APRECIERI ASUPRA METODEI

PAVEL KOZAK

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- Canadian Medical Association Journal;
- Therapeutic Consideration in Epidermolysis Bullosa by Pavel Kozak;
- Epidermolysis Bullosa Assessment of a Treatment Regimen;
- Report to Minister of National Defence on The Status of Vital Klinik, West Germany;
- Anfragen aus dem Leserkreis;
- Remarks by The Honourable Larry Grossman Minister of Health to Hospital for Sick children, Friday,March19,1982;
- Note privind discursul tinut de Domnul Larry Grossman ministrul Sanatatii,Vineri,19 Martie,1982;

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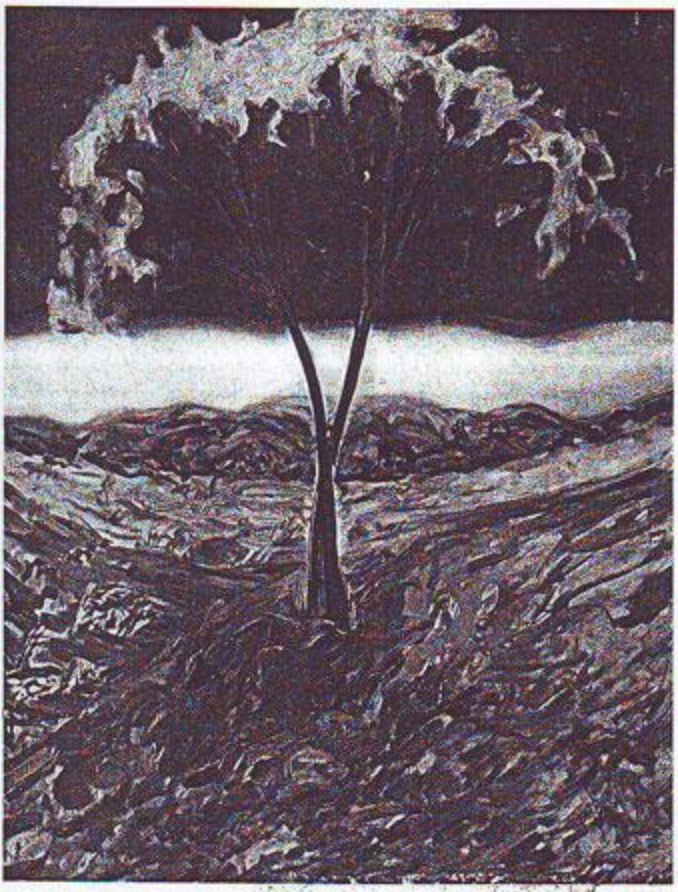

Should boxing be banned?

In Lynne Cohen's article on boxing (*Can Med Assoc J* 1984; 130: 767–768) Dr. William Ghent, chairman of the CMA's council on health care, states that boxing should be banned because its main objective is to injure the opponent. One can quibble and state that the main objective is to get more points than the opponent, not necessarily injure him. Injuring appears to be but one means to an end. In other contact sports, such as football, hockey and wrestling, the purpose is also to win by outscoring the opponent, but no "deliberate" injury is allowed. The problem is in interpreting "deliberate".

In football continually battering an opponent serves several purposes, including intimidation and "undeliberate" injury that may remove the injured player from the game. This enhances the opportunities to outscore the opponent, especially if the injured player has a key position.

In hockey, injuring a key player during a fistfight can have a bearing on the outcome of a game. The intent of such activity is clear: beating up the opponent to win the match.

In amateur freestyle wrestling no blows are actually exchanged, but certain holds and moves are executed with the intent to injure if the opponent does not give up. Here again, the interpretation of "deliberate" is impossible.

The CMA cites studies that have indicated that boxing causes brain damage. It would be interesting to see how much brain damage is suffered by football players of different ages at different levels of competition.

I am not extolling the virtues of boxing. But, while on the surface boxing appears to be the most violent and brutal of sports, other sports, such as football, wrestling and hockey, are just as violent and brutal. The only problem with these sports is trying to determine whether an injury is deliberate, whereas in boxing the intent to injure is explicit.

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CMAJ tries to publish as wide a selection of letters to the editor as possible. We can accept more letters and publish them more promptly if they are short and convenient to edit. We ask that letters be no longer than two typescript pages (450 words) and be typed double-spaced with wide margins, like a manuscript.

Assessment of a treatment for epidermolysis bullosa

The genetic forms of epidermolysis bullosa produce a variety of changes on the skin and mucous membranes. In general, the treatment of most forms of the disease is unsatisfactory. Most patients realize this and do not continue with regular follow-up but try to avoid the factors, such as trauma, that precipitate blisters. Several types of systemic therapy have been used. Oral therapy with phenytoin was reported to have some success in an uncontrolled trial in patients with the recessive dystrophic form of epidermolysis bullosa.[1] In addition, systemic steroid therapy[2] and oral therapy with vitamin E[3] have been recommended, usually on the basis of single case reports.

At the end of 1981, reports emerged of a form of treatment for epidermolysis bullosa developed by Pavel Kozak, a lay person, in West Germany. A number of patients from Canada were treated by Kozak, and some were judged by Canadian dermatologists to have improved. No published information is available on the numbers of patients treated, and the true rate of success of the therapy is unknown.

Kozak informed us of the details of his treatment when he visited Toronto in November 1981. Following this visit accusations were made in the lay press that the medical profession refused to acknowledge the treatment because it had been developed by a nonphysician and because they were jealous of the success of the therapy. It was decided that investigation of the treatment was warranted, and a program supported by a grant from the Ontario Ministry of Health was established at the University of Toronto.

The true effect, if any, of the treatment is unknown. The small number of patients involved and the specific diet led us to conclude that a controlled double-blind trial would be difficult, if not impossible, to conduct. We therefore decided to carry out an open study to determine whether it was possible to improve the skin of patients with epidermolysis bullosa using the Kozak protocol.

Methods and patients

The treatment had three components, as follows:

- Topical agents containing corticosteroids, tetracycline, bismuth subnitrate, salicylic acid, benzoic acid, phosphoric acid, resorcinol and hydroquinone. Camomile tea was used as a wet dressing.
- Vitamins A, E, B_6 and B_1 and nicotinic acid, together with orotic acid and glycine, administered orally.
- A diet.

There was no discernible rationale

for the diet, and it could not be precisely classified. In addition, because of the severe restrictions on the types, quantities and methods of preparation of foods in all four food groups, there was concern about the nutritional quality of the diet, particularly with regard to the content of iron, vitamin B_{12}, calcium and sodium. Because the diet was monotonous the potential for energy deficiency was great. To protect the patients from harm the diet was amended to ensure adequate intake according to age.

Nineteen patients with various types of epidermolysis bullosa were treated, 10 initially in hospital. There were 14 females and 5 males aged from 1.5 to 57 years. Sixteen patients were followed up for at least 3 and as long as 17 months. Two were lost to follow-up after 4 weeks of treatment, and one died. Eight patients received all three components of the therapy, seven received topical and systemic therapy but were unable or unwilling to follow the diet, and one patient received topical therapy alone.

Assessment of the treatment was by daily blister count and, while the patients were in hospital, by measurement of erosions. The skin was assessed as improved or showing no change. Improvement was subdivided into objective (when the number of blisters had decreased) and subjective (when the patient considered that the blisters were smaller, healed faster or were less painful).

Results

In 9 of the 10 patients who were admitted to hospital there was a clear pattern of improvement during their stay in hospital, with a mean decrease of 76% in the number of blisters. In one severely ill child fatal septicemia developed. Longer-term results of treatment were available for 16 patients, 7 of those admitted to hospital and all 9 of those treated as outpatients. Two patients showed continued objective and subjective improvement, eight showed subjective improvement alone, and six failed to improve in the long term.

Comments

Our experience strongly suggests that improvement with this treatment occurred when patients were admitted to hospital, although benefits were also seen in some outpatients. In the long term the treatment had little effect on the formation of new blisters, but accelerated healing of blisters did occur in 50% of our subjects. However, the improvement may simply have been due to the regular intense local treatment that was given. Some patients' improvement continued when they resumed a normal diet, and we are not convinced that the unusual diet that is recommended is essential. However, further studies are required to prove this point.

Unfortunately, there is little published on treatment regimens for epidermolysis bullosa in large numbers of patients with which our results can be compared. We feel that our patients benefited from the intensive inpatient treatment. Therefore, we suggest that patients with epidermolysis bullosa be regularly

followed by a dermatologist and receive intensive treatment of the kind we gave when their blisters are active and widespread, even if this means admission to hospital two or three times a year.

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Safety of intermediate doses of pyridoxine

Citing a report by Schaumburg and colleagues[1] on the development of a sensory neuropathy in patients receiving 2 to 6 g/d of pyridoxine, Dr. D. Crawford (*Can Med Assoc J* 1984; 130: 343) recommends that patients taking pyridoxine be warned to avoid increasing the dose without consulting their physician. However, Schaumburg and colleagues' article leaves the medical profession at a loss concerning the safety of intermediate doses of pyridoxine — that is, those in the range of 250 to 500 mg/d.

Even though Baker and Frank[2] reported no untoward effects in six patients receiving 225 mg/d of pyridoxine, Schaumburg[3] responded that, to his knowledge, "there has been no study using systematic quantitative sensory testing of large numbers of people undergoing long-term pyridoxine administration in the 200-to-500-mg range".

Pyridoxine in doses of 250 to 500 mg/d has been found to be effective in patients who have kidney stones secondary to hyperoxaluria.[4] We have followed 22 patients with kidney stones who were treated with intermediate doses of pyridoxine for 8 months to 6 years (average 2.3 years). None has shown any neurologic complication. Furthermore, we performed nerve conduction studies in seven of them (all men, ranging in age from 47 to 60 [average 43.4] years), who were treated with 250 to 500 mg/d of pyridoxine for 1 to 6 (average 2.8) years. The results, shown in Table I, were all within the normal range.

Our findings suggest that the administration of pyridoxine in doses of 250 to 500 mg/d for long periods (up to 6 years) is safe, and we have decided to continue this treatment in our patients.

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Table I—Results of nerve conduction studies performed in seven patients treated with pyridoxine, 250 to 500 mg/d for an average of 2.8 years

Measure and nerve	Mean ± standard deviation	
	Patients	Controls
Motor conduction velocity (m/s)		
Median	58.3 ± 3.2	57.3 ± 4.1
Ulnar	56.1 ± 2.6	60.2 ± 5.3
Peroneal	49.1 ± 2.5	49.0 ± 4.1
Distal motor latency (mm/s)		
Median	3.7 ± 0.3	3.2 ± 0.4
Ulnar	2.7 ± 0.2	2.6 ± 0.3
Peroneal	4.2 ± 0.5	4.2 ± 0.7
Distal sensory latency (mm/s)		
Median	3.1 ± 0.3	2.9 ± 0.4
Ulnar	2.8 ± 0.2	2.5 ± 0.3

Commercial malpractice insurance

I read with interest Dr. C.A. Johnson's letter on commercial malpractice insurance (*Can Med Assoc J* 1984; 130: 672). I agree completely with his sentiments.

However, Dr. Johnson suggests that insurance companies are the cause of the problems with commercial malpractice insurance in the United States. The insurance companies are only a symptom. The problems are actually due to an overabundance of lawyers; the jury system, which not only judges the facts of a case but also sets the damages; no limitation on the amount of damages due to pain and suffering; continuance fees (a percentage of the gross) for lawyers; and patients' attitudes towards physicians.

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Teaching medical students about alcoholism

We read with interest Milan Korcok's article entitled "How can we teach students about alcoholism?" (*Can Med Assoc J* 1984; 130: 305–308). We have no quarrel with his general thesis concerning the importance of integrating meaningful information and practical experience in the area of alcoholism and drug dependence into undergraduate medical curricula. We are, however, dismayed by Korcok's apparent lack of knowledge concerning the training in alcoholism and drug depen-

REPORT TO MINISTER OF NATIONAL DEFENCE ON THE STATUTUS OF VITAL- KLINIK WEST GERMANY

REPORT TO MINISTER OF NATIONAL DEFENCE

ON

THE STATUS OF VITAL-KLINIK, WEST GERMANY

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The enclosed report is a compilation of factual data obtained during my visit to the Vital-Klinik and a synopsis of my impressions gained both during and after the interviews.

On 29 October 1981 I had the opportunity to visit the Vital-Klinik and there spoke with the Administrator, Mr Gabriel Leonte, his wife, the Deputy Administrator, the two physicians involved with the clinic and Mr Kozak, the biochemist. All members fled their homeland, Rumania, from two to twelve years prior to establishing the clinic. The chief physician arrived in Germany seven years ago and the chemist, Mr Kozak, arrived two years ago. As they did not formally emigrate, all of their research, papers and medical documents were left behind. All of the amassed experience, therefore lies in their heads and has neither been formalized or journalized. The only historical data that exists are slides of patients treated in Rumania showing evidence of remarkable resolution of disease.

Probably because of the paucity of written data, casual interviews have, to date, been less then complimentary regarding the clinic. Charges of deviousness, protectionism, and suggestions of less than honourable practice have been made by journalists seeking simple solutions to very severe and complex diseases. I, too, had those same feelings until, through patient discussion with the physicians

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and with the assistance of the administrator, I understood perhaps the problems in information dissemination with which they contend.

All discussions were in Rumanian and German and I was aided excellently by Mrs Inge Power, the CPHE translator, without whose expert assistance none of this report would be possible.

II. THE FACILITY

1. Location and Structure

The Vital-Klinik is located east of Frankfurt, West Germany, near the town of Alzenau. The formal address is Streuweg 100, 8755 Alzenau-Michelbach. Telephone Number is 06023/1001. From Frankfurt it is approximately 20-30 minutes by car. From Lahr the total driving time is 2½-3 hours.

The clinic appears to be a converted Gasthaus, visible from the main road and divided into three main areas:

a. The "hotel" portion is the main patient area, with the administrative offices and out-patient department on the main floor and the bedrooms and treatment areas above.

b. The kitchen and "restaurant" portion is similar to many German Gasthofs and provides room for both patients and families to eat. Attached to this is a patient recreational area.

c. The "tavern" portion has been converted to a meeting or conference room for guests.

The structure is sound, functional, but not extravagant and shows evidence of good repair and maintenance. There is a large parking lot in front of the building, capable of holding thirty to forty automobiles.

2. Staff

There are, at present, thirty-three full-time staff in the clinic consisting of the following:

Administrative staff	-	2
Physicians	-	2
Nurses - RN or equivalent	-	4
Nursing Assistants	-	13
Cleaning, Maintenance, Secretarial and Kitchen staff	-	12

Negotiations are underway to employ two further full-time physicians. The chief physician, Dr Radovicci, is a graduate of medical school in Rumania (1950) and prior to her departure from that country in 1974 was chief of pathology at one of the large central hospitals there. She has always possessed an interest in dermatology and was involved in the

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treatment programmes with Dr Kozak prior to her departure. Following her arrival in West Germany, she worked as a general duty physician in a private hospital until 1980, when she began her own practice. I know little of the second physician who arrived in Germany two years ago coincident with Mr Kozak, who is a Rumanian biochemist. Mr Kozak was apparently involved directly with the empirical research regarding therapy of severe skin disease in Rumania and the available case examples were former patients of Mr Kozak.

Both physicians are in their late fifties or early sixties and Mr Kozak is about ten years younger as are the Administrator and his wife.

III. THE OPERATION

1. Concepts of Pathophysiology

With respect to pathophysiology, the clinic holds the view that there is a genetic predisposition in patients with dermatitides to acquire the disease and that affected patients are subjected to a variety of outside influences that cumulatively and collectively initiate the disease. Subsequently a wider number of influences can sustain the condition.

However, they have absolutely no research data with respect to pathophysiology that they can produce as all papers were left behind in Rumania. On close

questioning it would appear that little "scientific" method has gone into their current practice of dermatology; instead, they rely on a vast experience of multitudinous empirical trials and as stated by Dr Radovicci, "All our knowledge is in our heads".

Perhaps due in part to their senior years but also perhaps due to their methods of medical training, the physicians are apparently unaware of double-blind crossover methods of investigation and appear not to be well versed in objective methods of disease-state or severity classification. As a result, they are, at present, unable to describe lesion types, degrees of severity, temporal relationships in healing phases, etc in terms of objective criteria. Without this objective assessment and classification of the myriad lesions they see, they cannot discuss their rationale in the application of specific, repeatable and, therefore, transferrable modes of therapy to each lesion type. In my discussions with the clinic physicians, I fully realize that within their minds they constantly make these assessments before choosing a mode of therapy but, unfortunately, are unable to communicate their judgements in a manner useful to others who do not learn their methods through months or years of assimilation.

Therefore the remainder of this section discusses treatment options and methods in general terms only and specific therapeutic measures are not mentioned.

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2. Treatment Methods and Options

Repeatedly throughout our discussions, the physicians stressed that the total treatment programme was highly individualised and specific for each patient. Generally however, a three-pronged approach is taken with each patient, the course of initial therapy lasting one year. The main areas of therapy are topical, internal and dietary. As they have come from a country much different in climate, industrialization and dietary habits to that of the patients they treat, they freely admit ignorance of many geographical factors responsible for precipitating or sustaining their patients' ills. However, patients, especially adults, often bring with them lists of substances which cause problems. In spite of this lack of knowledge, however, good results are achieved.

At the onset, the clinic physicians stressed that, in their opinion, the main reason for failure of traditional Western methods was due to preoccupation with the skin as an isolated entity, treated mainly by topical therapy and, when frustration was coupled with failure of topical treatment, by irrational use of steroids.

Dietary therapy is rigid and resembles current methods of elimination diets. All patients receive dietary therapy but each diet is individually designed.

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All processed foods and foods with additives, preservatives and dyes are eliminated. The initial diet is highly vegetarian although potatoes are initially withheld. Gradually, one food substance is added at a time, initially in its blandest form (eg boiled) in small amounts and if no relapse or aggravation occurs then the substance is incorporated into this diet. By the end of one year the patient is taking a nearly full diet, eating even those foods to which he claimed "allergy", albeit in moderation. Simple vitamin supplementation may be included but never in mega-doses.

"Internal" therapy consists of a number of substances, all available in local pharmacies but combined by prescription from Mr Kozak and his team-mates. On almost no occasion is "cortisol" used either internally or externally. The clinic physicians claim that the internal use of steroids negates all other aspects of therapy and makes disease resolution remote. Remembering that the patients seen at the clinic are severely afflicted and "refractory to therapy" by the usually accepted treatment modalities, the non-use of steroids is a radical departure from currently promulgated teachings in these cases.

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However, I found it difficult to precisely determine what compounds and substances were actually used. This, for me, was somewhat frustrating but my lack of success may have been due to the length of the interview recalling that each question was asked in English, translated to German and then Rumanian, discussed in Rumanian, discussed in German and, finally, distilled to me in English.

Nevertheless, there is almost no use of analgesics and certainly no use of narcotics in therapy. Sedatives are rarely prescribed and, if so, are usually mild bromine compounds. No heavily advertised hypnotics or tranquilizers are used. Antihistamines may be used but in doses much less than seen in standard medical practice.

Topical therapy as practiced in the clinic is radically different from practice in North America. Intensive nursing care is provided to each patient during the acute phase with total treatments being repeated as often as every three hours. The intensity of nursing care is much akin to that seen by modern burn wards in North America. Moreover, at any one time many different topical therapies are initiated depending on body site, degree of acuteness, etc. As an example, lesions on the face might be treated with lotions to the chin, creams to the cheeks, ointments to the forehead with different active ingredients in each. Such an approach to therapy is virtually impossible to

describe in a manner suitable for transferance of medical knowledge without the development of objective measures of lesion type, site and severity.

The topical agents rarely contain steroids and, if they do, are in strengths which are fractional compared to Western methods. Active ingredients include resorcinal, zinc oxide, bismuth compounds and white petrolatum although not all substances are used with all patients or in every formulation.

Treatment methods, therefore, are directed to "the whole patient" rather than just to "the skin". Diet, medication and intensive topical therapy are blended into a rigid treatment programme, unique to each patient.

3. Treatment costs

Out-patients are seen weekly. In-patients are usually placed in hospital from two weeks to three months. Current costs are DM 225 per day plus medications. This can rise as high as DM 600-700 per day in very severe cases but full accounting records are maintained and accounts are itemized. As noted above, the clinic is approved for coverage through medical health plans.

4. Relapse and Recurrence

When asked about frequency of recurrence of illness and the incidence of total relapse, no

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factual data was available for reasons stated above and as the clinic has only been operational since August 1981 insufficient caseload has been accumulated to develop meaningful statistics. Anecdotally, Dr Radovicci suggested that she was unaware of any total relapse in patients who maintained all aspects of therapy and that recurrences, if any, were usually mild and readily controlled, those too being attributed to failure to maintain therapy in all respects.

IV. IMPRESSIONS AND CONCLUSIONS

The Vital-Klinik has been open since August 1981 for the treatment of severe dermatologic disease. Almost all claims of success have been with patients treated in Rumania with no hard factual evidence of cure other than one set of slides showing "before and after" photographs of patients with severe disease. The slides however are remarkable as they not only deal with patients who have extremely severe disease but also deal with diseases such as scleroderma and lupus erythematosus which, according to Western medicine, have no cure. In all cases shown there has been extensive or complete healing. However, no evidence is available on overall success or cure rate.

Notwithstanding the current lack of substantive evidence for a successful treatment method of a wide variety of skin diseases, cases treated at the clinic

have apparently remarkable resolution of disease. No final judgement on credibility of the treatment programme can be made until such time as the patient load and time span have allowed meaningful statistics to be compiled. I did not meet any reluctance on the part of the administrative or medical staff of the clinic to discuss patient care nor was there any obvious attempt to "hide" anything. My major criticism is the lack of objective tabulated criteria on the basis of which treatment methods are implemented. To date the criteria remain within the heads of only a few individuals.

With respect to treatment specifics, I can likewise make no final judgement. A biochemical basis for therapy appears to play a distant second to the vast accumulated evidence of empirical trials done in Rumania. The actual "active substances" have not been fully identified and the role of each mode of therapy, diet, medication and topical has not been isolated for study as to its necessity.

Whenever an extremely rigid therapeutic regime is initiated, it is always tempting to invoke failure of compliance as the cause of disease recurrence. Until such time as each mode of therapy has proved its worth it is not strictly valid to attribute the return of illness with improper compliance.

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Finally, and perhaps most importantly, one must take cognizance of the value of empirical treatment. For years Foxglove tea was used to treat heart failure. It would have been absurd to deny patients the benefits of the tea just because the active cardiac glycosides had not been isolated. In the treatment of the skin, claims of therapeutic success are supported by highly visible markers. Therefore, success where all else has failed augers highly for extreme interest in the proffered therapy. The cases handled by the clinic have been largely given up as "impossible" by the traditional medical community. The clinic's methods must be seriously regarded as its patients are claiming spectacular results. Unlike fly-by-night cancer clinics, the signs of success are highly visible.

V. RECOMMENDATIONS

1. This clinic should be considered by Canadian patients whose skin disease is so severe that meaningful quality of life is affected and who have failed in therapy despite the best efforts shown by Canadian physicians. No similar clinic exists in Canada.

2. As no similar unit exists in Canada, the Federal Government should negotiate with provincial health bodies regarding coverage of patients by their respective Health Plans when such patients are properly referred through normal medical channels.

3. Consideration should be given by a recognized school of dermatology to send a resident to the clinic for a year with the purpose of learning treatment methods and perhaps developing a tabulated treatment profile for implementation in Canada.

ANFRAGEN AUS DEM LESERKREIS

Dt. Dem. 29., Heft 10
Okt. 81 (1981)

Anfragen aus dem Leserkreis

Dr. P.H. in W.

Frage

Gibt es eine Möglichkeit, in Erfahrung zu bringen, unter welchen Bedingungen dieser Dr. P. Kotzak bei uns seine ärztliche Tätigkeit ausübt? Ich könnte mir vorstellen, daß der beigelegte Artikel in der NEUEN REVUE eine erhebliche Verunsicherung unserer Patienten verursachen dürfte.

Antwort

Informationen zur „Revita-Klinik"

Im Sommer 1980 etablierte sich in Homburg/Saar eine „Revita-Klinik für biologische Medizin, Spezialklinik für Hautkrankheiten" (in ihren Briefbögen auch als „Praxis und Diagnose Klinik für Hautkrankheiten" firmierend), die über Annoncen und durch teilweise reisserisch aufgemachte Artikel in diversen Illustrierten sich zur Behandlung von Hautkrankheiten anbot bzw. angepriesen wurde. Insbesondere sollten schulmedizinisch unheilbare chronische Dermatosen dort mit Erfolg behandelt werden können. Seit Anfang Mai diesen Jahres ist die „Revita Klinik" geschlossen. Ob vorläufig, mit der Absicht des Ortswechsels oder aus welchen Gründen, wissen wir nicht.

Durch die zufällige Nachbarschaft bedingte Anfragen zahlreicher Patienten und Kollegen veranlaßten uns, Informationen über die Praktiken der Einrichtung zu sammeln, die helfen sollen, auf entsprechende Fragen von Patienten Auskunft geben zu können. Die Fakten mögen für sich sprechen:

1) Die Behandelnden: An der „Klinik" übten der rumänische Emigrant Herr Pavel Kozak und die rumänische Ärztin Dr. med. Lucia D. Radovici die Heilkunde aus, zumindest zeitweilig auch ein Heilpraktiker Lenzen. Herr

Kozak, der Entdecker der angepriesenen Heilmethode, war bis zu seiner Emigration im Mai 1980 an einer Hautklinik in Rumänien als „wissenschaftlicher Hauptforscher 1. Grades" tätig. Er ist nicht Arzt und nach deutschem Recht kein Heilpraktiker. Frau Dr. Radovici ist hingegen im Besitz einer gültigen deutschen Approbation.

2) Die Werbung: Die aus dem Gebiet der ganzen Bundesrepublik (und darüber hinaus) anreisenden Patienten wurden in der Mehrzahl wohl angelockt durch Presseveröffentlichungen, denen Schlagzeilen wie „weltberühmter Experte arbeitet jetzt in Deutschland. Kinder mit unheilbarer Krankheit nach 4 Wochen gesund" (Neue Revue) oder „der rumänische Arzt Dr. Pavel Kozak hat eine aufsehenerregende Therapie entwickelt" (Goldenes Blatt) vorangestellt waren. Diese Schlagzeilen mögen von den Betreibern der Klinik nicht zu verantworten sein. Es wurden aber auch in den Zuschriften an die Patienten Versprechungen gemacht, die ein gewissenhafter Arzt nicht verantworten würde. So findet sich im Schreiben an einen Hamburger Patienten mit Schuppenflechte (Schreiben vom 5.1.1981) der Satz „Wenn unsere Behandlung beendet ist, sind sie von der Schuppenflechte geheilt" und zu einer Anfrage über Behandlungsmöglichkeiten bei Erythrodermie ichthyosiforme congenitale bullause die Aussage „Die Erkrankung kann bei uns mit Erfolg behandelt werden" (Schreiben vom 25.11.1980). Im Gespräch mit Patienten wurden allerdings Erfolgsgarantien in der Regel eingeschränkt, indem darauf hingewiesen wurde, daß ja niemand kontrollieren könne, ob die Diät, auf der die Behandlung beruhe, vom Patienten auch tatsächlich eingehalten werde.

3) Die Therapiemethoden: Nach eigener Auskunft der „Revita-Klinik" handelt es sich bei der dort durchgeführten Therapie um eine „komplexe Behandlung mit 3 Hauptkomponenten: 1. interne Behandlung, bestehend aus Aktivsubstanzen, Medizinaltees und Pflanzenextrakten, 2. äußerliche Behandlung aus Salben und Lotionen nach eigener Originalmethode, 3. Naturdiät. Grundlage der Behandlung ist eine teuere und sehr schwierig einzuhaltende Diät. So sind an Fleisch nur Huhn, Putenbrust und mageres Rindfleisch erlaubt, nach besonderen Zubereitungsvorschriften mit Wechsel des Kochwassers abzukochen. Rindfleisch, Geflügel und Fisch dürfen nur von frisch geschlachteten Tieren stammen (längstens 4 Tage nach der Schlachtung, Fisch sollte lebendig gekauft und selbst geschlachtet werden). Die Patienten erhalten einen umfangreichen Diätplan und absolutes Verbot, andere als die erlaubten Speisen für die Dauer der Behandlung zu essen, was aber nach Aussagen von Patienten, die sich in unsere Behandlung begeben haben, fast unmöglich ist.

Bei den zur innerlichen Behandlung verordneten Medikamenten („Aktivsubstanzen"), die in vom Apotheker zubereitenden Oblatenkapseln verabfolgt wurden, handelt es sich – von Fall zu Fall etwas abweichend – um verschiedene Vitamine, Methionin, Glykokol, so gut wie regelmäßig mit Beimischung von Atosil. Die äußerliche Behandlung („nach eigener Originalmethode") erfolgte mit alkoholischen Lösungen mit Zusatz von Resorcin, Hydrochinon, Salicylsäure, Benzoesäure sowie Phosphorsäure und mit Salbenmischungen, die in der Regel hochpotente Kortikosteroide enthielten (z.B. Volonimat Creme 50,0, Ultralan Creme 20,0 und Neribas Creme 20,0 gemischt oder rolonimat Salbe 20,0, Ultralan Salbe 20,0, Eucerin anhydricum 20,0 gemischt – weitere Rezepturen liegen hier vor). Dabei wurde ganz offensichtlich versucht, die Patienten darüber im Unklaren zu lassen, daß eine äußerliche Behandlung mit Koritkosteroiden erfolgte.

4) Das Geschäftsgebaren: Genauere Angaben

Anschriftenänderungen

REMARKS BY THE HONOURABLE LARRY GROSSMAN

MINISTER OF HEALTH TO HOSPITAL FOR SICK

CHILDREN, FRIDAY 19,MARCH,1982

Ontario

REMARKS BY

THE HONOURABLE LARRY GROSSMAN

MINISTER OF HEALTH

TO

HOSPITAL FOR SICK CHILDREN

FRIDAY, MARCH 19, 1982

CHECK AGAINST DELIVERY

Ladies and gentlemen: I am certain you are familiar with the work of Pavel Kozak, the biologist who has become the focus of some public attention because of his pioneering work in the treatment of the chronic skin disease Epidermolysis Bullosa. This disease has been one of the cruelest skin disorders: it can cause death and it does cause severe blistering and fragility of the skin dooming the sufferer to years of pain and isolation.

I am very pleased to be able to announce today that Ontario is about to become a key centre for research and treatment into chronic skin diseases and into the apparently successful treatment methods developed by Mr. Kozak.

The Ministry of Health of Ontario is awarding a new research grant of $900,000 to the University of Toronto so the university may establish an intensive research effort.

This new research program will be under the direction of Dr. Colin Ramsay who is head of Dermatology at Toronto General Hospital and Professor of Dermatology at the University of Toronto.

Dr. Ramsay will be getting in touch with Pavel Kozak immediately to tell him of the award and ask him to come to Toronto. We will be relying heavily on Mr. Kozak's findings and his expertise. His work has stimulated interest and concern throughout the health care community and this research effort is certainly a result of this focus.

It is our hope that this major grant will open a new era of medical inquiry into skin disorders. To the treatment procedures being applied at Mr. Kozak's clinic in West Germany, this research project will add studies into a variety of skin conditions.

Fifteen per cent of the patients who present themselves to their family physicians do so because they have a skin disorder. But of all patients seeing their family doctors for any complaint, close to one-third are found to have serious skin problems. Yet only limited research on skin diseases has been carried out in Canada and throughout the world.

By encouraging this emphasis into university-based research, the government believes that, within a few years, the province's pioneering efforts may lead the way toward improving the treatment or even discovering cures for those afflicted.

Patient care with backup from laboratory research will be the focus of this program as it has been with Mr. Kozak's program in West Germany.

I am sure we all have felt the impact of this kind of project through the successes of the Kozak clinic in working with actual patients. I might point out that treatment such as the Kozak procedures will be covered by Ontario's Health Insurance Plan if it is carried out at home by physicians. There would no longer be a need for Canadians to go outside the country.

I am gratified to find several Ontario institutions participating in a venture which should result in both immediate and long term benefits for clinical care and training.

The Toronto General Hospital, the Hospital for Sick Children, and Women's College Hospital have all agreed to make their facilities available for this research project.

Medical residents who are specializing in dermatology at McMaster University, the University of Western Ontario and U of T will also participate through the collaborative training program that now exists among them.

The actual research project will include several areas of study. The first will be an inquiry of treatment programs for a group of genetically-determined diseases known as epidermolysis bullosa: as I mentioned this is the disease on which Mr. Kozak has concentrated.

You will remember that Mr. Kozak met with a team of doctors in Toronto last Autumn and agreed to participate in a study of his methods with treatment of this ailment.

But the project will go quite a bit farther. Studies will be conducted into abnormal reactions to ultraviolet radiation and even ordinary daylight. Another area to be studied is clinical pharmacology or the study of drugs as they relate to the treatment of skin disease...

My Ministry is indebted to those who have worked so hard to bring this proposal to fruition.

I would like to thank, particularly, Dr. Gerrard Burrow, Chairman of the Department of Medicine at the University of Toronto, Dr. Lionel Boxall, Head of Dermatology at the Hospital for Sick Children and Dr. Ricky Schachter, Chief of Dermatology at Women's College Hospital.

Of course, I would like to express our deep gratitude to Mr. Pavel Kozak for bringing to the attention of the health care community the need for such research into skin disorders. He has turned on the light, so to speak: it is up to us to explore as well as we can the many areas which that light has illuminated.

I would ask Dr. Ramsay if he would join me now so that I can present the government's award to him for this new research venture which should make Ontario and our health care community a key centre in finding ways to bring blessed relief for all of those suffering from these dread skin diseases.

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NOTE PRIVIND DISCURSUL TINUT DE DOMNUL LARRY GROSSMAN

MINISTRUL SANATATII, VINERI ,19MARTIE ,1982

NOTE PRIVIND
DISCURSUL ŢINUT DE

DOMNUL LARRY GROSSMAN
MINISTRUL SĂNĂTĂŢII

SPITALUL DE COPII - TORONTO

VINERI, 19 MARTIE, 1982

DOAMNELOR ŞI DOMNILOR: SÎNT CONVINS CĂ SÎNTEŢI FAMILIARIZAŢI CU LUCRĂRILE DOMNULUI PAVEL KOZAK, BIOLOGUL CARE SE AFLĂ ÎN CENTRUL ATENŢIEI PUBLICE DATORITĂ ACTIVITĂŢII SALE DE PIONERAT IN DOMENIUL TRATAMENTULUI MALADIEI CRONICE DE PIELE EPIDERMOLYSIS BULLOSA. ACEASTĂ MALADIE ESTE UNA DIN CELE MAI GRAVE AFECŢIUNI ALE PIELII, PRODUCÎND O DESCUAMARE FOARTE ACCENTUATĂ ŞI O AVANSATĂ FRAGILITATE A PIELII, CONDAMNÎND BOLNAVUL LA O LUNGĂ SUFERINŢĂ ŞI IZOLARE ŞI POATE CAUZA MOARTEA.

AM PLĂCEREA SĂ FIU ÎN SITUAŢIA DE A ANUNŢA AZI CĂ ONTARIO ESTE PE CALE SĂ DEVINĂ CENTRUL CHEIE DE CERCETARE ŞI TRATAMENT AL MALADIEI CRONICE DE PIELE, PRECUM ŞI DE APLICARE A REUŞITELOR METODE DE TRATAMENT DESCOPERITE DE DL. KOZAK.

MINISTERUL SĂNĂTAŢII DIN ONTARIO A DECERNAT UNIVERSITĂŢII DIN TORONTO, O NOUĂ SUBVENŢIE PENTRU CERCETĂRI ÎN VALOARE DE 900.000 DOLARI, ASTFEL CA UNIVERSITATEA SĂ POATĂ PORNI LA UN INTENS EFORT DE CERCETĂRI.

ACEST NOU PROGRAM DE CERCETĂRI VA FI SUB DIRECŢIA DOMNULUI DR. COLIN RAMSAY, CARE ESTE ŞEFUL SECŢIEI DE DERMATOLOGIE A SPITALULUI GENERAL DIN TORONTO ŞI PROFESOR DE DERMATOLOGIE LA UNIVERSITATEA DIN TORONTO.

DOCTORUL RAMSAY VA LUA IMEDIAT LEGĂTURA CU DL.PAVEL KOZAK PENTRU A-I COMUNICA DESPRE ACEASTĂ SUBVENŢIE ŞI PENTRU A-L INVITA SĂ VINĂ LA TORONTO. NOI NE VOM BAZA MULT PE DESCOPERIRILE ŞI COMPETENŢA DOMNULUI KOZAK. LUCRĂRILE DOMNIEI SALE AU STIMULAT UN INTERES CRESCÎND ÎN RÎNDURILE SPECIALIŞTILOR ŞI ACEST PROGRAM DE CERCETĂRI ESTE NEINDOIOS REZULTATUL ACESTEI CONCENTRĂRI DE INTERES.

SPERĂM CU TOŢII CĂ ACEASTĂ IMPORTANTĂ SUBVENŢIE VA DESCHIDE O NOUA ERĂ ÎN DOMENIUL CERCETĂRII AFECŢIUNILOR DE PIELE. ACEST PROGRAM DE CERCETĂRI VA ADĂUGA LA PROCEDEELE CARE SÎNT APLICATE ÎN CLINICA DOMNULUI KOZAK DIN GERMANIA DE WEST, STUDIEREA UNOR VARIATE MALADII DE PIELE.

UN PROCENT DE 15% DIN PACIENŢII CE CONSULTĂ DOCTORUL DE FAMILIE AU DREPT MOTIV O AFECŢIUNE DE PIELE. DAR APROAPE O TREIME DINTRE PACIENŢII CE SE PREZINTĂ PENTRU CONSULTAŢII LA DOCTORUL DE FAMILIE PENTRU INDEFERENT CE AFECŢIUNI, SÎNT DESCOPERIŢI CĂ SUFERĂ DE BOLI SERIOASE DE PIELE. CU TOATE ACESTEA, CERCETĂRILE ÎN DOMENIUL DERMATOLOGIEI, ATÎT ÎN CANADA CÎT ŞI LUMEA INTREAGĂ, SÎNT LIMITATE.

INCURAJÎND ACESTE CERCETĂRI ŞTIINŢIFICE DE SUB EGIDA UNIVERSITARĂ, GUVERNUL ESTE CONVINS CĂ DUPĂ CÎŢIVA ANI, EFORTUL DE PIONERAT AL PROVINCIEI VA DUCE LA ÎMBUNĂTĂŢIREA TRATAMENTULUI SAU CHIAR LA DESCOPERIREA UNOR CURE PENTRU CEI CE SUFERĂ DE ACESTE AFECŢIUNI.

CENTRUL DE ATENŢIE AL ACESTUI PROGRAM VA FI TRATAMENTUL PACIENŢILOR ÎN PARALEL CU CERCETĂRI DE LABORATOR, AŞA CUM SE DESFĂŞOARĂ PROGRAMUL DOMNULUI KOZAK ÎN GERMANIA DE WEST.

AM FERMA CONVINGERE CĂ FIECARE DINTRE NOI REALIZEAZĂ IMPORTANŢA UNUI ASEMENEA PROGRAM DATORITĂ SUCCESELOR CLINICII DOMNULUI KOZAK ÎN TRATAREA PACIENŢILOR. AŞ DORI SĂ SUBLINIEZ CĂ TRATAMENTUL APLICÎND PROCEDEELE KOZAK, VA FI ACOPERIT DE PLANUL DE ASIGURARE A SĂNĂTĂŢII DIN ONTARIO, CU CONDIŢIA DE A FI APLICAT AICI DE CĂTRE MEDICII NOŞTRII. NU VA MAI FI NECESAR PENTRU CANADIENI SĂ PLECE ÎN STRĂINATATE PENTRU TRATAMENT.

MĂ BUCURĂ FAPTUL CĂ MAI MULTE INSTITUŢII DIN ONTARIO PARTICIPĂ LA ACEASTĂ ACŢIUNE CURAJOASĂ CARE VA DA NEINDOIOS REZULTATE ATÎT IMEDIATE CÎT ŞI PE TERMEN LUNG, DE CARE VOR BENEFICIA ÎN EGALĂ MASURĂ INGRIJIREA MEDICALĂ ŞI STUDIUL TEORETIC.

SPITALUL GENERAL, SPITALUL DE COPII ŞI SPITALUL COLEGIAL AL FEMEILOR DIN TORONTO AU CĂZUT DE ACORD PENTRU A OFERI TOATE CONDIŢIILE ŞI PERSONALUL NECESAR ACESTUI PROIECT DE CERCETĂRI.

MEDICII REZIDENŢI CARE SE SPECIALIZEAZĂ ÎN DERMATOLOGIE LA UNIVERSITATEA McMASTER, UNIVERSITATEA WESTERN ONTARIO ŞI U OF T, VOR PARTICIPA DE ASEMENEA ÎN CADRUL PROGRAMULUI DE COLABORARE ŞTIINŢIFICĂ CE EXISTĂ ÎN PREZENT ÎNTRE ACESTE ACESTE INSTITUŢII.

PROIECTUL ACTUAL DE CERCETĂRI VA INCLUDE CITEVA DOMENII DE CERCETARE. PRIMUL VA FI O CERCETARE A PROGRAMELOR DE TRATAMENT AL UNUI GRUP DE MALADII DETERMINATE GENETIC, CUNOSCUTE SUB DENUMIREA DE EPIDERMOLYSIS BULLOSA. AŞA CUM AM MENŢIONAT, ACEASTA ESTE MALADIA ASUPRA CĂREIA SE CONCENTREAZĂ EPORTURILE DOMNULUI KOZAK.

DEASEMENEA, VĂ AMINTIŢI CĂ DOMNUL KOZAK S-A ÎNTÎLNIT TOAMNA TRECUTĂ CU UN GRUP DE DOCTORI ÎN TORONTO, ŞI A ACCEPTAT SĂ PARTICIPE LA UN STUDIU AL METODELOR SALE DE TRATARE ALE ACESTEI MALADII.

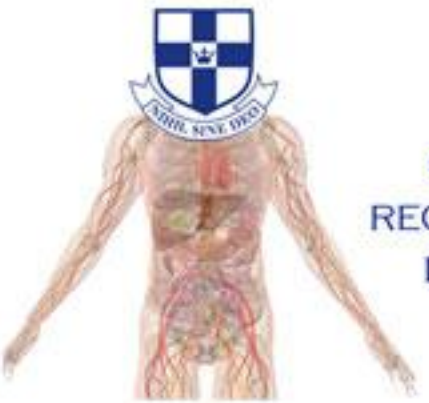
DAR PROIECTUL NOSTRU VA MERGE CEVA MAI DEPARTE. CERCETĂRILE VOR FI CONDUSE ÎN DOMENIUL REACŢIILOR ANORMALE LA RADIAŢII ULTRA VIOLETE SAU CHIAR LA OBIŞNUITA LUMINĂ DE ZI. UN ALT DOMENIU DE CERCETARE ESTE FARMACOLOGIA CLINICĂ SAU STUDIEREA MEDICAMENTELOR ŞI A INFLUENŢII ACESTORA ASUPRA TRATAMENTULUI MALADIILOR DE PIELE.

MINISTERUL MEU ESTE ÎNDATORAT CELOR CARE AU MUNCIT ATÎT DE GREU LA TRADUCEREA ÎN VIAŢĂ A ACESTEI PROPUNERI.

AŞ DORI SĂ MULŢUMESC ÎN MOD DEOSEBIT DOCTORULUI GERRARD BURROW, ŞEFUL DEPARTAMENTULUI DE MEDICINĂ AL UNIVERSITĂŢII DIN TORONTO, DOCTORULUI LIONEL BOXALL, ŞEFUL SECŢIEI DE DERMATOLOGIE A SPITALULUI DE COPII ŞI DOCTORULUI RICKY SHACHTER, ŞEFUL SECŢIEI DE DERMATOLOGIE A SPITALULUI COLEGIAL AL FEMEILOR .

DESIGUR, AŞ DORI SĂ EXPRIM RECUNOŞTIINŢA NOASTRĂ PROFUNDĂ DOMNULUI PAVEL KOZAK PENTRU ADUCEREA LA ATENŢIA COMUNITĂŢII MEDICALE A NECESITĂŢII UNOR ASEMENEA CERCETĂRI ÎN DOMENIUL BOLILOR DE PIELE. EL A APRINS LUMINA, DACĂ POT SĂ MĂ EXPRIM ASTFEL, ACUM NOUĂ NE REVINE MISIUNEA DE A EXPLORA CÎT PUTEM MAI BINE DOMENIILE PE CARE ACEASTĂ LUMINA LE-A CONTURAT.

AŞ DORI ACUM SĂ-L ROG PE DOCTORUL RAMSAY SĂ SE APROPIE PENTRU A-I ÎNMÎNA DECIZIA DE SUBVENŢIE A GUVERNULUI PENTRU ACESTE CERCETĂRI ÎNDRĂZNEŢE, CARE VOR FACE CA ONTARIO ŞI COMUNITATEA NOASTRA MEDICALĂ SĂ DEVINĂ UN PUNCT CHEIE ÎN GĂSIREA UNOR CĂI NOI DE A ADUCE UŞURARE BINECUVINTATĂ TUTUROR CELOR CE SUFERĂ DE ACESTE ÎNSPĂIMÎNTĂTOARE MALADII DE PIELE.



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