



"The Accordion Reserve®"

Enlightened Medicine™

**Alan R. Vinitzky, M.D.**

DIPLOMATE OF THE AMERICAN BOARD OF INTERNAL MEDICINE  
DIPLOMATE OF THE AMERICAN BOARD OF PEDIATRICS

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WRITTEN TESTIMONY

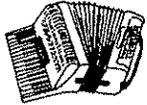
Re: Public Health Committee: H.B. 6200

I am a physician who treats patients who are diagnosed with Lyme Disease and other tick-born "co-infections." These patients are self-referred, referred by their friends and relatives, having been told by "consensus" physicians – referenced by Dr. Gershon, Dr. Baker and Dr. Simms – that they have already been treated for Lyme disease and don't require any further treatment. There are also some physicians who follow the consensus treatment protocols and are rightfully concerned that their patients are still symptomatic. These practitioners and other health care providers also refer their patients to me to enhance the treatment thus far provided. To put my experience in a proper context, I averaged 1-2 new patients daily over most of 2008, most of who present as above.

These patients present with a broad variety of symptoms – some of which are not typically considered as "Lyme" symptoms by the "consensus." From my extensive reading and listening to and learning from those who have studied "chronic Lyme" and other tick-born infections, I have concluded that the "monolithic consensus" is not that. There is a considerable array of opinions.

When offered a variety of diagnostic and treatment options, those who can afford to do so opt out of the insurance restricted monolithic testing of the designated laboratory. The monolithic testing misses diagnoses of Lyme disease and other co-infections. Testing includes parameters of more than just Lyme disease. I emphasize assessment of an individual's ability to repair and heal, which includes metabolic, genetic, hormonal, and immune factors. Most often, I discover that patients show evidence of wasting from chronic illness, and sometimes the tests for "chronic Lyme" and the co-infections are "negative," even when the symptoms are suggestive of those infections. Consequently, their immune systems function as innocent bystanders because they are TOO WEAK to fight back. I call their bodies a "Lyme Hotel." At this stage of their illness I usually choose NOT to treat with antibiotics, because such treatment may become too stressful. [So here it looks like I am agreeing with the consensus – but I AM NOT!] It is only a matter of time – usually 8-12 weeks – with my recommendations that patients can start to mount an attack against the invaders!! They are now "arming the troops" – like the Sergeant at Arms vigorously escorting the offenders – "GET OUT! NOW!" **Much to my surprise, the previously negative or equivocal tests turn POSITIVE!**

That's when I start antibiotic treatment to assist the immune system to do its intended job. This task is a finely tuned art which requires careful listening, coaxing, guiding, adjusting and tinkering to help that special individual get the most from all the treatments – Antibiotics, nutrients, exercise, sleep, nutrition, and energy building. Many other modalities are required to relieve pain, re-educate bodies and minds, and modulate responses of the nervous system and other organ systems. And most importantly, these folks need support from their families, peers, employers, teachers and others, who **MUST BE EDUCATED TO UNDERSTAND THAT THEIR SYMPTOMS ARE REAL, THAT THEY ARE NOT CRAZY, AND THAT THEY CAN BE HELPED.**



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Thus, what is needed is **flexibility** of dosage, duration and combinations of antibiotics administered based on physician judgment. There are many instances when one combination of antibiotics kills some of the "bugs," and another set of symptoms arise. A different organism has now grown into the niche, previously occupied by the last resident bugs. Testing sometimes documents this change. Thus, a change of antibiotics is required. Then, too, the magnitude or burden of the infecting organisms is dependent on the efficiency of the immune system. When the immune system is stronger, lower doses and shorter duration of antibiotics may suffice. However, when there are more organisms in residence, longer and more varied the treatments and combinations are required.

In summary, I strongly endorse Public Health Committee H.B. 6200. Flexibility of treatment is an absolute requirement in the treatment of Lyme disease and other co-infections. Wise physicians who are perceptive and are willing to examine both sides and all areas in between **must be permitted to treat their patients using informed choices without threat of sanction. A monolithic approach to Lyme disease and co-infections will leave our patients chronically ill and saddled with medications and treatments that do nothing for their worsening medical illness.**

Respectfully submitted,

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