RECURRENT MISCARRIAGE SYNDROME TREATED WITH ACUPUNCTURE AND AN ALLERGY ELIMINATION/DESENSITIZATION TECHNIQUE

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In December, 2001, a 33-year-old female—“SC”—gravid 2, para 0-0-2-0, came in with the chief complaints of repeated miscarriage, pain, recent weight gain, circulation problems, feeling cold, premenstrual syndrome, and food and environmental allergies. She had been diagnosed with allergies to dust, mold, ragweed, cats, and sage, a minor reaction to dogs, and also reported that fast foods and milk were difficult to digest. She had frequent ear infections as a child. She complained of fatigue, sinusitis, sinus congestion and sinus pain, dry skin and eyes, frontal headaches, frequent sneezing, stuffy nose, postnasal drip, and phlegm in her throat.

SC also had jaw pain, abdominal pain and cramping, dull pain in her back and neck, and sharp pain in her joints, and she admitted to grinding her teeth. She became very emotionally upset after each of her 4 miscarriages. She felt irritable, angry, anxious, moody, hostile, and impatient and awakened easily.

Menarche began at age 13. She had a regular 29-day cycle with 5 days of red-colored blood with clots, premenstrual abdominal bloating, and emotional changes. She had had 2 artificial abortions before trying to get pregnant. Prior to our treatment, SC had 2 miscarriages, one in August 1999 at 5 weeks’ gestation with no fetal heart tone detected and one in June 2001 at 10 weeks’ gestation after a fetal heart tone had been heard. In total, she had 4 miscarriages, 2 of them while receiving acupuncture.

She and her husband showed no karyotypic abnormalities. Her conventional physician diagnosed her with low serum progesterone levels and treated her with clomiphene citrate (Clomid, Sanofi-Aventis US LLC, Bridgewater, New Jersey). The patient did not menstruate for several months after taking clomiphene citrate and was prescribed first oral and then injectable progesterone.

During week 9 of her fourth pregnancy, the patient’s progesterone levels dropped below 20 nmol/L despite treatment with 17 hydroxyprogesterone (17 OHP). She was diagnosed with luteal phase defect and congenital AT III deficiency after she miscarried on March 8, 2002. By July 1, 2002, she was pregnant for the fifth time. On July 26, 2002, her serum progesterone level dropped to 11 nmol/L. On July 29, 2002 (8 weeks pregnant), she experienced spotting but had no bleeding or cramping. By August 2 (9 weeks pregnant), her serum progesterone was 12 nmol/L, and it needed to be at least 20 nmol/L at that point to support a continued pregnancy. Women with ongoing pregnancies have serum progesterone level range of 390 to 500 nmol/L with the median being 430 nmol/L.

On August 5, 2002, SC began treatment for cholesterol metabolism abnormalities and allergies with acupuncture and an allergy elimination and desensitization program (BioSET, Bioenergetic Sensitivity and Enzyme Therapy). Three days later, her serum progesterone rose to 20.8 nmol/L. She stopped taking the drugs ASA, heparin, and 17 OHP at this point (10-weeks gestation). SC continued to have allergy treatments with acupuncture once a month for the last 5 months of the pregnancy and then once 2 weeks before her due date. She delivered a healthy baby girl in March 2003. Blood tests taken on January 29, 2008, determined that the patient no longer has luteal phase defect nor AT III gene deficiency.

DISCUSSION

Recurrent miscarriage syndrome (RMS) affects more than 500000 American women annually. Approximately 7% of recurrent miscarriages are due to chromosomal defects, 10% are due to anatomic abnormalities, and approximately 15% are related to endocrine or hormonal abnormalities. Six percent of recurrent miscarriages cannot be explained, and 55% to 62% of cases are due to blood coagulation protein/platelet defects.

Women with congenital or inherited antithrombin III (AT III) deficiency and luteal phase defect may experience RMS. There are between 60000 and 600000 people with this blood disorder in the United States. It is a dominant pattern with a 50% chance that a child will have the disorder if one of the parents has it. Men and women are equally affected. Inherited antithrombin deficiency contributes to about 1% of thrombotic events in the affected population with approximately 65% of biochemically affected individuals experiencing a thrombotic event.

Another cause of miscarriages is low serum progesterone levels or luteal phase defect or LPD. Some investigators claim that LPD accounts for over one-fourth of cases of RMS, but studies of this disorder have not included concurrently tested controls. The conventional medical approach for the treatment of low progesterone levels is the use of clomiphene citrate or injectable or oral progesterone.

As seen in this case, taking these drugs may not be effective in raising progesterone levels during pregnancy. Women with RMS who have not had success with conventional medical treatment...
often seek CAM approaches such as Chinese medicine including acupuncture, and patients with allergies often turn to allergy elimination and desensitization.

The patient was treated with an allergy elimination and desensitization system called BioSET. Allergies are determined via computerized testing using electroacupuncture according to Voll or through muscle response testing (MRT). MRT is the practice of using manual muscle strength testing to diagnose patients. In this system, patients touch the allergen while receiving acupuncture or acupressure to balance the immune system and organs and treat symptoms. It is postulated that the treatments SC received allowed for the normal metabolism of cholesterol and allowed her to engender her missing AT III gene, thereby preventing thrombosis during pregnancy. Previous to her last and successful pregnancy, this patient’s AT III activity was less than 0.20 to 0.45 mg/mL, as reported by the Mayo Clinic Laboratory in Minnesota. After this patient was treated for her allergies and malabsorption, she was not only able to carry a baby to full term but no longer had evidence of either the luteal phase defect or congenital AT III deficiency. Her follow-up blood work, also reported by the Mayo Clinic Laboratory in Minnesota, showed that her AT III activity is now normal and that her luteal phase defect has resolved. These treatments may have turned on the AT III gene in this patient by facilitating protein metabolism and allowing for normal metabolism of cholesterol and production of progesterone and other hormones. The elimination of this patient’s suspected allergy to cholesterol allowed her to normally metabolize cholesterol and produce progesterone, thereby eliminating her luteal phase defect. We hypothesized that the allergy elimination and desensitization treatments remitted the antibodies produced in response to allergic reactions and therefore prevented blood clots and that the acupuncture treatments allowed for the dispersal and circulation of qi and blood.

CONCLUSION

This case study presents preliminary evidence that acupuncture and allergy elimination and desensitization may increase serum progesterone remediating luteal phase defect and prevent thrombosis due to AT III deficiency. Ultimately it may be a suitable treatment option for women with these blood disorders to prevent RMS. The author hypothesizes that the intervention will result in progesterone levels of 20 nmol/L or higher during pregnancy, sufficient to maintain pregnancy, and the absence of thrombosis during and after pregnancy. The combined use of biomedical technology, Chinese medicine, and allergy elimination and desensitization enabled this patient to bring her pregnancy to term.

REFERENCES