

MCS - The Poisoned WEB

by Don Richard Paladin

The obstacles to understanding Multiple Chemical Sensitivity (MCS) provide mankind an opportunity to extend its knowledge about health and scientific issues. It also provides us all an opportunity to learn to listen to the wisdom of our bodies as we interact with the nature around us. As a former educator, the issues of learning and understanding become the context through which I filter the issue of chemical injury. We need to recognize the problems before we can find a solution. There are a variety of perspectives on this issue. This paper has mine. Once we come to accept that although there may be some psychological overlay to MCS, it is an affect, the symptoms, of reactions to acute and/or low level chemical exposures. I attempt to explain what I see as the problems in preventing understanding of the issues and then suggest some explanations and direction for action. Ultimately, open, independent search for truth and understanding about chemical injury will be beneficial to us all.

The Hystorical Pattern

" Experience never misleads; what you are misled by is only your judgment, and this misleads you by anticipating results from experience of a kind that is not produced by your experiments." - Leonardo Da Vinci

In 1995 while going to my environmental physician for an appointment for treatment of my chemical sensitivity, he asked me sign a release to send copies of his office notes because the "benefits manager" at my Health Maintenance Organization (HMO) had requested them to determine whether she would approve reimbursement of my treatments. I told my doctor to go ahead and send copies and asked him for the name and phone number of the lady who requested this information. I wanted an open dialogue with her...to educate her about MCS.

The next day I called her at the HMO office. She at first became defensive when I asked her why she needed the records. I got into a discussion about MCS and the fact that there was new promising research linking MCS with a disorder of porphyrin metabolism. I told her that I had gone to conference at which Dr. William Morton of Oregon Health Science University presented his research (1) on the relationship. She became unusually interested. I told her I had both a copy of the research and a video of his presentation. She asked to see them. I dropped them off at her office with a note to return them to me when she was through viewing them

To my surprise all my visits to my environmental physician and the tests he prescribed were approved. After not hearing back from the HMO risk manager for several months, I called her at her office. She was very apologetic for keeping the video and research paper so long. She promised she would drop them off at my home the next day. And she did. We chatted briefly about the information I had shared. I told her about the problem people with environmental illness have with conventional doctors and insurance companies. She told me she knew and understood.

This is when she shared with me her experience with her own environmental illness. Before she had move to the Northwest, she had lived in Ohio and Tennessee . When she lived in Ohio, she said she had some strange facial swelling and visual irritation that she felt was from reaction to the pollution there. She went to the doctor to find out what was bothering her and for treatment. As she was with the doctor, she saw him write in her file, "neurotic female." She said she was very upset with him. Later she decided to move away from the pollution in Ohio to Tennessee. Her symptoms from the pollution in Ohio ended. Before she left, she gave me her business card and asked me to fax or send her any of the latest research on MCS.

I tell this story because in the years I have been involved with support groups with people with MCS, I have often heard the females report similar mistreatment by male (and yes, some female) doctors. It is an old pattern of sexist attitudes toward female illnesses. It is a result of ignorance and being too arrogant to admit that. Over the years I would cut out newspaper articles of the latest illness in which females (and males) were dismissed away by doctors as having psychological problems only to be find out that there was something physiologically wrong with them. I call this pattern of male lack of awareness and understanding of female related illnesses the ""hystorical" pattern. "There is a pattern throughout history where female problems are referred to as hysterical and dismissed away rather than understood and treated. MCS fits in the "hystorical pattern." It often happens in illnesses in which the incidence is predominantly women.

It was reported in the [ATSDR MCS Draft Report](#) on "Epidemiological Studies" (line 477) that there is an incidence of 77% females. It is no surprise that MCS has a 77% incidence of females; and, it has been consistently dismissed away as a psychological problem. MCS fits this "hystorical pattern." If one thinks this "hystorical pattern" is not real, let me simply cite three newspaper articles I have collected over the years. I have three, but one article I did not write the date I cut it out . Still I will quote from it. All articles are from The *Bellingham Herald* in Bellingham, WA.

Title: "Rare heart disease hits mostly women," January 17, 1990, and I quote, "San Antonio (AP) -Tens of thousands of American women are being misdiagnosed as suffering from psychiatric disorders when they are in fact suffering from an unusual form of heart disease, a researcher says.

The women, who have chest pain but not signs of heart disease by conventional tests, are suffering from a treatable disorder of the small arteries, said Dr. Richard Cannon of the National Heart Lung and Blood Institute in Bethesda, Md."

This is the most classic example of the "hystorical" pattern. Survey a few hundred females with MCS and ask them how they were treated by many of the conventional allopathic physicians to whom they went to seek diagnosis and treatment. The next example relates a story about an illness in which 90% of patients are female.

Title: "Bladder ailment disrupts lives of thousands," (no date, sorry) , and I quote, "Washington (AP) -- A painful, debilitating bladder condition -and not always taking seriously by the medical profession -is a real disease that disrupts the lives of thousands, experts say.

The first major study of the impact of the disease, released at a two-day National Institutes of Health meeting that ended Saturday, estimates that as many as 90,000 Americans have been diagnosed with the condition which undoubtedly afflicts many times that number.

At least 90 percent of those who suffer with interstitial cystitis, or IC, are women and the remainder are men and children, specialists said. ...

... Dr. Vicki Ratner, founder and president of the Interstitial Cystitis Association and an IC sufferer herself, said the condition long went unrecognized because it is difficult to diagnose and has no obvious cause.

In addition, she said in an interview, some doctors dismissed it as an imaginary "women problem" stemming from emotional difficulties rather considering it a life-disrupting disease."

This pattern of unenlightened disdain is exactly what people with MCS must face. Although, as a male, I was always treated respectfully by the allopathic doctors to whom I went to for diagnosis and treatment, I had to on occasion force them to admit that they did not know what was going on with me. I eventually went for alternative treatments because the allopathic physicians refused to look for an answer beyond their current level of understanding and attempt to understand what was happening with my environmental illness.

The third article is not particularly about women...but the "hystorical" factor is reported in this one, too. Title: "Neurological disorder often misdiagnosed as psychological," June 5, 1991, and I quote, " New York (AP) -People whose hands cramp only when doing certain tasks, whose voices break or tremble or whose eyes shut uncontrollably often are misdiagnosed with a psychological problem when they really have a treatable neurological disorder, researchers say.

The condition, called dystonia, can also twist the neck, limbs or body, hampering walking and other actions.

Some patients see psychologist for years before getting the correct diagnosis, said neurologist Stanley Fahn of Columbia University in New York. ..." It makes one wonder how many of the patients with dystonia are female.

Historical Pattern - Looking for a Pattern throughout History

Any piece of knowledge I acquire today has a value at this moment exactly proportioned to my skill to deal with it. Tomorrow, when I know more, I recall that piece of knowledge and use it better. - Mark Van Doren

All our knowledge has its origins in our perceptions. - Leonardo Da Vinci

Although I have alluded to an unawareness, another problem is presumptuousness and a belief that "all" essential information is already known. Interestingly these two

human limitations and patterns are the real culprit to impeding the understanding of new information. Throughout human history the gatekeepers of truth assume that they have access to all the fundamentals of truth. They are limited by their own ability to understand beyond the limits of what has already been learned. The information they know becomes their "belief system" and the filter through which they evaluate all new information. Many times these gatekeepers cannot reason past their own limited understanding, dogmatic views, and rigid protocols. They are not the innovative thinkers of their time. They discover nothing new. Often the gatekeepers of truth are motivated by their own power and maintaining it. They assume they have the "truth" and their role as gatekeeper is to protect others from the false prophets who exist to challenge the conventional wisdom. Look at human history and find this pattern continually repeated. When The Church was the absolute power, it was the gatekeepers of conventional wisdom then who were obstacles to new knowledge being accepted.

When religious power was displaced by scientific power in society, its adherents became the possessors of conventional knowledge of their times. They had acted as obstacles in the movement to greater understanding about what was then not known. The doctors and scientists of their times knew what they knew. Each new leap in understanding never came any easier than it ever has.

Look at the historical pattern and one will understand why MCS has not been recognized as an disorder. The opponents of MCS could not reason beyond their current level of understanding. They most often functioned from a premise that MCS was a psychogenic, psychological disorder that was not an illness that responded to "treatment." This premise absolved them of any responsibility to treat something that was in their opinion not an illness. They became vested in the belief system that MCS was psychological. It was the only possibility that offered them an explanation they understood. Their objective conventional testing protocols demonstrated that most people with MCS did not have cancer, infections or antibody mediated allergies. This major premise was so strong that any new information which was not part of their conventional knowledge and training was rejected. Because they are in the power structure, they can reject any new knowledge submitted to their peer reviewed journals that contradict their current level of understanding.

This is not to imply that proponents of MCS as an illness understood the issues completely. If they did, they could have satisfactorily explained it to the skeptics in the opposition who needed "objective evidence" that this is truly an illness. The MCS proponents did better understand the issues and did try to explain with new objective measures to document the disorder.

The problem was that anything new immediately became suspect because its association with what had already been determined was a psychological condition reinforced by quacks.

Many who discovered new information in their times did not receive immediate acceptance of this new knowledge. Ignaz Semmelweis (the relationship between germs, hand washing, and infection) , Joseph Goldberger (the relationship between niacin and pellagra), Kilmer McCully (the relationship between heart disease and homocysteine) and Barry Marshall (the relationship between Helicobacter. pylori

and ulcers) all faced the dismissal of their new discoveries by their peers because the information they presented was not part of the conventional wisdom and understanding by those within the established order. Unfortunately, those without personal experience with MCS know what their perceptions and understandings tell them is the truth. Their knowledge and experience tell them it is not possible to be sensitive to low levels of volatile chemicals.

The greatest hole in the logic of those who use a long held, rigid protocol or belief system to explain problems is the assumption that the current understanding and knowledge reflect what is always going on. One must assume that the biochemical issues of MCS and other similar disorders have always existed. The explanation that they had a purely psychological cause is a result of that lack of understanding of what is happening at the cellular and biochemical level. The opponents of recognition of MCS and other similar disorders often go back to history to point to the diagnosis of psychological problems in the past. This is tantamount to the expert mechanical engineers of the Motel T Ford being used to explain with their level of understanding the mechanical problems of a Boeing 777. The basic problems may be recognized. The solutions will not.

Using "stress" as a cause or explanation of any illness or "ailment" does not explain what is specifically happening. There is no significant explanation why someone reports the symptoms they have. This translates into a medical diagnosis that there is NO problem except a psychological one. Even purely psychological problems have been found to have a biochemical component.

The real question becomes: What causes the symptoms of MCS?

Finding the Root Cause

The issue of attempting to explain a cause of MCS is most crucial. There may be some psychological overlay; but, there is with many illnesses. Symptoms are not causes

The research by Dr. Robert Haley (2) on Gulf War Vets helps in understanding the issue of detoxification. Haley investigated a genetic deficiency of the enzyme serum paraoxonase. A deficiency is implicated in the inability of some to detoxify organophosphates and similar toxins.(3)

"One of the biggest questions about Gulf War syndrome has been why one person got sick when the person next to him didn't," Haley said.

"That is one of the major puzzles that made many people think the symptoms were just due to stress.

"But now we know that there appears to be a genetic reason why some people got sick and others didn't, and this genetic difference links the illness to damage from certain chemicals."

Haley's study showed that people with a gene that causes them to produce high amounts of a particular enzyme did not get sick after exposure to certain chemicals in Operation Desert Storm, while others who produce low amounts of the same enzyme did get sick.

The culprit gene is the one that controls production of type Q paraoxonase, or PON-Q, an enzyme that allows the body to fight off chemical toxins by destroying them. This particular enzyme is highly specific for the chemical nerve agents sarin and soman as well as for the common pesticide diazinon.

It is highly likely that many individuals with a deficiency of the enzyme PON Q will have problems detoxifying this poison. Please note that scientist have known since around 1976 that a PON 1 deficiency predisposed one to an inability to detoxify organophosphates. We are just now learning who those people are who carry this genetic predisposition.

Professor Michael Aviram, a biochemist, head of the Lipid Research Laboratory, Faculty of Medicine at the Technion-Israel Institute of Technology and at Rambam Medical Center in Haifa, Israel has the following to say about paraoxonase: 'The real function of the enzyme has been something of a mystery since it was discovered more than 40 years ago. Its previously known function was to break down organophosphates, chemicals that are used as insecticides and poison gasses. That activity was obviously not the complete story of paraoxonase, as humans do not normally contain these substances in their blood, Aviram realized.' [Source]

If one thinks that genetic differences in ability to detoxify a variety of substances is not a real problem, then one has not heard about a 1998 study in The Journal of the American Medical Association about people becoming ill and dying from drug reactions. (4) On July 29, 1999 CBS News reported: "Approximately two million people are hospitalized each year for drug reactions and nearly 100,000 die. Now doctors are paying more attention to the fact that nearly thirty percent of the population may be taking drugs their genetic makeup can't handle" (5)

All these drugs, like many toxic chemicals, have been tested and approved for use. The problem with most research conducted by industry is that they don't consider biochemical individuality and that we all cannot detoxify the same chemicals.

Both environment and nature (genes) have an impact upon all lives. In the case of some of us, genes like the gene for the PON Q enzyme that detoxifies organophosphates existed in humans and animals way before the creation of these synthetic poisons. The fact that some of us CANNOT detoxify these synthetic poisons does not necessarily mean our genes are defective. It probably means that the synthetic poisons should not be imposed upon the living. Think about it!!!

Chemical-Induced Porphyrinopathies

Although serum paraoxonase may not explain and/or be implicated in the cause of all detoxification issues of MCS, researchers need to follow a path that suggests a connection to a disorder. William E. Morton, M.D. tried to follow a connection to the

pattern he saw in individuals with environmental sensitivities. His research on over 100 subjects with chemical sensitivity and a disorder of porphyrin metabolism was rejected by those gatekeepers of conventional wisdom. He found a 90% congruence between MCS and porphyriopathy, so that he believes porphyriopathy could be used as a biomarker. (source) Dr. Morton shares more in common with the likes of Barry Marshal and Kilmer McCulley than many of his peers who could not reason beyond their current level understanding in the discovery of new information. He will long be remembered after all the gatekeepers of conventional wisdom have been forgotten.

There is a controversy surrounding the diagnosis of a porphyrin disorder as it relates to MCS. The Washington State Department of Labor and Industry in collaboration with others changed their reference range of lab results used for acceptance of a disorder of porphyrin metabolism. (7) When I took statistics as a college student, I learned one fact that gives me hope. In a normal distribution, abnormal is abnormal. It may be "economically correct" to change the reference ranges to prevent individuals documenting their abnormal responses to a toxic induced porphyriopathy, but the normal distribution that exists in the real world population will not be changed with this kind of manipulation.

The major controversy is about the amount of porphyrins in our blood, urn, and stool tests. I will let the experts split hairs about this issue. The porphyrinologists say we cannot have "true porphyria" because those of us with MCS don't have acute levels in all three tests. Rather than being able to discern a continuum of response, they have defined a rigid set of criteria that excludes out only the most extreme possibilities. Although MCS is not likely an acute porphyria, the similarities and diagnostic evidence suggests a relationship that must be followed and researched.

In "The Porphyrins" (Disease-a-Month, January 1989, Year Book Medical Publishers, Inc. p. 9-10.) Drs. Joseph R. Bloomer and Hebert L. Bonkovsky write, " It is also important for the clinician to realize that several different diseases, particularly hepatobiliary disorders, may be associated with a mild to moderate increase in urinary porphyrin excretion, especially coproporphyrin. This is termed secondary porphyrinuria. Since some of these patients may have symptoms that suggest porphyria, they may be misdiagnosed unless careful biochemical studies are performed. Most importantly, the secondary porphyrinurias can be separated from true Porphyrias by measuring the urinary level of ALA and porphobilinogen. These compounds are not elevated in the second porphyrinurias."

Am I the only one who wonders why no one sees a relationship between the ability for the liver to detoxify and a mild to moderate increased level of porphyrins?

In the same article they go on to write about the "Clinical and Biomedical Features" (p.35) that, "The hallmark of HCP is moderately to markedly increased excretion of coproporphyrin III in the feces, and to a lesser extent in the urine. During acute attacks, urinary excretion of ALA and PBG are also increased. Unlike AIP, acute attacks of HCP typically are characterized by urinary ALA excretions exceeding those of PBG (in mg/24 hr)."

Many porphyrinologists believe that MCS with a lower range of abnormal levels of porphyrins cannot be "true porphyria" because there must be high levels of aminolevulinic acid (ALA) and porphobilinogen (PBG) to have Hereditary Coproporphyria (HCP). Much of the controversy over the relationship of MCS to a disorder of porphyrin metabolism, particularly acute attacks of HCP, hinges on this diagnostic criteria. I would like to present what Dr. Dave C. Downey, D.M.D., Assistant Professor, Department of Pathology, Oregon Sciences University, School of Dentistry in Portland, Oregon wrote on this issue.

In a paper titled "Hereditary Coproporphyria" Dr. Downey writes in his "discussion," "Moore (1) describes the urine finds as variable if the patient is not in an attack. Bissell (3) agrees saying heme precursors vary widely in carriers. Wintrob (11) states urine Coproporphyria may be profoundly increased during symptomatic periods but usually is normal during remissions. Stool porphyrins appear to be most critical in identifying Coproporphyria according to Berger(12) and Cripps.(13). Even in Acute Intermittent Porphyria where it is thought that urine porphyrins are always elevated, Tishler (14) found 18 patients in a mental hospital with diminished uroporphyrinogen-1-synthase levels while only 8 had elevated levels of porphobilinogen in the urine."

Dr. William. Morton , as mentioned, is a proponent of the relationship between a disorder of porphyrin metabolism and Multiple Chemical Sensitivity. Dr. Morton reviews his research in his paper presented on 6-6-95 at the Second International Congress on Hazardous Waste: Impact on Human and Ecological Health titled: "Redefinition of Abnormal Susceptibility to Environmental Chemicals." Dr. Morton shares the view with Dr. Downey that, " Quantitative 24-hour urine and stool porphyrin excess will identify metabolically active cases. Excess 24-hour urine porphobilinogen (PBG) and/or aminolevulinic acid (ALA) will usually be present in acute attacks of porphyria but not in cases with chronic or absent symptoms (Moore 6, Ellefson 7)."

On table 5, Comparison of Abnormal Deficiencies of Blood-Cell Porphyrin Enzymes by Excess Urinary and Fecal Porphyrin Excretion, Dr. Morton documents this pattern of elevated porphyrins in the stool but not necessarily in the urine of MCS patients who were test for Coproporphyria CPG-O deficiency. In a population of 16 subjects that test positive for Coproporphyria eight test with excess porphyrins in their stool and 4 with it in their urn. Four had no porphyrins in their stool and eight had none in urn.

Dr. Morton does not draw a conclusion that MCS is an acute porphyria. Instead, he believes that, " The MCS syndrome overlaps to a strong degree with the clinical symptoms and courses of chronic Porphyrias. The activating environmental chemicals, medications, and foods are virtually the same for MCS and the Porphyrias."

Although many of the opponents of MCS, and those with rigid belief systems, would like everyone to believe that there are no valid biomarkers for MCS, many of the lab results on patients reflect abnormal porphyrin levels. Some of these tests are criticized by the opponents as being invalid because they are not in the upper limits (acute levels) of abnormal. They also exclude the possibility that people with chemical hypersensitivity REACT to low levels of toxic chemicals. It would seem perfectly

logical that an abnormal response at less extreme levels would reflect the pattern of the unique sensitivity of the individual to the "chemical-induced porphyriopathy." In other words one would expect that lab results would reflect a low but abnormal level of porphyrin metabolism commensurate with the quantity of the porphyrinogenic substance. Have the porphyrinologists ever considered the possibility that lab results are porphyrinogenic substance dose dependent? Have they ever considered that a liver dysfunction may be implicated in both detoxification and porphyria?

The questions an investigator with an open mind would propose would be: What is the mechanism by which those who are chemically sensitive become ill? What are potential biomarkers that indicate both physiological and emotional imbalance? Are individuals with MCS a reflection of a continuum of response from the porphyrin mechanism or are they a secondary (type II) and only peripherally related illness? There are many more questions to be answered than we presently have answers for now. RESEARCH must be funded.

[Searching for the Elusive Biomarker](#)

Without validating and corroborating objective evidence the opponents of Multiple Chemical Sensitivity (MCS) as a disorder can persist in denying any relationship between low level toxic chemical exposure and the symptoms they trigger. We must set the burden of disproof of the existence of MCS at an even higher level. If evidence of reactions at a physiological level to low level toxins can be consistently demonstrated, then the use of argument that MCS is a purely psychological condition cannot be used to neutralize those with and those who support the existence of MCS. Because at this point there is no "universally accepted" diagnostic marker for MCS that demonstrates a relationship between low level exposure and symptoms, we must use all available tests that indicate a possible biochemical imbalance. We must use a number of objective assays to challenge the notion that there is no evidence of a physiological disorder. If we can find objective evidence that is universally accepted then all other related issues will be resolved. A cause for the mechanism must be found through active research in order to prevent further injury and to remediate and treat those who presently are impaired. In order to find solutions of problems faced by the chemically injured, let us all resolve to advocate for the research to find these biomarkers

How can low levels of mixed volatile chemicals impact humans?

All things are connected. Whatever befalls the Earth befalls the sons of Earth. Man does not weave the web of life, he is merely a strand in it. Whatever he does to the web, he does to himself. - Chief Seattle

It is always important to recognize the pattern and the relationships between things. Often we dismiss off hand those things that are not apparently obvious. It just does not seem logical to us that a mixture of low level toxic chemicals could have a detrimental impact on humans. People do not immediately die from exposure to them. For many, there is no "noticeable" effect of the thousands of daily exposures. It does not seem possible that anyone could be sensitive to small amounts of air borne, water borne and material borne toxics. For most of us, it is not our experience.

There is research to indicate that human, like lower animals respond to low level volatiles. Anyone with doubts about this ability should review the research on human pheromones. Although pheromone research may not explain a mechanism for MCS, it may demonstrate that humans, like lower animals, respond to very low level volatiles, in this case human hormone odors..

We don't understand the mechanisms; but, humans, as demonstrated by research, respond to and are unconsciously aware of other human's pheromones. In an article on CNN on August 17, 1998, they report: "Study: Male substance affects women's mood." According to their report, "Women who breathed in substance related to testosterone stayed in a better mood than when they weren't exposed. ... The study suggests such hidden chemical signals may affect people's minds more than scientists have assumed, said psychologist Martha McClintock of the University of Chicago. ...Scientists have long known that smells affect how people feel. The new work is the best evidence yet that undetected olfactory signals can do it too, McClintock said."

Anyone with chemical sensitivity who is aware of their interactions with their environments will not find it difficult to believe that we can detect and respond to low level exposures of chemical combinations in our environment. Dr. McClintock's research documents that some odors (low level odors) can have a positive impact upon the receptor. It should be no stretch of logic to realize that other chemicals, particularly estrogen mimickers and other endocrine disrupters, have a negative psychological and physiological reaction upon some receptors. It is highly likely that it is a function of evolution that certain odors trigger an aversive reaction (both emotional and physiologically) so that we have a fail-safe protection against potential harmful environmental triggers. There are some of us who are just more sensitive to chemical messages in our environment.

This is why it is critical to understand and accept the relationship between environmental triggers and symptoms of psychological and physiological distress. These messages received have been programmed throughout evolution to both protect and propagate the species. Some odors attract and enhance life. Other odors repel because they were designed to deplete life or are detrimental to the processes of evolution. The common denominator becomes biochemical responsiveness. The fact that humans react to very low levels of hormone like substances has been recognized and documented. (source). It should be not surprise to anyone that many of the environmental triggers for MCS are endocrine disrupters like pesticides and plastics.

The Co-factors: Nature and Nurture

When evaluating the impact of human response to an environmental stimuli, we must consider both the environmental trigger and the responder's [biochemical tolerance](#) for that particular trigger. It has been suggested by some that odor intolerance can be a conditioned "chemophobia." In other words, the responder has learned to avoid a chemical odor for which s/he has developed an aversion. This may be possible; but, it must be taken in context of learned behavior in response to biochemical individuality. Nature and nurture work together.

For example, when I was sixteen and thought I was very cool, I became extremely drunk on Four Roses Whiskey. I did not like the taste; so, I drank it down as fast as I

could. Being my very first experience with hard liquor, I did not know what to expect. I got the lesson of my life. I became extremely sick. I vomited and vomited. I remember before becoming sick, gagging at the smell of the last drinks of whiskey I took. In fact, gagging was my most powerful memory of that experience. After I could vomit no more, I went to my bed and passed out. The next morning I awoke still dazed and somewhat depressed from the experience. I walked past the empty glass with the smell of whiskey still in it. It caused the gag reflex. In fact, for two years after that, the smell of whiskey would cause me to gag. It is obvious that my experience set up a conditioned response to whiskey. I never drank it again.

Knowing now that I was never a fast metabolizer of alcohol, I realize that my body's response to the alcohol was its way of protecting me from a nonessential and possibly harmful substance. If milk was non bio-compatible with my chemical predisposition, I probably could develop an aversion to it in the same manner. It would be much more unlikely that I would develop a gag response to pure water. When looking at the impact of any environmental stimuli, one must also consider the unique tolerances of the responder. We are all unique.

One wonders why it is so hard for our logical scientists and medical professionals to accept that toxic chemicals cannot be detected and responded to with negative symptoms by those who have a more highly evolved level of sensitivity and a lower level of tolerance. Common sense tells us that it is not illogical for living organisms to respond negatively to synthetic chemicals and biocides that have never been a function of evolution. Toxic chemicals do impact all life, including humans. There are many of us who can detect and respond adversely to them. Our bodies scream at us to avoid them. Do not discount the elegant wisdom programmed into our bodies.

The best hope is that those with a short term economic self interest to prevent recognition of MCS because of the potential liabilities caused by their products realize that it is in their best interest to find the cause of MCS and find a treatment for those who suffer from it. It is highly likely that since MCS is not an allergy, is not an infection, and is not cancer; but, that it may be a metabolic problem with some psychological overlay. I realize it might be naive to think that those with a vested interest in maintaining a strong "bottom line" would ever consider stopping their campaign and lobbying against recognition of MCS unless they realized that it was in their long term best interests to treat the symptoms of this illness.

This may actually be feasible. One must accept the hypothesis that MCS is a result of a deficiency of some metabolic enzyme(s) that prevents the natural detoxification of toxic chemicals even at low levels. If this true, then like in the case of those with diabetes with a deficiency of insulin, a natural occurring enzyme may be given as a shot or worn as a patch as a treatment to those who cannot effectively detoxify even low levels of chemicals. Although MCS is not an antibody mediated response, there may be yet [undiscovered knowledge](#) that will help understand the overlapping of MCS and allergy.

The questions that flood my mind at the possibilities of solving a metabolic problem are: Can [enzyme enhancements](#) be found that solve metabolic problems? Are many of the chronic illnesses that don't respond to drug therapies really metabolic and will they all respond to a new school of medical treatment: Enzyme Enhancement

Therapy? Are many emotional problems (also not cancer, not infections, and not allergies) really metabolic deficiencies that will respond to this new Enhancement Therapy? And so on....And so on.

Conclusions

Since I have developed chemical hypersensitivity, much of the processed food is intolerable. The water, air, and soil are often intolerable. The roads, the parks, and the buildings have become inaccessible. Why? We are presently living under the assumption that we are smarter, we are wiser, and we are more clever than the original Great Design. Some of us believe that we have found the "final solution" to all our problems. Some believe that we need to kill the weeds, the insects, and other living creatures to have a better world. We have interfered with the natural ecological processes; and, there are consequences. Those of us with toxic induced disorders are consequences of this reckless and short sighted behavior.

Instead of looking upon negative information about chemically induced toxicity as an obstacle to personal and corporate profit, we should be looking at that information about the consequences of toxic chemicals not being metabolized as a potential for solution to new problems and the creation of new products and new and more effective treatments . We must always stay open in the investigation of truth. MCS research must be FUNDED. Please, help us find effective treatments to this illness. Please help us restore the planet.

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addendum: A recent article - [Scientists Identify A Cause Of Fainting Syndrome](http://www.sciencedaily.com/releases/2001/02/010215074346.htm) in Science Daily magazine documents how a fainting syndrome found mostly in young women which was once thought "hysterical" has discovered a physiological cause. (<http://www.sciencedaily.com/releases/2001/02/010215074346.htm>)

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