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Stress Detoxification

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Background

- [Free eBook on stress detoxification here.](#)
- [Chloride Cycle and Toxin Addiction](#) (Alcohol, Nicotine, Opiates, etc.)
- [Video Narration/Tutorial Here](#)

Regardless of pH, Alkalosis is always present when the breath rate is depressed.

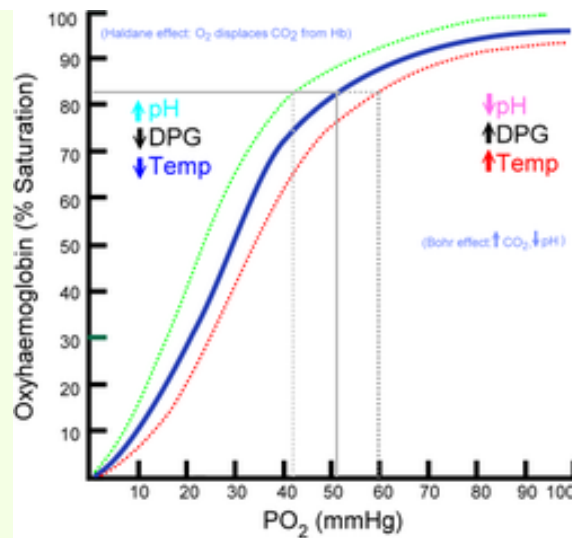
When breath rate is below 16 breaths per minute, the body is retaining Carbon Dioxide as carbonic acid. [This is the Bohr Effect](#), documented by Christian Bohr, Niels Bohr's father.

Sponsors

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Legal Notices



If breath rate is greater than 17 Breaths/Minute, then acidosis is likely. Do not use these protocols.

Metabolic Acid Titration

Metabolic acids are often used to replenish metabolic acid depletion at each urination. Application of these acids accelerates the normalization rate by providing phosphate and chloride agents which enable accelerated detoxification and symptomatic neutralization in cases where infection is present.

Urinary alkalosis is a telltale for systemic alkalosis, the body dumps alkali mineral to compensate for the absence of acid, causing the urine to swing alkali. Switch from alkali to acid urine is an interim indicator of partial correction. The body stops dumping alkali mineral to compensate for acid depletion.

Test the [Breath rate as alkalosis indicator](#). Use the breath rate alkalosis level to determine titration level at a 4 hour interval. Repeat the titration whenever breath rate decreases.

Protocol Overview

Stress detoxification is a four stage protocol. The protocol consists of taking 1-3 capsules each morning depending on weight and tolerance. In cases where alkalosis does not resolve within three days, then use Ammonium Phosphate capsules to titrate pH into range as necessary.

The protocol uses combination of chloride and phosphate donor substances to restore metabolic acid nutrients.

Phase	Description	Duration	Purpose
0	Flow Test	2 hours	Confirms ability to release bile into the digestive system to prior to activating toxin flow. Toxin release without bile flow indicates you should not use this protocol until bile flow is restored..
1	Buffer Restoration	2d -1w	Restores acid buffers to resolve metabolic crisis.
2	Caustic Flow	2d - 2w	Active elimination of caustic toxins, flourine, and high priority toxins from the body. Tends to create bladder stress for gall and urine bladders.
3	Casual Flow	2w- 2m	Ongoing elimination of cellular toxins to resolve long-term accumulation.
4	Maintenance	as needed	Repeat flush at intervals necessary to maintain gains

Breath Rate Test

Sit quietly with a timer. Count your breaths for 5 minutes. Use the following table to determine the level of alkalosis. Disregard both Urine and Saliva pH values for titration (see Bohr Effect above).

For the titration, test breath rate every 4 hours. In the beginning, test your breath rate hourly. When it decreases, repeat the titration using the schedule below. Within a day you should get a feel for your titration schedule. The salts, over a period of 1-3 months usually normalize the metabolism.

Regardless of Urine And Saliva pH, breath rate determines alkalosis. Only when the breath rate is normal, 16 breaths/minute, do Urine/Saliva values indicate acidosis/alkalosis.

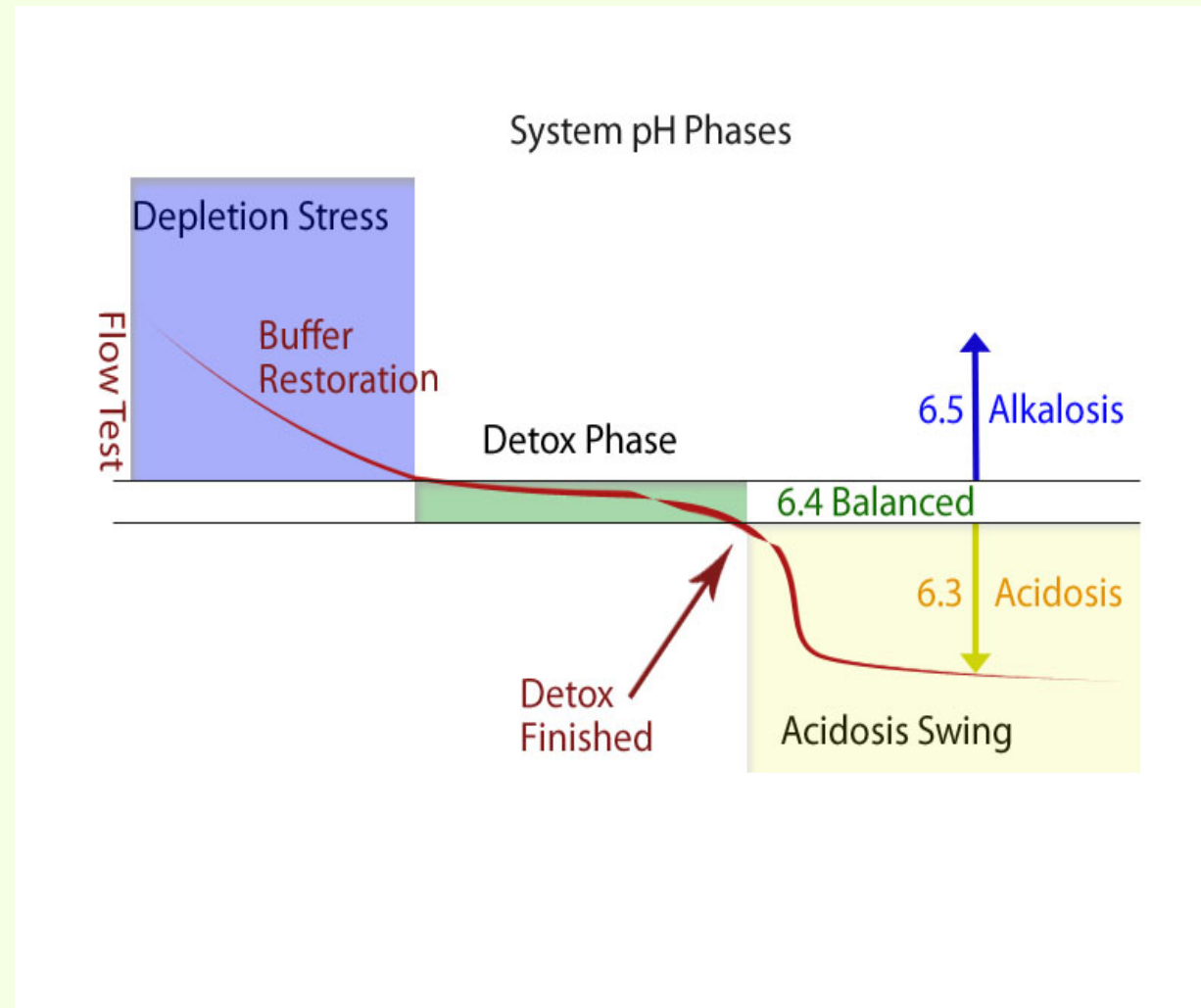
Breaths / Minute	Alkalosis Degree	Respiratory Alkalosis Index	Notes
17+	Acidosis Potential	0	
16	None	0	
14	Minor / Tending	1	Increase dietary salt intake. Use acid salts with meals to replenish reserves.
13	Minor	2	Consider titration. Use Alkalosis Severity index to manage titration below.
12	Increasing Severity	3	
11	+	4	
10	++	5	
9	+++	6	
8	++++	7	Consider titration. Monitor Breath Rate and ASpH. Tendency to chronic hypochlorhydria and phosphate depletion.
7	Severe	8	
6-	COPD Candidate	9+	

Note: Individuals with an alkalosis severity index greater than 6 should obtain a medical assessment for COPD prior to using a hyperbaric chamber.

pH Testing

When the breath rate is normal, about 16 breaths/minute, or below, then Urine and Saliva pH indicate collateral metabolic compensation response.

Depletion stress indicates the body is dumping alkali minerals to compensate for acid depletion. Acid tending pH indicates the body is likely dumping H⁺ as a compensation response.



pH Titration

Always use pH titration when the Breath rate is in normal range.

pH testing uses either a pH meter or pH paper. Testing uses both saliva and urine to determine systemic pH. Both urine and saliva values are important. Calculate Adjusted pH using the Urine and saliva pH values.

This schedule should be used during each urination until alkalosis no longer presents. There is a tendency for ASpH to swing acidic during titration. This occurs when the body stops dumping alkali mineral to compensate for acid depletion. Use [Breath rate as alkalosis indicator](#). Use the breath rate alkalosis level to determine titration level.

Test and calculate the Adjusted System pH at each urination. Use the indicated number of Ammonium Phosphate and salt blend capsules. If the breath rate does not increase, then reduce the test interval by one hour. This will increase administration frequency and titration.

After you determine ASpH, then use the value to determine your status

Process
Measure Saliva pH = SpH
Measure Urine pH = UpH
$(SpH + SpH + UpH) / 3 = ASpH$

The status indicates how you should proceed with the detox.

ASpH Value	Status
Greater than 6.5	Alkalosis
Equal 6.4	Balanced
Less than 6.3	Acidosis

pH Titration Schedule with Saliva/Urine When Breath Rate=16

ASpH	Weight					
	Supplement Timing: U-Urination M-Morning					
	30-90		90-150		150+	
	Child Capsule	Capsules	Adult Capsule	Capsules	Capsules	
Secondary Indicator Use when Breath rate is normal (16)	Child Salt Blend	Ammonium Phosphate	Salt Blend	Ammonium Phosphate	Adult Salt Blend	Ammonium Phosphate
7.0+	1 M	3 U	1 M	5 U	1M	7 U
6.9	1 M	3 U	1 M	4 U	1 M	6 U
6.8	1 M	2 U	1 M	4 U	1 M	5 U
6.7	1 M	2 U		3 U		4 U
6.6		1 U		2 U		3 U
6.5		1 U		1 U		2 U
6.4	Not in Alkalosis					
below						

Distress Indications

Distress indications normally indicate progress. They also indicate you should take a rest day or two from the protocol to allow you body keep pace with the detoxification stress.

Indication	Indicates	Response
Persistent Diarrhea	Bile is too toxic to remain in intestines.	Tolerate up to 3 stools daily. Take a protocol break of 2 days after 2 days of diarrhea *
Gall Bladder Discomfort	Toxic gall is resident in the gall bladder and is likely causing discomfort	Take 4 choline - Relief in 15 minutes Take a rest day and skip acid balance salts tomorrow
Uncomfortable Urination	Strong urine present in urine bladder.	Drink 8 ounces of water every 30 minutes for 2 hours

*Protocol breaks have a delayed response in resolving diarrhea. It usually takes about 2 days for cell to liver toxin flow to diminish enough to reduce bile toxicity enough to stop diarrhea. Diarrhea is a

detoxification success indicator. It stops when the intestines can tolerate the bile that exits the liver.

In extreme detoxification cases cases, diarrhea may persist for a week.

Betaine-HCL Support

Most individuals with alkalosis required digestive support. [Use the Betaine HowTo at each meal.](#)

Betaine-HCL provides stomach acid and will aid digestion and reduce malnutrition which virtually always accompanies alkalosis stress.

[Use of insufficient amounts of Betaine-HCL may increase digestive discomfort.](#)

Chloride Nutrients

The recommended daily amounts for individuals of various weights. Amounts are in milligrams. These amounts should preferably be taken in the morning with breakfast. This salt blend is also used in the Alkalosis titration schedule below.

	Weight in Pounds and Salt in Milligrams				
	Under 30	30-90	90-150	150-225	225+
Magnesium Chloride	0	110	225	450	675
Ammonium Chloride	0	110	225	450	675
Magnesium Thiosulfate	0	110	225	450	675
Salt Blend Total	0	330	675	1350	2025
Capsules (c=child a=adult)		1 c	1 a	2 a	3 a

In most cases individuals will tolerate the amounts recommended without stomach upset. If this is too much salt to take at once, half dose and take at 30 minute intervals.

Flow Test

The flow test is a two hour program to confirm bile flow. Release of cellular toxins when the bile path is clogged creates significant stress. If the flow test fails, consider a biliary dissolving or clearing program.

The bile flow test enables whether your bile path is open enough to allow toxins released from cells to pass to the gut. Choline is a B Vitamin which causes the gall bladder to spasm. The test works by successive increasing the choline dosage.

Do not use large choline tablets which come in 600 mg dosages. In congested cases, this is often enough to trigger a severe gall bladder attack. This schedule gradually increases.

The test is successful if either:

- The sequence completes without discomfort;
- You experience a loose stool, which indicates successful gall bladder spasm released bile.
- Stop the sequence if this occurs before you complete the schedule.

Minutes	150mg Capsules	Choline (mg)
0	1	150
30	2	300
60	3	450
90	4	600
120	6	900

If you complete this sequence successfully then your bile path is likely clear enough to support the detoxification process which will create larger quantities of toxic bile.

Background

Chlorine and metabolic acids play a major role in metabolic process including immunity and stress management.

Revisi documented that creation of certain fatty acids in abnormal cells consumed very large quantities of chlorine causing systemic deficiency both under stress, or shock, and as a component of pathogenic process.

Most individuals chlorine imbalance tend to have an elevated urinary pH, and salivary pH presenting as systemic alkalosis.

It is unknown if the chlorine dysregulation is pathogenic effect, or a response to pathogenic effect. It seems likely it is a response, because of similarity of the physiological condition across pathogenic and non-pathogenic challenge. Experience suggests mobilization of NO₃, toxins having an acidic character, likely indicating enhanced cellular release of acidic toxins.

Regardless of cause, it is clear however that chlorine depletion presents chronic, escalating and often dangerous, consequence of physiological challenge. This protocol is designed to address both chlorine deficiency, as well as restore chlorine/sodium balance in the digestive system.

The protocol was developed in response to the inability to restore digestion in certain individuals with acute chlorine deficiency. These individuals took 50 betaine tablets, and still did not seem to have restored the acid component of digestion.

This inability suggests that other methods are needed.

Chlorine Dysregulation

Chlorine dysregulation has been observed frequently. Individuals usually report upper GI discomfort. Doctors respond by using a scope to search for blockage. Normally none is found.

There are several typical complaints:

- Heartburn or acid reflux (see betaine page);
- Chronic bloating below center/left rib cage;
- Poor digestion/flow in the upper GI tract.

Long term chlorine deficiency may result in uncomfortable esophageal lesions, irritation, and in severe chronic cases may result in cancer as chronic lesions mutate into cancerous tissue.

Evidence of Chlorine Accumulation

This research is supported by Chinese practitioners who use electric currents to treat cancer tumors, who report that treatment releases large quantities of chlorine into the air during treatment. This chlorine release is not consistent with electrolysis which would cause salt to precipitate.

Individuals with acute chlorine imbalance often report digestive stress with excessive bloating in the upper GI tract, typically below the rib cage.

Probable cause of digestive issue, upper GI bloating/distension:

- Long term stress has triggered overproduction of abnormal UFAs in cells throughout body;
- These UFAs absorb huge quantities of chlorine causing systemic chlorine deficiency;
- The chlorine deficiency imbalances Sodium, ([Sodium Bicarbonate](#)) in the pancreas and upper small intestine
- Creating persistent, and often acute, inflammatory constriction of the upper GI;

Stress, from any combination of physical trauma, disease, or psychological challenges, are a big factor in the phenomenon.

Revisi documented that the upper GI inflammation, top part of the small intestine, was a universal autopsy finding, in animals which were “stressed to death”. He asserted that stress triggered creation of anti-fatty acids UFAs, which absorbed sufficient chlorine to trigger systemic jeopardy and accelerate death from other factors. [See P-230](#).

So... The immediate problem appears to be to restore chlorine/sodium balance. There are at least three potential agents for this job.

Settling the imbalance should normalize the ionic balance in the [Small Intestine](#) and the inflammation should reduce. Salt, NaCl is a poor option because it contributes Sodium, which is part of the problem. The chlorine is used as needed, but the sodium contributes to the imbalance. This means that either:

- Add Chlorine
- Remove Sodium
- Or Both

Available Chlorine reagents:

- [Betaine-HCL](#) – Included in the kit we sent. [Betaine is TMG](#), from sugar beets bonded to Hydrochloric Acid. Betaine performance is usually good for moderate chlorine deficiency. In severe cases, individuals took up to 50 capsules without restoring digestion, often creating nausea, etc. This suggests that the amount of chlorine in Betaine sometimes isn't enough to get the job done. This is frequent with individuals cancer, or acute stress.
- [Magnesium Chloride](#) - Is a preferred reagent with elevated urea levels, which are a typical response. Elevated chlorine, with sulfur enable cellular mobilization of lipids, and increase NH₄, which are part of the detox
- [Ammonium Chloride](#) – Is a preferred reagent because the NH₄ is rapidly converted to [Urea](#), which have simple detox paths. This is the simplest way to settle the imbalance because it contributes a lot of chlorine without creating a strong anionic imbalance. NH₄ is a weak base that's easy to dump.
- [KCl – Potassium chloride](#) – Is a backup option. The good news is that you can buy it in the grocery store as “Sodium Free – Salt substitute” . This strategy presumes balanced potassium metabolism, with functional potassium release. Some research references suggest that Potassium may swap with sodium. In this case, KCl, will reduce the sodium side of the imbalance. If not, there is a good chance it will likely help.
- [Ammonium Thiosulfate](#) - is a catalyst for cellular chlorine binding. It also aids in liver flow.
- [Ammonium Cations](#) are preferred in this model because they provide a weak base with a stable exit path, and no toxicity. Ammonium is used in the body to bind noxious acids and is a primary a detoxifying agent.

Research Info

[Experiment Log](#)

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