Mastering Food Allergies

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Yeast Infections Revisited

Definitive Diagnosis Still Tricky - Two Tests That Help

An interview with Warren M. Levin, M.D.
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Dr. Levin practices environmental medicine in New York City. He has been treating yeast infections successfully for years. Together with a few other cutting-edge physicians in his area Dr. Levin has helped develop reliable testing methods to firmly establish - and add credibility to - the diagnosis of deep-seated yeast infections. Unfortunately, this diagnosis still isn't recognized by many physicians and insurance companies. Widespread use of the definitive testing procedures Dr. Levin discusses would go a long way toward confirming and documenting this diagnosis, and ending the controversy surrounding it.

MJ Please tell us why a diagnosis of candida yeast infection has been so tough to get a handle on. What's the big deal about it?

WL In a nutshell, it's been difficult to prove a causative role in health problems because candida and other yeasts are part of our "normal flora". In other words, healthy people have them in their gut, too. When an organism is generally present in people who are well - and it doesn't make *them* sick - it becomes very difficult to prove to everyone's satisfaction that under certain circumstances that organism causes a wide range of signs and symptoms, and results in multiple health problems.

MJ I can see that if everyone carries yeasts in their body, just identifying yeast in a patient wouldn't prove much. So perhaps we should hear about those "certain circumstances" that might predispose a person to becoming ill.

WL In a healthy body yeasts live in the fecal stream with other microorganisms in a delicately balanced ecosystem, without causing disease. Lactobacilli, Bifidobacteria, Streptococcus faecium, probably some kind of bulgarius and other strains of beneficial (or at least not disease-causing) bacteria thrive and keep the yeasts under control. Let's say this person develops an upper respiratory infection. Though miserable, his or her gut still remains in pretty good balance.

But the patient becomes *im*patient with the illness, goes to a physician and is given a broad spectrum antibiotic. The potent drug probably wipes out the infective bacteria - plus all of those "good guy" bacteria that were holding the yeast in check. With no opposition or competition, the yeast respond by madly reproducing. Antibiotics are a leading cause of this scenario happening, though birth control pills and other factors also contribute.

Just as mammals need to eliminate urine and feces, every living organism gives off a waste product. As the number of yeasts grow, the amount of waste they generate increases, too. Yeast wastes are toxic to humans. While the yeast themselves *may* be confined to the gut, the toxins readily pass into the blood-stream and circulate throughout the body. This explains how yeast infections may manifest such a wide variety of symptoms from head to toe, from headaches to depression to infected toenails and more.

The opportunistic yeast settle into their environment by forming "roots", called hyphae. They sink them into the mucous membrane that lines the intestinal tract. Now they aren't just present in the gut, they are becoming *embedded* in the gut walls. An antifungal that would have wiped out most of the yeast at an earlier stage may not be effective now.

MJ You're saying the yeast infection is more difficult to treat after it latches onto the gut wall?
WL Absolutely. Further, the situation may be complicated by the presence of parasites or *harmful* bacteria, so we must identify the organisms present in order to use the right treatment to restore a really healthy internal environment.

When yeasts attach to the gut wall by hyphae, they shift into another form and technically become fungi. This is why antifungal medications are part of our first line of defense. But all antifungals are not equally effective against deeply entrenched fungi, nor are they effective against parasites or bacteria.

MJ Tell us about the tests you find most helpful.
WL I think two tests are especially important. One of the most exciting and useful tests is called darkfield microscopy. It is an extraordinary tool for identifying patients whose immune systems are not coping well with a candida overgrowth. This test correlates with the clinical picture about 85% of the time. At this point I can't explain that other 15%, but a positive correlation of 85% is pretty good.

The physician puts a drop of fresh, unstained, and unfixed blood from a finger stick, still wet, under a darkfield microscope, and he can see living microbial forms, if present. Some investigators (Hoekstra, Ali, and others) have identified these organisms with immunological tests as being candida organisms.

This flies in the face of conventional medical wisdom which says that candida does not invade the bloodstream until a patient is at death's door - as in AIDS, cancer and other terminal conditions. I consider this visualization of microbes strong evidence that the yeast/fungi have overrun the boundary of the gut wall and are circulating in the blood to all of the vital organs.

We can also check for red blood cell aggregation. It is not desirable or healthy for cells to clump together - it can lead to an embolism and all sorts of cardiovascular problems. If we think they look a little sticky we sometimes order a little niacin to improve the electrical charge on cell walls and raise the metabolic energy. This seems to diminish any tendency of the red cells to clump together.

We can also note any number of other blood cell abnormalities that may occur. One of the most significant is to see if the blood cells are uniform or of varying sizes. Healthy people have uniform-sized red cells, across the board; compromised people do not. I don't care if all of the vitamin assays are normal, or if the patient claims to be much improved. People with mixed sizes of red cells are not well.

MJ I'm impressed that you obtain so much information from a single drop of blood - and from the patient's perspective, parting with a drop of blood doesn't seem terribly traumatic. Can we hear about the other test now?
WL In 1985 I selected a dozen tough patients who, after using all of the tricks I knew, still weren't well. I was pretty sure that if their problem was just candida I would have had them well by then. So I decided to use a new technique to test them for parasites. Despite knowing that amoeba, giardia, blastocystis, etc, burrow into the gut wall, the tests to determine if a patient had parasites, to that point, were being done on stool specimens - and were usually negative. Even testing purged stools produces a lot of false negatives. Do you understand? Even though both candida and parasites were present they were so firmly attached to the intestinal wall that neither showed up in an analysis of the stool.

Dr. Herman Bueno saw the folly of our testing methods and developed a new technique that really makes sense to me. He tells me he was on vacation, lying in a hammock, looking upward and watching insects fly into - and stick to - sticky flypaper. He thought about parasites sticking to the intestinal wall, and said to himself, "If we scraped the lining of the rectum, would we find more parasites?"

It worked! Using a simple anoscope and a swab (now changed to a conical brush), Dr. Bueno was able to obtain a specimen of the mucus lining the rectum. He smeared the mucus on a slide so he could stain it and analyze the organisms present. He then taught the collecting technique to other physicians (I actually learned this first from Dr. Louis Parrish), and arranged for a few labs to do the analysis. The test is minimally uncomfortable for the patient for a few minutes, but that hasn't proven to be a problem.

All medical laboratories aren't equally able to give accurate results. I've used Great Smokies Lab, of Ashville, North Carolina, for years and still send to them, and there are others. In addition to parasites, I want to know *what kind of bacteria* are in the specimen, and all of the other helpful information Great Smokies' comprehensive analysis gives me.

Identification of even a single parasite gives us a positive diagnosis. Finally, we know what to treat! Of that first group of twelve patients, ten were positive for parasites. Of those ten, six had a dramatic response to treatment. Roughly, those percentages probably still hold true today.

I'm not claiming this is the answer to every difficult patient's problems. Parasites have to be the problem for this to be the answer. But I am talking about a very effective test that identifies parasites much better than anything ever available before.

Don't forget, all twelve patients initially selected for this test had had standard treatments for candida and food allergy. They were the non-responders. For

the six who were "cured", parasites were IT. I have to assume that the other four patients with confirmed parasites, whose response was less dramatic, were still being held down by another as yet unidentified factor.

All of those other techniques that we know help patients are still valid and necessary - we want to improve immune function, restore the integrity and function of the intestinal wall, supplement with nutrients, help patients start to detoxify, etc. But every physician knows that a certain small percentage of patients either fail to improve or improve only a little bit - and remain far from well. Such patients were the ones I chose to help me evaluate this test.

MJ Your patients must have been relieved to finally have a diagnosis for their ill health. How did you treat the parasites?

WL Different organisms require different drugs. I often use diflucan or sporonox to reach the deeply entrenched yeast and fungi. Once those organisms become embedded in the mucosa, nystatin just doesn't do it. Then I add whatever drug I need to eradicate the organism(s) identified in the smear. I don't use nizoral a lot, yet it's the only drug effective against both candida and Blastocystis hominus. Clearly, the patient's treatment must be very specifically tailored.

I just want to add that I think what Dr. Orion Truss first described was a critical breakthrough in our thinking - that a chronic vaginal yeast infection was really a manifestation of a chronic intestinal problem. At that time we assumed that the yeast were growing in the fecal stream, and I think this is true for some people yet today. Now these patients may be very sick - they may be allergic to the organisms, as well as toxic from them.

I have found in my practice that those who exhibit multiple symptoms of the yeast *syndrome*, the advanced ones with involvement of multiple systems, almost always have a penetration of the intestinal mucosal barrier, representing an on-going assault against the immune system. These are the ones who are in trouble, or who experience increased difficulty.

MJ One reason I wanted to talk with you is that it sounds like you treat patients aggressively, to really get to the bottom of their problems. It seems to me that many patients go on the sugar-free candida diet, which apparently controls their symptoms to some extent, and then just live that way - for years. Some that I talk to sound like they don't even *expect* to be well again.

WL The patient and doctor need to work together closely to achieve recovery, and I think patients will cooperate better if and when they understand what we're trying to accomplish. I have a little analogy I use in educating my patients, it goes like this:

I compare the human gut with a lawn. A healthy organic lawn supports its own ecologic balance. While its getting established I pull any weeds by hand and nurture the grass by watering and fertilizing it. Soon the grass has grown into a solid blanket, with interlocking roots. Now strong and healthy, my lawn isn't bothered by my neighbor's dandelions blowing onto it. Seeds either fail to germinate or sprout briefly and die, because the roots can't grab hold.

One Monday morning as I go to work I notice a small brown spot, and one healthy-looking dandelion sprouting in it. I tell myself I will dig that dandelion out on the weekend. It pours rain all weekend. The following weekend we go out of town, so no yard work gets done. Finally, on the third weekend, I go out to dig the dandelion. But now I find the brown spot is as big as a dinner plate, and several dandelions are sprouting up - and looking healthy. Furthermore, I notice a few buttercups, chickweeds, and thistles have moved in, too. Now I have to decide how to treat my sick lawn.

Mowing the dandelions and other weeds with a lawn mower is like a complex candida syndrome patient taking nystatin. In both instances, the treatment will appear to help for a while. But the underlying problem is not solved. Such patients, with candida (and probably one or more parasite) colonies deeply-embedded in their mucus gut lining, fail to get well. And nystatin is only "mowing the dandelions". Once the organisms become deeply imbedded in the mucosa - and we can prove that now with the rectal smear I described - we need to go straight to the heavy artillery, and choose the appropriate drug for the specific organism.

MJ Thank you for sharing that analogy with us. It certainly makes it clear why patients may need more than the sugar-free diet to overcome a yeast overgrowth. I think some patients will be saddened, though, to learn that they can't overcome their health problems strictly by natural means - herbs, diet, over-the-counter antifungals from the health food store, and so on.

WL Those things may very well be effective for earlier cases of yeast infection. I have been focusing on advanced and stubborn cases, often of long duration. The two tests I mentioned are for those kinds of patients, too.

MJ I find it encouraging to know a game plan is in place for diagnosing and treating the really sick yeast patients. For input on treatment of stubborn yeast infections from six other environmental physicians MFA readers may refer to Issue #72. But when all else fails, the tests you suggest may literally be the life saver! Thank you, Dr. Levin.