ALL ABOUT PORPHYRAZYME

by Ronald L. Myers, CNC

PorphyraZyme is a concentrated ***porphyrin*** extract from green plant life. It has been said that PorphyraZyme is spirulina. This is incorrect. In 1980, the biochemists at Biotics Research Corporation began investigating the use and production of a spirulina plankton product. Fortunately for Biotics, the world's leading academic expert on spirulina was at the University of Texas at Austin. He provided insight into past research and present production methods. Two years into the research Biotics halted production of a spirulina product due to concerns of microbial contamination. Spirulina is a microorganism and grows where other microorganisms grow. For this reason cross-contamination can be common. The biochemists at Biotics came to the conclusion that it would be too time consuming and costly to produce the porphyrin product they had in mind from spirulina, so they chose to concentrate and extract porphyrins from non-aquatic plant life. For this reason, I feel PorphyraZyme is the superior porphyrin product in the market place today. If you or your patients use a spirulina product, you should request certification that it is free of microbial contaminants (or better yet, order your own analysis).

Porphyrins have the unique character of being able to complex divalent metals, with the heavier metals being complexed first. These heavy divalent metals are toxic, e.g. mercury, lead, cadmium, arsenic, etc. After available heavy metals are chelated, calcium will be removed. The theoretical order of removal of these metals is based on weight/charge and is Mercury, Lead, Chromium, Nickel, Cadmium and Arsenic. We can see from this that PorphyraZyme will chelate Chromium, and that this will occur before it removes nickel or cadmium. If you are supplementing a patient with PorphyraZyme to remove nickel or cadmium, I recommend giving them chromium in some form (CR-Zyme, Chromium Picolinate, MultiMins, etc), at another time of day.

Research conducted by Biotics Research Corporation showed very clearly that PorphyraZyme would remove mercury and aluminum. These can be very difficult to remove because they are actually metalloids. Each tablet of PorphyraZyme contains 120mg. of Vitamin C, which is effective in the removal of lead. However, lead removed with Vitamin C goes out through the bowel instead of the kidney, so urinary lead values show no increase in this case.

PHYSIOLOGY

When Porphyrins are isolated and taken out of the cell and concentrated, they have a very useful quality—they complex divalent metals. They will complex, remove or chelate those of greater molecular weight first, and then as we said above, will remove calcium. It is this ability to chelate calcium that makes PorphyraZyme effective in removing the calcium in vascular plaques. This product should be taken on an empty stomach, 60 minutes before meals to facilitate its chelating ability. If the patient has clinical or subjective indicators of hypochlorhydria, 2 tablets of Hydrozyme should be taken with their dosage of PorphyraZyme. The acid medium of the empty stomach removes the magnesium center of the porphyrin ring and allows for the "exchange" of the heavy metal component.

HEAVY METAL INDICATORS

Tissue Mineral Analysis (TMA) or what is generally referred to as a hair analysis, or a 24-hour urinalysis, are common methods used to determine the presence of heavy metals. But even using the latest technology, some heavy metals like mercury may not show until challenged with some form of chelating agent.

SOURCES OF MERCURY TOXICITY

I think we can all agree that mercury amalgam dental fillings are a source of toxic mercury. Consider the use of PorphyraZyme for patients with mercury fillings. I suggest a dosage of 3 tablets a day of PorphyraZyme on an empty stomach along with 1 capsule of MCS.

Here is a source of mercury exposure that you may not have considered. Simon Yu, M.D., an Internal Medicine specialist in St. Louis, reports of a patient with mercury toxicity but without mercury fillings who also does NOT eat fish, and is not in an occupation that would lead to mercury exposure. Where did the mercury toxicity come from? The patient had been taking shark cartilage for a long time to help with his arthritis. This was found to be the source of the mercury. I have personally felt for some time now that fish and fish products are a source of mercury (and other heavy metals) that can be easily avoided. It is a known fact that shark cartilage supplements are extremely high in calcium, and now here is one report by an astute physician, of the mercury content of these supplements.

SOME COMMON SOURCES OF HEAVY METALS			
ALUMINUM	Aluminum Cans Deodorants Cooking Utensils Antacids	**ARSENIC**	Air Pollution Some Seafood Tap Water Tobacco
CADMIUM	Dental Amalgams Cigarette Paper Margarine Refined foods	**COPPER**	Tap Water Soy Beans Soft Drink Dispensers Processed Meats
LEAD	Air Pollution News Print Lead Pipes Processed Meats	**MERCURY**	Fish Air Pollution Dental Amalgams Pharmaceuticals
NICKEL	Air Pollution Costume Jewelry Cigarette Smoke Hydrogenated Oils	**TIN**	Air Pollution Tap Water Processed Fish Pasta

NUTRITIONAL HEAVY METAL DETOX PROTOCOL

This is a general heavy metal detox protocol. For a specific heavy metal treatment program, please contact me at nclinician@earthlink.net.

PorphyraZyme 4 tablets 3 times a day on an empty stomach
BioProtect 2 capsules 3 times a day
MCS 2 capsules twice daily.

PORPHYRAZYME AND ATHEROSCLEROSIS

What follows is a summary of a small study conducted by three Doctors of Podiatry regarding the use of PorphyraZyme in patients with reduced pedal circulation. In addition to the general discomfort these patients suffer, foot ulcerations and foot wounds heal very slowly and may lead to more severe conditions. Any improvement in pedal circulation would be beneficial to these patients. The doctors decided to investigate oral chelation therapy as a means of improving circulation in these patients.

Ten patients with various circulatory complaints, ranging from intermittent claudication to coldness of feet, were chosen to participate in the study. The ages of the patients ranged from 47 to 76 years of age. Prior to beginning oral chelation therapy, baseline peripheral circulation measurements were recorded using a Pulse Volume Recorder. Patients were divided into two groups of five patients each. Group One received PorphyraZyme and Group Two received PorphyraZyme and Intenzyme Forte. In both groups, the dosage of PorphyraZyme was determined by the baseline circulatory measurements, the poorer the circulation the higher the dosage of PorphyraZyme. The dosage varied as follows: 3 tablets 4 times per day; 2 tablets 4 times per day; or 1 tablet 4 times per day. Patients in Group Two received 1 tablet 4 times per day of Intenzyme Forte in addition to the PorphyraZyme. Group Two consisted of patients with the poorest pulse volume measurements. All supplements were taken on an empty stomach at least one hour before meals and at bedtime. Patients were instructed to take one tablet of MultiMins (a multi mineral product containing chromium) daily with a meal. The patients were followed for 18 weeks, with follow-up pulse volume recording made at weeks 6, 12 and 18.

Initial dosage determined by baseline Pulse Volume Recorder measurements

Group One		**Group Two**			
PorphyraZyme Dose	Patients	PorphyraZyme Dose	Patients	Intenzyme Forte Dose	Patients
3 tablets qid	0	3 tablets qid	4	1 tablet qid	4
2 tablets qid	2	2 tablets qid	1	1 tablet qid	1
1 tablet qid	3	1 tablet qid	0	1 tablet qid	0
All patients took MultiMins 1 tablet daily with a meal.					

RESULTS OF STUDY

At the end of week 6, pulse volume recording showed marked improvement over the baseline in 6 of the 10 patients. Three patients in Group One showed marked improvement. Two of those patients were taking PorphyraZyme, 2 tablets 4 times per day, one patient was taking PorphyraZyme, 1 tablet 4 times per day. Three patients from Group Two (those patients with the poorest pulse volume measurements) also showed marked improvement. Two of those patients were taking PorphyraZyme, 3 tablets 4 times per day, and Intenzyme Forte, 1 tablet 4 times per day. The other improved patient from Group Two had been taking PorphyraZyme, 2 tablets 4 times per day, and Intenzyme Forte, 1 tablet 4 times per day. The following table shows patient improvement by group and dosage schedules.

Dosage schedule of patients with marked improvement in pulse volume measurements over baseline at week 6

Group One		**Group Two**			
PorphyraZyme Dose	Patients	PorphyraZyme Dose	Patients	Intenzyme Forte Dose	Patients
3 tablets qid	0	3 tablets qid	2	1 tablet qid	2
2 tablets qid	2	2 tablets qid	1	1 tablet qid	1
1 tablet qid	1	1 tablet qid	0	1 tablet qid	0

At the end of week 12, pulse volume recordings showed marked improvement over the baseline in 8 of the 10 patients in the study. All of the patients in Group One (5 patients) showed marked improvement. Two of those patients were taking PorphyraZyme, 2 tablets 4 times per day, and 3 were taking PorphyraZyme, 1 tablet 4 times per day. Two of the 3 patients from Group Two, who showed marked improvement at the end of week 6, continued their improvement through week 12. The other patient from Group Two maintained the same improvement recorded at week 6. This patient dropped from the study after the week 12 recordings were completed. The 5 patients from Group One who showed marked improvement had their dosage reduced after week 12. The dosage reductions were as follows: those taking PorphyraZyme @ 2 tabs qid were reduced to 2 tabs *tid*, and those taking PorphyraZyme @ 1 tab qid were reduced to 1 tab *tid*.

A final measurement was recorded at week 18. One additional patient from Group Two, who had been taking PorphyraZyme, 3 tablets qid, and Intenzyme Forte, 1 tablet qid, showed marked improvement based on the week 18 recordings. Those patients from Group One who had their dosage reduced after the week 12 measurements maintained their improvement through week 18. One patient dropped out after week 12, so 8 out of the 10 patients showed marked improvement by the conclusion of the study.

One patient in the study had 2 leg ulcerations of about one year duration heal shortly after beginning participation in the study. Three patients, who had poor balance and diminished mental alertness prior to entering the study, noted marked improvement in balance and alertness shortly after entering the study. A 47-year-old patient entered the study with complaints of cold hands and feet; after 14 days in the study, he no longer complained of cold hands and feet.

CONCLUSION

This was a small study, 10 subjects. However, it does show the value of oral chelation therapy with PorphyraZyme, and its ability to improve circulation in a high percentage of patients undergoing this therapy. In recommending PorphyraZyme in a clinical setting, I have consistently seen results like these empirically. PorphyraZyme can provide you with a tool to help your patients with various heavy metal body burdens and/or circulatory problems (atherosclerosis). It is inexpensive and non-invasive, and completely free of drug side effects. You can feel confident using PorphyraZyme, it will produce results for your patients. Always dose PorphyraZyme on an empty stomach, i.e., one hour before meals.

ATHEROSCLEROSIS PROTOCOL

Beta TCP 2-3 tablets with meals (this will insure the bile route is open).
PorphyraZyme 3-4 tablets one hour before meals and at bedtime (dose dependent on severity).
Intenzyme Forte 3 tablets one hour before meals and at bedtime.
Super Phosphozyme 1 tablet one hour before meals.

We end this issue of e-Bytes with the results of an in-vitro study of the heavy metal complexing potential of PorphyraZyme.

Metal	Original	After PorphyraZyme	Complexed
Lead	20PPM	4.8PPM	15.2PPM
Mercury	10PPM	0.8PPM	9.2PPM
Cobalt	30PPM	3.4PPM	26.6PPM
Cadmium	15PPM	3.6PPM	11.4PPM
Arsenic	10PPM	1.4PPM	8.6PPM
Aluminum	20PPM	7.0PPM	13.0PPM
Nickel	10PPM	3.3PPM	6.7PPM
Chromium	20PPM	3.8PPM	16.2PPM

*Measurements were made using atomic absorption techniques, using a Perkin-Elmer 603 spectrophotometer.

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