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The Nightingale Research Foundation

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Nightingale's October 2021 Newsletter

Dear Readers,

We recently accepted four new board members in addition to the following three members.

1. **Dr. Byron Hyde** – Chairman
2. **Steve Gee** – Treasury
3. **Ann Frampton** – Financial Advisor

6. **Lydia Neilson**, CEO and founder of National ME/FM Action Network and organizer of the Canadian Consensus Diagnostic Criteria of M.E. and previous senior executive of Nightingale at its founding in 1989.
7. **Claire Castel**: highly knowledgeable M.E. authority concerning International M.E. Associations.

A New Directions to Nightingale Research Foundation.

To change the charter of Nightingale Research Foundation to include the enteroviral diseases causing both Poliomyelitis 1, 2 and 3 and the approximate other 25 enteroviruses which are also causing paralytic poliomyelitis. These other enteroviruses were (a) not in the Salk or Sabin polio immunizations. At the moment they are referred to as (a) **Acute Flaccid Paralysis (AFP)** in Europe and also the same spectrum in known as (b) **Acute Flaccid Myelitis (AFM**) in the USA.

Dr. Hyde discussed:

A Brief History of Myalgic Encephalomyelitis

(1) Prior to 1850 to 1905 Polio gradually increased as an epidemic disease in Europe and North America. Initially there were never more than 20 victims when Polio occurred. The first documented major poliomyelitis epidemic involved over 2000 individuals. This occurred on both sides of the Sweden and Norway boarder in 1905.

1. In the 1905 Polio epidemic in Scandinavia, there were over 2000 children and adults who fell ill. This was previously unheard of. In France leading physicians wrote that this was mass hysteria. This paralytic disease was also accompanied by a disease spectrum consistent with the 1950s English term, **Myalgic Encephalomyelitis.**
2. Dr Wickman referred to this new disease spectrum in 1905 as a disease component of Paralytic Polio, but these patients did not include paralysis but had the following classical M.E. stigmata which he called Non-Paralytic Polio:
    a. Encephalitis,
    b. Polyneuritis (fibromyalgia) (painful body symptoms),
    c. Ataxia (balance difficulties),
    d. Meningitic painful symptoms of the head.

(2) The 1934 Los Angeles Epidemic: This was also a Polio/ M.E. epidemic where both diseases

attempted to refer those with M.E. as anxiety neurosis. The staff took it to court and it was settled for the equivalent of over ten million dollars in todays terms. Ever since the insurance industries have fought tooth and nail to provide M.E. patients with disability pensions. Since the majority of adult M.E. patients are teachers or health care workers, they all have good pensions and the insurance companies sometimes keep these going for years before the patient collapses. The point here is that M.E. and Polio occur together.

(3) In the 1946-1950 Epidemic of M.E. in Akureyri in Iceland there also occurred as **a major M.E. Polio epidemic**. At the time this disease consistent with M.E. was referred to as Iceland Disease and then Akureyri disease.

(4) In the 1954-1956 Royal Free Epidemic, this occurred during a major **epidemic of M.E. and Paralytic Polio.**

In conclusion, until the 1955 and 1960 introduction of Salk and Sabin polio immunizations M.E. occurred during paralytic polio epidemics. Dr Sabin, the inventor of the oral killed polio immunization, stated that the immunization failed to include the newly discovered polio viruses. Since the 1960s the new Polios known as AFP and AFM have been slowly increasing, particularly with the major emergence of the 1983-1993 M.E. pan epidemic. This grumbling pan-epidemic has never ceased but has been hidden by the emergence of the non-related corona virus pan-epidemic.

(5) The South East Asia Polio and M.E. Epidemic which began in Sarawak in 1989 and has continued twenty until at least 2010. It started with hand-foot-and mouth disease in children causing **paralytic polio and classical M.E. It is caused by the same enteroviruses which cause death, new Polio** (Acute Flaccid Paralysis and M.E.)

For the above reasons Nightingale believes the same as Dr Wickman, that M.E. is a variation of polio and what he called in 1905, non-paralytic Polio.

Dr Hyde then discussed the following:

Years of USA Health Centers Bureaucratic Incompetence

How was this known knowledge of M.E. hidden by the National Institute of Health (NIH) in Bethesda founded in 1930 and by the Centers of Disease Control (CDC) in Marietta Georgia (Atlanta), the knowledge that M.E. is only a variant of Paralytic Polio? This is nothing new.

that Polio was caused by a bacteria he called the globoid body and he only funded US researchers in investigating this non-existent bacteria cause of Polio.

2. Drs. Erwin Popper and Karl Landsteiner in Germany proved that Polio was caused by an enterovirus. The Americans under Flexner refused to accept this discovery although physicians of Europe did. Because of Flexner's misdirection, a polio immunization could have been developed any time after 1910. It was only in 1939-40 that the USA decided that Polio was caused by the then known three enteroviruses now commonly referred to as Polio 1, 2 and 3. In effect, Flexner could be held responsible for possibly millions of deaths and paralysis of polio children and adults due to his stubborn ignorance. This is exactly the same injury caused to M.E. patients with M.E. since 1985. **The same major error occurred with the USA CDC and NIH with influenza.**

Haemophilus influenza

Although the 1888-9 and the 1918-21 massive influenza epidemics killed millions of individual around the world. Although the 1988-89 influenza epidemic is referred to as the Russian influenza and the 1917-1920 influenza epidemic is called the Spanish Flu but appear to have begun in the USA. Never-the-less the various USA centres of research believed from 1920-1930s that a common bacteria called haemophilus influenza was the cause of influenza epidemics, thus delaying research in preventing influenza for decades. The Americans even named this bacteria "influenza" although it had nothing to do with influenza.

Due to this delay, influenza virus was only first isolated in humans only in 1936.

In the 1940s **Dr. Jonah Salk,** along with Dr. Thomas Francis Jr. developed the first immunization for influenza. In 1945 the first inactivated influenza immunization was licensed for use in civilians. Dr Salk did not receive a Nobel Prize for this discovery or for the 1955 Polio Immunizations. Although Salk was responsible for saving the lives of millions of children and adults in the world, he was never to receive a Nobel Prize for his work.

I believe the CDC and NIH tragic delays and mis-direction in both influenza and polio research were in a large part responsible for the delays of both polio and influenza immunizations and subsequently for M.E.

This occurred when the NIH and the CDC, under Dr. Stephen Straus tried to define a non-existing disease they called Chronic Fatigue Syndrome (CFS). They sent a medical intern to Lake Tahoe, incline Village in

technicians drew blood to test for Epstein Barr Syndrome (EBS). *(Straus believed EBS was the cause of M.E.)* Meanwhile the Canadian Government in Ontario clearly documented that this M.E. epidemic in the USA and Canada was the same enteroviruses which also caused the new polio (AFP and AFM). The CDC and NIH didn't listen. Straus then published after 3-4 days visit by a student at CDC that this was Chronic Fatigue Syndrome and it was caused by EBV virus. It was not and even the intern stated in the definition summary that there was no EBV.

Meanwhile, Hilary Johnson author of Osler's Web, in interviewing CDC specialists and directors, was told that CFS was a form of anxiety neurosis. Most physicians in the USA and the UK now also believe that CFS does not exist except in the minds of the uneducated patients. Due to total incompetence, neither of the two CDC definitions for CFS demonstrate a single testable injury only symptoms. In general, most busy physicians believe that when a patient has symptoms but not obvious and easily testable pathologies, they are dealing with psychiatric problems.

Nightingale has tried in its publications and lectures in trying to change this view of M.E. We also believe that melding the term M.E. with CFS, (M.E./CFS) has continued to destroy what is already known about the relationship of M.E. which unlike CFS, has clearly demonstrated:

1. Measurable encephalitic injury of the brain by Segami SPECT
2. Measurable enterovirus recovery at onset and during the first 6 months of illness.
3. Measurable single muscle fibre abnormality
4. Recovery of early brain neuron damage indicators in spinal fluid in M.E.
5. Enterovirus recovery from the gut mucosa in chronic M.E. patients.

We would also like to include a tasty recipe for the Autumn.

Bon Appetit,

Liz Stevenson's Canadian Apple Crumble

Begin by buttering the base and sides of a casserole dish

Step Two: The Apple Base Mixture

1. a half cup of butter,
2. three-quarters cup of white sugar,
3. eight-apples, peeled, cored and chopped into chunks,

- Turn apple mixture into the casserole dish and r**efrigerate** to chill

Step Three: The Crumble Topping

Mix the following into a crumb-like consistency:

1. 1.5 cups of either all-purpose, whole wheat or rye flour
2. 1/3 cup of regular oats with 3/4 of a cup of butter
3. 1 cup of brown sugar and 2/3 teaspoon of cinnamon
4. mix until well combined
5. beat an egg and blend into the mixture until it is tacky, but still crumbly,
6. Spread mixture onto a baking sheet and **refrigerate** for half an hour

Step Four

Break up the above mixture with your hands and sprinkle on top of the apple compote in the casserole dish

Keep at room temperature until dinner begins then: Bake at 370F for about 25 minutes or until the crust is golden brown and the crumble perfumes the house.

- Serve hot with vanilla ice cream, or thick cream or crème-fraiche.