

Marshall Protocol (MP) Phase One Quick Reference

Please read/understand full [Marshall Protocol Phase One Document](http://MarshallProtocol.info) (at MarshallProtocol.info)
Follow all aspects of the MP for safe and successful treatment.

MP TIMELINE, ALL PHASES (VARIES SLIGHTLY PER INDIVIDUAL'S JARISCH-HERXHEIMER RESPONSE):
PHASE ONE: +/- 3 months. At end of Phase One, request questionnaire at sarcinfo.com or MarshallProtocol.info
PHASE TWO: (Two synergistic antibiotics) +/- 12 months.
PHASE THREE: (Three synergistic antibiotics) +/- 12-36 months.
MAINTENANCE: Annual short course of low-dose, pulsed antibiotics with Benicar.

DAY 1 ••••• MP PHASE ONE ••••• Aprox. 3 MOS.

<p>BLOOD TESTS: - 25-D - 1, 25-D (gold standard: clot, centrifuge, freeze, then lab) -ACE -Lymphocytes -CRP -Alkaline Phosphatase -Triglycerides -SED rate -Creatinine -BUN Rx: Benicar 40mg Minocycline Ketoconazole (2% cream) OTC: Pure Quercetin</p>	<p>DO WEAR NoIR sunglasses INdoors/OUTdoors & KETOCONAZOLE CREAM on uncovered skin. AVOID Light, darken house, stay indoors, cover up if one must go outdoors (layers, hat, gloves). NO D supplements or foods (see MarshallProtocol.info for full list), NO FOLIC ACID (folates). NO ABX other than MP ABX. STOP MP for acute infection or prophylaxis (resume MP later). MD monitor closely if patient taking thyroid medications or anticoagulants. Drink adequate fluids; low-carb diet recommended. Quality probiotics products if needed (like Lactobacillus Acidophilus/Bifidus). NO alteration of MP; MDs access ALL 3 MP Phases at MarshallProtocol.info Prof. Forum.</p>				
<p>HAVE EXTRA BENICAR AVAILABLE</p>	<p>ONLY BENICAR 40mg Q6H to Q8H approx 2 wks. (Q8H: every 8 hours)</p>	<p>+Minocycline 25mg Q48 hrs* (half 50mg capsules) INCREASE TO 50 MINO WHEN NO SIGNIFICANT HERX</p>	<p>Minocycline 50mg Q48 hrs* INCREASE TO 75 MINO WHEN NO SIGNIFICANT HERX</p>	<p>Minocycline 75mg Q48 hrs* INCREASE TO 100 MINO WHEN NO SIGNIFICANT HERX</p>	<p>Minocycline 100mg Q48 hrs* GO TO PHASE II AFTER 100mg GIVES NO SIGNIFICANT HERX</p>

COMPLETELY WEAN OFF PREDNISONE BEFORE BEGINNING ANY ANTIBIOTICS.

"HERX"

****Benicar 40mg/4hr, or even 20mg/2hr may help ease intolerable Herxes but doesn't stop them. If high Herx lasts more than 24hrs, manage with mino dose &/or frequency.**

<p>The Jarisch-Herxheimer Reaction (JHR, Herx) —AN ESSENTIAL INDICATOR—</p> <p>*Pulsed ABX helps the immune system find and kill the bacteria that cause Th1 Disease. As bacteria die, the immune system responds with various symptoms known as the Jarisch-Herxheimer Reaction or "Herx." Minocycline elicits the maximum Herx response as its tissue concentration decays away to zero. (A typical "increased Herx day" is 2nd in 48hr cycle.)</p>	<p>Should the Herx become intolerable, symptoms may be managed by stopping the mino or with a 25mg dose of mino every 12 or 24hrs (or if at the 50, 75 or 100mg mino dose increment, then use 25mg or 50mg at 12 or 24hrs). Frequent minocycline dosing dampens the Herxheimer reaction best because the mino is maintained at a level of concentration which is not as effective at killing intraphagocytic bacteria. As symptoms ease, gradually lengthen the dosing frequency back to 48hrs for optimal therapeutic results.</p>
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D TESTS – Refer to Basic Blood Tests for the Marshall Protocol at MarshallProtocol.info

- Testing only precursor 25-D and assuming that a low level indicates a Vit. D deficiency is a misdiagnosis.
- Patients ingesting Vitamin D in food and/or supplements may have a high 25-D, well above 20ng/ml.
- **D TESTS NOT INFALLIBLE. If symptoms indicate Th1 inflammation, MP may be used as therapeutic probe.**

<p>1,25-D test ICD code: Osteoporosis 733.0 LAB: Quest, OR Osteopenia 733.90 not LabCorp OR Fatigue 780.9 00</p>	<p>1,25-D: 60+ pg/ml indicates well perfused inflammation, close to bloodstream lung/heart. 80+ cardiac Herx risk (q4hr Benicar avail.) 25-hydroxyvitamin D (25-D) converts to 1,25 dihydroxyvitamin D (1,25-D) hormone. Key factor in Th1 chronic disease is extra-renal conversion activity of secosteroid 25-D into 1,25-D by pathogen-altered inflammatory macrophages. D supplementation is immunosuppressive. Therapy ideal for 25-D is 15ng/ml or lower. Test frequently, restrict diet and dc supplements. 1,25-D will fluctuate during therapy, test once a year.</p>
<p>>12pg/ml 1,25-D represents dominant Th1 inflammatory response, not dominant Th2 response.</p>	<p>Use NUMBERS for D tests. Norm ranges not useful.</p>
<p>TELLTALE: Low 25-D (<20ng/ml) w Moderate or High 1,25-D. High 1,25-D always reliable, if low, test may not have been handled or frozen correctly.</p>	<p>Inert Precursor 25-D Active Metabolite 1,25-D $\frac{\text{nmol/L}}{2.5} = \text{ng/ml}$ $\frac{\text{pmol/L}}{2.4} = \text{pg/ml}$</p>
<p>C3a assay & sIL2R confirm errors in 1,25-D assay. ACE helpful, not definitive.</p>	

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