake has been shown for all stones.</p> <p>INDICATIONS FOR METABOLIC ASSESSMENT OF STONES. Patients with 2 or more stones, fever or infection with a stone, patients with disabilities the urinary tract is tested for serum Ca, electrolytes, phosphates, uric acid, and a 24-hour urine test for Ca citrate, uric acid and oxalates.</p> <p>Bladder stones are usually associated with narrowing of the outlet from the bladder, urinary stasis due to prostatic hyperplasia, neurological damage to the bladder, and trauma to the bladder. Metabolic abnormalities are also observed and treatment includes laser lithotripsy. STONES IN CHILDREN. In 50%, they are accompanied by pain in the pelvis and abdomen, in most hematuria, the score includes</p>	<p>Conducting bioresonance therapy according to the algorithm for correcting metabolic pH processes, acid-base balance. urine Testing prescribed medications, taking into account individual parameters of metabolism and anamnesis</p>

urinalysis, urine culture, renal, ureter, bladder and metabolic assessment.	
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The given comparative data show that the use of methods of electro-acupuncture diagnostics and bioresonance therapy is acceptable at all stages of patient care, including pre- and postoperative therapy, optimization of drug treatment, taking into account the individual metabolic characteristics of the patient, which may well be used in the work of a family doctor in Russia. ...

#### Literature

1.FAMILY PRACTICE Volume 53, issue 37, October 7, 2005.

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