THERAPY GUIDE
POST-VACCIN SYNDROME & LONG-COVID

Florian Schilling

www.florianschillingscience.org

Version 3.2, Status 03/2023

CONTENT

ACCELERATE CLEARANCE

*Both the vaccine components and the virus exhibit a high degree of **biopersistence** (months, sometimes > 1 year). Acceleration of clearance is often useful and advisable, especially initially.*

***Detection of viral persistence**, vaccine RNA or circulating spike is difficult from a laboratory point of view and ultimately not satisfactory/can be demonstrated with reasonable effort, i.e. if necessary assume persistence and implement initial clearance support prophylactically.*

***ACE2 autoantibodies** may cause similar detrimental effects as the spike itself; their testing and, if necessary, lowering is of high importance and obligatory.*

CRITERIA

Presence of any of the following:

- **Frustrating course of the specific measures**
- **Vaccination less than 2 months ago**
- **Detection of ACE2 autoantibodies**
- **Detection of SARS-CoV2 from blood and/or stool**
- **Detection of spike protein from tissue or cellular material (e.g., IGL laboratory) > 4 weeks after vaccination/covid disease.**

INTERVENTION

1. **Accelerate spike clearance**
   - 1.1. NAC (50mg/kg/d)
   - 1.2. Alternative: CDL protocol C for 3 weeks; CAVE: CDL must not be given in parallel with NAC; other antioxidants must be staggered.

   In combination with 1.1 or 1.2:

   - 1.3. Enzyme therapy: nattokinase NSK-SD (2,000 FU/d) + serrapeptase (240,000 U/d)
   - 1.4. Supplementary to 1.1 - 1.3 possible:
     - 1.4.1. Artemisinin with 200mg/d
     - 1.4.2. Ivermectin (especially useful after breakthrough infection), 0.2mg/kg/d for 3 weeks.

2. **In case of virus persistence** (disseminated in tissue and microbiome possible!) additionally to 1.:
   - 2.1. Ivermectin: 0.4mg/kg/d for 1 week + 0.2mg/kg/d for 2 weeks.
   - 2.2. Alternative: CDL with Protocol F (5 days) + Protocol C (2 weeks).
   - 2.3. Supportive:
     - 2.3.1. Quercetin (2x200mg/d) + Zinc (70mg/d)
     - 2.3.2. For intestinal persistence: initial laxative (e.g., Eziclen, Moviprep, or Epsom salts).
3. **ACE2 autoantibodies**
   - 3.1. See page 15 "**Basic therapy**"

CHRONIC ENDOTHELIITIS

CRITERIA

- Detectable elevation of relevant biomarkers:
  - **VEGF**
  - **RANTES (CCL5)**
  - **IL-6**
  - **TNF-α**
  - **hsCRP**
  - IFN-y
  - IL-2
  - IL-4
  - IL-10
  - CCL3

Values marked in bold are mandatory

INTERVENTION

1. **Any positive result:**
   1.1. Serrapeptase 2x120,000 U/d
   1.2. Polyphenols (Combined!): Resveratrol (500mg/d), Quercetin (500mg/d), EGCG (2x500mg/d)
   1.3. Berberine: 2x500mg/d
   1.4. Strengthen NO and prevent perfusion disorders (vasodilation): Arginine 50mg/kg/d + Vitamin C 20mg/kg/d
      - CAVE: Either exclude nitrosative stress, or give curcumin (150mg/d, optimally liposomal) concomitantly with arginine.
2. **Lack of improvement / Severity / Cardiovascular risks present:**
   2.1. Sartans with >10mg/d
   2.2. Statin at 10mg/d (note Q10, concomitant 1mg/kg/d).
   2.3. If RANTES and/or VEGF positive: maraviroc at 2x300mg/d.
   2.4. Vedicinals 1x1 ampoule per day
3. **IL-6 and or presence of CFS/ME**: LDN (low dose naltrexone) at 1 - 1.5mg/d.
4. **Accompanying: Accelerate spike clearance** *(see there).*

(MICRO)CLOTS

CRITERIA

Note: Spike and associated coagulation disorders may still be pronounced after months! Observe clearance!

1st Line	2nd Line
In any case check	***Check as far as possible, or in the case of*** ⇒ *Presence of cardiovascular risk diseases* ⇒ *Negative result 1st line or* ⇒ *frustrating course*
• **Increase D-dimer** • **Increase α2-antiplasmin** • **ACE2 autoantibodies (ACE2-AAK)** • **(Intermittent) thrombocytopenia** • **Positive findings in endotheliitis** • **Antiphospholipid antibody**	• Angiotensin receptor autoantibodies (AT1-AAK) • Complement activation (C3q, C4q) • Elevated ferritin • Elevated calprotectin • Striking RDW

CAVE: Negative D-dimer findings do not exclude atypical amyloid clots.

- Detection/exclusion via fluorescence microscopy possible (e.g. Dr. Beate Jäger)
- **Alternative: Probatory intervention with nattokinase and serrapeptase** *(see intervention 1.1+1.2).*
- If improvement: continue, extend with Eliquis/Heparin if necessary.

INTERVENTION

1. **D-dimer positive:**
   - 1.1. Nattokinase NSK-SD with 2000 U/d
   - 1.2. Serrapeptase2x120,000 U/d
   - 1.3. Eliquis 2x2.5mg/d
   - 1.4. Insufficient improvement: Vedicinals 1x1 ampoule per day.
2. **D-dimer negative:**
   - 2.1. Use points 1.1 + 1.2 on a trial basis, continue if there is improvement
   - 2.2. *Alternative: exclusion of amyloid formation via fluorescence microscopy*
3. **Parallel to 1. and 2. general supportive therapy**
   - 3.1. Strengthen NO and prevent perfusion disorders (vasodilation): Arginine 50mg/kg/d + vitamin C 20mg/kg/d; CAVE: For arginine exclude nitrostress or give concomitant curcumin (150mg/d).
   - 3.2. Intravascularly active antioxidants
     - 3.2.1. Oral vitamin C 3x1000mg/d, alternatively 2-4/week 5-7.5g iv.
     - 3.2.2. Liposomal glutathione150mg/d
   - 3.3. Optional: O2 (iv via oxyvenation or HBO); *CAVE: IHHT not effective in this regard.*
4. **Positive RDW**: isovolemic phlebotomy + nattokinase (see above).
   - 4.1. Normal Hb: 500ml
   - 4.2. Limit/Decreased Hb: <250ml, Wh if applicable.
   - 4.3. Parallel bone marrow support, e.g. Haematogen®/Moferrin® (iron) + B-complex
   - 4.4. supplementary: O2 (iv or HBO)
5. **In severe cases** (High risk potential, relevant preexisting conditions, AI/insufficient efficacy for pharmacological therapy, history of apoplexy/CHD): HELP apheresis

AUTOIMMUNITY / MCAS

CRITERIA

- **Detection of specific auto-AK** (laboratories e.g.: IMD Berlin, Erde, Cell-Trend, BerlinCures)
  - **GPCR-AAK (ß1- and ß2-adrenergic, m3- and m4-muscarinergic receptor-AAK).**
  - **ACE2-AAK**
  - **AT1 receptor AAC**
- **Detection of classic auto-AK**
  - **TPO-AK, TRAK**
  - **ANA, ENA, ANCA**
  - **APLA, ACLA**
  - **AMA/M2**
  - GAD-AK
  - Ganglioside-AK (IMD Berlin)
  - TG-AK
  - CCP-AK
  - Diabetes type 1 autoantibodies (IAA, ICA, GAD65A)
- **Mast cell activation syndrome (MCAS)**
  - Increased **histamine level** (serum) and/or stool/urine
  - Histamine degradation profile (urine)
  - Increased serum tryptase
  - IgM-PEG-AK
  - IgE-PEG-AK

Values marked in bold are mandatory

INTERVENTION

CAVE: successful spike clearance is a prerequisite for sustained calming autoreactivity / MCAS!

1. **Basic therapy**
   1.1. Dexamethasone 20mg/d
   1.2. Polyphenols 3x5/d or Silent Immune 3x2/d
   1.3. Chondroitin and glucosamine (e.g. Orthojoint)
   1.4. ACE2-AAK: Sartans
2. Alternatively or in case of a frustrating course: **reduction of auto-AK**
   2.1. Apheresis 2-4 sessions each 2/week (optimal: inuspheresis).
   2.2. Alternative to apheresis: Rituximab 2x1000mg at intervals of 2 weeks (observe concomitant medication).
   2.3. Alternative to 1.1, 2.1 and 2.2: Microimmunotherapy
3. **MCAS: Combined administration of antihistamines**
   3.1. Disloratadine 1x10mg/d
   3.2. Famotidine 2x20mg/d; compensate hypoacidity with betaine HCl if necessary to prevent dyspeptic symptoms.
   3.3. Absolute PEG abstinence (contained in care products, medicines, detergents, etc.)
   3.4. Low histamine diet

Continue on next page

4. **Specific Antidotes:**
   4.1. GPCR-AK+: are antagonized by maraviroc (cf. endotheliitis).

4.2. ACE2-AK+ and in case of cardiovascular clinic/amnesia: sartans.
4.3. AT1-R-AAK: ACE inhibitors

5. **Follow up of auto-AK** after completion of apheresis or 2 weeks after completion Rituximab.
6. AK-negative findings:
   6.1. Adjustment of dexamethasone dose, if possible dose reduction (10mg - 5mg - discontinuation trial).
   6.2. Continuation of polyphenols/chondroitin for > 2 months
7. AK-positive findings:
   7.1. Wh. of apheresis until an AK-negative result is achieved.
   7.2. Alternatively: dose increase dexamethasone to <100mg.
   7.3. Alternative: Wh. Rituximab analog 2.2
8. Follow up of auto-AK every 3 months (assumed remission time on average 4-6 months).

MITOCHONDRIOPATHY

CRITERIA

- Evidence of mitochondriopathy:
  - **LDH isoenzymes, alternatively: lactate-pyruvate quotient**
  - **Cancer patients (active, remission, precancerous): TKTL1/Apo10**
  - M2PK
  - Mitochondrial density/cell
- Supplemental: proxy parameters of mitochondrial gene expression (e.g. Nrf2, PRARγ, PGC-1a, mtDNA copy number, etc.).

Values marked in bold are mandatory

INTERVENTION

1. **Mitochondrial micronutrients**, e.g. Mitochondria Formula Sport 2x2/d
2. **IHHT** 2-3/week; CAVE: initially choose the lowest possible intensity, otherwise there is a risk of considerable initial deterioration!
3. **Mitochondria activation**
   3.1. Polyphenols3x3/d
   3.2. Melatonin 20-50mg/d
   3.3. PQQ + Q10 in combination (ratio 1:1), total dose for both together 1mg/kg/d.
   3.4. NAC> 1,200mg/d (note DAO inhibition in MCAS).
   3.5. Liposomal glutathione (150mg/d) with phospholipids
   3.6. Tagatose + Galactose (e.g. TAGA-Mix)
4. **Accompanying & supporting:**
   4.1.1. Medicinal mushrooms, e.g. vital mushrooms 2x2/d
   4.1.2. HBO 1-2/week (optimal: 2.0 atm with 100% O_2 *) or* ozone i.v. ("large autologous blood", OHT) 1x/week; CAVE: ozone i.v. requires stable Hb!
   4.1.3. Butyrate 2-3x500mg/d

Follow up of positive markers after 6-8 weeks with adjustment of measures.

NEUROINFLAMMATION

CRITERIA

1. Evidence **IDO/KMO** activity increase
   1.1. Alternative: Detection of **quinolinic acid** increase
   1.2. Cave: For 1. + 1.1. the exclusion of a Trp depletion is required to avoid false-negative results!
2. Evidence of neuronal damage**: NSE**
3. Optional: detection of blood brain barrier damage: S-100, zonulin (serum), alpha-1-antitrypsin (serum).

Values marked in bold are mandatory

INTERVENTION

1. **Basic measures**
   1.1. Polyphenols3x3/d
   1.2. Melatonin 20-50mg/d (can be increased to <2mg/kg bw).
   1.3. Artemisinin 2x50mg/d (e.g. via Burg pharmacy)
   1.4. Magnesium high dose (e.g. 4x250mg/d or 0.1mmol/kg i.v.)
   1.5. Benfothiamine (e.g. Milgamma) 300mg/d
   1.6. Liposomal glutathione and phospholipids
2. **In severe cases (massive brain fog, tinnitus, dizziness, fatigue):**
   2.1. Intranasal therapy
      2.1.1. 2mg dexamethasone 2x/week
      2.1.2. Optional additional: 20 IU short-term insulin 2x/week
   2.2. NMDA antagonists
      2.2.1. Dextromethorphan 4-20mg/d
      2.2.2. Alternative: memantine 10-20mg/d
3. For trp depletion:
   3.1. 5-HTP (200mg/d)
   3.2. Metabolic cofactors, e.g. neuroactive according to specification
4. **Supportive therapy:**
   4.1. Change of diet to ketogenic diet
   4.2. Interval fasting
   4.3. Exogenous ketone bodies
5. Follow up of positive markers after 4 weeks
   5.1. In the event of a favorable course:
      5.1.1. Tapering of intranasal therapy
      5.1.2. Continuation of (1.) and (4.) for 6 weeks

FREE RADICAL BURDEN

CRITERIA

Initially, pronounced oxidosis is likely after vaccination/Covid-19, especially in those at risk (age, hypertension, diabetes, obesity). This may be extended over time by the initiated pathomechanisms. Adequate antioxidation is a key factor in overall stabilization.

- Positive finding of one or more of the following radical markers:
  - **oxLDL (MDA-LDL)**
  - **Lipid peroxides**
  - **Nitrotyrosine**
  - 8-OHDG
  - Nitrophenylacetic acid
  - Methylmalonic acid
- *Caution: The measurement of antioxidant capacity is unsuitable and provides an extremely high rate of false-negative results.*

Values marked in bold are mandatory

INTERVENTION

1. **Oral therapy**
   1.1. NAC 2x50mg/kg bw/d; Caution: In histamine intolerance or mast cell syndrome, concomitant medication with histamine blockers is required, as DAO activity is reduced.
   1.2. Vitamin C >3x1000mg/d
   1.3. PQQ + Q10 in combination (ratio 1:1), total dose for both together 1mg/kg/d.
   1.4. Vitamin E 10-20mg/d
   1.5. ALA (alpha lipoic acid) 2x300mg/d
   1.6. Melatonin >20mg/d
   1.7. Benfothiamine 300mg/d (e.g. Milgamma)
   1.8. Liposomal glutathione > 150mg/d
2. **In case of high radical load Initial infusion therapy:**
   2.1. Implementation <3x/week
   - Vitamin C <7.5g as a short infusion
   - Glutathione 50mg/kg bw as injection; CAVE: exclude sulfur intolerances by microdoses in advance!
   - Optional: NAD with >5mg/kg bw.

VAIDS

CRITERIA

- Recurrent infections, reactivation of latent/chronic infections, recurrent activity in oncological indications.
- Positive result in >2 of the following examinations:
  - **NK activity** <10% and insufficient activity enhancement by IL-2 supplementation (<25%).
  - **Th1 insufficiency (**IFN-y, stimulated), often in combination with Th2 dominance (IL-4, stimulated).
  - **Increased T-Reg (CD4+ CD25+)**
  - **CD profile: quantitative deficit in cytotoxic cells (CD8+, CD56+) and /or helper cells (CD4+)**
  - Neutralizing spike IgG <10% of total spike AK.
  - Increased TGF-ß
  - IL-2 depletion (stimulated)

Values marked in bold are mandatory

INTERVENTION

A generally valid medication recommendation is only possible to a limited extent here. Beyond basal measures, potential drug candidates should be identified in advance by appropriate in vitro tests. Spike clearance is a mandatory prerequisite for successful remediation! First implement package A, then and if necessary package B!

Package A

1. **Basal stimulation**
   - 1.1. Colostrum
   - 1.2. Biobran (MGM-3) with 2x1000mg/d
   - 1.3. Vitamin D binding protein (e.g. BIC Immunl)
   - 1.4. Support of the bone marrow with B vitamins (methylated!), iron, essential amino acids, and nucleotides.
2. **Exclusion or therapy of the following processes:**
   - 2.1. Vit. D metabolism disorder
     - 2.1.1. VDR blockade: Vit. D ratio >2 (quotient of 1.25OH D_3 /25OH D_3); positive result: Vit. D binding protein over 3-4 months + ADEK + Ca (500mg/d)/Mg (500mg/d), in case of cardiovascular preload concomitant sartans.
     - 2.1.2. Vit. D deficiency: 25OH D_3 < 40nmol/l *and* 1.25OH D_3 < 40pmol/l; positive result: vitamin D 20,000 IU/d for 2 weeks, concomitant ADEK + Ca/Mg as in 2.2.1.
   - 2.2. Leaky Gut
     - 2.2.1. Stool: increase zonulin and/or a-1-antitrypsin and/or decrease sIgA, serum: LPS; CAVE: test all four together due to high risk of false-negative findings!
     - 2.2.2. TAGA-Mix + Dysbiosan + Salutosil, in case of severe dysbiosis bacteriophages
   - 2.3. Increased T-Reg
     - 2.3.1. CD profile, CD4+CD25+ increase
     - 2.3.2. Conservative: cimetidine 4x200mg/d; CAVE: prevent dyspepsia and maldigestion (e.g. betaine HCl).
     - 2.3.3. In case of oncological history (active cancer process): Metronomic chemotherapy with low-dose cyclophosphamide (50mg/d for 2 weeks, then recheck T-Reg, Wh. if necessary).

Package B

3. **Unsatisfactory status after implementation Package A: In vitro identification of individual** immunostimulants.
   (*CAVE: Some of the following cell approaches are conventionally called "inhibition tests", since the regular indication is chronic inflammatory processes, i.e. an immune-inhibiting effect is aimed at. Here a contrary interpretation is indicated!)*

   3.1. NK activation test (target value: >20%)
   3.2. IFN-y release assay
   3.3. *Alternative to 3.2-3.4:* Effector cell typing (release of IFN-y, TNF-a, IL-10 and IL-2 on an agent; e.g. IMD Berlin).
   3.4. Examples of classic immunomodulators: vitamin D (check VDR!), polyphenols, transfer factors, mushroom extracts, mistletoe extracts, MGM-3, thymus extract.

4. **In case of quantitative depletion** (especially CD4+, CD8+, CD56+).
   4.1. Organotropic: thymus extract or regenerates (bone marrow, lymph nodes, thymus).
   4.2. Alternative to 4.1: Microimmunotherapy
   4.3. Alternatively or in addition to 4.1 + 4.2: Ozone i.v. (increase IFN-y, IL-2), target 30-55µg/cm.^{3}
5. **Occurrence of opportunistic reactivated infections**
   5.1. Frequent: herpes zoster, herpes viruses i.A., EBV, Lyme disease, CMV, Hep. B
   5.2. Nosodes / Microimmunotherapy
   5.3. Alternatively or accompanying:
      5.3.1. Oxidative therapy: ozone i.v. / CDL (initial protocol F, then change to C)
      5.3.2. Quercetin (2x250mg/d) + Zinc (70mg/d)
      5.3.3. Virustatic plant extracts

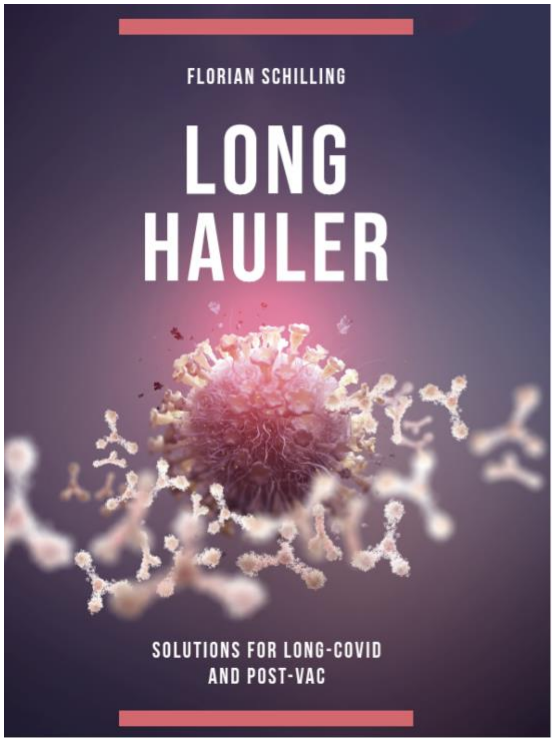
6. In case of frustrating course or detection of specific biomarkers (see 4.2.2 and 4.2.3): **Use of PD-1 checkpoint inhibitors.**
   6.1. Positive study situation for breakthrough infections, not for pure post-vac
   6.2. The following findings are indicative:
      6.2.1. Increase in specific lymphocyte subpopulations (CD127+, PD-1+/CD4+).
      6.2.2. Positive for >2 of the following biomarkers: ICOS, OX40, CD40L, CD127, 2B4, LAG3.
      6.2.3. Increase in IL-1ß (or IL-1R), IL-8, IL-10, or IFN-y).
   6.3. Checkpoint inhibitor: nivolumab, orientation: 1mg/kg weekly.

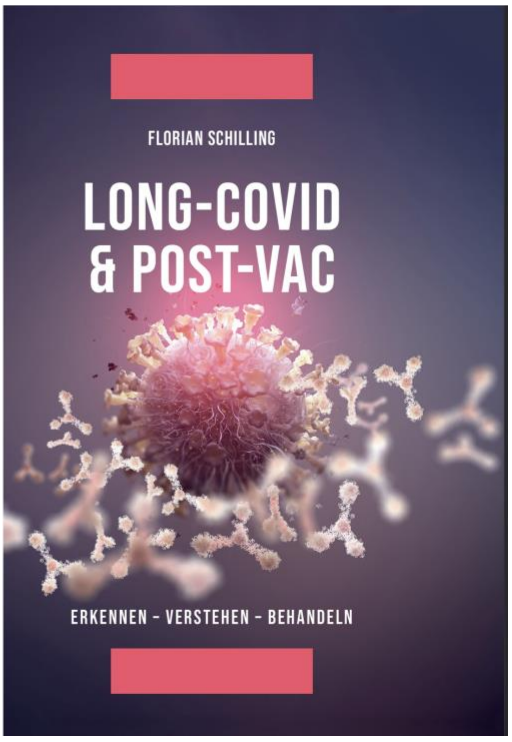
GENERAL REGENERATIVE THERAPY

Sufficient availability of basal micro- and macronutrients must be ensured, taking into account a simultaneous increased need. The dosages are to be adjusted individually.

1. **Macronutrients**
   - 1.1. Essential amino acids (e.g. MAP-based preparations)
   - 1.2. Polyunsaturated fatty acids and phospholipids (e.g. Omega PL)
     - 1.2.1. Phospholipids iv. may be considered for neuroinflammation
     - 1.2.2. Nucleotides
2. **Micronutrients**
   - 2.1. Fat-soluble vitamins (e.g. ADEK)
   - 2.2. B-complex (pay attention to bioavailable preparation, especially methylfolate and methylcobalamin)
   - 2.3. Vitamin C
   - 2.4. Mitochondrial micronutrient combinations (e.g. Mitochondrien Formula Sport, Pro Dialvit 44)
   - 2.5. Mineral complexes (electrolytes plus trace elements)

DETAILED PRESENTATION OF DIAGNOSTIC AND THERAPEUTIC APPROACHES FOR AFFECTED PERSONS & THERAPISTS IN THE NEW MANUAL (GERMAN AND ENGLISH VERSION AVAILABLE)





Available at **Tredition** & in bookstores

www.tredition.com