Andy protocol vs. DAN! protocol, does the difference matter?

Subject: Andy protocol vs. DAN! protocol, does the difference matter?
From: "andrewhallcutler" <AndyCutler>
Date: Sun, 21 Jul 2002 22:45:45 -0000
Yahoo! Message Number: 53055
Onibasu Link: http://onibasu.com/archives/am/53055.html

I'm going to answer this and in it, also answer the post of about a week ago to explain why the DAN! and "Andy" protocols are so different in their use of chelators and sulfury things (though they are quite similar in most other areas).

Please note from the post below, and many prior posts by others, it is not proper to say there IS a "DAN! chelation protocol" since it seems to be a point of pride that every single DAN! doctor just HAS to do something different with the chelating agents to put his mark on the protocol. This is not at all the same as the "Andy chelation protocol" which is extremely well defined, and what parts are or aren't optional are clearly spelled out.

--- In Autism-Mercury, MacsM7 wrote:

> Hi,
> My DAN doctor, who we have been with for four years,

In all honesty, the fact that you still need a DAN! doctor after 4 years is troubling. You should have seen excellent or dramatic improvements in this time if any of the treatments were on target. "Dramatic" means things like he didn't used to talk at all and now he speaks in complete and gramatically correct sentences.

> has given me a
> chelation protocol for my son which is very different from the one you
> recommend. Since I have been reading your posts with great interest and
> admiration I would like your opinion before I decide what to do. My son is 11
> (100lbs) and tested extremely high in mercury, silver, nickel and aluminum.

The way you put this sounds like it was a challenged urine test, which has precisely no meaning and no diagnostic utility. A proper test is a hair element profile from Doctor's Data or Trace Elements (the current TEI report is in effect the same, though you have to stare at it for a while and think about it if you are used to DDI reports).

Also, does your son have amalgam fillings in place? He can't chelate with them in. They must be removed first.

> Our doctor suggests a 12-week cycle of:
> ALA 100mg 3 times a day every day

If the only thing I succeeed in doing is convincing you not to do this, it will be worthwhile.

One of the great advantages of having years of experience with what happens to adults when they chelate this way and that is that I have a zillion first hand reports of what almost any protocol you can imagine feels like from the inside, and what it does to people who can report how they feel accurately. By selectively concentrating mercury into the brain instead of causing its excretion, improper use of ALA dramatically increases both neurological and psychiatric problems.

> DMSA 500mg 3 times a day for 3 days, then 11 days off, then repeat
> this is to be combined with a specially compounded mercury detox combo
> of C,E,B6,Taurine, zinc, selenium, melatonin

This is not a mercury detox combo. I have no idea why anyone would call it that. Also I have no idea why it would be "specially compounded," as you can easily get whatever combination of those things you want in standard OTC products which are commercially available from many sources.

Your kid needs to take appopriate supplements whether or not you chelate him. Chelation doesn't change this.

> Our doctor says he has NOT seen very impressive results with this
> chelation protocol alone,

Unsurprising. I am surprised that he considers it on average to help the patients, rather than hurt them. You might try a proper chelation protocol instead on which most people report somewhere between noticeable and dramatic progress. Please see the polls section and the love letters file (if you aren't using the web interface for the listserver, you go to http://groups.yahoo.com/group/Autism-Mercury and click the hotlinks on the left for "Polls" and "Files" and see what is there) for typical reports of progress.

I have a suggestion. He says give your kid 1,500 mg of DMSA a day on cycle, and 300 mg ALA every day. Why not just use MY protocol once or twice and see what happens? Then you can decide whether to try his, and can compare them. Use perhaps 50 mg DMSA and 25 mg ALA every 3 hours during the day (and 4 at night to sleep a little more) for 3

days. This is 350-400 mg of DMSA and 175-200 mg of ALA. Both MUCH less than Dr. DAN! Protocol prescribes.

> but adding IV glutathione once a week has been very impressive.
> What do you think?

I am having a hard time biting my tongue. I have had a number of "alternative" doctors call ME up and ask what the (@#*&$*(is going on with some of their colleagues saying intravenous glutathione makes EVERYONE SO MUCH BETTER but when THEY use it on THEIR patients, half get a lot worse. This is confirmed by repeated private reports - and a few on list - by parents who made the mistake of letting their doctor do this to their kid. The worsenings are usually long term or permanent, too. What is actually happening is many doctors are not all that perceptive about the effectiveness of their therapies (the standard 36 hour shifts with 12 hour rest periods most of them worked in residencies during training are one of the more well accepted ways to brainwash people and are considered serious offenses against the laws of war when committed in POW camps. After these experiences they are not always that good at noticing things clinically that disagree with what authority figures told them).

If you know what your kid's plasma cysteine is you can decide if it is worthwhile to increase his thiol (sulfur) intake, but there is no reason to use glutathione IV - if he needs more appropriate use of oral agents is much more effective and long lasting than the injection.

Also, I am curious what rationale he uses for wanting to chelate your kid if he thinks the IV glutathione is what helps and the chelation isn't very helpful? This makes no sense at all.

BTW, if your doc can't tell you what your son's plasma cysteine is and proposes to shoot him up with glutathione I really would like to spend some time trying to convince you to go elsewhere. This is THE most basic measurement of "sulfur" metabolism, is inexpensive and easy to do, and is part of a test most DAN! doctors typically order the rest of (the Great Smokies Lab comprehensive detoxification profile - almost all DAN! doc's order either that or the regular detox profile which is very similar but doesn't have cysteine).

> Mary

First, in discussing the DAN! protocol I do have to note that it started with a few of the early DAN! doctors following the protocol as laid out in my book Amalgam Illness: Diagnosis and Treatment. They got excellent results with this. However, they also spent a lot of time arguing with parents about the need to get up at night because the doc's weren't all that convinced it was necessary (for the most part they had not chelated people before or had used protocols that don't require the patient to get up).

Based on the excellent response achived early on with this every 3-4 hour low dose protocol, DAN! decided to use a DMSA and ALA protocol.

However, based on the fact that nobody at the relevant meeting understood any pharmacokinetics so they weren't able to figure out why 3-4 hour dosing was a crucial part of the protocol, they decided it would make no difference to dose every 8 hours so they arbitrarily changed the protocol. They also arbitrarily decided that since one textbook talks about using 10 mg/kg of DMSA every 8 hours and they didn't understand why there was any reason to use less, they would also arbitrarily change the dosage because more must be better, and using a higher dose must speed things up a lot.

So the existing DAN! protocol was made up by a room full of doctors who had never used it clinically and didn't understand what the important differences were between it and the protoccol they had heard was successful. Basically, they were arrogant enough in their ignorance to believe that their (lack of) understanding was adequate to change the protocol willy-nilly and still have it work fine without even doing a trial of the new protocol on people, or animals, before endorsing it.

This is the same combination of arrogance and ignorance that leads most current pediatricians to continue injecting children with the thimerosal preserved vaccines they have in the stockroom rather than take the economic loss of throwing them away, because the doc's don't see how the thimerosal could hurt the kids and are certain they know everything important there is to know about the subject. This unfortunately is part of the medical culture and is not unique to the mainstream or alternative medicine communities.

So, after that DAN! meeting, a new, randomly modified and untested protocol was emitted. As is easily verified in the polls section of this list and in its archives, what actually happened is that a lot of kids who had been getting better on the every 4 hour protocol were switcched to the every 8 hour protocol and started to get worse again. Once the parents realized that the doc's had gone off the deep end and switched back to the 3-4 hour protocol, their kids resumed improving. While informal, this is a "controlled crossover study," which is among the most powerful evidence doctors claim to believe in. It provided conclusive proof that the lower dose 3-4 hour protocol is dramatically superior to the DAN! 8 hour, high dose protocol. Like the mainstream, however, DAN! has ignored those results that don't agree with its position.

In fact, when using the 3-4 hour protocol, the early DAN! doctors were reporting dramatic, rapid improvements in their patients. Since switching to the 8 hour protocol they are reporting rough going, some improvement in perhaps 60% of patients, and are getting really interested in using other interventions (like MT promoter) in place of chelation.

I believe that the reports of the DAN! doctors actually are correct. Dramatic progress in most cases on 3-4 hour chelation, rough going with modest progress on 8 hour chelation. I believe these are in fact the rule. They are consistent with reports on this list, with what I have heard from many adults, with what one would expect from basic pharmacologic and pharmacokinetic considerations, and with how things felt when I was very toxic and chelated a few different random ways at

first before I figured out what I was doing.

The difference in administration frequency between the DAN! protocol (every 8-12 hours for ALA, every 8 for DMSA) and the "Andy" protocol (every 4 hours or more often for DMSA, every 3 hours or more often for ALA with occasional 4 hour use) are pretty straightforward to explain. First, chelating agents serve two functions. They mobilize toxic metals. They also bind toxic metals. They do NOT "hold on tight" and do NOT bind irreversibly. They pick up and drop the metals often. Thus, you need to maintain a rough balance between mobilization and binding so that the chelators grab most of the free toxic metals rather than letting them grab back on to the body. In order to do this, you need to keep the blood level of chelating agents reasonably constant. This is done by giving them roughly a half life apart, so that blood levels don't fluctuate by more than a factor of 2. The half life of DMSA (directly measured in human children) is 2.5 to 3.5 hours. The kinetics of ALA are much more complicated but are adequately described as a half life of 1.5 to 2.5 hours. The peaks get smeared out over a 2 hour period due to it taking about 2 hours for the stuff to slowly be absorbed when it is given by mouth. EXACTLY how long you can wait between doses varies from individual to individual and I have determined my numbers based on the experience of a lot of people who have done it this way. They are theoretically sound and empirically verified. While I can't really tell you exactly why ALA is best every 3 hours or whether DMSA could be stretched to 5 and still be OK, I can tell you with great certainty that 8 hours is way beyond the bounds of reason.

Now please note that everyone is different. Everyone is a unique individual. This is just as true biochemically as socially. Thus while there is perfect certainty that the above applies to any large group of people, and is best for most people in that group, any given individual may need to do it differently and in any large group there will be a few who do better on something other than the "one size fits all" average protocol. This leads to the following conditions which I believe any responsible person would adhere to:

1. Try the "best" approach on everyone, no matter what. Just try it.

2. If some particular person repeatedly does poorly on the "best" approach and well on something else, respect their individual needs and do what works for them.

Please also note something else covered under "everyone is different." Not all autistic children have mercury (or a related heavy metal) as the root cause of their condition. Good diagnosis is needed. Any doctor who chelates ALL of the children who come in the door isn't doing it right. The first step is make some attempt to figure out WHAT is wrong, and direct treatment at that. If treatment is not leading to the expected progress, go back to the diagnostic step. A diagnosis is only an opinion as to what is going on. Opinions can be wrong.

As to dosing differences between the "Andy" and DAN! protocols, the important factor is that increasing the dose increases side effects rapidly, but does not increase metal removal much. Doubling the

amount of DMSA or ALA in a dose more than doubles side effects. However, it speeds up metal removal by less than 33%. Once you are using enough chelator to get some response and have some side effects there really is no reason to push things. You can double your dose and go from noticeable side effects to a horrendous, intolerable experience and make it so you can get through a given amount of metal in 3 months instead of 4. Also, as the side effects increase, your ability to chelate frequently will decrease so sticking to a lower dose and doing it routinely every weekend or every other weekend will in practice get your kid cleared of metal faster than using a very high dose and spending weeks or months putting your kid back together after each cycle. This is clearest in the discussions regarding all the yeast problems kids have with chelation that are in the archives.

Summarizing the dosage and administration differences:

8 vs 3-4 hour dosing. Why dose more often? It is necessary for most children if they are going to get better. This is supported by the fact that DAN! doctors were reporting dramatic progress when doing it this way and no longer are now that they use 8 hour dosing.

1500 mg/day versus 350 mg/day. Why use more DMSA/ALA? There is no real need to use a lot, since it makes the kid dramatically more uncomfortable without really speeding things up much.

Let me work the arithmetic on this one and you will quickly see what I mean about dosing. The relevant formulae are in the appendix to my book Amalgam Illness: Diagnosis and Treatment (described at www.noamalgam.com).

Each 500 mg dose of DMSA removes (500/50)^0.409 = 2.56 times as much metal as each 50 mg dose.

3 500 mg doses daily remove 7.69 units of metal.

7 50 mg doses daily remove 7.00 units of metal.

The difference in metal removed by DMSA between the DAN! high dose protocol and the Andy low dose protocol is 10% in this case. If you use 100 mg DMSA every 4 hours versus 500 mg every 8 hours the lower dose protocol actually removes 21% MORE metal than the higher dose protocol.

Similarly for lipoic acid, the arithmetic is:

Three 100 mg doses remove 5.29 units of metal, while seven 25 mg doses remove 7.00 units of metal. Again, the "lower dose" protocol actually removes more metal in a 24 hour period.

The really important thing to keep in mind is some further human biochemistry as far as heavy metals are concerned. That is, why is it such a bad idea to let the metals bounce around by just giving chelator randomly? Don't the metals come out eventually no matter how you do it?

The real issue is that the metals do NOT sit where they are until they

come out. Chelators ccan move them all over the body. The most damaging place they can be is in the brain, and the next most damaging is in the liver. A lot of the metal that is sitting quietly in a muscle, bone, kidney, or ligament and not really causing much damage there can be moved INTO the brain and liver if it gets stirred up and there isn't chelator around to keep it company until it is excreted. So improper chelation with too long an interval between doses actually can make people MORE poisoned by INCREASING the amount of toxic metal in the brain and liver even though the total amount in their body does decline. This has been observed innumerable times with adults for many years, and DAN! has now experimentally demonstrated that it works just the same way in children. With proper chelation everything gets BETTER from the start. With improper chelation some things get WORSE. Then it takes LONGER for those to get better than if proper chelation had been used all along.

I hope this rather long post clarifies the differences between the DAN! and Andy chelation approaches, and explains why I think it is important to do it one way instead of another.

What I hope you will consider the "take home lesson" here is to just try it both ways a couple of times if you are considering the DAN! protoccol or if your doctor insists

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