Bob's Treatment History and Our Research - Chronological Order

Between the beginning **August 2002** and **October 2002** Bob was prescribed a variety of pain killers, anti-inflammatories and muscle relaxants to try and stop the excruciating pain in his left shoulder, forearm, hand and fingers.

There were lots of visits to the GP's surgery and Accident and Emergency during this period, each time they would either increase the dose of the medication, change the medication or add more, but nothing helped.
After several visits with no improvement in his condition he was seen to hospital for an examination by an Orthopaedic consultant who then prescribed additional medication and referred him for investigative physiotherapy.

He was also given an X-ray at the GP's surgery which showed nothing.

Between the end of **August 2002** and beginning of **October 2002** Bob attended the investigative physiotherapy on a weekly basis.

By the beginning of **September 2002** Bob was suffering with intolerable pain, vomiting, diarrhoea and fatigue/exhaustion, by the end of September he had started to lose weight and muscle tone with ever increasing bouts of sickness, diarrhoea and extreme tiredness.
His muscles were very weak and he also experienced muscle cramps, any activity, immediately and dramatically increased the pain throughout the left side of his body.
He also experienced severe pain in other muscles and joints all over his body.

Consequently, because of the above symptoms Bob was unable to attend all of these appointments.

The last appointment he attended was the beginning of **October 2002**; the physiotherapist took one look at him and immediately noticed that he had lost a lot of weight; 36lbs in just 14 days.
The Physiotherapist immediately phoned the senior partner at his GP's Surgery, who made him an emergency appointment to see him that day.

When Bob saw the senior partner at the surgery that day he was taken off all medication and was referred for an emergency appointment at the medical clinic for the sudden weight loss to be investigated. Blood tests were also taken at the surgery but found nothing.

By the time he received an appointment for the medical clinic in **November 2002** his weight was in recovery, although all of the other symptoms were getting worse and Bob was now also suffering with excessive sweating and palpitations.
The medical clinic could offer no help or explanation for any of his symptoms but gave him a follow up appointment.

During the period between **November 2002** and **July 2003** Bob saw the GP several times and was prescribed further medication for pain relief, this medication did nothing what so ever for the pain so the GP increased the dosage.
By **March 2003** Bob had to be taken off the medication as the side effects were too debilitating.
In **March 2003** Bob also gave the GP a typed history of his symptoms as it seemed that they were not listening, as a result the GP referred him back to the Orthopaedic consultant for further investigation of his shoulder, arm etc and his 'other symptoms'

The orthopaedic consultant referred him for an EMG test (nerve conduction studies) and advised Bob that they would not investigate his other symptoms until they had the

results of this. Although the consultant did inform Bob that it was highly unlikely that his other symptoms were connected to his shoulder problem.

During this period Bob was also prescribed medication for the Diarrhoea but again the medication caused him severe side effects and was taken off them.

In **August 2003** Bob had to attend an appointment with a disability doctor, who diagnosed his shoulder as Physical Neuralgia and his other symptoms as classic ME.
He also informed Bob that the dose of the medication he had been on earlier in the year should not have been increased as Bob would be highly sensitive to all medication given the ME. He told Bob to report his diagnosis and information to his GP.

The GP was not amused when Bob reported the diagnosis of ME and remarked 'you have not presented with symptoms of ME!' and that was that!

During **August 2003** Bob also attended an appointment for the EMG tests, Just as Bob went in for the test there was a fire alarm, we had to evacuate the building for half an hour. The problems began after this when Bob was taken in for the EMG test; the Doctor hurriedly proceeded with the tests and diagnosed the problem with his shoulder arm, hand and fingers as 'Brachial Neuritis in recovery'.

The doctor had not carried the test out properly, Bob being a control and instrumentation specialist and having been involved in the development and research of this test equipment he knew the test had not been carried out in the correct manner. When we tried to discuss her diagnosis and the fact that she stated it was 'in recovery' Bob asked 'why is it getting worse then?, she replied in an aggravated manner that because of the fire alarm at the beginning of the appointment she did not have time to explain or discuss anything, in fact at one point she told us to 'shut up', she did not have time to talk about it, go home and look it up on the internet!. We did look it up on the internet and the symptoms did not fit. Consequently Bob ended up with a wrong diagnosis for 12 months!

In **September 2003** Bob informed his GP with the results of the EMG test and the fact that the tests were carried out incorrectly and explained why but the GP did not want to discuss this. Bob then tried to discuss the fact that the symptoms did not fit the diagnosis either and the fact that it was getting worse and he was losing the use of his arm, the GP was not willing to discuss this either.
The GP informed Bob that she would refer him to an ME consultant to prove that his 'other symptoms' were not ME.
We had also looked up on the internet regarding ME and no he did not fit all the symptoms, just most of them, but whatever it was we needed some answers.

During this appointment Bob also informed his GP that he was experiencing violent pains in his head and behind his eyes with neuralgia over the left side of his face, he was referred for a CT scan, when the GP received the results from the scan Bob was told that it showed nothing other than his brain was normal.
The GP did not investigate any further.

In **December 2003** Bob saw the Orthopaedic consultant regarding the results of the EMG test; he could not understand the diagnosis either and referred Bob for an MRI scan, which he had in January 2004.

When he finally saw the Orthopaedic consultant in **March 2004** regarding the results of this scan it did not shed any light on what was wrong with his shoulder, arm, hand and fingers either. The orthopaedic consultant did not know what else to do so he informed Bob that he would write to an excellent Neurological consultant, which happened to be

the same one as the GP had referred him to disprove ME, we informed the consultant of this.

Between **January 2004** and April **2004** Bob was tried with several other medications for pain relief by his GP but he had to stop taking all of them after a very short period because of debilitating side effects.

In **March 2004** the GP pressurised Bob to give up smoking and prescribed him nicotine patches.

In **April 2004** Bob saw the Neurological consultant that his GP and Orthopaedic consultant had referred him to, he gave him a thorough examination but informed us that he could not make a diagnosis as he had not seen the MRI and EMG results.
He also raised concern at what looked like bruises all over Bob's arms; this was caused by the nicotine patches, the consultant recommended that he saw the GP to discuss this problem and also to suggest that the GP prescribe a lower dose of nicotine patches.
He informed Bob that he would write to his GP after seeing the scans etc.

A few days later Bob had an appointment to see the GP, when we arrived were told by the receptionist that he did not have an appointment and that there was no doctor at the surgery. After an argument with the receptionist about the appointment that was made it was established the GP had cancelled the appointment but had failed to notify Bob. Another appointment was scheduled.
Bob expressed concern about needing more nicotine patches and the problem he was having with them bruising his arms, he was told by the receptionist that he would either have to chew gum or suck sweets! Bob left the surgery both stressed and distressed and had a cigarette.

We had to cancel the re-scheduled appointment with the GP as Bob was too ill with exhaustion, increased pain, vomiting, and diarrhoea.

At the beginning of **May 2004** the GP surgery contacted us to inform Bob they had received the report from the Neurological consultant, an appointment was made for the following day. To our horror given the time we had waited for this report the GP said she would speed read it for now. The GP then refused to discuss any of the reports contents in detail, the only part of the report the GP was interested in was that
the consultant neurologist had stated he had not seen the MRI scan and EMG results, the GP then went on to insist that she had sent these to the Neurological consultant.
As the GP was unwilling to discuss the reports contents Bob asked for a copy of the report, this request was refused, the GP's reply was 'you will have to ask to the author of the report!'
The GP then proceeded to prescribe the medication recommended by the Neurological consultant in his report.
Bob tried to discuss the possible side effects of the medication given that all medication so far had caused debilitating side effects.
The GP's reply was 'do you not want to take them then?

Bob left the surgery stressed, distressed and disgusted at the way he was being treated and decided to find a new practice.

In the middle of **May 2004** Bob saw a practice nurse at the new practice, Bob and I explained his condition and problems to the nurse who then immediately made an appointment for him to see the doctor a few days later.

After taking in all the information about Bob's condition and seeing his notes, which were very sparse, the new GP concluded that Bob had been let down badly by the medical profession and was horrified that his chronic diarrhoea had not even been investigated

and referred him to the bowel clinic for urgent investigation.
A blood pressure check revealed that Bob had high blood pressure; the GP said that this was highly likely to be causing the violent pains in his head etc., blood pressure medication was prescribed.
A chest x-ray and blood tests were also carried out at the surgery but neither of these found anything.
The GP had to take Bob off the medication which was prescribed by the Neurological consultant again because it was having severe detrimental effects.
The GP referred Bob to the pain management clinic, homeopathic clinic and back to the medical clinic for a full general medical.
He was also prescribed Anusol to try and help with the inflammation, blistering and soreness associated with the chronic diarrhoea, unfortunately, this did not help much.

At the beginning of **July 2004** Bob had a follow up appointment with his Neurological consultant, after discussing the side effects of the medication he had previously prescribed it was decided that he would try two other low dose medications to try and help with the migraine type headaches, muscle cramps and for more generalised pain relief, in the hope that this would give Bob a better night's sleep, particularly to try and get him some REM sleep which he was severely lacking.
The consultant had also received the results from Bob's MRI scan and EMG test, he informed us that given the physical examination the he had done on Bob, he did not agree with the Diagnosis of 'Brachial Neuritis in recovery'.
Bob discussed with him the fact that the test had not been done correctly and explained why, the consultant agreed with Bob and ordered a further EMG test to be carried out by the head of Neurological sciences.

During the month of **July 2004** Bob attended the Colectoral clinic for a rigid Sigmoidoscopy to investigate the chronic diarrhoea, he also had to provide three days specimens and was informed he would be sent an appointment for a colonoscopy.

By the middle of **July 2004** the GP had received a report from his Neurological consultant, the new low dose medication recommended was prescribed.
A blood pressure check showed that Bob's blood pressure was still high so he had to stay on the medication prescribed for this.
Further blood tests were carried but again showed nothing.

Whilst initially the low dose medication the Neurologist had recommended had some minimal positive effects and did give Bob some better quality sleep, after two weeks the positives had stopped and the side effects were too severe, the side effects caused a further deterioration in his condition and rendered him incapable of doing anything at all, confining him to bed. After speaking to the GP on the phone we were advised that Bob should stop taking the medication immediately.

*Given Bob's blood pressure was still high, it was clear that the medication was not working and it was also having detrimental effects,so in **July 2004** we started searching for anything which might help to lower his blood pressure, first we looked into our diet, whilst we ate a pretty good diet and we cooked most meals from scratch, we found that antibiotics, growth hormones, pesticides and other additives added to our food would be aggravating his overall condition and diarrhoea, let alone his blood pressure.*
Our research also showed that sugar, processed food and dairy products such as cheese were a big problem too, whilst we rarely ate processed food, Bob was partial to cheese and our main source of sugar in our diet was in tea, we cut these out completely and to minimise the amount antibiotics and pesticides etc we adopted a stone age diet plan using fresh organic produce.
Our research also showed that including foods such as garlic and ginger could have a positive effect on blood pressure so these were also included in our diet on a daily basis.

The change of diet had a positive effect, after about three/four months on this diet Bob's blood pressure had returned to normal and he was able to stop taking the medication, his blood pressure continued to be normal thereafter.
The headaches and violent pains behind his eyes also stopped.
Whilst this diet did not stop the chronic diarrhoea it did reduce the ferocity of it and helped to calm the inflammation and blistering associated with the diarrhoea. It also dramatically reduced the occurrences of the vomiting which after about six months stopped completely.

At the end of **August 2004** Bob attended the Medical Clinic for the full medical requested by his GP, Blood tests and urine samples were taken but they informed Bob that his condition was too complicated and that they could not help.

Bob also had the EMG test at the end of **August 2004** which was requested by his Neurologist, this time it was carried out correctly.

At the beginning of **September 2004** Bob had the colonoscopy to investigate the chronic diarrhoea. After the consultant and anaesthetist discussed with Bob the history of severe side effects when taking medication even with low dose pain killers they decided that it would not be safe to sedate him, they said the danger was that if Bob's body went into spasms they would not be able to get the camera out.
They carefully proceeded with the colonoscopy without sedation which took about 40 minutes, they were very good with Bob and informed him at all stages during the procedure what was happening and what they were seeing, which was mainly inflammation.
Bob voiced his concern about all the red he was seeing in his intestines, the consultant reassured Bob that the red he was seeing was just inflammation caused by the chronic diarrhoea and that they were not surprised, as this was to be expected in someone who has chronic diarrhoea, not to worry about it. A biopsy was taken of his colon.

In **September 2004** Bob received a medical report from his Neurological consultant;
The report detailed the consultant's final diagnosis which was:
1. Multi-Level Cervical Nerve Root Injury on the left with no recovery. 2. Chronic Pain and Fatigue Syndromes 3. Irritable Bowel Syndrome.
He also stated that as Bob was due back in his clinic for a review some additional tests might be necessary, largely for exclusion of less common conditions.

Between **October 2004** and **December 2004** Bob attended three appointments at the pain management clinic, on the third appointment it was decided that Bob might benefit from seeing the Community Disability Team, Bob was informed that he should receive an appointment for this early 2005.

In **October 2004** Bob saw his Neurological consultant to discuss the results of the EMG tests and his Medical report.
He concluded that Bob did not have 'Brachial Neuritis in recovery', although he could not give a diagnosis, only report that the EMG test showed he had Multi-Level Cervical Nerve root damage in his left shoulder nerve junction box.
He discussed with Bob that because it was two years since the problem with his shoulder, arm, hand and fingers had started, he could not provide an definite answer as to what had caused this damage, he thought that it was highly likely that a virus had attacked the nerve endings which in turn caused the inflammation, but he confirmed there was no virus active now.
He explained it to Bob as a virus had eaten away the nerve endings and now he was left with the damage.
The result of the damaged nerve endings being the consistent pain in his shoulder, arm and hand with consistent tingling and throbbing in his fingers together with muscle wastage in his arm.

He had minimal use of his arm and hand etc, the sensors in his hand and fingers were not working, he could not grip properly or feel things properly, he also experienced severe cramp in his hand and fingers.

During this appointment the Neurological consultant also informed Bob that as he had severe side effects from the low dose medication he had prescribed it was not worth trying any other medication because they all have side effects that would be too debilitating for Bob, the consultant also stipulated that Bob should also stay away from antibiotics unless it was a life or death situation and even then he should only be prescribed a certain type of antibiotic, he requested us to report this to Bob's GP. Further blood tests were also taken.

The consultant also discussed his report and the final diagnosis he had made. He confirmed and assured Bob that he did not have ME and explained why, but that he did have Chronic Fatigue along with Chronic Pain and Irritable Bowel syndrome in addition to the multi-level cervical nerve root damage.

Bob saw the neurological consultant again at the beginning of **November 2004** for the results of the blood tests but nothing was found.
The consultant concluded that he could not do anything further to help and that over the time that he had been seeing Bob he had given him
every blood test that he could but could not find anything; he also assured Bob that whatever had caused his shoulder problems etc it was definitely not active now.

He suggested that Bob's 'other symptoms' in particular the Chronic Fatigue and chronic diarrhoea were likely to have came about because his body had become intolerant to the medication as these 'other symptoms' started after Bob had been given the conundrum of medication between August 2002 and October 2002 and whilst he could not help he would continue to see Bob in his clinic every three months and had told us to phone him any time if we were concerned.

During **November 2004** Bob attended the Homeopathic clinic; he was prescribed a cannabis Indica tincture for pain relief and was asked to think about trying acupuncture.

On **Christmas Eve 2004** I phoned Bob's Neurological consultant, we were concerned that his symptoms were worsening rapidly and discussed with him what he thought about homeopathic treatment and acupuncture, his advice was to try them it would do no harm.

When Bob saw the Homeopathic nurse in **January 2005** he agreed to try acupuncture and was put on the waiting list.

In **January 2005** Bob attended an appointment with the Community Disability Team, given that Bob could not take any medication because of the severe debilitating side effects he experienced we were told that the options were limited.
He was referred for a trial of a tens machine for pain relief and after an assessment examination with a senior physiotherapist he was put on her list for corrective tissue massage to try and help calm the trauma in his lower back, around his waist and left leg.

During the period between **January 2005** and **April 2006** Bob attended nine appointments at the Homeopathic clinic and had three telephone appointments. Bob was prescribed various homeopathic tinctures but none really helped.
The appointments were initially once a month but from August they became every six to eight weeks, although the nurse had told us to phone her in between appointments for any advice needed.
The last tinctures Bob was prescribed had actually made things worse and affected Bob's mood in a negative way, the problem was that you could not contact the Nurse and Bob

had to stop taking the tinctures as the Nurse did not reply to our calls and Bob received no further appointments.

In **February 2005** Bob received a letter from his Neurological consultant regarding the continuity of care following his decision to make a career move away from our area; He had requested an appointment for Bob with one of his consultant colleagues.

In **March 2005** Bob attended an appointment with a member from the disability team for the trial of the Tens machine, unfortunately Bob became very ill and was sick during the appointment and could not try the tens machine, after further discussion with Bob the team member decided that the tens machine was not going to help.

As the options for pain relief seemed to be exhausted, we began research for natural pain relief.
Back in November 2004 the first homeopathic tincture prescribed was a cannabis tincture, we knew that cannabis was supposed to be very effective for pain but the tincture had not provided any relief, having not found anything else to help with the pain we researched cannabis, we found that smoking cannabis was reported to provide pain relief, there were many anecdotal reports of its success.
The only problem was that it was illegal. We found a source but still did not go ahead with it because of it being illegal, after months of deliberation Bob decided to try it, enough was enough as he could not stand the pain and discomfort in his shoulder, arm, hand and fingers any longer, the pain was through the roof. Well, it was amazing the pain and discomfort in his shoulder in particular was reduced by about 80%.
In due course Bob discussed this with his GP, Senior physiotherapist and Neurologist, there reply was if it is helping then use it as they could not provide any pain relief because of the severe side effects Bob experienced from all the prescribed medication.

During **March 2005** Bob also had an appointment for the results of the Biopsy that had been taken when he had the colonoscopy in September 2004. Nothing was found.

In **April 2005** Bob saw the new Neurological consultant, Bob's condition was discussed and some of the blood tests which were taken previously by his Neurological consultant were repeated, particularly for inflammatory diseases, Lyme's disease and to check his anti bodies, all of these tests apart from Lyme's disease came back negative.
The Lyme's disease test came back equivocal so a further test for Lyme's disease was carried out at the GP surgery at the request of the neurological consultant, this came back negative.
A follow up appointment with the neurological consultant was scheduled for November 2005.

The corrective tissue massage started in **June 2005**; Bob attended these appointments on a fortnightly basis throughout the year.
Bob had limited and temporary relief from the pain and discomfort in his lower back, waist and left leg, usually only lasting for a few hours.

Bob had a course of acupuncture treatments between **July 2005** and **October 2005**, apart from one of the acupuncture treatments where Bob felt very alert for the three days afterwards and woke up early in the mornings without brain fog, the acupuncture did not give Bob any other benefits or pain relief.

In **November 2005** Bob attended the follow up appointment with the Neurological consultant, as Bob's condition was not improving the consultant referred him to the Endocrinology Clinic and requested another EMG test to check if there was any sign of an active neurogenic process.

In **April 2006** Bob had the EMG tests repeated by the head of Neuroscientists which was requested by his Neurological consultant in November 2005, the results showed undoubtedly that Bob had suffered some multi-level neurogenic problem but it was not active now.

Bob attended an appointment at the Endocrine clinic in **April 2006** to investigate his symptoms of chronic and violent diarrhoea, excessive sweating, adrenalin fight/flight feelings, and fatigue/exhaustion. The consultant physician was very thorough and took the time to listen and discuss Bob's medical problems and explained the tests they were going to do. Blood tests were taken to check his testosterone levels and his pituitary hormones, Bob also had to provide a 24hr urine test.
The consultant physician informed Bob about a new program called corrective behaviour therapy (CBT) which had been rolled out for depressed patients, whilst Bob was in no way depressed, the physician explained that her understanding of it was that it could possibly teach Bob to train his brain to either switch off or ignore pain, Bob agreed for her to refer him for an assessment for this therapy.

Throughout 2006 Bob continued to have corrective tissue massage with the senior physiotherapist on a fortnightly basis, although he had to cancel two of the appointments due to being too ill with a total energy drain, vomiting and diarrhoea, together with wind and excruciating stomach pain.
He had also developed a hypersensitivity to draughts causing him to sneeze often which dramatically increased the pain in his shoulder.

Whilst the corrective tissue massage did give Bob a few hours of limited relief from the pain and discomfort in his lower back and around his waist, he still experienced incredible excruciating pain and discomfort in these areas at all other times.
In **May 2006** the senior Physiotherapist suggested that it may be beneficial for Bob to see a psychologist, to see if they could help Bob to be less tense when walking, the physiotherapist thought that because his body was always sub-consciously tensed when walking it was this that was causing a lot of the pain, severe aches and discomfort he experienced in his lower back and waist.

Bob agreed to this as he was desperate for any help.

During 2006 whilst we were continuing our research for anything to help Bob we found Angel Fingers massage tool. see Angel Fingers.
Angel Fingers is a massage tool with copper Fingers and our research showed that Angel Fingers used the same principals of Corrective Tissue Massage, for pain management and muscle relaxation. We purchased two and took one with us for the physiotherapist on the next appointment.

At the end of the corrective tissue massage on Bob's lower back the physiotherapist would use calming strokes down the whole of Bob's back, when we introduced the Angel Fingers massage tool, the physiotherapist used this at the end of the session instead of using her hands, this calmed the trauma down further, the physiotherapist thought it was the perfect tool for ending a session with and continued to use it in her clinic.
The physiotherapist also taught me how to administer corrective tissue massage so Bob could benefit from it at home as well.

We used the Angel fingers massage tool in conjunction with the corrective tissue massage at home, it relaxed the trembles he experienced throughout his body and relaxed his muscles. We also found that using the Angel Fingers just before bed relaxed him to point of being able to get to sleep more easily.
The seven copper fingers of the massage tool gently stimulate nerve endings creating warm relaxing tingling sensations that help our bodies to produce endorphins - the happy drug!

In **June 2006** Bob attended the appointment with the Psychologist his physiotherapist had referred him for.
Bob needed someone with him at all times because of the crashes he used to experience which would happen suddenly at any time and when they did he would need help to get to a safe place and then home if we were out, together with the fact he needed help and support when walking because of so much pain and his left leg would give way at any time.
He also suffered from brain fog and at times could not string a sentence together and have trouble in retaining information.
We arrived at the appointment only to be told that she did not have Bob's medical records and that as she had a colleague (a Consultant Anaesthetist) sitting in with her the room was too small for me to be present.
We calmly expressed the reasons for me being there and that Bob was not happy to go in on his own, particularly as she had no medical records and therefore no history, and he could not remember everything, so with reluctance the psychologist agreed.
There was actually plenty of room!
The Psychologist began by asking Bob to explain his medical history, which was very stressful for him to do, so I intervened and explained most of it to her and informed her of the appointments with his Consultant Neurologist and what had been tried previously regarding medications and pacing regimes and that Bob had had severe side effects from the medications and no success with the pacing regimes.

The Psychologist argued with me about some of the information I was giving, particularly about some of the medications and pacing regimes Bob had tried, Bob found this very stressful. Bob tried to explain the problems he was having when walking which is why he had been referred to her, the Psychologist was not willing to listen and insisted that Bob should be trying the things that she was suggesting regardless of the problems he had had with these things in the past and was not willing to discuss the issues, just argued with him.

This appointment resulted in Bob feeling very stressed, frustrated and very ill; he was sweating excessively, felt very sick and had ever increasing pain throughout his body, Bob informed the psychologist that this was making him feel very ill and that he had to leave the room.

Bob left the room and sat outside, I tried to explain to the psychologist what was happening to him but had no success, the psychologist was not concerned in any way about Bob's condition and the fact that he had to leave the room because he felt so ill.

You could actually see that Bob was sweating profusely, his body was visibly trembling and he had turned very pale.

Bob's physiotherapist and GP received a letter from the psychologist stating that 'Bob was clearly not interested in a collaborative approach in dealing with the problems which he described and was verbally aggressive to her'.

Bob was in no way verbally aggressive at any point, just firm, it was very frustrating that the Psychologist would not listen or discuss anything at all, it was just 'do what I say' manner. It was very intimidating and certainly lacked due care and attention.
Both his Physiotherapist and GP were shocked and bewildered.

We enquired about how to put in a complaint and to get this removed from his medical records because it was a blatant lie, but it was just going to be further stress and at the end of the day it would not be removed from his records, so for the sake of Bob's health we decided not to pursue it, his GP agreed that it would be too stressful.

In **August 2006** Bob attended a follow up appointment with his neurological consultant, the endocrinology report was discussed; the blood tests showed that whilst Bob's testosterone levels were in the normal range they were at the low end of normal, the consultant physician stated in the report that this hormone can be affected by stress and strain, it also stated that however Bob had normal levels of testosterone in his blood.
The pituitary hormone tests showed Bob's hormone levels were within the normal laboratory reference ranges and there was nothing to suggest that his pituitary gland was not working properly. The consultant neurologist went on to explain that whilst he experienced flight or fight feelings the tests had also concluded that he did not have excessive levels of Adrenaline being released in his body, the consultant explained that it was his nervous system that was stuck in overdrive.
The neurological consultant explained that as the recent EMG test had not shown an ongoing neurological problem and that they had done all they could to try and explain his physical symptoms he saw no purpose in continuing to see Bob.
The consultant did discuss in detail with Bob about his physical problems and he thought that a psychological/psychiatric approach possibly via the Corrective Behaviour Therapy (CBT) was a sensible route and that no matter what had caused Bob's problems we should concentrate on any practical measures that might improve them.

Other than the CBT referral and the corrective tissue massage we were now on our own, no one was interested in finding the cause and they could no more.

In **November 2006** Bob had a fall due to his left leg collapsing; apart from excruciating pain in his left knee it made all of his others symptoms worse and rendered him incapable of any activity for about four months. He had no energy at all and felt completely exhausted, weak and very shaky, the chronic diarrhoea was even more frequent during the day and night than usual.

Back in 2002 when Bob's problems started with his shoulder etc he was also bitten just above his right knee, we thought it was a bite from some insect, but it did not heal and it left a small red pimple/lump, throughout the following months and years other small red dots would appear on his lower legs, groin and above his right ear, they too looked like bites but after a while they developed into red itchy sores which then developed white scaly patches on them. Bob reported this many times to his GP and other consultants from the beginning but it was never investigated.

In **2007** Bob attempted to get this issue addressed.
He was due to see his GP about this in **January 2007** but as a result of the fall in November 2006 he was too ill to attend. Bob managed to see his GP in **February 2007** and the GP diagnosed the skin problems as psoriasis and prescribed Trimovate cream to apply to the affected areas on his legs, groin and above his right ear.
Bob's finger and toe nails had also become discoloured and distorted, the GP diagnosed this as psoriasis too and prescribed medication to paint on his nails.
The GP also referred Bob to the dermatology clinic for a biopsy of the lump above his right knee to see if this had anything to do with the cause of his shoulder problems etc.

The trimovate cream made Bob feel very ill and nauseous after about seven days so he could only apply it for a few days at a time.

From **June 2007** onwards Bob was able to attend the corrective Tissue massage appointments with his senior physiotherapist again.

In **July 2007** Bob saw a consultant at the Dermatology clinic, the consultant dermatologist refused to take a biopsy of the lump and informed
Bob that it was nothing to worry about it was just a classic dermatofibroma and that it was just a result of an insect bite.

He confirmed the other skin problems were psoriasis and diagnosed mild psoriasis affecting his nails with onycholysis.
He recommended Trimovate cream, Bob told the consultant that he had been using this and it made him feel ill and nauseous after a few days use and also that when he applied it to the psoriasis above his right ear it gave him a strange sensation in his head, the consultant said he could not explain why and recommended some alternatives and informed Bob he would write to his GP.

In **August 2007** Bob had an assessment appointment for Corrective Behaviour Therapy (CBT) with a consultant Liaison Psychiatrist, it was explained that the therapy course would consist of block appointments for weekly attendance and that Bob would be put on the waiting list.

Bob continued to have corrective tissue massage throughout 2007.

During our continued research for anything that would help Bob we came across oxygen therapy, this triggered Bob's memory back to when he was a young electrical engineer with a head full of broken bottles on a Saturday morning, (after a Friday night out with the boys), he would have 10 minutes on the oxygen and feel brand new and able to run a 100yd sprint in just 11 seconds, on a good day!

Our research on oxygen began, after many hours of research we found the OXYFARM SA-2500 Oxygen Generator/concentrator, an Oxygen Therapy Machine that naturally produces negatively ionised oxygen enriched air. See OXYfarm SA-2500.

Prior to purchasing the OXYfarm SA-2500 we found and visited an oxygen bar where Bob had 20 minutes of 99% oxygen, during the hours after this he felt he had more energy and felt a little stronger.

*In **October 2007** Bob discussed this with his senior physiotherapist and it was decided that he would go to the oxygen bar immediately before his next corrective tissue massage appointment.*

The results were astounding, whilst normally it would take his body about 15/20 minutes to respond to the corrective tissue massage, his body responded instantaneously after having the oxygen and where normally he would only feel limited benefits from the treatment for a few hours after, this time he felt the benefits for five days!

Bob repeated this test with the next three appointments and the results were the same, when he did not have oxygen prior to the corrective tissue massage his body took 15/20 minutes to respond and he did not feel the benefits for longer than a few hours, as before.

We went ahead and purchased the OXYfarm SA-2500, but we did think that because the OXYfarm only gave 30% oxygen enriched air it would not have quite the same benefits, this was not the case, Bob had the same amazing results after having 30 minutes of oxygen using the OXYfarm.

Being a systems engineer Bob needed to know the OXYfarm worked; how did it give the same results as the 99% oxygen at the oxygen bar?

The OXYfarm was different to any other oxygen generator/concentrator in that after it enriches the air with oxygen at the purity of 30% it passes this oxygen enriched air through a water chamber creating bubbles which burst on the surface of the water. Bob's research showed that by doing this it was naturally negatively ionising the oxygen enriched air just as nature does after a thunder and rain storm, the rain drops burst on

the ground which release the negative ions in to the air and the positive ions are left on the ground. Negative ions are responsible for the feel good factor after such a storm.

Further research showed that negatively ionised oxygen is absorbed by our cells much easier and faster, so hence the results when using the OXYfarm SA-2500.

As a result of the benefits that was seen by Bob's senior physiotherapist when she was administering Corrective Tissue massage in conjunction with oxygen therapy, she made a case to her manager for the need of oxygen therapy to be used in the pain clinic, the manager refused, he *stated that there had not been enough research on oxygen therapy!*

Bob used the OXYfarm on a daily basis, this eliminated the brain fog, increased his concentration levels, improved his mood and increased his energy levels reducing the fatigue and exhaustion. It was the first time he felt he was going forward.

As the OXYfarm was highly beneficial for Bob and became an important part of his lifestyle and treatment, we decided that everyone should know about the OXYfarm and how beneficial it could be for everyone and given that his physiotherapist and Neurological consultant said he had to keep his brain more active Live Longer and Healthier product review was born.

Bob had also been continuing using cannabis for pain relief, whilst this initially gave an 80% reduction in the pain in his shoulder, over time he became tolerant to it and had to use more, the problem with this was that he would feel stoned all the time. When he used the OXYfarm he quickly found that the oxygen therapy was counteracting the stoned feeling which was definitely beneficial!

Between **January 2008** and **June 2008** Bob had a series of scheduled block appointments for Corrective Behaviour Therapy at the Medically Unexplained Symptoms Clinic. Bob attended the first of these appointments.
At the beginning of the appointment Bob explained that he was having corrective tissue massage and went on to explain about the oxygen therapy and the results he had when having had oxygen before his corrective tissue massage, he also informed him that we had purchased the OXYfarm and that Bob had oxygen therapy on a daily basis, it was part of his lifestyle and treatment.
The consultant told Bob that having oxygen was cheating and that not enough research had been done.
Bob tried to explain the benefits he was getting from it but the consultant insisted that it was cheating; stating the benefits were not real and that he should not use oxygen. The consultant then proceeded to explain about the corrective behaviour therapy, Bob had a few questions along the way but the consultant told him that he should not ask questions at this stage, just listen.

The fact that the consultant had said using oxygen was cheating got into Bob's head somehow and Bob stopped using the OXYfarm, whilst Bob had experienced the benefits from using the OXYfarm he could not get what the consultant had said about cheating out of his head.
Bob also could not understand how the consultant had got into his head and made such an impact on him.

Unfortunately *t*he remaining appointments in the block had to be cancelled as Bob was having a really bad time with the diarrhoea being constant, excessive sweating, feeling really weak and exhausted.
I spoke with the consultant Liaisons physiatrist's secretary and explained Bob's condition.

It was decided by the consultant to cancel the block of appointments scheduled during this period because the appointments were meant for weekly attendance and that he would reschedule for a later date when Bob was hopefully in a better condition and could attend every week. It was arranged and agreed for us to contact his secretary in February 2009 to either confirm a block of appointments which would begin in March/April 2009 or to postpone again.

Between **January 2008** and **April 2008** Bob had five corrective tissue massage appointments but unfortunately this treatment came to an end in April 2008 because the senior physiotherapist with the hands of an angel had handed her notice in and was leaving the NHS Service to set up a private practice. The physiotherapist had had enough of the pain clinic pushing medications and not being willing to incorporate or try alternative treatments that had proved to be beneficial to her patients.

The Pain clinic said that they could not offer Bob any further treatment due to the fact that he could not take medication because of the side effects, not only that but they also informed him that he should only have had the Corrective Tissue Massage (CTM) treatment for a maximum of six weeks and that he had been having it for over 18mths. They were not interested in the fact that it was beneficial for Bob and had no answer as to what to do without it.

In **April 2009** the re-scheduled block appointments for Corrective Behaviour Therapy (CBT) to help with pain at the Medically unexplained Symptoms Outpatient Clinic had to be cancelled as Bob was not well enough to attend.
It was decided by the consultant that because of Bob's illness and disabilities; the constant pain, exhaustion, and diarrhoea etc that this treatment was not going to be suitable.

We were now effectively on our own, Bob's GP could not offer any help either because of his body's intolerance to medication, but it was agreed with the GP that we would contact her if we thought there was something she could do to help Bob, otherwise he would not see her as the very act of going to see her, as with all appointments, would exasperate his condition and quite often as a result of being in a waiting room full of other ill people Bob would pick something up such as a bug, cold, or chest infection.

We continued with our own research for anything that could help Bob, we found that raw organic virgin coconut oil could help Bob if taken orally as it could strengthen the immune system and reduce colds and viruses which Bob suffered from almost consistently.
Our research also showed that if used topically it could help to calm the blisters and inflammation associated with the chronic diarrhoea.

One of the problems with having friends visit was that Bob would often be ill afterwards with a cold or virus, whilst the person was not ill themselves they could have unknowingly been in contact with others that had colds or viruses.
In fact if they had knowingly been in contact with others who were ill they would not visit as they knew Bob was very fragile and could easily pick up anything.
Consequently visits from friends were kept to a minimum.
The same risks applied when I had to go out.

Bob started to take raw organic virgin coconut oil orally; see Tiana raw organic virgin coconut oil, he started with one tablespoon a day and gradually increased it to three tablespoons a day over a couple of weeks and after about three/four months it did seem to reduce the amount of colds and viruses Bob suffered from.
We were actually able to have friends visit without Bob being ill afterwards!

I also used the coconut oil daily, orally and externally as an overall body moisturiser, when I had to go out I would also put a small amount of coconut oil inside my nostrils as research showed that doing this helps to stop bacteria and viruses entering the nasal cavity, therefore further reducing the risk to Bob.

The raw organic virgin coconut oil did calm and heal the blistering and inflammation caused by the chronic diarrhoea, sometimes it was that bad Bob could not even sit comfortably, the coconut oil made it possible to sit down.

Having found and experienced the benefits of raw organic coconut oil we went on to find and research coconut water; see cocowell organic coconut water.
Our research revealed that coconut water contains the five essential electrolytes your body needs to keep nerves firing and muscles moving and to prevent cramping, Bob experienced a lot of cramp, mainly in his left hand and fingers.
We also discovered that as a result of prolonged diarrhoea it causes your body to lose more fluid than it can take in and as a result your essential salts; electrolytes are lost too. Whilst we knew that you should replace fluids, we did not know specifically about the electrolytes.
Our research also revealed that coconut water could enhance concentration, reduce stress, and that it was used worldwide in the treatment of digestive ailments, to re-hydrate and to naturally repair our body's cells.

When Bob first tasted organic coconut water he liked it so much that he drank two 330ml cartons in very quick succession, this resulted in instant diarrhoea, after a little more research we found that it can also detox your body, especially if you drink a lot of it when your body is not used to it and this can result in diarrhoea!
So we started to dilute the coconut water 50/50 ratio with water, this helped tremendously, whilst it did not stop the chronic diarrhoea Bob suffered with daily it did not make it any worse. After a couple of weeks Bob gradually reduced the amount of water used to dilute the coconut water until he was drinking it without any dilution. After about a month Bob started to find that he did not feel as ill and weak after the bouts of chronic diarrhoea, he felt a little stronger and had more energy. Whilst he still experienced cramp in his left hand and fingers it was not as frequent.

*In **September 2009** we purchased Microsoft Flight Simulator, Bob liked flying and we thought it would help to exercise his brain in mental acuity such as concentration, focus and multi tasking, as he struggled with these aspects due to the brain fog he experienced.*
When using flight simulator Bob also thankfully, got back into using the OXYfarm oxygen therapy machine, which previously the corrective behaviour therapy consultant had put Bob off by somehow getting into his head that having oxygen therapy was cheating and producing false results, consequently Bob had then stopped using the OXYfarm. This was very detrimental to Bob as he had had amazing benefits from the oxygen therapy.

Bob started to use the OXYfarm on a daily basis, he would have at least 45 minutes up to 2 hours oxygen therapy whist he was using flight simulator.

Over the next twelve months Bob gradually became stronger as his energy levels increased, his concentration levels and focus also improved, together with his memory.

Whilst Bob did not feel as ill and weak after the bouts of chronic diarrhoea he was still plagued with it on a daily basis, it would normally start early morning through to lunch time, whilst we had changed our diet to a stone age organic diet, it had only reduced the ferocity of it.
Bob still experienced the crashes; the sudden episodes of excessive sweating, overwhelming fatigue, palpitations, feeling ill etc., but these were reduced to once or twice a week and then once a month instead of every day and they were not as

devastating when they happened and he would recover quicker from them, although any excess stress, mental or physical would still invoke a crash with devastating results. So all stress was kept to a minimum as we had always tried to do.

When possible we started to go out once a week/fortnight during the afternoons for social interaction as we had been told by Bob's senior physiotherapist and neurological consultant that it was important to do so.

Unfortunately in **December 2010** Bob had a very bad fall due to his left leg giving way.

Bob had delayed onset of pain 6 days after the fall which then lasted for approximately a month. This also made his other symptoms of fatigue/exhaustion, excessive sweating, palpitations and diarrhoea worse, he was bedridden for most of this time.

At the end of **December 2010** Bob received an invitation for bowel screening.
As Bob did not provide a specimen for the bowel screening he received two reminders, one in February 2011 and one in March 2011.
Bob had not provided as specimen as he had had a colonoscopy and a biopsy taken from his colon previously to investigate the chronic diarrhoea and nothing other than inflammation was found. He also wanted to discuss it with his GP first.

During the early part of **2011** once he had recovered well enough from the fall Bob visited his GP. he was referred for a hip X-ray to see if it would identify a reason to explain his left leg problems. Bob also discussed whether he should participate in the bowel screening program, his GP thought he should as it was back in 2004 when he had the colonoscopy etc, the GP also informed us that the bowel screening program was primarily looking for cancer.

In **March 2011** Bob provided the three specimens for the bowel screening program.

In **April 2011** Bob received a letter from the Bowel Screening informing him that he had had a positive result which showed traces of blood in his bowel motion. It was requested that Bob contact the bowel screening clinic within seven days to have a discussion with a nurse before having a colonoscopy.

We spoke to the nurse and informed her of Bob's medical condition as she had no records; we also discussed the fact that Bob could not have any medication or sedatives etc and explained why. The nurse informed us that she had noted all the information we gave her together with the fact that Bob would need to have the colonoscopy without sedation and that he knew what to expect having had the previous one without sedation.

Bob received a letter from the bowel screening informing him that his colonoscopy had been set for the beginning of August 2011.

In **July 2011** Bob received a letter from his GP regarding the results of his hip X-ray; Whilst his hips generally seemed to be fine, a reduction in bone density had been noticed. Bob was referred to the Mineral Metabolism Clinic for a Dexa Scan to check his bone density.

At the beginning of **August 2011** Bob attended the appointment for the colonoscopy. The clean prep you have to take to clean your bowels out prior to the appointment gave Bob a lot of stomach pain, but it had calmed down and Bob felt relaxed about having the procedure which was scheduled for the afternoon.
When we arrived at the appointment Bob was called to get gowned up etc, the nurse turned to me and said that I should go away and come back to pick him up a few hours later, I explained that I whilst I was Bob's partner I was also his carer and that Bob

needed me to help him undress etc, together with the fact he wanted me to be there. The nurse replied that because of the sedation he would not be ready to come home for at least couple of hours afterwards. I explained to her that he could not have any sedatives and that this had been explained and arranged with the nurse on the telephone a few weeks ago. The nurse then directed us to the bed and left us alone whilst Bob changed into the gown etc.

After Bob had changed into the gown another nurse appeared and started to ask some tick box questions, one of the questions was 'do you have any pre-existing conditions'

Bob started to explain his medical problems, the nurse interrupted and stated that there was nothing on their system other than dental treatment Bob had had at the dental hospital, I could see that Bob was starting to get stressed so I quickly intervened and informed the nurse that all this information had been given to the nurse on the telephone prior to receiving this appointment and that it had been arranged for Bob to have the colonoscopy without sedation.

The nurse went to have another look on their computer system but came back stating that there was definitely nothing on their computer system to say that Bob had any medical conditions and therefore there was no reason for Bob not to have the sedatives.

We tried to explain why he could not have the sedatives, the nurse interrupted us and told us that she would go and get one of the surgeons to come and talk to Bob about it, the surgeon appeared after about 10 minutes, we explained about the previous colonoscopy which had been performed successfully without any sedation and the fact that as Bob had suffered severe side effects from all medication even low dose medication it was the Anaesthetist who had decided it would not be safe to sedate Bob, as the danger was that his body was highly likely to go into spasms and if this happened they would not be able to get the camera out.

The surgeon proceeded to tell Bob that there was no Anaesthetist in the hospital and that it would be ok to have the sedatives and that he shouldn't worry as they only puncture one in a thousand! He also informed Bob that if anything did go wrong they could not do anything about it and that he would have to be taken to another hospital.

The surgeon then informed us that whilst one of the surgeons within the bowel screening program performed colonoscopies without sedation he did not and had never done so. He offered to perform a partial colonoscopy but stated he would not perform a full colonoscopy without sedation.

By now, Bob was feeling very stressed, abused and bullied down to the fact that no one would not listen or accept that Bob had any pre-existing medical conditions never mind the problems he suffered with medications and the potential danger of sedatives.
The nurses had constantly barracked Bob and were adamant that because there was nothing on their computer screen about pre existing conditions, Bob did not have any.

Bob was certainly not in any way relaxed enough to have any procedure and the fact that the surgeon had said that they only puncture one in a thousand did not instil any confidence or trust in their ability to perform a safe procedure.
He could also not see the point in having a partial colonoscopy.

Bob decided to leave the hospital and re-arrange an appointment with the surgeon who could perform the colonoscopy without sedation.

A few days later we telephoned the co-ordinator at the bowel screening clinic to explain what had happened at the appointment and to re-arrange an appointment with the surgeon who could perform the colonoscopy without sedation.

The co-ordinator was very helpful, he asked us to give him time to look into the case and that he would call us later.

When the co-ordinator called us back later he suggested that we see Bob's GP as indeed there was no information about Bob's medical conditions on their computer system other than the dental work. He could also not find any notes from the telephone discussion with the nurse prior to the allocation of the colonoscopy appointment.

He also asked Bob to give the GP his details and consent for him to liaise with Bob's GP to sort this out. He also informed us that he would be putting in a complaint regarding the way Bob had been treated. He asked us to phone him again once we had seen the GP.

Bob saw his GP and explained what had happened, the GP looked into this and found that Bob's medical history was not showing on the correct screen in the computer records, so therefore it would not show on all the computer systems. This was apparently because only certain diagnosis's automatically appeared on all systems.
The GP manually corrected this. We also informed her that the co-ordinator would like to speak to her and that Bob agreed for her to liaise with him.

When we contacted the co-ordinator again he informed us that he had spoken with the GP and that the GP had also faxed over to him all of Bob's medical details so that he could put this in Bob's file together with the fact that Bob was to have the colonoscopy without sedation.
The co-ordinator thought that by doing this is it would fail safe so the nurses would have all the information in his file in case they did not look at the computer system before seeing Bob.
This way Bob would not have to explain anything and be able to remain relaxed for the procedure.
The co-ordinator then re-arranged the colonoscopy for the beginning of September 2011 with the correct surgeon.

At the end of **August 2011** Bob attended the appointment for the Dexa Scan, prior to the scan a nurse checked and recorded his weight and height. When the nurse informed Bob of the weight and height measurements Bob asked what was that in old money; i.e. feet and inches etc, when the nurse converted his weight it was correct but when the nurse converted his height it was two and a half inches shorter than he had always been, Bob questioned this, the nurses reply was that it was common for people to lose height when they get older, Bob replied that if his height had changed that much he would have noticed, the nurse re-checked the conversion but would not recheck the actual height measurement as she was insistent that she had measured this correctly.
This was very worrying because how could Bob have lost two and a half inches in height without us noticing?
Later that day when we got home we measured Bob's height and this confirmed that he had not lost two and half inches in height!

At the beginning of **September 2011** Bob attended the appointment for the colonoscopy.
This time when Bob took the Klean prep to prepare for the colonoscopy he experienced excruciating stomach pains and it felt like his insides were falling apart.
Whilst the pains did not cease they did calm down enough for him to attend the appointment, he was also determined to get the procedure done out of the way.
When we arrived a nurse took us through to the ward for Bob to get changed into the gown. As she was drawing the curtains she informed Bob that someone would be along shortly to give him the sedatives. I quickly said to her that he was not having any sedatives and that all this information had been put in his file, which she was holding in

her arms, she replied she had not got this information and remarked that everyone has to have the sedatives, she then walked away.
Bob was relaxed when we arrived but now he was feeling stressed again as this was yet another mess up.
The co-ordinator and the GP had done everything they could so that this appointment went smoothly so that Bob remained relaxed for the colonoscopy, but this time the nurse had not even bothered to look at his file, even though she had it in her arms.
Bob decided enough was enough; he was not prepared to be abused and bullied again so we left the ward.
As we were walking down the corridor, a nurse called out to Bob and said come and have a seat and the surgeon will come and speak to you and that she had now found the notes in his file. Bob replied that it was too late, he was now too stressed.
So we left the hospital.

After we got home we contacted the co-ordinator, he was disgusted at what had happened and asked us to leave it with him.
When he got back to us he informed us that he had rescheduled the appointment for October 2011, but this time he had spoken to the surgeon so that he knew prior to the appointment Bob was having the colonoscopy without sedation and could then liaise with the nurses on the day of the appointment before Bob arrived to make sure that there would be no further aggravation to Bob.

From this point on Bob suffered with stomach pains on a daily basis and felt generally unwell on top of all the other problems he suffered with.

Bob saw his GP regarding the stomach pains and the problems in trying to get the colonoscopy without sedation.
The GP informed Bob that as he had had two Klean Prep courses within a very short space of time and that this had obviously caused his stomach problems, he should not take any more anytime soon.

Bob also discussed with the GP that the fact blood was shown in his bowel motion would likely be down to the fact that occasionally at the beginning of diarrhoea he would have a hard plug like stool which was difficult to pass and would tear his rectum making it bleed which would show on the tissue paper, whilst the GP agreed she explained that because it was a bowel screening program and they were looking for cancer she could not remove him from the program, but told us to postpone the procedure until after November 2011 to give his stomach and bowels time to recover.

We informed the co-ordinator at the bowel screening clinic of this information.
The co-ordinator informed us that as the surgeon who performed colonoscopies without sedation was only available at certain times in the bowel screening clinic and due to the surgeon also being on holiday he would have to send an appointment once he knew when the next clinic with the this surgeon would be available.

In **October 2011** Bob attended the follow up appointment at the Mineral Metabolism Clinic for the results of the dexa scan.
Prior to seeing the consultant his weight and height were taken and recorded again, this time the height was measured correctly, Bob voiced his concern that the previous height measurement taken was wrong and asked the nurse to correct this in his records; the nurse informed us that she could not change the previous record of his height.
It would have to stay in his records. This was very frustrating for Bob as this meant more incorrect information in his medical records.
When he saw the consultant he was informed that the results of his bone density scan was just above the criteria for having Osteoporosis and that they would see him again in two years.

Bob also informed his GP that his height had been measured and recorded wrong but the GP said that she could not do anything about it.

Towards to the end of **2011** Bob received an appointment for the colonoscopy at the bowel screening clinic for January 2012.

In **January 2012** Bob was still suffering from stomach problems caused by the Klean prep, so we contacted the co-ordinator at the bowel clinic to inform him of the problems Bob was still having and to postpone the appointment again.

The co-ordinator informed us that the surgeon who performed the colonoscopies without sedation would no longer be working in the bowel screening clinic so he was unable to schedule another appointment for this surgeon. He informed us that he thought it would be best to take Bob out of the bowel screening program, but to do this his GP would need to make a new referral for Bob through the normal channels to have a colonoscopy, which would also ensure that Bob would be able to have the procedure without sedation as they do not have targets and can spend more time completing the procedure.

The co-ordinator explained that within the bowel screening program they have targets to complete each week which means that each colonoscopy is allocated a 20 minute slot which is why they give everyone a sedative because this means that they can complete the procedure within the 20 minutes allocated, without sedation they have to take more time for obvious reasons, they can't just shove the camera in and out if one has not had sedation. (no wonder they puncture one in a thousand when sedated!)
Although the co-ordinator did explain that there were exceptions allowed within this if one cannot have sedation, the problem was that most of the surgeons had never performed them without sedation and were not willing to do so.

The co-ordinator informed us that he would speak to Bob's GP regarding a new referral for a colonoscopy through the normal channels so that he could take Bob out of the program. He recommended we made an appointment to see his GP in about a weeks' time which would give him chance to contact her.

Before the end of **January 2012** Bob saw his GP, the GP explained that she would have to make a new referral to the Gastro/medical clinic for investigation of the chronic diarrhoea in order to get a colonoscopy. She also informed us that she would fax a copy of the referral to the co-ordinator at the bowel screening clinic so that he could take Bob out of the bowel screening program.
The GP also asked Bob to provide a stool specimen, which he did the following day. This came back negative, no blood showing this time.

Bob received an appointment for the Gastro/medical clinic in July 2012.
At this appointment with a very nice gastroenterology registrar Bob's chronic diarrhoea was discussed. we also informed the registrar that we had changed our diet but it had only reduced the ferocity of it, the registrar informed us that we were doing everything right and that indeed Bob was not eating anything which should cause the diarrhoea. Blood tests were taken and Bob was asked to provide another stool specimen, which he did a few days later. During this appointment the problems with the Klean prep were also discussed and whilst the registrar recommended that Bob should have another colonoscopy she also agreed that Bob should not take any more Klean prep until the problems with his stomach had ceased, therefore she would schedule the colonoscopy for September 2012 in the hope that his stomach problems would have ceased by then given it would be a full year since taking the last Klean Prep.
The registrar also informed us that she would request the colonoscopy to be conducted without sedation with the help of the scope guide which aids them in getting round the bowel especially with patients who aren't taking sedation.

Bob stomach problems did start to calm down but were still a problem in August 2012 and he also felt generally unwell so we contacted the gastro clinic and asked for the colonoscopy to be cancelled and rescheduled for October 2012 to give Bob more time to recover further.

In **September 2012** Bob received a letter from the Gastroenterology registrar informing him that the blood tests which were taken at the clinic in July 2012 and the stool samples he had submitted were all normal. The registrar also informed us that as Bob wanted to postpone the colonoscopy until October 2012 unfortunately the endoscopy system did not allow her to pre-book scopes too far in advance and that she would hang on to the referral and then re-book nearer the time. The registrar also confirmed that she would again request it to be conducted unsedated with the help of the scope guide which aids then in getting round the bowel.

Towards the end of **September 2012** Bob saw his GP to discuss the issue of Bob having another colonoscopy and it was decided that Bob was definitely not up to having a colonoscopy anytime soon and that the GP was happy as Bob's stool tests had showed no traces of blood again.
The GP informed Bob that she would write to the clinic and inform them of the decision.

In **October 2012** Bob received a letter from the gastroenterology registrar confirming that she had received correspondence informing her that Bob no longer wished to have the colonoscopy procedure. It was stated in the letter that no future follow up in the clinic had been arranged but they were happy to do so should Bob change his mind and wish to undergo the colonoscopy.

During our continued research, in 2012 we came across H2O2 therapy.
Our research showed that H2O2 therapy could detox your body; fight infections, eliminate toxins, bacteria, viruses and neutralise germs, creating a foundation to rebuild the immune system.

This therapy involved taking drops of H2O2 in distilled water for a month.
After completing this therapy you then need to rebuild your immune system by taking good bacteria for a period of eight months.

As our research had also shown that toxins from medications can stay in your body for many years, Bob decided to implement this therapy, he started on 1st October 2012 and to give himself every chance whilst he was rebuilding his immune system he imposed an eight month self incarceration i.e. not going out and not having friends visit until June 2013. This way he could not pick up any infections, colds or viruses etc.

During the second week on the H2O2 therapy Bob started to lose his appetite and his stomach became bloated. If he tried to eat it would make him feel sick.
By the beginning of the third week he had started vomiting.
He was mainly vomiting liquid as he had not been able to eat for several days, but in this liquid there were a lot of what looked like coarsely ground grains of black pepper.
As Bob had hardly eaten anything and certainly not black pepper he decided to inspect them under a microscope.
On inspection they looked like a very small worm rolled up, Bob opened out the rolled up specimen with a cocktail stick and after further examination under a more powerful microscope it had a hook on one end of it.

Research in Google images identified it as a hook worm (parasite), the research also showed that if you have this parasite you will also have two others.

Further research showed that parasites can bury themselves and lie dormant for 18 months in your bones and marrow etc, whilst H2O2 therapy eliminates parasites this is

mainly from your stomach and bowels, to rid your body of them completely you need to complete a set protocol over sixteen days using three herbs, Clove, Wormwood and Black walnut tincture. It was recommended to do one course then have a two week break and then do another course. To catch the ones that can lie dormant for up to eighteen months the protocol should be completed once every six months for eighteen months, proceeded by a maintenance course every six months.

At the beginning of the parasite cleansing and for a period of eight months continuously the research showed that this is when you should build your immune system with good bacteria.

After Bob had completed the H2O2 therapy he immediately started the parasite cleansing and the building up of his immune system with good bacteria.
Towards the end of the first parasite cleanse his bowel movements were back to normal with regular bowel movements every day, the chronic diarrhoea he had suffered with for ten years had ceased. His left arm and hand had also started to work again, he could now use a knife and fork which he hadn't been able to do for many years.

Bob felt and looked 20 years younger, he had more energy and the chronic fatigue etc had vanished.

He proceeded to do a lot of manual work fixing things in the house etc which had built up over the years as he had not been able to do anything and created an air conditioning system.

The self incarceration Bob had imposed on himself was due to end on Saturday 1st June 2013, so we planned a celebratory evening out.
Unfortunately Bob did not feel great that day and had a headache but he could not put his finger on what was wrong, so instead of going out as arranged we invited a friend over for the evening.

During the **Saturday evening of June 1st 2013** after having a meal and sharing a couple of bottles of wine with a friend, Bob suddenly experienced problems with his left arm and legs, his balance went and he collapsed on the floor onto his knees, when our friend tried to help him up he had no strength in his legs to get up to support himself. After about ten minutes of oxygen he was able to stand up on his own but he did not feel good so he went to lie down on the bed, a few minutes later he had a cup of tea and then fell asleep.

The next morning **Sunday 2nd June 2013** he felt absolutely fine and had no further problems that day.

On the evening of **Monday June 3rd 2013** his left arm, hand and fingers would not work for a few seconds and his legs felt a bit wobbly for a few minutes.

On **Tuesday 4th June 2013** he kept losing his balance and falling, so he lay down for most of the day and evening.

On **Wednesday 5th June 2013** he had a stroke; his left arm was moving erratically and involuntary, his mouth drooped on the left side and his balance went completely and his legs gave way, he could not get up for several hours.

The whole of his left side from head to toe became paralysed.

Effects after the stroke:

UNABLE TO WALK - LEFT SIDE OF BODY COMPLETELY DEAD FROM HEAD TO TOE.
COLD SWEATS AND BREATHING PROBLEMS WITH FEELINGS OF SUFFOCATION.
SUDDEN UNCONTROLLABLE URGE TO PASS URINE ONCE AN HOUR, DAY AND NIGHT.
PROBLEMS WITH SPEECH DUE TO FROZEN FACE MUSCLES.

LEFT SCALP - TINGLING SENSATION THAT FEELS LIKE DENTAL INJECTIONS WEARING OFF.
LEFT EYE - SMALL MOVEMENT OF UPPER EYELID, NO MOVEMENT OF MUSCLES AROUND EYE, TINGLING SENSATION.
LEFT EAR - TINGLING SENSATION, NO OTHER FEELINGS.
LEFT CHEEK - TINGLING SENSATION, NO OTHER FEELINGS.
LEFT SIDE OF NOSE - TINGLING SENSATION WHERE LEFT SIDE OF NOSE MEETS RIGHT SIDE OF NOSE.
LEFT UPPER LIP - MUSCLES FROZEN, NO MOVEMENT, TINGLING SENSATION WHERE LEFT LIP MEETS RIGHT LIP.
LEFT LOWER LIP - MUSCLES RELAXED, NO MOVEMENT, TINGLING SENSATION WHERE LEFT LIP MEETS RIGHT.
LEFT SIDE OF CHIN - MUSCLE RELAXED, NO MOVEMENT, TINGLING SENSATION WHERE LEFT MEETS RIGHT.
LEFT SIDE OF NECK - MUSCLES RELAXED, NO MOVEMENT, NO OTHER FEELING.
LEFT SHOULDER - MUSCLES RELAXED, SHOULDER AND ARM SAGGING, NO MOVEMENT, NO OTHER FEELING.
LEFT UPPER ARM - MUSCLES RELAXED, NO MOVEMENT, NO OTHER FEELING.
LEFT ELBOW - NO MOVEMENT, NO OTHER FEELING.
LEFT LOWER ARM - COLD, MUSCLES RELAXED, NO MOVEMENT, NO OTHER FEELING.
LEFT WRIST - NO MOVEMENT, NO OTHER FEELING.
LEFT HAND - COLD, SWOLLEN, MUSCLES RELAXED, NO MOVEMENT, NO OTHER FEELING.
LEFT THUMB - COLD, SWOLLEN, MUSCLES RELAXED, NO MOVEMENT, NO OTHER FEELING.
ALL LEFT FINGERS - COLD, SWOLLEN, MUSCLES RELAXED, NO MOVEMENT, NO OTHER FEELING.
LEFT CHEST, BACK, SIDE AND WAIST - ALL MUSCLES RELAXED, NO MOVEMENT, NO FEELINGS.
LEFT BUTTOCK - MUSCLES RELAXED, NO MOVEMENT, NO FEELINGS.
LEFT UPPER LEG - ALL MUSCLES RELAXED, NO MOVEMENT, NO FEELINGS.
LEFT KNEE - MUSCLES RELAXED, NO MOVEMENT, NO FEELINGS.
LEFT LOWER LEG - COLD, SWOLLEN, MUSCLES RELAXED, NO MOVEMENT, NO FEELINGS.
LEFT ANKLE - SWOLLEN, NO MOVEMENT, NO FEELINGS.
LEFT FOOT - COLD, SWOLLEN, NO MOVEMENT, NO FEELINGS.
LEFT TOES - COLD, SWOLLEN, NO MOVEMENT, NO FEELINGS.

Bob insisted he did not want me to call an ambulance or have any intervention by the NHS given all the problems they had caused him previously. Bob felt he was a perfect candidate for being put on the Liverpool pathway as they had already said that his condition was too complicated for them and the fact that they would not listen to him about the severe side effects he suffered with all prescribed medication and the potential danger of giving him sedatives in the bowel screening clinic.

He was concerned that they would not listen to him about his body's intolerance to medication and bully or force him to have medication as they had tried to do in the bowel screening clinic where he had had to get up off the operation trolley to stop the verbal bullying and insistence that there was nothing wrong with him and he could have the sedation and/or medication that could potential kill him.

From the moment of the stroke Bob used the OXYfarm oxygen machine 24/7.

On the Wednesday evening we checked Bob's blood pressure, it was very high.
After a quick research for something natural to bring his blood pressure down I found Lemon Grass Tea.
Our friend delivered some to us on the Thursday morning.
After drinking with a lot of difficulty half a cup of the lemon grass tea Bob's blood

pressure came down from 195/95 with a heart rate of 102 to 150/85 with a heart rate of 86 within minutes.
Every time Bob needed to go to the bathroom to urinate which was only five steps from the bed his blood pressure would increase dramatically, he would drink the lemon grass tea once back in bed which would bring his blood pressure down again, he later found that drinking it immediately before going stopped the blood pressure increasing to danger levels.

Bob continued to drink lemon grass tea throughout the following days and weeks and his blood pressure remained stable in normal range.

As half of Bob's mouth was paralysed and he had problems in swallowing he had to have a liquidised diet for the first three months after the stroke.

Speech was a problem in that it was difficult to form words, so he practised saying 'the rain in Spain falls mainly on the plain' in front of a mirror for lots of hours every day to stop his mouth dropping.

A week after the stroke Bob managed to wiggle his index finger, this gave him hope and the realisation that he could recover from the paralysis. It was a very emotional moment for him. The next day he was able to move his thumb.

Whilst he could lock his knee so that he could stand for a few moments, he could not walk. He would have to pull his left leg forward with his right hand, being an engineer he quickly devised a bungee system attached to a moccasin which allowed him to use his body to control his left leg, leaving his right hand free to control balance.

During the night Bob suffered with breathing problems, feeling that he was suffocating, which was impossible as he was having the oxygen 24/7, even when he was asleep.
He would also be covered in sweat; the bed was so wet it was like someone had chucked a bucket of water over it. His blood pressure was also high during these episodes.

We knew from the neurologist that many of the pains that would suddenly happen particularly in the right side of his body were not real (no physical damage) and were being caused by faulty signals to and from the brain, they were nothing to worry about physically. We wondered if the breathing problems were being caused by wrong signals.

We also remembered research we had found when we were researching COPD that smoking raw cannabis (without tobacco) opened up and cleared the airways.
I had tested this too, as a few years ago I was diagnosed with COPD.
I used our OXYfarm oxygen machine daily and smoked raw cannabis in the evenings, after three months further tests showed I was clear from COPD.

A combination of the oxygen, lemon grass tea and smoking raw cannabis stabilised the problems and enabled him to breathe properly within 20 minutes.

Our research showed that to help the body repair it needs the full range of minerals and trace minerals in a form that is easily absorbed.
We found a product called Cellfood concentrate which provided these minerals etc in an ionic form which was easily absorbed by the body, Bob started using this immediately after the stroke. Further research showed that Silica was also needed by the body to help repair connective tissue and strengthen your main aorta and arteries, so Bob also used Cellfood Silica.

Until April 2015 Bob's recovery had been two steps forward and three back.

Between the **end of January 2015** and **beginning of March 2015** Bob's recovery put a spurt on, then one morning he had an excruciating pain in his left hip and all down his leg, his balance had gone and he could hardly move his left arm again, his fingers felt like fat sausages, he also had pains in his head and felt very ill and exhausted all the time. He had vibrations; high frequency tremors all over his body, spasticity in his left arm and leg and the left side of his face felt like he had been punched.
He was also very stressed about what was happening to him and stressing about stressing and had no clue what to do.

In April 2015 a friend with MS told me about a totally legal CBD hemp Oil that you vaped from a company called Kustomvape and that he thought it may help calm Bob's trauma down.
I told Bob about it and we researched it all afternoon and evening, Bob decided to try it, he vaped constantly and after four hours he said whilst he could not say what specifically, he had a feeling that the trauma was calming down.
The next day he continued vaping and he remarked that his head felt clearer and he felt more alert and less stressed as the day went on.
Further research highlighted that the low levels of CBD in hemp oil was not enough to cure anything but that they were accumulative and would build up in the body if he kept vaping. Our research highlighted that much higher levels of CBD were required.

Research also showed that one of the most important things was how organically pure the plants, be they hemp or cannabis, were grown.

We found that CBD has many medicinal properties, we also found that most CBD oils available were extracted from the Industrial Hemp plant, as was the Kustomvape CBD oil and whilst this had helped, for real medical benefits international research shows that you need CBD oil from the female cannabis plant that are bred for high CBD levels and low THC. Typically the levels of CBD in these plants is 20% whereas CBD extracted from Industrial Hemp is only 2%.
Research also showed that to get CBD to our cellular level to help repair the body you need to take it as drops held for 3 minutes under the tongue where it absorbs through the membranes and then straight into your bloodstream.

After further research we found the CBD Brothers, a UK supplier of CBD oil extracted from pure organic female cannabis plants grown in the Netherlands.
These plants are bred for high CBD levels, typically 20%.

We purchased a bottle of White Label CBD oil from the CBD Brothers.
Bob took 6 to 8 drops under his tongue three times a day.
It quickly reduced the traumas to a tolerable level and completely restored his balance.
This greatly improved his walking.

Eight days later he wrote this in the dairy:

Chronic fatigue - gone - fixed
Eyesight - improved
Balance - back to normal - fixed
Vibrations/trauma - calmed down - making life tolerable
Physical and mental stress - calmed down
Getting up out of a chair and walking - improved greatly
Lack of trauma and balance being good has improved mobility
Fingers no longer feel like sausages
Spasticity - less
Stress levels - minimal not stressing, if anything getting frustrated again
Very powerful in sorting out the trauma only a week and a day
Stopped a lot of random pains in head - head a lot clearer - cleared brain fog

Side of face, lips etc - calmed down
Psoriasis - Improving - calming down - infection/redness calming down
Without doubt I am going forward and beginning to recover

Over the next two months there were noticeable signs of improvement in his overall wellbeing and ability to cope with the situation on a weekly basis.

During the third month he felt he had hit a brick wall, he felt wretched and had no energy, unable to stay awake for any length of time.
It was established that he was going through a healing crisis and needed to rest more.

Given the improvements the White label CBD oil had made we decided to step up to the more powerful red label, after a couple of days things started to improve, after 4/5 days things started to go forward again, particularly with his frozen arm and leg.

Two months after starting the red label things are still slowly improving, with each day feeling like a step forward toward complete recovery.

In addition to taking the CBD oil Bob continues to have Oxygen and Cellfood Concentrate on a daily basis.

Update - September 2015

Over the last few months Bob has had increasing problems in focusing whilst reading, so I arranged for Specsavers to come out and do an eye test.
The results were amazing, his eyesight had improved dramatically and he no longer requires glasses for long distance vision, he still requires glasses for reading but even this had improved and required a weaker prescription. This dramatic improvement to Bob's eyesight could only have been caused by the introduction of CBD Oil four months ago as part of his treatment and lifestyle.

Inspired by this and as I have been taking the CBD oil for as long as Bob I had my eyes tested. The optician couldn't believe her eyes after many years of gradual deterioration my eyesight had also shown a dramatic improvement which according to the optician hardly ever happens and she had never experienced it in her career.

Update - October 2015

Bob had an itchy bum which is a potential indication for having parasites, this reminded Bob that because of the stroke he had not completed the parasite cleansing course he had started prior to the stroke and would have to do it again to rid himself of the ones that could have been hibernating for eighteen months.

Bob started the 16 day parasite cleanse on Thursday 15th October, we also introduced good bacteria, zinc and Vitamin D to the regime to build up his immune system and to help repair any damage caused by the parasites or damage left over from the conundrum of medications that he had been trying to rid his body of when he did the Hydrogen Peroxide (H2O2) protocol in 2012 and discovered he was riddled with parasites.

Bob has had many stool tests and blood tests and not once were parasites ever mentioned. In hind sight we now know that the NHS does not report on parasites and seems not to realise they are the major cause of viruses/infections spreading throughout our body. They are only interested when there is blood found in the stools!

More to follow...