Fecal Infusion – Bacteriotherapy

Jini Patel Thompson Interviews Bianca James, R.N.

Hi, this is Jini Patel Thompson from www.ListenToYourGut.com
I specialize in natural healing for digestive diseases like Crohn's, ulcerative colitis, IBS, and diverticulitis. Today, I am thrilled to be talking once again to Bianca James from the Sydney Colon Health Clinic.

Bianca is a registered nurse with additional training in gastroenterology and she also owns and runs the Sydney Colon Health Clinic. You'll hear more about what she actually does at the clinic as we get into it, but just in case you need to look her up or look at her website for more information, her website is www.ColonHealth.com.au - because she's in Australia.

Today, Bianca and I are going to talk about something called fecal bacteriotherapy and it's often called fecal infusion here in North America, but Bianca is the one who originally worked with the famous gastroenterologist, Dr. Thomas J. Borody in developing this protocol in the very initial stages of it. We want to find out from Bianca everything that went into that and how she does it and safety parameters and all the rest of it.

Bianca, thanks so much for joining us today.

Bianca: It's a great pleasure, Jini. It's nice to speak with you again.

Jini: Now, maybe what we can start with it – I'll tell you what I'm seeing on the forums in terms of what people think this therapy is. If you go onto the forums, first of all, people are just doing this themselves at home and they are getting a donor who they consider to be healthy and the donor is giving them their stool from their bowel movement. They are liquefying it in a blender with filtered water and then they are using an enema bag to give themselves an implant enema or a fecal infusion of the donor's stool. The purpose in doing that is to give themselves all the healthy species of bacteria that they have been

missing as a result of either inflammatory bowel disease or C. difficile infection or some such thing.

That's what's going on in the public arena right now concerning this therapy. Maybe you can now – just jump in wherever you want and start telling us about what it's supposed to be and how you developed it and then what people need to know about this therapy.

Bianca: Basically what you have described is pretty much what we do, except for a few of things that we add to the fecal matter, etc. The problem with that is – and my great concern with that, is that they may well be picking out a donor that they think is healthy, but the donor might not themselves know that they have some bug in their gut that the recipient would certainly not want to receive. To me, that's quite dangerous because things like E. coli have no symptomatology. There are a lot of the protozoa like Giardia that take a long time to blossom enough to give symptoms. Now, if a person, that is the donor, has this, then they're going to transmit all of that bacteria, good and bad, into the recipient and that's not a good thing. That is a concern.

Once, of course, the fecal matter is obtained and it's blended and all of that is done, the infusion side of it - apart from needing to add some nutrients and some supplements into that fecal matter so that the bacteria that's being implanted aren't going to die - is okay. The problem on the recipient side is that if their bowel is unclean and if their bowel isn't free of the harmful bacteria or whatever the bacteria is that has caused their health concern in the first place, then putting bugs from somebody else in, is not going to survive, because the bad bacteria that is still in the recipient is going to kill that. Because they see it as a threat and they will kill it, and so it will go on.

Jini: Right. When you developed this protocol… Was anyone doing this protocol before you and Dr. Borody came up with it?

Bianca: Not that I know of.

Jini: You were the inventors of this protocol?

Bianca: Yeah, probably.

Jini: Well, credit where credit is due.

Bianca: *{Laughs}* I mean, look, Tom came to me and possibly he read it somewhere or possibly, it was an idea that sprung up in his own mind because Tom is quite a brilliant man. In many cases, he really is so brilliant that a lot of other gastros in Australia classify him as a cowboy, but he is, no doubt, a brilliant man and he may well have just come up with this concept himself – that wouldn't surprise me – and then brought it to me, or maybe he did read it about it somewhere.

I don't know how he came about, but I know that there was absolutely nobody doing it and it was really quite something that turned a lot of heads and we got a lot of criticism about initially. It certainly wasn't something people knew about.

Jini: Why did he bring it to you? Had he heard about you?

Bianca: Oh yes, we knew each other because I had done a postgraduate degree in gastroenterology a lot of years ago and you sort of crossed paths with people, you know. Plus, he had sent me a lot of his patients who were difficult cases and people with very severe chronic constipation, laxative abuse – that sort of thing that he was at his wit's end knowing what to do with. We had a history, absolutely, and he knew my clinic. He had visited on a number of occasions. We had discussed patients in the past. Yes, absolutely.

Jini: When you were setting up the donor for the poo, what were your parameters? What did you put into place then to ensure that you were going to get a stool sample that was non-infective?

Bianca: I put together a very stringent protocol where I would bring both… Well, I was seeing the recipient before, anyway, because we needed to do a bowel cleansing, we needed to get as many of the bugs out as we could get. Tom, on his side, was doing what he was doing and then we were cleaning the patient out before we even decided

that they were a candidate for what we called, or what I called, human-to-human probiotic infusion.

Jini: Okay, so I'm going to jump in here. The clear-out; was that purely using the colonics… Okay, but was he using any oral?

Bianca: He was using very – and I still believe he does today, which is why it was a bit difficult because I didn't agree with some of that – but he was using very, very heavy antibiotics. He was using Vancomycin on a very long-term basis to try and kill off whatever was in the gut that was causing the problem and to give him his due – that's his area. It wasn't up to me to say yes or no about that, but I do know that we used very, very heavy duty long -term antibiotics in order to get rid of the bad bacteria and while that was happening, the patient or the client was coming to me and we were cleaning them out and trying to see if that in itself would make a difference.

In some people, it did. In those that it didn't, we then looked at, going into the human-to-human probiotic infusion program. I wrote very stringent protocols to that where I invited the recipient to hopefully find a member of their own family because that was the best way to go, because at least then they knew the person because it was a family member. It was either brother, sister, mother, father - that sort of thing – very close family to be a donor. We would then bring the two people into the clinic and go through what the procedure would entail because as I say, it was a very, very stringent month-long procedure, sometimes more depending on what was going on and how much preparation we needed to do.

Once we had established that and had established that the donor would be happy to be the donor and would be happy to both give up smoking, give up drinking, give up meat, give up a lot of things, learn to poo on demand, do all of these things, I mean it was big deal. Once we had established that they were prepared and happy to do that, we would get them to give us a sample of stool and we sent that then off to the University of New South Wales and had it analyzed.

We had it analyzed for all the normal things - Blastocystis hominis and Candida albicans and the protozoas like Giardia and the enteric things and the C. difficile and the E. coli and the parasites. It was just a huge gamut of stool tests that we did to establish that there was nothing, nothing in that donor stool that would make it a contraindication of infusing it into the recipient.

Sometimes, we were lucky and we got a great result, first off. Sometimes, we had to go look for different donors because it just wasn't – their stool just didn't come up to scratch and we didn't want to infuse something into a recipient that was going to cause them more problems, different problems, exacerbate their problems. I mean, you don't want to do that. That's sort of how we started with that.

Jini: After you got essentially a clean, stool donor and that's quite a thing that they had to go through, how did you then – tell me the procedure for getting the stool from them and then how did you prepare it and how did you infuse it.

Bianca: After we got the donor, the first thing that we did is that I had written protocols and I changed that if I needed to, depending on the donor and the recipient. They were given that protocol and for one month – for one month, they had to follow this protocol, and so the donor – it was simply that they had to totally change their diet. They had to go to a high fiber, pretty much low protein. As far as meat was concerned, there was no red meat in the program. If they were going to eat any sort of meat like chicken or lamb, it had to be organic. They had to eat as much organic fruits and vegetables they could. There were a lot of – there was no smoking, no alcohol. It was very hard and every day, they had to go to the toilet and learn to poo on demand because I would bring these people into the clinic and while I was getting the recipient ready, the donor was in the toilet doing his thing or her thing. While the donor was doing that, the recipient was actually having their bowel cleansed. I was actually cleaning out what was in their bowel.

While they were still lying there, I would get the stool, I would prepare the same as you described – I would put it in the blender, I would add distilled water to that, I would add some stuff that fed the live bacteria that was in that stool, like psyllium. I would put in

some slippery elm. There were a few other things that I put in there, which are pretty difficult to get hold off these days, but I would blend all of that up.

I would put it into a 50-ml syringe rather than an enema bag because it was very thick. It was the consistency of thick custard, and so I would put that into a syringe. I would insert a special sterile rectal tube into the anus, which we had especially tooled, that had a hole just in the very top of it that was probably the size of – let me think, what, the top of a pin maybe, the opening, so that when I then injected the fecal matter in, it actually went past the sigmoid and up it went.

The person would then… We would only infuse 50 ml because anything more than that, we found that the recipient would eliminate – they couldn't retain it, it wasn't too much, and so they would end up losing it. A 50 ml they could retain and hold. They would then continue to lie on the bed on the treatment couch for the next 15-20 minutes and then they would get up and go home.

We repeated that process for as long as it took for the symptoms chart that we had, where at the very beginning of the process, the recipient wrote down their major symptoms and the score on those symptoms. Every day, they would fill that in and we would continue to infuse until the symptoms went from 8 to 0, and when they were at 0, we would stop. Many of those people are still in remission and this is 10 years ago, so we did very, very well. We didn't get success with all of them, but I would say 85 percent of people had excellent, excellent results. Some of them relapsed over time, some of them are still in remission, so I think we did pretty well.

Jini: A couple of questions for you – why did you need the donor to come in and defecate on demand? Why couldn't they just – say you provide them with a container or something to put across their toilet, they poo, and then they bring it in at whatever time they naturally…

Bianca: Because by then, it would have been cold and a lot of the bacteria would have died, and I wanted it warm and fresh, and I infuse it when it was still warm. It was only -

from the time I got the donation to the time I infused it, it would be no more, no more than 10 minutes – no more.

Jini: Okay, so that would probably have a lot to do with the potency and the efficacy of the therapy?

Bianca: Absolutely. Well, I believed that. I have no proof on that, but I believed that the fresher the stool was, the more potent the bacteria would be because the bacteria had not had time to be exposed to the air, it hadn't had time to be exposed to anything that was out there. I was putting it straight in from a sealed syringe and it went straight through into the person while it was still warm so I believed that, and I still very firmly believed that that's the way to do it because the bacteria is still alive and you want it to be alive. You want it to colonize and grow.

Jini: Right. What about probiotics? Did you have the donor take them? Did you have the recipient take them? Did you mix them with or did you just do the stool…

Bianca: I mixed some probiotic into the mix. Both the recipient and the donor took probiotics orally during that month laid-up and then over the time of the donation.

Jini: Okay, I know we talked about this in our last podcast together, but were you still using Natren Probiotics at that time?

Bianca: Yup, absolutely.

Jini: Did you use all three of the species?

Bianca: Yes, I used the bulgaricus and bifidus – mainly the bulgaricus and bifidus because acidophilus, as you know, is a small bowel bacteria. It wasn't really what we needed to put in there.

Jini: Did you put any in?

Bianca: I put a little bit, perhaps half a teaspoon, but I might have put 2 teaspoons of the bifidus and the bulgaricus.

Jini: Right, see that's what I have done too when I developed the probiotic retention enema that I have my readers do because I thought – here's the thing – for a lot of people with inflammatory bowel disease, the ileocecal valve is malfunctioning and you're getting the wash up of bacteria into the small intestine anyway, right? I thought, well, let's just cover the bases, just in case...

Bianca: Yeah. Well, I was talking to you about the suppositories and the probiotic infusion that I was developing. We've now got after samples of that out.

Jini: Well, tell me about that. What is that?

Bianca: Well, remember I told you the last time we spoke that I was going to do a probiotic infusion enema that people could take home and do by themselves and also suppositories for people with inflammatory bowel disease. Remember we talked about that and I said that was in the pipeline? Well, we're trialing it now. We're on trial with that now, so that might be great and exciting too.

Jini: Can you give any more details at this point as to what…?

Bianca: No, not really. I just want to see how successful it is whether we have to change any of the mix, what we have to do. It's in trial at the moment, so I'd rather just see how the trial pans out and whether we have to make any changes or change anything.

Jini: Exactly.

Bianca: I did tell you that I'd let you know when we were going on trial and now we are.

Jini: Excellent, and so people listening to this can just check with you directly to say, hey, have you got those suppositories or take-home infusion ready yet?

Bianca: Absolutely.

Jini: Okay. Now, a question for you – the 85 percent success rate – do you have any intuition or any ideas about the 15 percent for whom it didn't work, about why?

Bianca: I guess they didn't follow the protocols properly. A lot of them cheated, as people do. It just becomes too hard. A lot of them had other things that happened and went on antibiotics for whatever the reason might have been. I mean, people do what people do. Obviously, if you're in a program like this and you suddenly developed a terrible middle ear infection that is almost destroying you, then you have to do something. It was just attrition, I suppose, just a general fallout that happens when people embark on a program like this where it's so stringent that there are certain people that say, "Look, I just can't do this. I want to do it, I need it, but I just…"

I think that in part, for all of them, I really can't tell you because they came into the clinic, which is when I saw them. They were there for the hours that they were there and then I didn't see them again until the next day. What they did during that 23 hours, whether the donor went off the rails, went out, and went on a drinking binge and the next morning, the stool wasn't adequate or… It's rather unfortunate that good bugs from bad bugs don't have iridescent colors that fly around the place and you can see so that you could look at something and say, "No, no, this isn't good today. We're not expecting that" or say "This is great."

I mean, we don't see bugs. We don't see things that fly. If we did, we'd be absolutely devastated, I think, by the bugs that are flying around in our ear, but we don't see them in the same way as we don't have x-ray vision. I can't look into bowels, much as I'd love to. In my meditation, that's what I ask for everyday – let me be more, let be more intuitive. Let me know more than I know, but that hasn't happened yet. I still don't have x-ray vision nor does anybody to be able to look into a bowel and say, "Well, yeah, this is the problem. This is what we've got to hone in on." Yes, this fecal implant is really working on this area, but we need to push it up high to get it here because we just don't know.

I don't know why some of them fall off the wagon. I don't know why a certain percentage are still in remission today when others aren't because I pretty much did the same thing for everyone and I was very, very diligent and very careful. Some people might think this is rather crazy, but I had all my healing angels around while I did my mixing and infusing and I had everybody onside. All of them were onside in this endeavor to try and help people regain their health and for some of them, it was excellent and some of them, it just wasn't and I don't know why.

Jini: Yes, but also… I mean, I know from my experience working with people, but just anybody being a human being knows that okay, what are the odds that someone has had a disease where everything in their life has been restricted and limited and now they're healed, they're going to go, "Oh my gosh, I can eat this now and I can eat that now, and I can go out drinking with my friends."

Bianca: True, absolutely.

Jini: That's human nature. You got to be pretty assured that there was some of that going on.

Bianca: Absolutely. I mean, the people that I know are still in remission that I infused all of those years ago, still on occasion come to the clinic and they still have, well on occasion – on a monthly basis, they come to the clinic, we wash them out and we infuse them with a probiotic just to top them up, just that it's not human fecal matter now, it's just a pure probiotic. We put it directly into the bowel and even though they're taking their probiotics orally, the people that have been the most diligent and sure, they will cheat it and they've all gone off the routes and why wouldn't they and why shouldn't they? At least, they have had to foresight or the commitment to say, "Well we'll continue to come to the clinic every now and again when we feel we need it and we'll just have a top up and we'll just take it and they're the ones that have done the best.

Jini: Yes, exactly. Also, it depends too on whether the people continue to move their diet in positive directions, maybe if they're not taking probiotic supplements, but they're

now lacto-fermenting their own foods and they're having a lot of food-based probiotics like all of those and there's the whole emotional side because, of course, the gut is the second brain or some even hypothesize it's actually the first brain. You have to look at the stressors and the emotional things that are going on because that's really a huge role.

Bianca: Absolutely. That's a huge role in the overall well being of gut health, no doubt.

Jini: Are you still working with Dr. Borody doing this type of therapy, or what has happened with that?

Bianca: No, I'm not. Tom, for whatever reason, he chose and decided that he could do it on his own and he went off and did that. We still do correspond occasionally and occasionally, he still sends me people who have not done well with the infusion program that he is now doing. So yeah, we still have contact. To get the exact reason why it all stopped, you would really have to speak to him because personally, I don't know. I think it was just that he decided he could do it alone.

Jini: Right, and probably easier for him to do it all in-house. Is he following the same protocol that we just talked over?

Bianca: No. He's not following any of the protocol we talked about.

Jini: Do you know what he's doing differently?

Bianca: From what I understand, he is getting donors, and I'm sure, 100 percent sure, that he is culturing his stools the same way as we would have done because he would want to do that and make sure that the stool that he has got is squeaky clean. That's from what I understand. He is mixing multiple stools together and making them into a very watery substance and infusing them pretty much as you described originally through an enema bag or whatever however else. I think that that's how he is doing it.

Jini: Is he using the fresh, still warm stool as well?

Bianca: No. He's got multiple stools mixed together and he keeps those and uses them when he needs them.

Jini: Keeps them how?

Bianca: They're not fresh. I think he keeps them in the fridge, yeah. I believe so, but I've not seen it. I'm only telling you what I have heard and what I have heard from people who have had the process, the procedure done, and it hasn't been successful, and when I've asked them, that's what they have told me. That's the only way that I know. I've got no firsthand knowledge of how he actually does it, but that's what I understand he does.

Jini: Now when you guys did it together, did you use it on both Crohn's disease and ulcerative colitis?

Bianca: Yes, we did.

Jini: Did you do IBS or diverticulitis or just all of them?

Bianca: Yes, we did all of that. We did chronic constipation, we did chronic fatigue syndrome, we did Lyme disease, we did all sorts of thing – all sorts of different things. We had people that had all different diseases and we did it on anyone that we thought may benefit because we were trialing it too. I mean, we didn't know whether it would work on people with chronic constipation, we didn't know if it would work for people who had Lyme disease or who had chronic fatigue syndrome. We even did it on a number of MS patients that I was seeing in the clinic.

We trialed it because we felt that a lot of it all was related to the gut and if we could change the ecology of the gut, maybe, just maybe, it would make a difference to other diseases as well and it actually did. I mean, it was an amazing, amazing thing.

Jini: What kind of differences did you see in someone with Lyme disease or MS, for example?

Bianca: We found that they had better mobility, that they had less pain, that they didn't shake as much. We put a number of them for a little time into remission, but as soon as we stopped infusing within a month, it went back. We couldn't just keep doing it forever, but it was an interesting exercise. They were very pleased to participate because it was safer than a lot of other things that people are being asked to do these days.

Jini: Right. Because for Crohn's disease, I know a big thing that we get into is the whole MAP (Mycobacterium avium paratuberculosis) and the fact that it has a dormant/active lifecycle. You treat it, you eradicate whatever is active, but then you have to wait, say, anywhere from three to four months for the next batch to come active, then you have to kill them again.

Tell me how this fecal bacteriotherapy would fit in to someone with that pathology, do you…?

Bianca: I think that's probably why Tom was giving them heavy duty antibiotics.

Jini: Oh, so he was trying to eradicate the MAP before?

Bianca: He was eradicating all the bacteria – good and bad that they have left in their gut and in their system. He was eradicating all of that and we were trying to start from fresh. We were starting from scratch. That was the concept, that was a hope.

Jini: I can see why you'd have a problem with that, though – I mean, systemic antibiotics.

Bianca: I had a huge problem with that.

Jini: Yeah, I would too.

Bianca: We argued about that on many occasions, which is perhaps another reason that he pulled the plug on us. Again, I don't know that, but that was a very difficult thing for me.

Jini: Yes, and also, I mean in a way, he's doing the classic medical thing, which is to compartmentalize the body and just look at the gut, but meanwhile, you're giving someone a systemic antibiotic and so what's happening to the bacteria, as you pointed it out in the ear canal, in the joints, on the skin – I mean, we can't segment the body like that and say well…

Bianca: That was the problem – that was the major stumbling block that we had. I supposed, in one way, I was quite happy when he decided to go alone because I just wasn't happy with that side of it, but going back to what I said right at the beginning, he is a very well respected, very brilliant gastroenterologist. It is not for me to say that what he's doing isn't right because it may well prove in the long run to be exactly what we have to do. It just, at the time, didn't fit right with me and I didn't want to do it and so it was as simple as that. It had nothing to do with money, it was purely how I felt about doing the right thing and it just didn't fit right with me and I just… that was sort of how it went.

Jini: Well, we have one of our readers who goes by the name of Morris who has – he's used fecal infusion therapy, I think, a fair amount on his daughter and he's been in quite close contact with Dr. Borody and he writes in the webcast, "I had spoken to Dr. Borody recently and he informed me that he had better success with the infusions when he pulsated them one per week for 10 weeks rather than on consecutive days." That's interesting, isn't it?

Bianca: Well, maybe that so. At the time that we were doing this, we believed that doing the infusion once per week - we supposed talked about it - but doing the infusion once a week gave the body too much opportunity of growing bad bacteria that would kill whatever we had put in that was good. Considering that if you had a hundred percent of good bacteria that you would infuse in, within 24 hours, you would lose at least a quarter

of that. By the time the week was up, if you maybe had 10 percent of good stuff left in there, you would be lucky.

That's why we didn't do it that way. That's why we did it everyday, because everyday we were putting more good stuff in, more good stuff in and that multiplied and grew and finally overran whatever bad stuff might have still been there and then it just took over and grew with good.

To me, and again, Tom is the expert. I mean, Tom is the gastro not me, but in my logical mind, it seems that to infuse once a week and then continue to eat three meals a day and do everything that we do and take in the pollutants that we take in from the motorcars and all of that, we're taking constantly, we're taking in bad bugs all the time, all the time, all the time. If you've got nothing good in there to start with and you are putting good in and leaving it for one week, the bad that's going in is far, far greater than any good that might survive in that week.

Jini: I've discussed with Natasha Trenev, who's the founder of Natren Probiotics, and we've found extensively with my readership, when your gut environment has deteriorated to the point where Crohn's disease or ulcerative colitis is taking place, it is very hard to implant good bacteria to the point where they'll stick.

Bianca: Absolutely. If you do it once a week – that's just my humble opinion – that doing it once a week in my humble opinion… This reader of yours, Morris, how's his daughter going with it?

Jini: I'm not sure about him specifically, but from my readers who have done it, they've said that it's brilliant and all of your symptoms disappear, but within a few months, they're all back.

Bianca: Yeah, because the good bacteria hasn't really stuck. It's just being made to mask the bad stuff and the minute all the good bugs die again because they haven't really stuck, they haven't really colonized, they're only there as visitors. The bad stuff is the one that's stuck, and so the bad stuff takes over again and you're back to square

one. Well, what's the point in that? If you're going to do something so stringent and for such a long period of time, it needs such - both the monetary and time - commitment to this, you want it to stick more than a month.

Jini: Well for sure. On the other hand, people could take the opposite approach, which is well, rather than Remicade and Imuran, I just got to do a fecal infusion every month and I'm okay. You can see from the person's point of view. Here's the thing that comes to my mind with Dr. Borody as to why he's doing it one per week instead of consecutive is if you look at patient compliance – because I know for the elemental diet, which is the completely liquid predigested diet that you go on for six weeks, the #1 question I get from people is why didn't my gastroenterologist tell me about this.

I actually know the answer to that because I've spoken to a number of them and they said they don't even bother to tell people about it because nobody will stick to it. Nobody's willing to go through that kind of - like you pointed out – very strict, very regimented, everyday you've got to do exactly this, and they all fall off wagon. They all become noncompliant and then there's no point.

I'm thinking, okay, he's the gastroenterologist, so he's not getting the kind of clients that you and I get, like we would get people who were very highly motivated, very committed to their own health. He's getting the 'just give me a pill and make it go away' type of client. Maybe, it's his patient who's not willing to commit to… So he said, well, this is better than nothing. I don't know, I'm guessing, of course.

Bianca: I mean it would be interesting to know when you say they do this program for 10 weeks, you said, once a week for 10 weeks and then after a month, their symptoms come back and they relapse. Does then one infusion a month put them back into remission or do they have to do ten weeks again and then…?

Jini: Wait a minute, Dr. Borody's protocol that this guy Morris has said he's following now, which is pulsating one per week for ten weeks, I have no idea what the remission rate is with that. I'm saying what the people on the forum have been doing, they've been

doing it themselves at home and they do it once and they say that clears their symptoms for a couple of months and then it all comes back and whether it completely clears…

Bianca: And they do it again and they go back into remission?

Jini: Yes, but what I've heard from some people is that then after a while, it stopped working.

Bianca: Because the ecology of the gut changes too. The ecology of the gut changes to make room for all of these contingencies and all this bacterium and it's the same as you take a pill and after a while, it stops working. Well, it's the same sort of thing. After a while, you have to take more and more to get the same result.

Jini: Exactly. Really, if you even look at it from the basis of antibiotics, like what's the #1 thing the doctor tells you? Don't stop before the course because they'll just come back stronger. So think about it, that the pathogens – they're very intelligent. They're probably mutating and evolving and if you're giving them lots of time to figure out their strategy…

Bianca: This was again my great concern with the Vancomycin that we were giving people way back then – that Vancomycin still today is the strongest antibiotic that we have and if people become resistant to that, what are they going to use, what's going to happen? That's a great problem. I mean these people – like Morris who is following Tom Borody's protocol for his daughter, did he give her antibiotics before he started?

Jini: That I wouldn't know.

Bianca: Is that in the protocol?

Jini: I wouldn't think so because he was following my protocols.

Bianca: Right, but how did he get rid of all the bad bugs then, I mean what was his…?

Jini: He may have used my wild oregano oil protocol combined with the probiotic oral and retention enema supplementation. I'm not sure.

Bianca: What was his daughter's problem?

Jini: Colitis. Here it has just come in from him. He says, "I forgot to add that the reason for the pulsation schedule that Dr. Borody is doing is because much like in the triple antibiotic therapy for Crohn's, spores are not affected by the treatment and after a few months may reinfect the patient again. Hence, the treatment is long term, so it is important to maintain therapy in order to address this issue.

Bianca: Okay, so he's obviously not taking the antibiotics?

Jini: Yes.

Bianca: Because the antibiotics he's taken long term, as we were doing, was killing off all of that. It was killing off the eggs, it was killing off the spores, it was killing everything that was in – everything it was killing.

Jini: Even if that's the reason, it still doesn't make sense because 10 weeks is not long enough to kill MAP. Mycobacterium – you're looking at the research is every three to four months for two to three years. You know what, here's the thing – it doesn't make any sense for us even discussing this because Dr. Borody, if he were to listen to this, would be probably like, "No, that's not what I'm doing, you know that's not what I said." Let's forget all this.

I want to ask you a question – if you were to do this, to start a fresh and knowing everything you know now, what would be your ideal protocol for treating someone…?

Bianca: With human to human?

Jini: Yeah, well for treating someone with Crohn's or colitis, utilizing this treatment and whatever others you have in your arsenal.

Bianca: It's a hard question because it really – a lot of it depends on the person that you're dealing with. There are people with Crohn's disease who will do far better than other people and it has to do with their mental attitude, their stress levels, the jobs that they have, the commitment that they make to their health, etc. I am saying we have a lot of Crohn's disease people in our clinic. These days, we have a number of them who are in remission and have been for a long time simply by giving them… I mean, they've gone through the series of colonics, but now they're on maintenance, they do a colonic once a month or when they feel they need it and they usually know because they get niggles and they know when something's happening…

Jini: Is part of your colonics a probiotic retention enema?

Bianca: Absolutely. At the end of the treatment, we would do a probiotic infusion. We have a special mix of things that we put into - it's just not probiotics; it's a number of other things that we put in there and we would infuse that. They would lie on the treatment unit for another half hour or so, so that it actually absorbs into the system into the bowel and then they go off. I mean, they follow diet, they are very careful with the foods that they eat, they watch their stress levels, they meditate.

There's a lot of things that we have when they get a bit of abdominal pain, as part of the symptoms that arise with Crohn's. We advise them to put castor oil packs on their tummy while they're doing their meditating and that sort of thing. I mean, why do they stay in remission when others don't? I think it's compliance. I really think it's compliance and of course, Crohn's disease is one of these really, really nasty diseases that affect people when they're so young. I mean, we have 12-year-olds with Crohn's disease and they don't want to live a life like that. They want to be normal like normal kids and it's very hard for them. It's very easy to fall off the wagon when you're young.

Obviously, the longer you have Crohn's disease, the more it affects the bowel and I mean it can go from the mouth all the way through. I mean, if you were going to have an inflammatory bowel disease, you'd want to have ulcerative colitis far more than you want Crohn's disease. If you have to have one of them.

Jini: Yeah, exactly.

Bianca: Well, that is not easy. There is no easy solution.

Jini: No, there isn't and it's very hard to make people understand the incredibly crucial importance of the emotional component to these things because we see it person after person, day after day, and especially our whole mindset, our whole culture is geared towards symptom-pill, physical occurrence, physical solution. To get them to switch their mind to go, "Oh my diarrhea has increased to six times a day," or "Oh, I've had some blood," what happened emotionally? What do I need to do emotionally? To get someone to go there first is really difficult.

Bianca: Well, and I think that has a lot to do with the fact that they don't connect parts of their body to the other parts of their body. I'm constantly saying to people, "Look, how has your stress been in the last week?" "Well, I've been very stressed." As I explain to them, your bowel is 100 percent muscle. When you get stressed and the whole of your body tightens up and you cleanse your jaw and you shoulders are tight and everything about you is tightening, you're in a knot, you can physically have the ability to relax your jaw and clench your hands, move your shoulders to relax them, but you have no control over the muscle of your bowel. When it tightens up, it needs to take time to unwind and relax itself. If you don't then sit there and physically go into a state of relaxation, meditation, where everything is allowed to calm down even the muscles that are not under your control, if you just get up and just go on, it just doesn't help them.

It's not until people understand that their bowel is not under their control. The muscle of their bowel is not under their control. It's the same as the only control that they have of anything they eat is while it's still in their mouth and before they swallow it. After that, it is no longer in their control unless they put their fingers down their throat and bring it all up again. Once it's swallowed, it goes into a system that they have no control of - other than to try and relax and eat in a conducive manner, in a relaxed state, eat slowly, chew their food better.

Ulcerative colitis and, well, inflammatory bowel disease people tend to eat quite quickly and so their food is not able to be metabolized and processed and assimilated properly. You speak to 90 percent of people out there and you say to them, "You eat too quickly and you don't chew properly," they will say, "Yeah, you're right." You go to a restaurant and watch it and people on average chew six times before they swallow.

Jini: I know, it's quite something. I am, of course, always at least half an hour to 45 minutes slower to eat than everybody at the table. It's a little bit embarrassing, but then of course, it's funny because I say, yeah, I know I'm a really slow eater and everyone says, "No that's good. I need to slow down." Everybody knows they need to slow down.

Bianca: Exactly, and people will then say, "Well what has that got to do with my inflammatory bowel disease?" Well, it's got everything to do with it because everything goes through the bowel. There is not one morsel of food that you eat, the residue of which doesn't go through your bowel.

Jini: Not only that, but like you said, like, okay, so you've had stress – you need to do whatever you do, meditation or prayer or yoga, whatever gets you into that state of deep relaxation, but then I even say to people – let's go a step back beyond that to say what are these people, situations, beliefs, patterns, relationships in your life that are causing this continual, ongoing stress and you need to get those resolved or you're never going to be free of this. You're never going to be free of it.

Bianca: Of course. I mean, I talked to people about good stress and bad stress and all of these things and this is why going out to dinner is such a wonderful thing because you do it in a relaxed state. You do it – well, unless you're having an argument with your boyfriend at the time or your husband or whatever. Generally speaking, we go out to dinner, we're relaxed, we eat more slowly, we have conversation, we are laughing, and that's how you should eat every meal.

Generally speaking, people go out and they're at work, they gulp it down while they're running, they're in a hurry all the time and all of that has a part to play in the bowel, the end result.

Jini: Definitely. Well, Bianca, this has been yet again really wonderful and I'm going to give out your website again. It's www.ColonHealth.com.au and so anybody who wants further information or who would like to consult with Bianca can reach her there.

Bianca, thanks once again for sharing your absolute wellspring of information with us. This has just been wonderful.

Bianca: It has been a pleasure.

Jini: Thank you. Bye.

Bianca: Bye.