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Liver PPARs bedside Evaluation and Lipid-Glucose Metabolism.

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Introduction.

The metabolic syndrome, admittedly a multi-component risk factor for CVD, may be more or less strongly linked with insulin resistance. In my opinion, neither the ATP III nor the WHO definitions consider the many other similarly related CVD risk factors, such as age, physical activity, or history of CVD events, not to speak of until now overlooked CVD Quantum-Biophysical-Semeiotic Inherited Real Risk, I've discovered, which proved to be, in my long clinical experience, *conditio sine qua non* of such macro- and micro-vessels disorders (1-5).

Really, the Framingham risk equation, largely accepted by authors who ignore Quantum-Biophysical Semeiotics, does not unfortunately include important CVD risk factors (e.g., previous CVD events, family history), and has been shown to be much less useful than other risk equations in predicting future CVD events in people with diabetes.

Other newly identified CVD risk factors have been shown to be strongly associated with insulin resistance and CVD, but, taking no knowledge on above-mentioned CVD congenital real risk, it is unclear if they should be added to the syndrome and given equal or greater weight than the current components [1-5].

Because the criteria for the syndrome will capture individuals with frank disease (e.g., diabetes, hypertension, dyslipidaemia, microalbuminuria, clinical CVD), as well as people with far milder forms of the same conditions, it is likely that there is a risk gradient for CVD events among patients with both Pre-Metabolic and Metabolic Syndrome.

First of all, without CVD quantum-biophysical-semeiotic inherited real risk, CVD is not possible, despite presence and seriousness of all components of Metabolic Syndrome. Thus, the definition will capture a spectrum of severities, and it is likely that a person who satisfies the diagnostic criteria with risk factor levels just over the cut point will have a much lower CVD risk than another individual with the same combination but higher risk factor levels (4).

Such as problem solution is far more practical and exhaustive with the aid of Quantum-biophysical Semeiotics, as well as less expensive than that of the Framingham and UKPDS (U.K. Prospective Diabetes Study) risk models, in which the spectrum of severities is weighted, so that it is clear who may be at greater or lesser risk. In addition, all authors, who have been studying Metabolic Syndrome, do not know Pre-Metabolic Syndrome, that comes first for decades in individuals involved by some quantum-biophysical-semeiotic constitutions and related congenital real risks, as I illustrated in earlier articles [1-5].

Interestingly, all around the world, physicians can now-a-days utilize easily an original clinical tool, among a lot of others, reliable and efficient in recognising and monitoring individuals with diabetic and/or dyslipidemic and/or arteriosclerotic and/or hypertensive and/or gouthy, a.s.o., quantum-biophysical-semeiotic constitutions, slowly evolving firstly to Pre-Metabolic and then to Metabolic Syndrome (2).

As a matter of fact, physicians can bedside evaluate PPARs activity in the liver, adipose tissue, and skeletal muscles by means of Quantum-biophysical Semeiotics (www.semeioticabiofisica.it, Practical Applications), as suggested briefly in following.

Whereas it's sufficiently known the role of PPARs (especially γ) in regulating adipocyte differentiation and insulin-responsive glucose up-take, at my best knowledge, no author knows the possibility to utilize liver PPARS (α) activity bedside evaluation of glucose-lipid metabolism, in assessing Pre-Metabolic Syndrome, and monitoring its slow evolution to Metabolic Syndrome.

Interestingly, such assessment can be performed at the bedside in individuals at rest, and soon thereafter, under stress tests, i.e., stimulating PPARs with endogenous Melatonin, Thyroid hormones, and adipokine, obtained respectively, e.g., by closing both eyes, stimulating thyroid trigger-points, i.e., pinching the skin upon thyroid gland (= trigger points of thyroid), and finally by pinching adipose tissue of lateral abdominal regions (= adipokine secretion). For further information about aspecific gastric reflex evaluation, See www.semeioticabiofisica.it, Practical Applications, Technical Page N° 1, URL:
http://www.semeioticabiofisica.it/semeioticabiofisica/Documenti/Eng/pagina1stomaco_eng.doc

From diagnostic view-point, important is the rate of increasing PPARs activity in the second evaluation, i.e., under stress conditions, paralleling the efficiency of these nuclear receptors.

As regards liver PPARs (α) bedside assessment, we can gather this way a large number of precious information on present glucose-lipid metabolism, surely more precise than all other laboratory data [1-10].

A) In health, lying down in supine position, relaxed and with open eyes to inhibit melatonin secretion, "mean-intense" hand pressure applied on liver skin projection area brings about hepatic-aspecific gastric reflex, after a latency time of 8 sec. exactly. Moreover, reflex duration lasts less than 4 sec. (= paramount parameter value, paralleling the efficiency of hepatic Microcirculatory Functional Reserve, and thus informing on microcirculatory structure and function) (1-5). Such as result excludes local microcirculatory remodelling, and thus the presence of newborn-pathological Endoarteriolar Blocking Devices.
Under above-referred stress tests, or immediately after their stopping, latency time raises to the highest value, i.e., from basal value 8 sec. to 16 sec., doubling former value.

B) On the contrary, in individuals involved by both diabetic and dyslipidaemic constitutions, showing related Inherited Real Risk, basal hepatic-aspecific gastric reflex latency time, caused my "mean-intense" stimulation of liver trigger-points, results still 8 sec. (NN = 8 sec.), but reflex duration is 4 sec., indicating initial, pathologically modified, microcirculatory bed, i.e., microcirculatory remodelling, characterized by newborn-pathological, type I, subtype b), aspecific, Endoarteriolar Blocking Devices, as demonstrates a more difficult, refined evaluation, based on the uretheral reflexes (1-5). Such data are really important from diagnostic viewpoint. After stress tests, latency time raises to about 15 sec. (NN = 16 sec.), augmenting of about 90% of basal value.

C) In individuals with Pre-Metabolic Syndrome, basal hepatic- aspecific gastric reflex latency time persists still 8 sec. (NN = 8 sec.), whereas reflex duration rises to 5 sec. (in health, less than 4 sec.), showing that metabolic disorder is evolving slowly. As above referred, reflex duration give precise, as well as rapid information about PPARs efficiency, allowing also the therapeutic monitoring.
Interestingly, soon thereafter stress tests, latency time raises to >13 <15 sec., i.e., about 70% of initial value, indicating the worsening of glucose-lipids metabolism impairment.

D) In patients with Metabolic Syndrome, the latency time of basal hepatic-aspecific gastric reflex decreases to about 7 sec. (NN = 8 sec.); reflex duration is clearly prolonged: > 5 sec. ≤ 6 sec. In addition, either during dynamic tests or immediately after stress test stopping, latency time raises ≥ 12 < 13 (augmenting about 50% of basal value)

Finally, in overt diabetes and/or dyslipidaemia, basal hepatic-aspecific gastric reflex latency time may be pathologically lowered, less than 8 sec. (NN = 8 sec.), especially in overt disorder, but reflex duration is always prolonged as far as to its highest levels: ≥ 6 sec. Moreover, in health, under above-mentioned stress tests or soon thereafter, latency time rises in a significant manner to 16 sec. (double value than that at rest).
On thy contrary, in patients involved by glucose and lipid metabolism impairment, latency time either do not change at all, or ameliorates, but no significantly, in relation to the severity of underlying disorder.
At this point, I remember the numerous quantum-biophysical-semeiotic signs and manoeuvres, which allow doctors to bedside evaluate, in reliable way, blood glucose level, insulin secretion, insulin receptor sensitivity in every peripheral target tissue (10-19).
Finally, we must take into accounts the paramount diagnostic value of liver preconditioning: after exact 5 sec. since the end of first assessing hepatic PPARs, doctor performs a second evaluation.
In health, negative for both diabetic and dyslipidaemic constitutions, after preconditioning the reflex duration raises significantly from 8 sec. to 16 sec. , doubling basal value, as it happen under above-illustrated stress tests.
On the contrary, in case B) duration lowers from 16 sec. to 15 sec. or less, rather than increasing: the intensity of pathological reflex duration lowering parallels the seriousness of underlying metabolism impairment.

At this point, I must emphasize that the absence of dyslipidaemic constitution among individuals is indeed very rear in my experience, occurring about 1 every 100 individuals, due perhaps to thrift genes.
In conclusion, aiming to realise an efficacious primary prevention of Pre-Metabolic and Metabolic Syndrome and its slow evolution towards various disorders on very large scale, in individuals rationally enrolled, doctors have to bedside recognize, possibly since birth, all subjects positive for dylsipidaemic and/or diabetic constitutions, *conditio sine qua non* of dyslipidaemias and diabetes, when both conditions are associated.
Subsequently, physicians have to ascertain the presence of related inherited real risks of dyslipidaemia and diabetes [1-5,20-25].
From the above remarks, the numerous suggested predictors of future cardiovascular events, as moderate elevations in CPR present in apparently healthy individuals [26-28], seem less significant than admitted now.

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CAD Inherited Real Risk In Preventing Myocardial Infarct.

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Introduction.

In the following, I illustrate some original methods of biophysical semeiotics (www.semeioticabiofisica.it) [1], utilizing bedside biophysical-semeiotic reflex parameters, useful and reliable in detecting coronary artery ischemic disease, even clinically silent, from its very initial stage, i.e. CAD inherited real risk, characterized by microcirculatory remodeling, wherein newborn-pathological, type I, subtype b, aspecific, endoarteriolar blocking devices play a central role [2-7]. To easily evaluate all these events it is sufficient to know stomach auscultatory percussion [See: Practical Applications, Technical Page 1, and Bibliography in above-cited website]. With regard to bedside evaluation of biophysical-semeiotic ureteral-reflexes, unavoidable in directly assessing coronary vasomotion and vasomotility, it is necessary for the doctor to have further technical knowledge.

Myocardial Vasomotility and Vasomotion Deterministic Chaos

In health, in the supine position and psycho-physically relaxed, with his/her eyes opened, aiming to inhibit melatonin secretion, digital pressure of "low-mean" intensity, applied on the heart cutaneous projection area, brings about aspecific gastric reflex (a.g. R.), as well as upper, middle, low-ureteral, caecal-, and choledocic- reflexes, i.e. upper-, mean, low-ureter as well as stomach, caecum, and choledocus dilation, the latter three after a latency time of 8 seconds exactly.

In health, at rest, the dilation of upper and low ureteral reflexes appears after 6 seconds, lasting 6 seconds, while all other reflex duration is less than 4 seconds. Such a parameter value proved to be of paramount importance, from a diagnostic viewpoint, identifying precisely the local microvascular structures and function, i.e. local microcirculatory functional reserve (MFR), hence indicating microvessel remodeling. Importantly, when a.g.R. duration is less than 4 seconds, the doctor may exclude whatever coronary disorder!

In fact, "light-mean" digital pressure, applied upon coronary trigger-points, provokes rapid oscillations of upper and choledocic reflexes (= small arteries, according to Hammersen) and subsequently those of lower ureter (= nutritional capillaries), which parallel fluctuations of the related microvessel structure, according to synergistic model. In addition, "more intense" digital stimulation causes numerous, pressure-dependent, middle ureteral reflexes, informing respectively on various type EBD, type A, group I, and II, AVA, and type B, group I and group II, AVA, according to Bucciante [8,9].

Interestingly, in health, the intensity of these reflexes – their diameter – appears to oscillate from 0.5 cm. to 1.5 cm. at rest, in an unpredictable manner, which last about 10.5 seconds (fractal number) and vary from 9 seconds to 12 seconds (6 cycles per minute). Physiologically, after two normal, different in intensity, unpredictable fluctuations, we observe the highest oscillation - highest spike (HS) – that corresponds to "quantic," maximal, periodic adrenalin and nor-adrenalin discharge from autonomic nervous system endings, which occurs exactly every 25 seconds, as I demonstrated earlier [1,8-15]. Finally, these signs must be evaluated also under stress tests.

I emphasize that the duration of a.g.R. disappearing, before the subsequent reflex, is physiologically > 3 seconds < 4 seconds, average value 3.81, paralleling the fractal dimension of these microvessel deterministic-chaotic dynamics, evaluated in a more difficult, refined way. To summarize, biophysical-semeiotics allows doctor to detect the chaotic behavior of both the intensity and period of ureteral (and choledocic) oscillations. However, doctors can gather at the bedside the same data – vasomotility (= upper ureteral reflex: small arteries) and vasomotion (= low ureteral reflex: nutritional capillaries)

of the microcirculatory bed of all organs and tissues, including the heart – in an indirect and easier way, by means of aspecific gastric reflex duration (NN < 4 seconds).

From the biophysical-semeiotic point of view, it is useful and easy to calculate the so-called fractal dimension (D) of microvascular chaotic system: in 120 seconds we observe 4 HS that divide the space in 4 segments; each segment is subdivided in 3 tracts by two normal oscillations. It is, therefore, possible to calculate the fractal dimension, which, roughly speaking indicates how much space a figure takes up, i.e. the degree of chaos, and is a measure of the complexity of the figure [16]:

From the biophysical-semeiotics viewpoint, fractal factor – f – corresponds to the ratio HS/minimal oscillation. In health, for example, D is > 3 < 4 (precisely 3.81); in the case of the metabolic syndrome, both classical and variant, evolving to diabetes mellitus, D is > 2 ≥ 3 (i.e. 2.4); and in type I and type 2 diabetes, D is 1, a topological dimension [3,11-27].

Assessed in the phase space, the trajectories of a deterministic chaotic system of D 3, present as a strange attractor; in case of D > 1 < 3 the trajectories correspond to a closed loop attractor. Finally, when D is 1, the attractor is at fixed point.

In day-to-day practice, it is sufficient to assess the fluctuation intensity of low ureteral reflex (= nutritional capillaries), caused by the digital pressure of mean intensity, applied upon the skin projection area of the heart, and evaluate the ratio HS/minimal oscillation, i.e. "f," fractal factor. However, as I noted above, the fractal dimension D is directly related to the value, calculated easily in seconds, of the differential latency time (= disappearing time) of caecum- and/or aspecific gastric-reflex [1,12]: in health, during digital pressure of "mean" intensity upon heart projection area, as above-illustrated, both caecum- and aspecific gastric-reflex appear physiologically after an 8-second latency time, then persist for less than 4 seconds (the parameter value is of paramount importance from a diagnostic view-point), before disappearing. After > 3 < 4 seconds (= "differential latency time," identical to the related fractal dimension), caecum- and aspecific gastric-reflex occur again; as such, the parameter value, positively related to coronary microvascular functional reserve (MFR), proved to be the same to fractal dimension, indicating myocardial oxygenation, myocardial pH, microcirculatory bed structure/function, local metabolic situation, and then myocardial preconditioning. Under such conditions, the doctor can exclude the presence of CAD inherited real risk [28-33].

Myocardial Biophysical-semeiotic Preconditioning

It is well known that a precise sympathetic nervous correlation exists between dermatomeres and related visceromeres, which I fully corroborated with the aid of biophysical semeiotics [1,3,11,12,14,15]. Due to this fact, ischemic coronary diseases bring about an alteration of the corresponding dermatomeres, Th 1 - Th 8, easily detectable by means of palpation [16,17]. With the condition reversed, Th 1- Th 2 dermatomere stimulation of diverse intensity brings about sympathetic-dependent coronary tone modifications.

In the day-to-day practice, myocardial ischemic preconditioning can be evaluated at the bedside in a rapid, easy, and reliable way: in health, in the supine position and psycho-physically relaxed, with open eyes, digital pressure of "mean" intensity, applied upon skin projection area of the heart, and than exactly upon ventricular and/or atrial, as well as valvular projection areas, induces the aspecific gastric- and/or caecal-reflex (i.e. their dilation) after latency time (lt) of 8 seconds; reflex duration of less than 4 seconds gives information on MFR (this value is inversely correlated with disappearing time of reflex, i.e. fractal dimension: NN = 3.81), indicating normal tissue acidosis, as clinical and experimental evidence suggests [1,3,11,12,14,15]. After exactly a 5-second interruption, the newly applied digital pressure, as mentioned above, causes the caecal-, and aspecific gastric-reflex after doubled latency time, i.e. 16 seconds: type I, physiological preconditioning.

On the contrary, in the case of CAD congenital real risk, the first value at base line may be normal (i.e. 8 seconds), but reflex duration is 4 seconds or more. In addition, after preconditioning, latency time raising is impaired, namely less than 16 seconds, in inverse relation to the seriousness of underlying real risk: type II, intermediate, preconditioning.
Finally, in overt CAD, since its initial stage, basal l.t. is already altered, resulting less than 8 seconds, and the gastric aspecific reflex is clearly pathologically prolonged, i.e. more than 4 seconds, paralleling disorder seriousness: type III, pathological preconditioning.

In conclusion, 53 years of clinical experience allows me to state that a new era in the war against CAD has been initiated [18,33]. In fact, we are now able to recognize from birth all individuals at real risk of CAD at bedside, treat them successfully with the Mediterranean diet, conjugated melatonin, according to Di Bella-Ferrari, associated with personalized NIR-LED (LLLT) application, under clinical monitoring.

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MICROALBUMINURIA AND ARTERIOSCLEROTIC CONSTITUTION.

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Sergio Stagnaro.

Abstract

In the paper the author demonstrates that microalbuminuria represents surely a risk factor of cardiovascular risk in both diabetic and non-diabetic patients, since such as disorder is a biophysical-semeiotic sign of the "arteriosclerotic constitution", really not present in all cases. As a matter of fact, from biophysical-semeiotic data, it is likely that the base of , influencing, in a negative manner, both microvessel dynamics and haemoreology (hyperviscosity) under sympathetic hypertonus conditions, ischaemia, and hormonal impairement, like hyperinsulinemia-insulin resistance (IIR), as observed frequently in pre-morbid or pre-metabolic syndrome, as wel as in subsequent Metabolic Syndrome, classic and "variant", described by the author (3, 4).αmicroalbuminuria is an inherited microvascular-microcirculatory alteration of nephrone (i.e. microcirculatory remodelling), even circumscribed, primarily functional, acidosic, that cause dysfunction of the vascular smooth muscle cells and, then, of Endoarterial Blocking Devices (EBD), involved selectively, although systematically (including vasa vasorum), by a particular mitochondrial cytopathology, CAEMH-

Introduction.

Before illustrating the contribution of Quantum-Biophysical Semeiotics (www.semeioticabiofisica.it) to enlighten significance and etiopathogenesis of microalbuminuria, as follows, theorical and practical interesting aspects of such renal pathology are investigated, which, without the aid of this original physical semeiotics, persists for years or decades unrecognized, untreated and, therefore, worsening under environmental risk factors.

Although the association between microalbuminuria and cardiovascular disease was initially described in individuals with diabetes, it is now well established that microalbuminuria is associated with a 1,5- to 4-fold increased risk of cardiovascular disease among individuals with and without diabetes. However, the pathophysiological mechanisms linking microalbuminuria to cardiovascular disease are unknown (1, 2). It is important to stress that the association between microalbuminuria and cardiovascular disease is unlikely to reflect a direct, causal pathway, because there is no plausible mechanism that can directly link the quantitatively trivial urinary loss of albumin (15-300 mg per 24 hours) to atherothrombosis.

Authors do not agree on causal relation, due to the fact that are lacking acceptable mechanisms, which should link the trivial urinary loss of albumin (15-300 mgr/24 ore) to arteriosclerosis.

In following, I will examine the present view-point on this argument and will illustrate the original quantum-biophysical-semeiotic interpretation.

Microalbuminuria and Cardiovascular Diseases: the common point of view.

Microalbuminuria is associated with several cardiovascular risk factors, notably age, male gender, race, hypertension, smoking, obesity, dyslipidemia (high triglyceride and low HDL-cholesterol), diabetes, hyperhomocysteinemia and, among diabetic individuals, glycemic control. According to some investigators, microalbuminuria is also associated with insulin resistance, but this is controversial.

An obvious hypothesis, therefore, is that the association of microalbuminuria with cardiovascular disease simply reflects, and can be explained by, the

association of microalbuminuria with one or more of these well-known cardiovascular risk factors. However, and perhaps somewhat surprisingly, epidemiological studies show that the association between microalbuminuria and cardiovascular disease remains when such conventional cardiovascular risk factors are taken into account, even though all these risk factors have been associated with the development of microalbuminuria in prospective studies, i.e. they may play a role in its pathogenesis (www.ATHERO-ORG..com, 3 July 2002, Coen D.A. Stehouwer, MD PhD, Professor of Medicine, Department of Internal Medicine, Institute for Cardiovascular Research, and Institute for Research in Extramural Medicine,
Vrije Universiteit Medical Center).
Finally, although there is not agreement among authors, hyperinsulinemia-insulinresistance has been correlated with microalbuminuria, as corroborate personal research (data unpublished, I shall refer next in a Commentary on www.Athero.com). It seems, therefore, that a strong relation probably exists between one or more well-known cardiovascular risk factors and the loss of small amount of albumine in urine.
On the contrary, and really not surprisingly, epidemiological study demonstrate that the association between microalbuminuria and cardiovascular disease is unsolved, even when the common risk factors, cited above, show to end, over the time, in albuminuria, indicating, therefore, to play a "possible" role in its pathogenesis.
At this point, it is advisable to examine an interesting aspect of the problem, on which all authors are in agreement, summarized in a fascinating way by Coen D.A. Stehouwer (paper cited above), who suggested me the following quantum-biophysical-semeiotic considerations on the relation between microalbuminuria, inflammation, endothelial dysfunction, and atherosclerosis. I assessed such parameters "clinically" with the aid of Quantum-biophysical Semeiotics.
The most commonly held view is that microalbuminuria reflects a pathophysiological process predisposing to atherothrombosis. Atherothrombosis is a low-grade inflammatory disease of the vessel wall characterized by endothelial dysfunction and increased transendothelial passage of leukocytes. These features, therefore, could be the pathogenic factor linking microalbuminuria to cardiovascular disease.
In support of this hypothesis, increased levels of C-reactive protein (CRP), bedside evaluated now with Quantum-biophysical Semeiotics (See above-cited website, URL
http://www.semeioticabiofisica.it/semeioticabiofisica/Documenti/Eng/C%20Reactive%20Protein%20engl.doc) which reflect inflammatory activity, increased plasma levels of von Willebrand factor (vWf), a marker of endothelial dysfunction, and increased plasma levels of soluble vascular cell adhesion molecule-1 (sVCAM-1), an adhesion molecule which reflects recruitment of leukocytes into the vessel wall (1, 2), have all been associated not only with the increased risk of cardiovascular events, but also with the development of microalbuminuria. Such associations, moreover, were independent of conventional cardiovascular risk factors. These findings indicate, on the one hand, that inflammatory activity, endothelial dysfunction and leukocyte adhesion play a role in the pathogenesis of microalbuminuria, and, on the other hand, that these processes may, perhaps, explain microalbuminuria's link with cardiovascular disease (Stehouwer CDA:, above-cited article).
In other words, above-referred data, on the one hand, show that the inflammatory activity, endothelial dysfunction and cellular adhesion play a role in the pathogenesis of albuminuria, and, on the other hand, these processes can, probably, enlighten some-how the link between microalbuminuria and cardiovascula diseases.
At the moment, without disclosing biophysical-semeiotic view-point on the significancy and real nature of urinary loss of small amount of albumin, it is opportune, however, to underscore a remarkable fact: in the really "initial", and "primary" stages of microalbuminuria, I observed at first "clinically", and then coroborated by laboratory data, hepato-aspecific gastric reflex, type II, which is physiologically negative (= Acute Phase Proteins absent) (See in my site, HONCode, N° 233736, http://digilander.libero.it/semeioticabiofisica, Practical Applications, and Article N° 2, Appendicitis, in the Page, I hold

weekly in the italian site www.katamed.it), as well as all other biophysical semeiotic signs of inflammation: Rethiculo-Endothelial System Hyperfunction Syndrome, Antibody Synthesis, a.s.o.

Microalbuminuria Etiopathogenesis from Quantum-biophysical-semeiotic view-point.

From a renal pathophysiological point of view, microalbuminuria must be caused by increased glomerular permeability to albumin, increased glomerular pressure, and (or) decreased tubular albumin reabsorption. The renal endothelium is intimately involved in the regulation of these processes, but how endothelial dysfunction and increased leukocyte adhesion cause microalbuminuria in molecular terms is not completely understood.
In addition, it is plausible that low-grade inflammation is causally related to the development of microalbuminuria. The main stimulators of production of acute phase reactants such as CRP are proinflammatory cytokines. Interleukin-6 may be an important mediator of mesangial cell proliferation and matrix overproduction, but also of an increase in general vascular permeability without involvement of the kidney. Thus, increased proinflammatory cytokines, as reflected by increased acute phase reactants such as CRP, may cause microalbuminuria through both renal and non renal vascular mechanisms.
As I will refer later in detail, quantum-biophysical-semeiotic data, at least in initial stages, do not agree with those of such, otherwise interesting, theories. In fact, in initial stage we can not observe neither increase of Acute Phase Proteins (APP), nor body's defence reactions (Rethiculo-Endothelial System Hyperfunction Syndrome, Antibody Synthesis, a.s.o.). In addition, there is no inflammation at glomerular level (= renal-aspecific gastric reflex, type II, i.e., caused by ungueal stimulation of kidney trigger-points, is absent).
In fact, the above-referred results should invite us to consider inflammatory activity and endothelial dysfunction as probable, and even plausible, causes of microalbuminuria, on the one hand, and atherosclerosis, on the other hand, enlightening, by such way, the link between microalbuminuria and cardiovascular disease. However, the link between microalbuminuria and cardiovascular disease cannot be explained by increased inflammatory activity or endothelial dysfunction.
The findings reviewed above raise the possibility, and even the plausability, that inflammatory activity and endothelial dysfunction may cause microalbuminuria on the one hand and atherothrombosis on the other, and thus explain the link between microalbuminuria and cardiovascular disease. However, two recent studies (1, 2) (quite unexpectedly) show that the association between microalbuminuria and cardiovascular disease or mortality is not affected by adjustment for these determinants of microalbuminuria. Thus, inflammatory activity, endothelial dysfunction, and leukocyte adhesion apparently cannot explain the association between microalbuminuria and cardiovascular mortality, either in individuals with or without diabetes.

Problem unsolved: What does explain the link between microalbuminuria and risk of cardiovascular mortality?

"One possibility is that microalbuminuria reflects a prothrombotic state or another, as yet unidentified cardiovascular risk factor. Alternatively, microalbuminuria may reflect a certain susceptibility to the vascular adverse effects of a variety of cardiovascular risk factors. This concept is supported by the observation that determinants of the development of microalbuminuria, such as diabetes, hypertension, inflammatory activity, and endothelial dysfunction, do not appear to confound the microalbuminuria-cardiovascular disease link. These possibilities require further study. For the present, microalbuminuria is a clinically useful marker of increased cardiovascular disease risk, even though the pathophysiological explanation of the association remains enigmatic", states Coen D.A. Stehouwer, author of the fascinating article, posted in the site www.ATHERO-ORG.com., often cited in the present paper, who thinks, in my opinion, in a compelling way, that microalbuminuria could be either the expression of pre-thrombotic state or of different condition, such as cardiovascular risk factor, untill now unidentified.

“Alternatively, microalbuminuria may reflect a certain susceptibility to the vascular adverse effects of a variety of cardiovascular risk factors”, the author suggests.
With this point of view is in agreement the observation, corroborated also by biophysical-semeiotic method, that determinant causes of albuminuria occurrence, such as DM, hypertension, inflammatory activity, endothelial dysfunction, are acceptable in linking microalbuminuria to cardiovascular disease. These possibilities, the author concludes, require further study.

Quantum-biophyical-semeiotic Contribution to clarifying the relation between Microalbuminuria and Cardiovascular Disease.

In order to understand, in the best and successful way, the following topic, it is unavoidable studying all articles on “Biophysical-Semeiotic Constitutions”, posted in my above-cited site (3-8).
In my mind, from the healthy state, white zone, slowly, really slowly, one reaches the morbid state, black zone – DM, ATS, arterial hypertension, gouthy, dyslipidemia, malignancy, a.s.o. – going through a long, very long, intermediate stage – pre-morbid stage, pre-metabolic stage – or grew zone, which, if undiagnosed, can last years or decades, without whatever clinical syntomatology, which is the subject of present consideration, as regards arteriosclerotic coronary diseases.
The grew zone is made up of an initial stage, or Zero Stage, and by successive poli-metabolic syndrome, X syndrome or Metabolic Syndrome, both classic and “variant”, I described previously (3, 4), which mostly goes before the black zone.
Due to this reason we define the grew zone as pre-morbid or pre-metabolic syndrome. (See papers also in www.semeioticabiofisica.it/microangiologia).
), that represents a functional mitochondrial cytopathology, inherited by mother, completely asyntomatic at the beginning, and over many years or decades, before ending up with poli-metabolic syndrome (5, 6, 7 and my sites, above referred).α (CAEMH-αMetabolic Syndrome, both classic and “variant”, is based on Congenital Acidosic Enzyme-Metabolic Hystangiopathy-
In order to understand and recognize “quantitatively” the “real” arteriosclerotic risk of an individual, it could be of interest the knowledge of the nature of link existing between microalbuminuria and arteriosclerotic cardiovascular disease, but, in my opinion, going “beyond microalbuminuria” gives doctor more information.
Certainly, primary problem, we face with, is bed-side recognizing and defining molecular-biological events, which characterize the grew zone, including its Zero Stage, with the aid of an efficacious method, reliable and rapidly to perform on very large scale, as Quantum Biophysical Semeiotics.
Such as method allows us to bedside recognize, in quantitative way, the Zero Stage of grew zone, and classic and “variant” Metabolic Syndrome, i.e., pre-morbid, pre-metabolic syndrome, which is the locus (space-time) of primary prevention of the most serious human diseases (8) (See above-cited sites).
First of all, we must find a key-stone (a new reading way), biophysical-semeiotic in origin, totally different from that based upon “classic” signs and symptoms of the traditional physical semeiotics, including the microalbuminuria, completely absent in pre-morbid, pre-metabolic syndrome, that permits us to make the proper bed-side diagnosis in a “quantitative” way, during the common physical examination, in whatever patient.
Let’us consider, therefore, what happen at metabolic-endocrine level in both extreme situations, at first, in white zone and, then, in black zone in order to underline existing differences, usefull to our aim, i.e., to recognize and describe the intermediate, asymptomatic stage, I named grew zone.
In fact, different metabolic-endocrine behaviour of healthy individual, and, respectively, of patient involved by classic and “variant” Reaven’s syndrome, will help us to recognize, clinically on a very large scale and during the common physical examination, people apparently “healthy”, but who absolutely need intense and accurate consideration, due to their “real” risk for

cardiovascular diseases, even at the moment without microalbuminuria, that is not always present, neither in successive stages.
At this point, I have illustrated in details in a previous Commentary the arterial abnormalities in off-spring of patients involved by Myocardial Infarction, even premature (?). The data gathered by these dynamic methods, on the contrary, result pathologically modified in those individuals at inherited real risk for arteriosclerosis, even in the first two decades of life, as we referred in former papers (17, 18, 19, 20).
These facts, I have been observing in a long clinical experience, corroborate, without any doubt, our Microangiological Theory of Arteriosclerosis, since they clearly underline the earliest functional and structural lesion of arterial wall, secondary to, however, as will be said later on, Endoarteriolar Blocking Devices (EBD) abnormality in related microvessel, that represents, in my mind, the first of all and essential alteration, genetically inherited: microcirculatory remodelling (5).
As a matter of fact, it has been demonstrated that family history of CAD points out an independent risk factor for cardiovascular diseases, showing in a clear manner "inherited" component of such as disorder (I identified it , and termed it as CAEMH).
These anamnestic data have been enclose to guide-lines for CAD prevention and is at present utilized in paediatric cardiology, beside genetic study of gene mutation, codifying lipoproteins receptors, a research surely complex and expensive, not possible to apply on very large scale ().
Since, at the present, we cannot know when the first vascular (and parenchymal) abnormalities occur, an useful "clinical" method, reliable in recognizing the presence and in quantifying the seriousness of such vascular alterations, appears to be an important event.
The data of our researches parallel, and agree with, those of other authors, carried out with sophysticated methods, in the sense that they show, as markers of early arteriosclerosis, the association between reduced reactivity of brachial artery and/or carotyd intimal-media thickening, observable in young individuals with positive family history for previous myocardial infarction.
Such an association is really interesting, due to the fact that abnormal vasodilatory response to acethyl-choline as well as endogenous insulin can be easy evaluated at the bed-side, as we referred in previous papers in individuals formerly involved by inherited alterations of microvessels, including particularly Arterial-Venous Anastomose (AVA), functionally speaking (19, 21, 22).
In other words, arteriosclerotic earliest abnormalities are "pre-clinical", i.e., pre-clinical lesions; they come before decades the so-called fatty-streaks. Now-a-days, for the first time, with the aid of the original physical semeiotics, doctor is able to recognize at the bed-side these alterations, primarily functional, also by means -mediated.αof analogous modifications of anastomoses, including EBD, as well as of reduced arterial vasodilation – caused by a large variety of methods – always associated with intimal-media thickening or functional-structural endothelial lesions, in our opinion, taking part of primitive alteration of vasa vasorum, CAEMH-
At this points, one must remember that arteriosclerosis is notoriously a systemic disorder, which involves all circulatory tree and notably, sooner or later, is accompanied by other common diseases.
Consequently, functional and structural alterations, observed in loco, are present also in other locations in youg men, completely asymptomatic, i.e., without any clinical phenomenology. In addition, such as association between altered vascular reactivity-intimal-media thickening, observed by many authors, has been corroborated by us in a clinical way. The same we can say also as regards hypertensive patients as well as patients with suspected CAD (23, 24).
These fact, on which almost all authors agree, are referred and discussed in detail because they offer further evidence to our microcirculatory theory of arteriosclerosis: endothelial suffering, provoked by CAEMH and worsened by numerous environmental risk factors, partly known (at least 300), due to reduced synthesis of free-radical NO, augmented secretion of vasoconstrictor factors and endothelial-dependent imbalance of haemostatic system, can predispose to

monocytes and platelets adhesion, proliferation of media vascular smooth muscle cells and their migration towards intima, storage of monocytes-derived macrophages, and lipoproteins in arterial wall.
Surely, numerous other factors, as inflammation, can take part of pathogenesis of arteriosclerosis, but later, in our opinion, and always in well-defined individuals. However, the genetic factor is of primary, essential importance. It is necessary in enlightening the various moments of natural history of arteriosclerosis.
To conclude, beyond practical aspects, as early bed-side recognizing primitive functional alterations of artery wall, and successively "anatomical" modifications in symptomless individuals, unavoidable to can define arteriosclerotic constitution, former discussion about the relation, surely existing, between altered reactivity of arterial wall and initial intimal-media thickening introduces to the explanation of our "intuition" on the existence of a particular constitution, conditio sine qua non of atherogenesis, which allows to give precise answers, we lack untill now, useful to primary prevention, hopefully efficacious when applied on very large scale.

Biophysical-Semeiotic Arteriosclerotic Constitution.

Clinical evidence suggests the existence of arteriosclerotic constitution:

a) Acute Myocardial Infarction, for instance, can involve an individual "without" well-known risk factors, but "always" CAEMH-positive and subsequent coronary microvessel remodelling, characterizad by newborn-pathological, type I, sub-type b) aspecific, Endoarteriolar Blocking Devices (5) (as in my personal case!).
Moreover, the so-called minimal changes are already present at an age, when known risk factors surely are absent;

b) not "all" dyslipidemic and/or diabetic and/or hypertensive and/or hyperomocysteinaemic patients die due to ictus, myocardial infarction or other arteriosclerotic complications;

c) not "all" hypertensive patients are going to suffer from generalized or localized (CAD) arteriosclerosis; by contrast, are described cases (15-19) of people died from arteriosclerotic complications during the first two life decades, "without" presenting well-known risk factors (18);

d) even in presence of well-known risk factors, arteriosclerosis involves defined, limited areas of arterial wall, rather than "all" wall;

Therefore, arteriosclerotic constitution does really exist, as that diabetic, osteoporotic, rheumatic, artrosic, hypertensive, glaucomatos, oncological, i.e., Oncological Terrain (See above cited site).
In the same individual, of course, can be present contemporaneously diverse constitutions, which, in fact, originate always on the base of common inherited alteration: CAEMH.

In following, easy clinical methods to recognize as well as to quantify the arteriosclerotic inherited real risk with the aid of Biophysical Semeiotics, since two first life decade, are described. Most accurate and refined ascertaining requires necessarily a very good knowledge of original diagnostic method (19, 20, 27).

1) In health, "mean-intense" digital pressure, applied on whatever artery (brachial, femoral, carotid artery, a.s.o.) of a supine, psycho-physically relaxed individual, with open eyes to avoid melatonin secretion, brings about aspecific gastric reflex (Fig.2) after latency time (lt) of 8 sec.
16 sec.≥Moreover, after artery preconditioning (doctor evaluates such a parameter value a second time, after exact 5 sec. interval) lt raises to

Fig.2

Figure indicates the correct location of the bell-piece of stethoscope and lines upon which doctor must apply digital percussion, directly and gently, in order to define the limit of stomach cutaneous projection area of the stomach great curve. It is sufficient to delimit a small segment of curve for assessing the reflex. Aspecific gastric reflex: in the stomach, both fundus and body dilate, while antral-pyloric region contracts.

8 sec., inversely related to the intensity of risk or underlying disease, with duration less tahan 4 sec.≤On the contrary, in a subject at inherited real risk of arteriosclerosis, and obviously in arteriosclerotic patient, basal artery-aspecific gastric reflex shows a lt

In addition, really interesting from diagnosis view-point, artery preconditioning results pathological: second evaluation, performed exactly after 5 sec. from the former, shows a lt small increased, unchanged (e.g., 8 sec.) or reduced in a clear-cut manner, when compared with basal value, in relation to the seriousness of arteriosclerotic constitution and respectively, in case of ATS overt disease.

Identical data as those of preconditioning, one can collect at the bed-side with Valsalva's manoeuvre, which brings about increase of acetyl-choline secretion, indicating internal and external coherence of biophysical-semeiotic theory (= loss of production and secretion of free-radical NO, due to endothelial alteration and consequently arterioles and small arterioles smooth muscle cells contractions, due to direct stimulation by acetyl-choline.

Interestingly, in case of vessel wall calcium deposit (calcification involves exclusively individuals positive for "variant" Metabolic Syndrome), aspecific gastric reflex, after reaching its highest intensity, and soon thereafter lowers of a third of it.

The reader understands correctly that it is easy to evaluate the actual condition of whatever arterial vessels, for example, coronary arteries (25) and cerebral arteries (26) (See above-cited site, Practical Applications: CAD and Cerebral Tumour).

2) the subject, doctor is examining, clenches his 1 cm. (Fig. 2), whereas in presence of either arteriosclerotic constitution or overt arteriosclerosis, lt results, once again,≤fists: boxer's test. In healthy, after a latency time of 10 sec. appears the aspecific gastric reflex of 10 sec. and reflex intensity≤ is > 1 cm.

If doctor performs such as evaluation, applying boxer's test, after exact 5 sec. from the first one (preconditioning), the data observed are the same of those formerly illustrated at point 1).

In conclusion, these two easy methods, applied also in "dynamic" way, are reliable and sufficient to allow recognizing arteriosclerotic constitution, that can be quantified with the aid of parameter values, observed during basal and dynamic evaluation.

Without facing physiopathological discussion of biophysical-semeiotic signs, certainly interesting, but not pertinent to the aims of present article, the illustrated physical examination allows doctor to collect useful information on function as well as structure of adventitial microcirculatory bed, steadly correlated with nutritional condition of local artery wall, i.e., with local Microcirculatory Functional Reserve.

It is easy to understand that the very good knowledge of this new physical semeiotics permits doctor to gather a large variety of clinical microangiological signs, really abundant of information.

Among these interesting signs, I am going to illustrate only some, which allow a refined evaluation of anatomy and function of microcircle, including the adventitial microvessels – vasa vasorum – both at rest and during activation:

1) in healthy, "mean-intense" (but not highest) digital pressure, applied upon a finger-pulp of a supine and psycho-physically relaxed individual, causes upper ureteral reflex (= dilation of upper third of ureter), which gives information on type II, group B AVA, according to Bucciante. At this point, if digital pressure becomes highest, reflex disappears, underscoring the normal structur-function (elasticity) of the same anastomoses, which physiologically control microcirculatory blood-flow.

2) under identical circumstances, the behaviour of mean ureteral reflex (= mean third of ureter dilation) appears the same: it gives information on the real situations of local Endoarteriolar Blocking Devices (EBD) (Fig.3)

Fig. 3

Arrow indicates a particular endoarteriolar formation, like elephant trunk (EBD), whose contraction increases the flow-motion towards, and along, capillaries and post-capillaries venules. On the contrary, the relaxation of EBD smooth muscle cells decreases the blood-flow towards nutritional capillaries. (For kind permission of Prof. S.B.Curri, whose as much excellent as large literature in the field of microcircle and microcirculation originated my enthusiasm about the study of this fascinating and almost ignored branch of Medicine)

3) "mean-intense" digital pressure, applied as illustrated above, provokes upper ureteral reflex (See example 1), which shows the opening of type II, group B AVA. However, if the individual arises his (her) arm in vertical position, the reflex rapidly disappears: closure of AVA, aimed to supply a larger amount of blood flow, and, consequently, to control histangic pH also during such posture test;

4) under identical condition, described above at point 3), if the subject lowers vertically his (her) arm, the intensity of upper third ureteral reflex increases rapidly: type II, group B AVA augment their diameter, and, therefore, their haemoderivative function increases, aiming to maintain a physiological microcirculatory blood-flow in normal ranges, under different positions. Such as physiological microcirculatory adaptations clearly suggest the normal functioning of venular-arteriolar reflex (VAR):

5) in healthy, "mean-intense" digital pressure on a finger-pulp brings about aspecific gastric reflex after a latency time of about 10 sec. (lt value is obviously age-dependent). This value persists unchanged, under physiological condition, when the arm is located in every of three posture positions, due to functional microvessel adaptations, explained above.
All these dynamic tests result altered, obviously of a different degree, in case of arteriosclerosis, starting from the earliest stage, i.e., arteriosclerotic constitution.

QUANTUM-BIOPHYSICAL-SEMEIOTICS OF MICROALBUMINURIA.

In table 1, is summarized the diagnostic biophysical-semeiotic iter, usefull and reliable in bed-side recognizing presence and nature of nephrone disease, even clinically silent and localized.
Really, Quantum-Biophysical Semeiotics does not allow doctor to make "clinical" diagnosis of microalbuminuria, but surely permits to exclude it (100%) or to

suspect it, in rational way, conditio sine qua non of ascertaining the real nature of an aspecific damage of nephrone, even limited in some areas of kidney. In fact, facing the problems of kidney showing normal size, i.e., when are absent biophysical-semeiotic signs of inflammation, parameter values of kidney-aspecific gastric and –caecal reflexes are still in "extreme" limits of normality or clearly pathological, preferably when assessed in selective way, by stimulating, at first, renal trigger-points of upper third, then those of mean third, and finally those of lower third.
Nephrone suffering, even circumscribed, is outlined by renal preconditioning, whose results – lt of kidney-aspecific gastric reflex unchanged or pathological, i.e., reduced in second evaluation – is aspecific expression of nephropathy.
Of primary importance proved to be the "selective" evaluation of renal vasomotion, which shows the characteristic type II, dyssociated microcirculatory activation or, in initial and slight forms, type III, dyssociated microcirculatory activation: the fluctuations of upper third of urether (vasomotility: arterioles and small arterioles, according to Hammersen) are increased with AL + PL of 7-8 sec. (NN = 6 sec.), while the oscillations of lower third of ureter (vasomotion: nutritional capillaries and post-capillary venules) are normal with AL + PL of 6 sec., but large "in toto" ureteral reflex: > 1 cm.(= interstitium).

From practical diagnostic view-point, the following quantum-biophysical-semeiotic manoeuvre plays a pivotal role excluding whatever disorders of renal apparatus, including MICROALBUMINURIA, in ONE SECOND: in health intense cutaneous pintching of a single urinary trigger points (= practically, the skin of lateral abdominal quadrant) does not bring about gastric aspecific reflex! On the contrary, in whatever disorder of urinary tract appears "simultaneously" such as reflex. In case of Inherited Oncological Real Risk and overt CANCER (in kidney, urether, urinary bladder, PROSTATE) "simultaneously appears gastric aspecific reflex, immediately followed by tonic Gastric Contraction ()

In conclusion, from quantum-biophysical-semeiotic data, it is likely that the base of , influencing in negative manner both microvessel dynamics and haemoreology (hyperviscosity) under sympathetic hypertonus conditions, ischaemia, and hormonal impairement (IIR), as we observe frequently in pre-morbid or pre-metabolic syndrome, as wel as in subsequent Metabolic Syndrome, classic and "variant" (3, 4).αmicroalbuminuria is an inherited microvascular-microcirculatory alteration of nephrone, i.e., local microcirculatory remodelling, even circumscribed, primarily functional, acidosic, that cause function abnormality of the vascular smooth muscle cells and, then, of newborn-pathological Endoarteriolar Blocking Devices (EBD), involved selectively, although systematically (including vasa vasorum), by a particular mitochondrial cytopathology, CAEMH-
Therefore, from the above-referred data, gathered by the aid of Quantum-Biophysical Semeiotics, microalbuminuria, if present, does not represent a "causal factor" of CAD, and , in general, of ATS, but an early microvascular functional CAEMH-induced abnormality of the nephrones, whose patho-physiological mechanisms are the same of ATS, according to our microcirculatory theory of arteriosclerosis, which allows doctor to foresee only the future onset of CAD.
In performing efficacious prevention of arteriosclerosis, applied on very large scale, I suggest to go "beyond microalbuminuria", that is present "exclusively" in case of selective microvessel suffering of the nephrone, caused by the mitochondrial cytopathology, we termed Congenital Aciodosic Enzyme-Metabolic Histangiopathy, conditio sine qua of the most serious human diseases (5, 6, 6, 7).

BIOPHYSICAL- SEMEIOTIC DIAGNOSTIC ITER OF GLOMERULAR-TUBULAR SUFFERING

KIDNEY AUSCULTATORY PERCUSSION

TEST OF SIMULATED URINATION

INFLAMMATORY SIGNS (RESHS “COMPLETE”, ACUTE PHASE PROTEINS, A.S.O.)

CIRCULATORY IMMUNOCOMPLEXES SYNDROME

AUTOIMMUNE LOCAL SYNDROME

TYPE I AND II KIDNEY-ASPECIFIC GASTRIC REFLEX

KIDNEY-CAECAL REFLEX

RENAL PRECONDITIONING

ERITHROPOIETINE TEST

VASOMOTILITY AND VASOMOTION OF KIDNEY

Tab. 1

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Quantum-Biophysical-Semeiotic Arteriosclerotic Constitution.

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Introduction.

The topic of this article, perhaps difficult to understand for physicians who are not skilled in quantum-biophysical semeiotics , is certainly fascinating, original, interesting, and useful, due to its clinical implications and, above all, arteriosclerosis primary prevention, particularly as regards coronary artery disease (CAD), as well as the most serious human diseases, sometimes ultimate stage of Metabolic Syndrome, both classic and "variant". The later, I described in previous papers, is characterized by physiological sensitivity of hepatic insulin receptors, evaluated clinically [1-3]. For further information, see my website www.semeioticabiofisica.it.
From the healthy stage, *white zone*, slowly, sometimes very slowly, one reaches the disease onset, *black zone* – DM, ATS, AH, dyslipidaemia, gout, malignancies, a.s.o., going through the pre-morbid stage, *grew zone*, that can last years or decades, without any clinical symptoms, which is the topic of this paper, as far as arteriosclerosis is concerned.
Metabolic Syndrome, also termed poly-metabolic syndrome, X syndrome, the deadly quartet, classic or "variant", represents the possible entrance of *grew zone*. Due to this reason, I term the *grew zone* as *pre-morbid* or Pre-Metabolic syndrome.
Interestingly, both *grew zone* and Metabolic Syndrome, classic or "variant", are based on Congenital Acidosic Enzyme-Metabolic Histangiopathy (CAEMH), a mitochondrial functional cytopathy [4-7], bedside detected since birth. It represents a remarkable mitochondrial dysfunction, inherited generally from the mother, mainly asymptomatic in initial stages, as well as for long time, before ending in Metabolic Syndrome.
The main problem, we have to face and hopefully resolve, is, therefore, to recognize and define clinically underlying molecular-biological events, characteristic of *grew zone* by means of efficacious method, rapid to perform at the bed-side in quantitative way, as quantum-biophysical Semeiotics, meaning it as conceptual and operative tool.
In the method are implicit all future, possible knowledge, and, thus, I ask to this method – but not only to logic-deductive method, according to our philosophy [8] - to allow us to recognize clinically pre-morbid syndrome, which represents the *locus* of primary prevention of most serious human diseases [3-8]. Therefore, as starting point of our reasoning, it is to be found a quantum-biophysical-semeiotic reading key, really different from that, based on "classic" signs and symptoms, which are, on the other hand, completely absent in pre-morbid stage or *grey zone*, which permits us to correctly diagnose in a quantitative manner Pre-Metabolic Syndrome, in easy and rapid way during common physical examination, even performed for whatever reason.
Firstly, let us consider what happens in two extreme situations, from metabolic-endocrine view-point, before in the *white zone* and, then, in the *black* one, in order to underline the existing differences, useful to our aim, i.e., to recognize and describe intermediate asymptomatic stage, i.e. *grey zone*: Pre-Metabolic Syndrome.
In fact, the different metabolic-endocrine behaviour in healthy individual and, respectively, in the patient involved by Metabolic Syndrome, classic and "variant", will help us in recognizing, clinically on a large scale, performing a common physical examination, subjects, who are apparently healthy, but really need to be taken into accurate consideration.

Arterial abnormalities in off-springs of patients involved by myocardial infarct, even premature.

Among the various and important risk factor for cardio-vascular events I have to consider the frequency of coronary heart disease in family history [9-11].

It is unavoidable necessary emphasize these relations, I can observe clinically by means of quantum-biophysical Semeiotics, due to the fact that they represent a relevant introduction to both explanation of microcirculatory theory of arteriosclerosis and its full understanding.
The numerous theories on arteriosclerosis pathogenesis clearly demonstrate our short knowledge of this really important topic, in spite of the progresses of sophisticated semeiotics, including images semeiotics. Fundamental of my theory is the general agreement on the "initial" lesion at level of endothelial cells (more precisely speaking, endothelial cells of HP zones). In fact, it is known that in vessels of experimental animals as well as in humans, atherosclerotic lesions develop nor randomly, but primarily in the zones near branching of arteries, bifurcations of vascular trees, or bending of vessels [12]. Sophisticated methods have allowed Authors to describe the regions with high-probability of atherosclerosis (HP Zones), and relatively resistant areas, or low-probability zones (LP Zones) [12].
With regard to the role played by endothelial cells, particularly by endothelial cells in HP zones, in both physiology and pathology, as reader can see in Bibliography of my website www.semeioticabiofisica.it, over a large number of years, I have tried hardly to attract the attention of colleagues on the primary role played by *endothelial cells,* for the first time examined bedside, namely from the clinical point of view, with the aid of quantum-biophysical-semeiotic methods.
At this moment, I must remember some important risk factors, which play relevant role in atherogenesis: tobacco smoking, glucose metabolism impairment, dyslipidaemia and arterial hypertension. However, such risk factors do not provoke atherosclerosis in "all" cases.
Moreover, when they "cause" artery wall damage, the artheropathy shows a different seriousness and location, in evident relation to underlying genetic factor, i.e., CVD inherited real risk factors, I have fully illustrated in earlier papers [4-8].
Interestingly, ischemia risk, as ECG shows, is about 40% higher and death risk due to cardiac cause is 2,5-7 % greater in individuals with family history "positive" for premature coronary heart disease in comparison to people without such family history [13].
At this point, I must underline the maternal heredity of Congenital Acidosic Enzyme-Metabolic Histangiopathy, most common and chronic diseases are based on.
Among the numerous papers about this topic, I remember that arteriosclerotic lesions have been observed by auotopsy in coronary arteries of very young individuals with family history positive for coronary artery disease [14].
Over the last decades, B-mode ultrasonography at high resolution proved to be a reliable and valid method in recognizing initial arteriosclerotic abnormalities in arterial walls [14]. Intimal and media thickening of the carotid artery has been observed in individuals with risk factors for cardiovascular disorders, proving to be a remarkable sign of the presence of coronary arteriosclerosis as of its complications.
The doctor, skill in such original diagnostic method, knows certainly that quantum-biophysical-Semeiotics allows to recognize, at the bed-side, these macrovascular lesions directly (vessel-gastric aspecific and -caecal reflex; pathological *preconditioning*), as well as indirectly with the aid of local *vasa-vasorum* (activation type II, dissociated), I shall describe later, illustrating the Arteriosclerotic Constitution.
With the aid of ultrasonography doctor can evaluate finally, with non-invasive method, endothelial function by observing diameters modifications of brachial artery, brought about by insufflation and deflation of elastic arm-band [15]. Finally, I remember that the brachial artery reactivity, e.g. to blood-flow, is abnormal in individuals with overt arteriosclerosis and in asymptomatic subjects with coronary risk factors [16].
It is now a lot of years that, in a clinical research, I have demonstrated the reduced reactivity of brachial artery in arteriosclerotic patients and their offspring [17].
As far as the easiest application of our method is concerned, doctor must assess "in toto" ureteral reflex intensity (= ureter dilation, www.semeioticabiofisica.it, Technical Applications, N° 5) caused by intense (non occlusive) digital pressure on the brachial artery (or on whatever other artery, of course), evaluating precisely the intensity in cm. Contemporaneously, appears artery-gastric aspecific reflex, more easily detected than the ureteral one, when the knowledge of the method is not yet steady.
Thereafter, the subject to be examined is invited to perform Valsalva's manoeuvre (increase of acethyl-choline) for about 10 sec.; then, doctor assesses the value of same parameter for a

second time. In healthy, the intensity of both "in toto" ureteral reflex and gastric aspecific reflex doubles or augments significantly.
Clinical evidence shows that the severity of arteriosclerosis and decreased intensity of "in toto" ureteral and gastric aspecific reflex during Valsalva's manoeuvre are inversely related.
A further easy evaluation of this event is the comparison of basal parameters values of the same reflexes and those observed during "*boxer's test*", which brings about vessels dilation, due to increase of the peripheral arterial resistance, increasing contemporaneously both vasomotility and vasomotion of related *vasa vasorum,* quantified by Quantum-Biophisical Semeiotics, as well known to skilled reader: the intensity of artery-"in toto" ureteral reflex appears practically doubled, in healthy, and latency time of artery-caecal reflex clearly extended (= temporaneously decreased tissue acidosis, due to Valsalva's manoeuvre).
In fact, in health, showing coherence, latency time of both caecal and gastric aspecific reflex at basal line results the half of that observed after acethyl-choline secretion du to Valsalva's manoeuvre and, in second experiment, after physiological endothelial secretion of radical NO.
In healthy, identical results are observed by the *test of acute pick of insulin secretion* (See in the site: Diabetes mellitus), applied after assessing the various basal parameters values [17-20].
On the contrary, all these data, collected by dynamic tests, are abnormaly modified in individuals, even in the two first life decedes, at "real" risk of arteriosclerosis, as I demonstrated in previous papers [20-22].
These facts, observed in a long, well established experience, on which all doctors must agree, corroborate our microangiological theory of arteriosclerosis, because they show clearly the very early *functional-structural* disorder of macrovascular wall, however, preceded, as I shall illustrate later in details, by Endoarterial Blocking Devices (EBD) abnormalities of related microvessels, which has to be considered, in our opinion, the first and essential alteration.
As a matter of fact, it has been notoriously demonstrated that family history of coronary artery disease represents an independent risk factor for cardiovascular pathology, showing clearly "inherited" component (I recognized as CAEMH). This anamnestic datum has been included in prevention guide-lines of CAD, and, at the moment, is used in paediatric cardiology as imortant indication in the screening of lipids blood concentrations, beside genetic assessment of gene mutations, which codify lipoproteins receptors, that is obviously an expensive and awesome research, certainly not suitable for a large scale prevention.
Since I do not know, at the moment, when originate precisely the first vascular abnormalities and those of related *parechyma*, according to Angiobiopathy (17-20), it appears to be an important and essential event the use of a "clinical" tool, reliable in detecting the presence as well as in quantifying the severity of such arterial structural abnormalities.
Our researches corroborate, from the "clinical" point of view, those of other authors, performed with sophisticated methods, because they indicate, as markers of early arteriosclerosis, the association between decreased reactivity of brachial artery and intimal-media thickening of carotid artery, present in young people with family history positive for *premature* myocardial infarct. This association is interesting, because the abnormal vasodilatory response to achethyl-choline and endogenous insulin can be easily evaluated at the bed-side, as above referred, in individuals earlier involved by microvascular dysfunctions, including "in primis" Arterious-Venous Anastomoses (AVA), functionally speaking, i.e. including EBD [18-24].
In other words, the very first arteriosclerotic arterial abnormalities are "pre-clinical", the so called *pre-clinical lesions,* and precede by decades the *fatty-streaks*.
For the first time, nowadays, by means of the original semeiotics doctor is able to recognize clinically these modifications, almost functional, even by the bed-side evaluation of analogous abnormalities of haemoderivative structures (including EBD) and the reduced arterial vasodilation, brought about by different manner, always associated to intimal-media thikening, based on endothelial insufficiency, which plays a primary role, in our opinion, in the most important alterations of *vasa vasorum*, CAEM-α dependent.
At this point, it is necessary to remember that arteriosclerosis is notoriously a systemic process which involves circulatory tree and, interestingly, is associated, sooner or later, to other disorders. Consequently, functional and structural abnormalities, observed *in loco,* are present also in other districts in young individuals without any clinical symptomatology. Moreover, the

association abnormal vascular reactivity-intimal-media thickening, observed by a large number of authors, has been corroborated by us, for the first time with the aid of "clinical" method.
Such statement is valid also for hypertensive patients and individuals with suspected CAD [24-26].
These noteworthy facts, about which a large number of authors agree, are referred and discussed extensively, since they provide further evidences in support of our Microcirculatory Theory of Arteriosclerosis: endothelial impairment, caused by CAEMH and worsened by about 300 environmental risk factors, until now only partially known, bringing about lowering synthesis of radical NO, increased secretion of vasocostrictors substances, and endothelial-dependent haemostatic unbalance, can predispose in these individuals to monocytes and platelets adesion, medial muscular cells proliferation and subsequently their migration to the intima, monocytes-derived macrophages as well as lipoproteins storage in the arterial wall.
Certainly, a large variety of other factors, as inflammation, intervene, in our opinion only in a subsequent stage, in arteriosclerosis pathogenesis, but *genetic factor* is really dominant, primary and necessary to explain completely the diverse phases of arteriosclerosis natural history.
To conclude, apart from practical aspects, as early *clinical* recognizing initial functional and then structural abnormalities of arterial wall, in asymptomatic subjects, unavoidable in defining arteriosclerotic constitution, previous discussion about the relation between abnormal reactivity of arterial wall and intimal-media tickening introduces the illustration of our "intuition" on the existence of a singular constitution, at the arteriosclerosis base, which allows to give satisfactory answers, lacking until now, and useful to primary prevention, hopefully efficacious, especially when applied on very large scale.

Arteriosclerotic Constitution.

Clinical evidence suggests the existence of arteriosclerotic constitution: for instance, acute myocardial infarct can involves an individual without any risk factors (about 300!), but CAEMH-positive (*as the personal case indicates*). In addition, not ALL dyslipidaemic and/or diabetic and/or hypertensive patients die from ictus, myocardial infarct, or other arteriosclerotic complications; not ALL hypertensive patients are suffering for generalized or localized arteriosclerosis (CAD).
On the contrary, there are acknowledged cases of dead due to arteriosclerotic complications over the first two decades of life, without any well-known risk factors [7,18,22,24-27].
Thus, arteriosclerotic constitution exists as the diabetic, osteoporotic, rheumatic, arthrosic, hypertensive, glaucomatous, oncological, dyslipidaemic one, a.s.o. In the same individual can be present obviously diverse constitutions, originated on the common inherited base, i.e. CAEMH.
In following, easy methods necessary to recognize clinically, starting from the first life decades, the inherited, arteriosclerotic real risk in a quantitative manner by Quantum-biophysical Semeiotics are described.
Surely, a thoroughly examination need a steady knowledge of this original diagnostic method.

1) In health, mean-intense, but not occlusive, digital pressure, applied upon a large artery (e.g. brachial, femoral, carotid artery) of a subject lying down psycho-physically relaxed in supine position, provokes the gastric aspecific reflex after a latency time (lt.) of 8 sec. exactly. In addition, after *artery preconditioning* (= doctor performs a second time this evaluation after an interval of exact 5 sec.) lt. increases to 16 sec. doubling basal value.
On the contrary, in an individual at inherited real risk of arteriosclerosis and obviously in arteriosclerotic patient, artery-gastric aspecific reflex shows a lt. less than 8 sec., showing an intensity inversely related to the severity of risk itself or of overt disorder.
In addition, interestingly from diagnostic view-point, the arterial *preconditioning* results pathological: the second evaluation, performed after 5 sec. exactly since the end of basal one, shows latency time (lt) either unchanged, e.g. 8 sec., or clearly decreased in comparison to first value. Interestingly, the later value is in relation to the seriousness of arteriosclerosis constitution, in the sense such lt. values appear lower than the basal ones, in inverse relation to the severity of underlying disease.

Identical results to those collected by arterial *preconditioning*, are those observed by Valsalva's manoeuvre (= acethyl-choline increase), outlining internal and external coherence of quantum-biophysical semeiotic theory.
As reader surely understands, it is easy to evaluate the condition of diverse arterial vessels, e.g., coronary arteries [3,27].

2) The subject to examine clenches his fists intensively: *boxer's test*. In health, after lt. of 10 sec., appears the gastric aspecific reflex, while in presence of arteriosclerotic constitution or in case of overt arteriosclerosis, once more, lt. results $\leq$ 10 sec. The second test performance, after an interval of exact 5 sec. (*preconditioning*), shows results identical to those referred at the point 1.
To summarize, both easy methods, applied also in dynamic way, are sufficient to give prominence to arteriosclerotic constitution, easy quantifiable on the ground of above-described parameters, on both static and dynamic tests.
Without deepening into a patho-physiolagical argument, surely interesting but out of our concern, the illustrated quantum-biophysical-semeiotic examination allows to collect, at the bed-side, useful information on both function and structure of the avventitial vessels, directly related to nutritional state of the local arterial walls, i. e. to Microcirculatory Functional Reserve.
It is easy to understand that the steady knowledge of the new physical semeiotics allows to recognize a large variety of clinical microangiological signs.
In following, I are going to summarize only some of them, which permit to assess, in a refined way, microvessels function and structure, including the so-called *vasa vasorum*:

1) the mean-intense (*not maximum*) digital pressure, applied upon a finger-pulp of an individual psycho-physically relaxed and in supine position, brings about upper ureteral reflex (= the ureteral upper third dilates), informing about Arterio-Venous Anastomoses (AVA) type II, group B, according to Bucciante. At this moment, if digital pressure increases *maximally*, in healthy, the reflex disappears completely, showing the structural-functional normality of these haemoderivative components, essential in regulating microcirculatory blood-flow; on the contrary, in diseased patients the reflex intensity lowers, without disappearing, due to AVA inherited alteration;
2) analogously, the mean ureteral reflex (the mean ureteral tract dilates) shows an identical behaviour under the same experimental conditions, as far as EBD are concerned;
3) the mean-intense pressure brings about the upper ureteral reflex (See point 1), which indicates the opening of AVA type II, group B. However, if the individual, at this moment, raises his (her) arm to vertical position, reflex rapidly disappears physiologically: closure of haemoderivative formations and consequently increase of blood supply to capillaries and post-capillaries venules, aiming to preserve the physiologic histangic pH: latency time pulp finger-aspecific gastric reflex persists identical to the basal one;
4) in health, under identical conditions described above, if the subject to examine lowers his arm vertically, the upper ureteral reflex intensity increases promptly: AVA type II, group B, dilates further and, then, their haemo-derivative function increases, once more aiming to keep microcirculatory blood-flow supply in normal, physiological ranges. These physiological reactions give prominence to the normality of venous-arteriolar reflex (VAR) [27-29];
5) in health, the mean-intense digital pressure on a finger pulp, under above-mentioned condition, causes gastric aspecific reflex after latency time of 8 sec.. Such as parameter value persists unchanged in all three positions (horizontal, high vertical and low vertical), due to above-illustrated reasons.
On the contrary, all these dynamic tests result abnormal, although of different degree, in case of arteriosclerosis, starting from the very initial stage: i.e., arteriosclerotic constitution and inherited real risk.
Quantum-biophysical Semeiotics allows doctors to bedside recognise in one second both arteriosclerotic constitution and overt arteriosclerosis, however without indicate the precise location, as reader easily understands.
Thanks to quantum *entanglement* [29-40], in health, "intense" digital pressure, applied upon every large artery (e.g., femoral artery at the groin), does not "simultaneously" causes gastric aspecific reflex, indicating that the walls of artery tree is perfectly normal.

On the contrary, in individuals involved by either arteriosclerotic constitution, or overt, even silent, arteriosclerosis, above-mentioned artery "intense" stimulation, brings about "simultaneously" a gastric aspecific reflex, whose intensity (from 0,5 cm. to 3 cm or more) is correlated with the seriousness of underlying disorders. Soon there after, doctor will localized the precise site of arterial wall lesion ith the aid of numerous quantum-biophysical-semeiotic manoeuvres and signs. Interestingly, in presence of arterial calcification, gastric aspecific reflex intensity lowers rapidly of one third of initial one [8, 39].

In conclusion, admittedly some problems in the pathogenesis of ATS are till now unsolved. However, quantum-biophysical-semeiotic Arteriosclerosis Microcirculatory Theory, corroborated by the Inherited Real Risk of CVD [3,39,40-42], allows us to comprehend paramount arteriosclerotic aspects, highlighting the importance of such original physical semeiotics.

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CAD Inherited Real Risk: Diagnosis and Therapy

20 July 2010, http://www.sci-vox.com/stories/story/2010-07 20cad+inherited+real+risk%3A+diagnosis+and+therapy.html

Editors,
a long, clinical, well established experience allows me to state that in the war against CAD, today's growing epidemics, physicians have to be able to bedside recognize and treat individuals at CAD INHERITED Real Risk (1-16). As a matter of fact, CAD environmental risk factors (about 300!) can facilitate and worsen CAD onset exclusively in individuals involved by CAD Inherited Real Risk, I discovered, bedside recognized with a simple stethoscope in quantitative way (1-8).Unfortunately, almost all cardiologists around the world ignore (sometimes overlook) biophysical-semeiotic constitutions and related inherited real risks, that accounts for the reason CAD is today s growing epidemics (www.semeioticabiofisica.it).
As far as CAD is concerned, notoriously coronary inherited real risk, as well as sub-clinical, and consequently very dangerous, coronary heart disease is very prevalent in western countries, independently associated with actually known risk of CAD, and substantially such risk increases. It is charaterized by newborn-pathological, type I, subtype b) aspecific, Endoarteriolar Blocking Devices in coronary small arteries, according to Hammersen, particularly frequent among patients with hypertension or diabetes mellitus. In following, I suggest - once again - an useful, reliable and easy clinical manoeuvre, that allows doctor to recognize both CAD Inherited Real Risk and silent CAD (2-4). This manoeuvre proved to be really useful in my 5-year-long clinical experience, also in order to the bed-side recognizing heart ischaemic disease before cardiac pathology occurs. Moreover, it is well known that patients with coronary artery disease (CAD) may have no symptoms at all for many years or decades and that the electrocardiographic features of ischaemia may be induced by exercise without accompaning angina (2). (For further information: See website http://www.semeioticabiofisica.it, Practical Applications). In other words, we need a clinical tool reliable in rapid detecting CAD, even clinically silent, initiating from CAD inheriterd real risk, doctor can now utilize in his day-to-day practice (2). I think surely that one method is "Myocardial Ischaemic Biophysical- Semeiotic Preconditioning", described elsewhere(2-4). From the tehnical viewpoint, doctor has to know, at least, the auscultatory percussion of the stomach (2, 3). Briefly, in health, digital pressure of mean intensity, applied upon heart cutaneous projection area, brings about the so-called gastric aspecific reflex (= in the stomach, fundus and body are dilated; on the contrary, antral-pyloric region contracts) after an age-dependent latency time of 8 sec., that lasts less than 4 sec. (= parameter value of paramount significance since it parallels the efficacy of coronary microvessel Microcirculatory Funcional Reserve). A second, successive evaluation after an interval of 5 sec. exactly, provokes the identical reflex, but after lt. of 12 sec. or more: physiological myocardial preconditioning, typeI. On the contrary, in patients involved by CAD, even silent, i.e. subclinical,latency time persists identical in both evaluations, or results clearly lower in the second one, in relation with disease seriousness: type II and respectively type III preconditioning. Of course, biophysical semeiotic preconditioning evaluation, really more complex than it appears in the above brief description, can be applied to all others biological systems, with favourable influences on primary prevention and diagnosis (2-8). Interestingly, since November 2007, thanks to Quantum Biophysical Semeiotics, based on non local Realm, I demonstrated for the first time, besides the local realm, in biological systems (9-12), in only one second physicians can recognize clinically healthy heart, excluding CAD Congenital Real Risk, even in individuals kilometres away (13-15). Finally, CAD Inherited Real Risk can be transformed in its residual variant, that proved to be not dangerous, with DIET, ethimologically speaking, Coniugated Melatonin, and

personalized application of LLLT, including NIR-LED, acting also stimulating hearth stem cells, among others well-known action mechanisms (16).

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http://www.sci-vox.com/stories/story/2010-07-21manuel%27s+story%3A+a+new+way+in+cancer+primary+prevention.html

Manuel's Story: A new Way in Cancer Primary Prevention

Author: Stagnaro
Member Since: 2010-07-20
Category: Biology
2010-07-21 13:26

A 55 year-long well established, clinical, experience allows me to state that either ignoring or overlooking the real existence of Oncological Terrain (http://www.semeioticabiofisica.it), as well as cancer Inherited Real Risk, in a quantitative way, we cannot prevent and diagnose cancer promptly since its initial stage (1-4). As a consequence, authors around the world are thinking "erroneously that all individuals may be involved by malignancy, and thus all individuals have urdergo to tumour bio-markers assessment, therefore spending uselessly NHS money, and physician's energy and time. As a matter of fact, e.g., a woman can be involved by Oncological Terrain, with or without precise location of Inherited Cancer Real Risk, localized in a well defined breast quadrant ("ab posse ad esse non licet illatio", Kant, Kritik der reinigen Vernunft) (5).
I think that because congenital functional mitochondrial cytopathology is overlooked--a "conditio sine qua non" of the most frequent and dangerous human disorders, including malignancies, current clinical researches are fundamentally biased. In other words, it does not consider the existence or assess the seriousness as well as the location of Congenital Acidosic Enzyme-Metabolic Histangiopathy (in my site), conditio sine qua non of both Oncological Terrain and, consequently cancer Inherited Real Risk (2-4). In fact, environmental risk factors, including oestrogens, suggested as a risk factor for breast cancer, could influence some human biological functions and/or bring about different disorders, such as cancers, exclusively in relation to both the presence and intensity of CAEMH in a well-defined biological system. For instance, despite either the well-known negative influence of oral contraceptive use or the beneficial, positive effects of selective cyclooxygenase-2 (COX-2) inhibitors on breast oncogenesis (1) we have to consider the importance of the "genetic predispositions", i.e., Oncological Terrain, as far as the onset of a lot of disorders is concerned, including breast cancer. In conclusion, we need at first (i.e., starting whatever screening or research) to investigate the presence and intensity of CAEMH in the "tested" population, i.e. in "every", "single" patient, and soon thereafter assessing presence, intensity of the CAEMH-dependent, "Oncological Terrain", and the precise location of cancer congenital "real risk", both always develop on the basis of the above -mentioned congenital mitochondrial cytopathology. In fact, without this alteration of psycho- neuro-endocrine-immunological system, oncogenesis is not possible, as allows me to state a 51-year-long clinical experience with Biophysical Semeiotics, Single Patient Based Medicine theory is based on (6). Finally, these pathological conditions are characterized by microcirculatory remodelling, wherein a central role is played by newborn-pathological, type I, "typical" a), i.e., oncological subtype Endoarteriolar Blocking Devices (1-5, 14, 15). The paramount Manuel' Story informs about the first newborn NEGATIVE for Oncological Terrain, in spite of the fact he is sohn of father and mother both involved by Oncological Terrain, who underwent to Coniugated-Melatonin treatment a lot of months before pregnancy begin. Technically speaking, his parents became positive exclusively for the residual variant form of predisposition to malignancy, which is not dangerous at all, because mitochondrial respiratory chain is perfectly functioning, so that endocellular energy level in every biological system results high. You may Ask Google: primo neonato senza...). Such as Medicine paramount progress open a new way in the war against cancer by means of Primary Prevention (16).

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22 July 2010-07-22.
http://www.sci-vox.com/stories/story/2010-07-22quantum+biophysical+semeiotics%3A+the+bases..html

Quantum Biophysical Semeiotics: The Bases.

Author: Stagnaro

Member Since: 2010-07-20

Category: Biology

2010-07-22 10:56

Among Medicine Disciplines there is also Quantum Biophysical Semeiotics which is a paramount Clinical tool in both bedside diagnosing and research. After 55 years of its origin as Auscultatory Percussion, the last development is the Psychokinetic Diagnostic (www.semeioticabiofisica.it). Interestingly, Quantum Biophysical Semeiotic Constitutions play a central role in tomorrow's Primary Prevention of most common and serious disorders, today's growing epidemics. For instance. Although my publications on Diabetic "and" Dyslipidaemic Constitutions are numerous since 1980 year (www.semeioticabiofisica.it, Practical Applications, DIABETES -6 article- and BIBLIOGRAPHY) in peer-reviews (1-6), unfortunately around the world there are individuals overlooking or ignoring such as fundamental knowledge, that plays a pivotal role in DIABETES PRIMARY PREVENTION! Accordingly, type 2 diabetes is a major problem worldwide, really a serious epidemics. Independent of different countries, in recent decades diabetes prevalence has increased rapidly over time among both developed and underdeveloped populations. Surely, genetic factors alone cannot explain these patterns. However, as allows me to state a 55-year- long clinical experience,(URL:www.semeioticabiofisica.it/constitutions.htm) an individual, without Diabetic "AND" dislipidemic biophysical-semeiotic constitutions, can not be involved by type 2 diabets, at all (1-6). Certainly, rapid changes in lifestyle and risk factors such as obesity, unhealthy diets, physical inactivity, tobacco smoking, a.s.o., acting on people with "diabetic and dyslipidemic constitution" may cause, AT FIRST, Pre-Metabolic Syndrome, I discovered formerly (2, 5, 6), then, over years or decades, metabolic syndrome, IGT, and finally type 2 diabetes. In a few words, the war against diabetes mellitus and its well-known and harmful complications, as well as the war against all other serious and common human diseases, is nowadays possible, all around the world, exclusively by means of a primary prevention, which must be achieved at the bed-side, i.e., "clinically", on a very large scale, using the simple stethoscope. In other words, in both Primary Prevention and screening programme for whatever disease, including DM (See my Cyber Lectures in indian website www.indmedica.com, URL http://cyberlectures.indmedica.com/show/50/1/Biophysical-Semeiotic_Dyslipidaemic_Constitution) and its so-called "complications", which begin as "diabetic Inherited Real Risk (7) and cancer, one needs efficacious "clinical" tools to obtain the best results. Really, early diagnosis must certainly be established in "asymptomatic" patients, who, for example, are evolving slowly towards diabetes mellitus, i.e. long time before disease onset, in order to avoid the well known, severe complications. In fact, to prevent these diabetic complications, including diabetic retinopathy, which initiate years or decades before diabetes onset, it is extremely necessary that doctors use a "clinical" tool reliable in diagnosing early diabetes mellitus stages, from initial stages, i.e., biophysical-semeiotic constitutions, and then the Pre-Metabolic Syndrome (8).

There are an awful number of other Constituions and related INHERITED Real Risks, bedside recognized quickly, initiating since individual's birth, which respond mainly to efficacious treatment (8-11).
In conclusion, I am very glad to be allowed to spread my theories (1-6).

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Bedside Diagnosing CAD Inherited Real Risk,

2010-07-24 09:34

CAD environmental risk factors (about 300!) can facilitate and worsen CAD onset, rather than cause CAD, which occurs exclusively in individuals involved by CAD Inherited Real Risk, I've discovered and illustrated formerly, bedside recognized with a simple stethoscope, in quantitative way (1-20).
Unfortunately, almost all physicians and cardiologists all around the world ignore (sometimes overlook) biophysical-semeiotic constitutions and related inherited real risk, that accounts for the reason CAD is a today's growing epidemics, as generally admitted (www.semeioticabiofisica.it).
Notoriously, Coronary Inherited Real Risk, as well as sub-clinical, very dangerous, silent, initial stages of this disorder precede for decades coronary heart disease clinical phenomenology.
Cad Inherited Real Risk is characterized by the presence of newborn-pathological, type I, subtype b) aspecific, Endoarterial Blocking Devices in coronary small arteries, according to Hammersen, especially associated with hypertension or diabetes mellitus. In following, I suggest - once again - an useful, reliable and easy clinical manoeuvre, that allows doctor to bedside recognize both CAD Inherited Real Risk and silent CAD (2-4, 20). This manoeuvre proved to be really useful in my long clinical experience, also in order to the bed-side recognizing heart ischemic disease before cardiac pathology occurs.
Moreover, it is well known that patients with coronary artery disease (CAD) may have no symptoms at all for many years or decades and that the electrocardiographic features of ischemia may be induced by exercise without accompanying angina (2). (For further information: See my website http://www.semeioticabiofisica.it, Practical Applications).
In other words, we need a clinical tool reliable in rapid detecting CAD, even clinically silent, initiating from CAD "inherited real risk", doctor can now utilize in day-to-day practice (2). I think surely that one easy method is "Myocardial Ischemic Biophysical- Semeiotic Preconditioning", described elsewhere(2-4). From the technical viewpoint, doctor has to know, at least, the auscultatory percussion of the stomach, described even in old academic books of two last centuries (Rasario IX edition). Briefly, in health, digital pressure of mean intensity, applied upon heart cutaneous projection area, brings about the so-called gastric aspecific reflex (= in the stomach, fundus and body are dilated; on the contrary, antral-pyloric region contracts) after an age-dependent latency time of 8 sec., that lasts less than 4 sec. (= parameter value of paramount significance since it parallels the efficacy of coronary microvessel Microcirculatory Functional Reserve).
A second, successive evaluation after an interval of 5 sec. exactly, provokes the identical reflex, but after lt. of 12 sec. or more: physiological myocardial preconditioning, type I.
On the contrary, in patients involved by CAD, even silent, i.e. subclinical, latency time persists identical in both evaluations, or results clearly lower in the second one, in relation with disease seriousness: type II and respectively type III preconditioning. Of course, biophysical semeiotic preconditioning evaluation, really more complex than it appears in the above brief description, can be applied to all others biological systems, with favourable influences on primary prevention and diagnosis (2-8).
Interestingly, since November 2007, thanks to Quantum Biophysical Semeiotics, based on non local Realm present in biological systems beside the local Realm, I demonstrated for the first time, besides the local realm, in biological systems (9-12), "simultaneously" with stimulation begin, physicians can recognize clinically healthy heart, excluding CAD Congenital Real Risk, even in individuals kilometres away: Caotino's Sign (13-20).

In health, “intense” digital pressure, necessary to bring about quantum entanglement, applied upon a single point of Precordium (skin projection area of the heart) does not bring about “simultaneously” stomach size increasing, i.e., heart-gastric aspecific reflex.
On the contrary, in individuals involved by CAD Inherited Real Risk, under identical experimental condition, cited above, “simultaneously” doctor observes a small heart-gastric aspecific reflex, whose intensity is about 0,5 cm., while in case of CAD intensity is 1 cm or more, in relation to the seriousness of underlying disorder.
Finally, CAD Inherited Real Risk can be transformed in its variant "residual", that's not dangerous, with DIET, etimologically speaking, Coniugated Melatonin, and personalized application of LLLT, including NIR-LED, acting also stimulating hearth stem cells, among others well-known action mechanisms (16-20).

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http://www.sci-vox.com/stories/story/2010-07-25diabetes+constitution-dependent++inherited+real+risk.html

Diabetes Constitution-Dependent Inherited Real Risk

2010-07-25 10:25

Thanks to bedside diagnosing Diabetes Constitution-Dependent, Inherited Real Risk, we can nowadays win the war against diabetes (1-15).
As a matter of fact, there are a lot of fascinating papers on diabetes, published on famous peer-reviews, but not useful at all to GPs in day-to- day practice, since Primary Prevention ON VERY LARGE SCALE is far better than therapy, also in diabetic field, where GP role is central in such as enterprise!
Primary Prevention must be performed exclusively in individuals correctly recognized in a quantitative way at Diabetic Constitution-Dependent, Inherited Real Risk with the aid of a stethoscope.
In fact, it is generally admitted that diabetes is a today's growing epidemics. However, I state that with the aid of Quantum Biophysical Semeiotics, the till now either unknown or overlooked newborn-pathological, subtype a) oncological , and b), aspecific, type I, Endoarteriolar Blocking Devices in the tissues, wherein does really exist the real risk of human common and severe diseases, as diabetes.
Obviously that happens in individuals with well-defined Quantum-Biophysical-Semeiotic Constitutions, in our case, Diabetic "and" Dislipidaemic (See Practical Applications, 6 article on Diabetes, in my website http://www.semeioticabiofisica.it) (1-6).
Interestingly, e.g., in Diabetes Primary Prevention (PP), we need new clinical tools, aiming to lower the increasing number of patients, although the present, expensive screening: in above-cited website Practical Applications: Diabetes, and Quantum-Biophysical-Semeiotic Constitutions (1-7).
For instance, in the normal Langheran's islets microcirculatory bed, there are exclusively "normal" type II (= in arterioles, according to Hammersen), but not type I (= in small arterioles) endoarteriolar blocking devices, i.e. EBD, of first and second classes, according to S.B.Curri (See http://www.semeioticabiofisica.it/microangiologia). In health, i.e., not involved by Diabetic Constitution, we cannot observe type I, newborn-pathological, EBD in above-mentioned biological system. On the contrary, in individuals involved by diabetic constitution as well as diabetic "Inherited Real Risk" and overt diabetes, of course, we observe with the aid of Quantum Biophysical Semeiotics also type I, newborn-pathological, subtype b) aspecific , EBD, facilitating the diagnosis and consequently diabetes primary prevention. In addition, the evaluation of Insulin Secretion Acute Pick Renal Test is significantly impaired, corroborating the clinical diagnosis (1-3).
Finally, an interesting clinical tool in recognizing diabetic constitution - dependent inherited real risk, as well as in diagnosing diabetes since early stages and diabetic monitoring proved to be bedside Quantum-Biophysical-Semeiotic Osteocalcin Test (10) As a matter of fact, Pre-hypertension during Young Adulthood may be involved by Coronary Calcium Later in Life exclusively in presence of Inherited Real Risk of CAD, typical for individuals with lithyasic Constitution, present in about 50% OF ALL CASES OF Pre-Metabolic and Metabolic Syndrome (13-15).
Considering the frequent association between hypertension and diabetes, with or without CAD INHERITED REAL RISK (14, 15) more important proved to be, in my 53-year-long clinical experience, bedside recognizing diabetic predisposition, now-a-days possible since birth, utilising a lot of methods, different in difficulty, but all reliable.
For the first time, from the clinical view-point, I have recently illustrated an original manoeuvre, based on a singular activity of osteocalcin, and reliable in bedside detecting diabetes in one minute, with the aid of a stethoscope (10). In fact, osteocalcin, a product of osteoblasts, among other action mechanisms, stimulates both insulin secretion and insulin receptor sensitivity. As a

consequence, osteocalcin, secreted by above-mentioned bone cells during mean-intense lasting digital pressure – for instance – applied upon lumbar vertebrae, brings about increasing pancreatic diameters, i.e., technically speaking, type I, associated, Langherans's islet microcirculatory activation, so that doctors assess pancreas size augmentation, which in health, lasts 10 seconds exactly (1-11). After that, pancreas diameters return to basal value for 3 sec. The second pancreas size increasing lasts 20 sec., and finally the third show the highest value: 30 sec. I terme such as clinical investigation. On the contrary, in case of diabetic constitution (3, 4, 11, 13) the first pancreas increasing persists normally (10 sec.), but both the second and the third are less than physiological ones (i.e., less than 20 sec. and respectively 30 sec.). In presence of intense inherited real risk of diabetes (6), such as impairment is greater. Finally, in case of diabetes the alteration is present already in the first evaluation, wherein duration appears less than 10 sec., inversely related with disorder seriousness. Subsequently, I have ascertained that Ronald's Manoeuvre result pathological already in individuals involved by both Diabetic Constitution and Inherited Diabetic Real Risk (1-11). Interestingly, not only in examining subject, but also in all others, even if kilometers way from him (her), according to Lory's experiment, based of non local realm in biological systems (12), pancreas show identical modifications, allowing doctors to made clinical diagnosis until now impossible (1-13).

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http://www.sci-vox.com/stories/story/2010-08-01psycokinetic+diagnostics%2C+original+bedside+diagnostic+method..html

Psycokinetic Diagnostics, Original Bedside Diagnostic Method.

Psycokinetic Diagnostics, the last evolution of Quantum Biophysical Semeiotics, is a new physical semeiotics discipline, based on the presence of no-local realm, beside the local realm, in every biological system, I have discovered and described earlier (1-12).
In addition, such as original physical semeiotics method is founded on quantum physics, according to which, both men and animal - personal experience on cats and dogs! - are communicating each other, under precise conditions, thanks to quantum entanglement (1-11)
Interestingly, in order to realize an efficacious primary prevention of all common disorders, including diabetes, CVD, Cancer, today growing epidemics, physicians must know biophysical semeiotic constitutions and related Inherited Real Risk (14-16).
Nowadays, it is possible and easy to bedside recognize above-mentioned constitutions in a few seconds.

As regards, e.g., "bedside" diagnosis of Diabetic Constitution-Dependent Inherited Real Risk, unavoidable to rationally enrol in primary prevention exclusively individuals at real risk of diabetes, since birth, from technical view-point, it is sufficient to learn the simple Stomach Auscultatory Percussion, which allows doctors to recognize gastric aspecific reflex (See my website www.semeioticabiofisica.it, Technical Page number 1).

In health, INTENSE stimulation of pancreas trigger-points, brought about by "thinking" to pinch the skin of VI thoracic dermatomere, located beneath costal arch, at right or left (= pancreas trigger-points), as it appears during the real stimulation, does not cause "simultaneously" gastric aspecific reflex. When the stimulation is very intense, Vibratory Energy level, i.e., ATP, results highest, so that it can produce Information Energy, allowing the entanglement, as both experimental evidence (= apnoea test) and clinical evidence (= seriously diseased biological system) demonstrate!
On the contrary, for instance, in presence of Diabetic Constitution-Dependent Inherited Real Risk, simultaneously appears dilation of both body and fundus of the stomach, i.e., gastric aspecific reflex, whose intensity parallels the seriousness of underlying disorders, in spite of the distance in km., between physician and examined patient.

Psycokinetic Diagnostics has opened a new wonderful way in physical semeiotics, allowing physician to diagnose disorders and monitor them under treatment, in patients even an awful number of kilometres away from examining doctor, at the condition that doctor knows the diseased individual.

The most recent advances on Psycokinetic Diagnostics one may read on my website at URL http://www.semeioticabiofisica.it/semeioticabiofisica/diagnostica_psicocinetica.htm

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Psychokinetic Diagnostics Practical Aspects.

http://www.sci-vox.com/stories/submit.html
2010-08-12

*Sergio Stagnaro**

On 26th July, 2010 I write the following mail to my dearest friend Simone Caramel, the greatest expert in the world of Quantum Biophysical Semeiotics:

«Dear Simone,

I am happy that YOU will write on my behalf the article on Diabetes I have been asked by Rana Ashour, Editorial Office, Experimental Diabetes Research, Hindawi Publishing Corporation Experimental Diabetes Research: they are a serious publishing house!
[…]

I tell you an interesting experiment of few minutes ago, to report to Chris (Simone's wife and expert in psychokinetic problems, Ed!): the door to my daughter and grandchildren's room was shut, to open it would mean the possibility to wake them up. Children are ANGELS only when they are asleep!
At this point I applied the Psychokinetic Diagnosis to the problem and I tried to visit Luigino "localizing him precisely in that particular space". No contact, no entanglement!!!
While writing I stopped to visit you sit on the rocking chair close to my computer: no contact!
Please explain it to me….
I think that local and non local realities, what is implicit and what is not, finite of Man-creature and INFINITE of God-creator, etc. are definitely separated, but not like Leibnitz's monads or Kant's phenomenon and nounmenon.
The important thing is that I enjoyed myself: my grandchildren and daughter were NOT in the room… the room was empty when I opened the door!

Bye

Sergio».

After this first experiment many others followed, which confirmed the influence of the doctor-observer's mind in modifying both matter, as once again proved here-above, and energy information at the basis of Psychokinetic Diagnosis. If the doctor lovingly thinks about the patient known to him at least visually, located in any position in space, – independently from the direction of the antero-posterior axis of the skull to the direction SW, EW, or any other – a link becomes established (quantum entanglement) made of the energy vibrations of doctor and patient, irradiating towards all the directions of the universe, allowing the necessary information exchange (7-11, 17-25).
However, if the doctor follows the above instructions, but placing his experimental subject in a precise spatial point (e.g. the living room, which can be wrong being the subject in the kitchen in that moment) the quantum entanglement doesn't take place and the psychokinetic diagnosis is not possible, due to the lack of the information exchange between the two.
This experiment confirms what was previously observed in old researches and talked about in many articles (7-11, 17-25); what provokes the quantum entanglement at the basis of psychokinetic diagnosis is the mind: by analogy only tuning our radio on a set frequency, or wavelength, it is possible to listen to the messages of a specific radio station.

Conclusive scientific note.

From my friend Simone Caramel, poet and scientist as it was usual in the old Greek literary period, I received an interesting answer, which suggests further developments of Medicine:

«Dear Sergio,
It is a very interesting experiment, because as it works in space (given the real localization), you can for amusement find out what happens in time (that is to visit a person as he/she was yesterday or a month ago) or how it will be in the "future" (according to the present initial conditions).
A hug and Good Night!!

Simone»

About the mind influence on quantum phenomena at the basis of Psychokinetic Diagnosis related to time we will talk in an upcoming article. At the moment I only wish to report my reply to my ingenious friend on the same day 27th July, 2010:

«Dear Simone
Your suggestion of trying in time (the experimental patient must BE alive, obviously, otherwise there is no vibratory energy, ATP!) the mind influence on quantum phenomena worked: I visited my grandson at 11am: NOTHING to report. Then immediately I visited Luigino placing both of us at 1pm: clear signs of flu (26-28), later confirmed at 2pm, even if he seems ok. […]
In the end, interesting were the results of the objective exam on Luigino with the Psychokinetic Diagnosis at 2pm, but mentally placing both, doctor and patient, at 8am: I didn't observe any of the characteristic signs of the flu viral infection!
A hug
Sergio Stagnaro»

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Bedside Recognizing Leukemia Oncological Inherited Real Risk.

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In my view, based on 54 year-long clinical experience, doctors around the world have to know new and more efficacious tools in the war against malignancies, easy to perform on very large scale and reliable in ascertain also blood oncological disorders "inherited real risk" in individuals always involved by oncological terrain, of course (2). In fact, nowadays a new bedside preventive medicine can be applied by every general practitioner worldwide in an efficient and practical manner in rationalised enrolled individuals (2-12) (For further information, See my site www.semeioticabiofisica.it, Biophysical-Semeiotic Constitutions, as well as Practical Applications).
As a matter of fact, today's physicians, knowing the progresses of physical semeiotics, can bedside recognize since birth, i.e., with a stethoscope, individuals at inherited real risk of malignancy, both solid and liquid, indicating their precise location (1, 2, 11 12). In following, I describe briefly an original physical sign, reliable in recognizing inherited real risk of blood malignancy, both myeloid and lymphatic in origin, and thus useful in primary preventing it, as well as in bed-side early detecting blood cancer, even since very early stage, including cancer in situ (2).
In health, due to quantum biophysical semeiotics, based on non-local realm in biological system, "INTENSE" digital pressure, applied on sternal body trigger points and respectively spleen trigger points, does NOT bring about SIMULTANEOUSLY gastric aspecific reflex.
On the contrary, in presence of leukemic inherited real risk, gastric aspecific reflex occurs SIMULTANEOUSLY, showing an intensity of about 0,5 cm.
In health, lying down on supine position and psycho-physically relaxed with open eyes to hinder melatonin secretion, a lasting, mean-intense digital pressure upon the middle line of sternal body, and respectively on spleen projection area, brings about gastric aspecific reflex (in the stomach both fundus and body dilate, while antral-pyloric region contracts = tissue acidosis; see above-cited site, Technical Pages, n° 1), after a latency time (lt) of 10 sec. The reflex lasts less than 4 sec. (parameter value of paramount diagnostic importance, paralleling local Microcirculatory Functional Reserve) and then disappears for > 3 < 4 sec., identical to fractal Dimension of local microvessel fluctuation.
On the contrary, in case of overt leukaemia, even in initial stage, latency time is < 10 sec., reflex duration 4 sec. or more and finally the entire stomach contracts, Gastric tonic Contraction (GtC): pathological parameter, typical of blood malignancy: myeloid in origine, if is stimulated sternal body trigger points; lymphatic in origine, in case spleen trigger points are stimulated.
All parameters values demonstrate local bone marrow or lymphatic tissue micorcirculatory oncological remodelling, Inherited Oncological Real Risk is based on (2-8), and their intensity is in relation to the severity of underlying malignancy.
For instance, latency time becomes shorter than the normal 10 sec. in inverse relation to the extension of tumour.
At this point, very useful and reliable (I perform it during physical examination, i.e., in every case, routinely) proved to be the biophysical semeiotic "preconditioning" of bone marrow : after 5 sec. exactly of interval after the basal performance, doctor applies this method a second time (interval must be 5 sec. precisely, due to bone marrow and respectively lymphatic microcirculatory functional reserve (MFR) activation).
In health, where there isn't tonic Gastric Contraction, parameters value ameliorate significantly: e.g., latency time results, doubled, i.e., 20 sec.
On the contrary, in blood cancer, since the first stages of Inherited Real Risk the values worsen significantly or persist identical in the later case (1-12) .
Finally, thanks to Quantum Biophysical Semeiotics, in health, INTENSE digital pressure, as above indicated, i.e., the stimulation of a SINGLE sternal trigger-

point, does not show "simultaneously" stomach modification, allowing doctors to exclude bone marrow disorder of whatever nature.
On the contrary, in case of leukaemia Inherited Real Risk or overt leukemia, since its initial stage, we observe above-illustrated stomach size changes simultaneously to begin of sternal or spleen stimulation.

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Psychokinetic Diagnosis and two Dimensions of Time, T1 and T2.

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"There are more things in heaven and earth, Horatio, than are dreamt of in your philosophy"

(HAMLET - Act I, sc. 5)

Sergio Stagnaro*

Introduction.

For the first time, with the help of Quantum Biophysical Semeiotics, term coined by my friend Paolo Manzelli, I proved that in biological systems next to a local reality a non-local reality exists (1-29).
Sure enough Lory's experiment is based on the fact that "all" the subatomic components and also atomic and molecular, structured to form a cell, and the cellular set or parenchyma, are correlated among themselves and among "all" those of identical embryological derivation, in a 4-dimentions space, 2 D/S and 2 D/T, where it is possible the formation of the tangle, entanglement, of the energy waves of two particles, as observed by A. Aspect in his famous experiment (1, 8, 15, 18-29).
Due to the effect of the entanglement the information takes on a "non-local" dimension.
In fact in A. Aspect's experiment two electrons separated and moved away in space (dis-entangled) behave in an identical way, simultaneous in space and synchronous in time, in the face of any measurement taken or perturbation imposed on only one of them by the observer, as if they were still in contact, so proving they possess the capability to communicate simultaneously at a distance.
The simple explanation of this apparently strange behaviour – known as Aspect's Experiment – resides in the existence of "non-local" reality (which I proved to be decisive in the different actions of biological systems) next to the more known local one.
If we consider that the subatomic elements which our bodies are made of, according to Schrödinger, have a double nature (particle, localized, and wave, non-localized), we can understand that only the particle can be localized in a 4-dimensions Cartesian coordinate system, 3 D/S and 1 D/T, while the wave defies any localization.
What results from this is the "uncertainty principle": we can calculate position (P) and velocity (V) of a moving electron "separately", but not concurrently (P and V).
If, on the other hand, we associate to each particle from Aspect's experiment a wave, we can observe that, while the particles separate, the two waves respectively associated to them remain interweaved. Consequently simultaneous consistent communication of information still exists between the two particles.
If the entanglement between the waves associated to the particles is active in a universal dimension, then it is possible to consider that the universe gets self-organized through the entanglement of the particles, linking the single particles of this cosmic hologram which evolves in simultaneous communication among its parts.

Lory's experiment can be summarized as follows, giving an exemplificative description of the operating way: applying digital pressure on the parotid gland, or a sublingual salivary gland, in a monovular twin (the first time the experiment had been carried out on two twin sisters, but afterwards it proved to

be equally reliable regardless of gender and degree of kinship between the two examinees!) it can be "simultaneously" observed type I associated microcirculatory activation of the other twin sister's pancreas regardless of the distance between them at that moment: metres or kilometres (1, 8, 15, 18-29). In this respect I remember that once the pancreas used to be called and recognized as the intestinal salivary gland.
One of my experiments was carried out with success on two twins where one was in Pavia and the other in Riva Trigoso! "Simultaneity" notoriously belongs to "non local" realism, which displays a 4-dimentions space/time matrix, but with coordinates 2 D/S + 2 D/T, that is bidimensional in space and time, as per Paolo Manzelli's teaching.

At this point, the analogy between Lory's experiment, microscopic-biological in nature, and Aspect's one, microscopic-subatomic, becomes extremely interesting. It is self-evident that Official Medicine, theoretically weak, but of great results, makes great strides but like a giant with clay feet (30), being incapable of offering satisfying explanations to these FACTS, due to the non-existence of nervous links among the structures above mentioned, which could justify at most the transmission of information from the stimulated tissues. Traditional Medicine, in fact, is big in offering likely explanations to the experiment, carried out by me for the first time, and many other signs of Quantum Biophysical Semeiotics.
As a matter of fact the above described cases are not explained by the "transmission" of information, which requires expenditure of time and energy. The term "Simultaneity" of information, a concept ignored by traditional Medicine, proud of easily objectionable triumphs, as much as incapable of disproving Quantum Biophysical Semeiotics, refers to an idea of the space/time matrix, unknown to the Doctors of this Age of Darkness, Middle Ages of Medicine (31, 32).
Only one example in support of my statements: the heart transplant in a 50-years-old sick patient, who became slowly suffering from a heart complaint, because he had the coronary real risk since BIRTH, never diagnosed because no doctor or cardiologist knows (better to say, don't want to know) the congenital microcirculatory coronary remodelling, characterized by type I, subtype b) aspecific, Endoarteriolar Blocking Devices, discovered by me (19-25).

Psychokinetic Diagnosis back and forward in two-dimensional, T1 and T2, Time typical of Biological Systems.

To understand as much as possible what follows I suggest people reading this article to read my previous one first (1), where, from the clinical point of view, I proved that the Mind modifies both Matter and Energy Information, at the basis of the quantum entanglement. Furthermore it is necessary to remember that Lory's experiment can be carried out in several variants, where however the physio-pathological mechanism at its basis is the same. For example, doctors know – better, should know – the physiological flux-mediated vasodilatation, that is the expansion of the artery due to the increase in the haematic flux inside the blood vessel, independently from the cause of the increase of shear-stress responsible for the release of radicals-NO by local endothelia.
Actually the mechanisms of these fascinating biological events are very complex and unfortunately known only by few doctors. Indeed it is not only a matter of "vasodilatation", but especially of intensification of arterial and arteriolar vaso-parietal fluctuations at the basis of the associated, type I, microcirculatory activation, which doctors still ignores.
If in a patient, known to the doctor who in that moment is examining him thanks to the Psychokinetic Diagnosis (1-19), a sudden increase of the haematic flux in a brachial artery occurs through the rapid reduction of pressure due to the inflatable arm cuff of a sphygmanometer, conveniently collocated and previously pumped up at its maximum, also in the examining doctor "simultaneously" and temporarily the oxygenation of the distal tissues (for ex., in digital fingertips) doubles, regardless of the distance, even if of kilometres, between the examiner and the examinee.
These experimental facts are at the basis of Psychokinetic Diagnosis.

In this case the physical examination happens in a PRESENT time of local reality (1). If on the other hand it is scientifically true, as I proved in previous articles (1-19), that in biological systems next to the local reality it exists also a non-local reality, where Time has two dimensions which nullify each other in the present, consequently psychokinetic diagnosis allows the doctor to visit a patient, physically known to him, in the past or in the future (respectively back and forward psychokinetic diagnosis). Only if examiner and examinee are mentally located in a moment in time enough precise: it is sufficient that the doctor mentally put his watch back or forward, virtually positioning also the patient in that precise moment he chooses.

All began on 27th July, 2010 with an e-mail from my precious friend Simone Caramel, who commendably undertook the duty to spread Quantum Semeiotics Biophysics, whose he is the maximum connoisseur in the world, thanks to his excellent hermeneutics.
The day before I had told him the results of my first experiment on the modification of the Mind on Matter and Energy Information at the basis of the entanglement, now explained in an article (1):

«Dear Sergio,
it is a really interesting experiment, because as it works in space (given the real localization), you can for amusement find out what happens in time (that is to visit a person as he/she was yesterday or a month ago) or how it will be in the "future" (according to the present initial conditions).
A hug and Good Night!!
Simone»

The first experiment of psychokinetic diagnosis mentally collocated in the future regards the physical visit of my grandson, Luigi, 3 years old: at 11 am on 27th July, 2010 he didn't show any quantum-biophysical-semeiotics sign of flu, not even during the exercise testing, that allowed me to exclude a viral inflammation in its earliest stage (26-28).
Immediately after, mentally collocating both of us in a later time, at 1 pm sharp, I visited Luigi for the second time: with my surprise I could observe all the signs of flu at pharynx-tracheal level.
At last, placing us in the two following days I foresee the behaviour of the pathological process. The diagnosis was then confirmed by the "direct" visit performed on the patient!
Later that evening I informed Simone:

«Dear Simone
Your suggestion of trying in past and future times (the experimental patient must BE alive!) the mind influence on back and respectively forward psychokinetic diagnosis, as you suggest, worked. I visited my grandson at 11am: NOTHING to report. Immediately after I visited Luigino, however placing both of us at 1pm: clear signs of flu, later confirmed, even if he seems ok! […]
At the moment I only speak of interference in SPACE, and only in the conclusions of the article I am writing (1) I mention your TIME suggestion.
A Hug,
Sergio»

An interesting experimental proof of the scientific value of Psychokinetic Diagnosis, applied in the past (back) and in the future (forward) of the patient, refers to the monitoring of the feverish state consequence of the polyvalent vaccine of little Manuel, a child by now part of Medicine Literature (33-35).
Invited to visit "the most famous child in the world", according to my own definition, I found that he's in very good developing conditions, however feverish due to the recent vaccination: only the signs of viral infections typical of common childhood diseases (33-36).
On the basis of the data of the forward psychokinetic diagnosis, that is applied thinking to the next two days, I foresee that the fever will disappear the next day with return to the normal general conditions on the third day.

And that’s what actually happened!

A friend of mine, 69 years old, suffered from rheumatic polymyalgia in ’98 and ’99. At the moment she is perfectly healthy from the rheumatologic point of view. The back psychokinetic diagnosis allows me to recognize the presence of the overcome of the rheumatic condition, when I mentally return to those two past periods above mentioned.
From what referred it is understandable the quantity of practical applications that exceed the boundaries of Medicine: through the therapeutic monitoring psychokinetic diagnosis allows the doctor to provide the best possible therapy or none at all, as in the case of a simple flu without complications.
Also it is possible to “localize” vanished people with accuracy and evaluate their present health conditions both in time and space (1).
In the end, it appears very dialectic and also disturbing the possibility presented by the forward psychokinetic diagnosis of precisely evaluating the very duration of life of an individual, possibly to insurance aims.
Conclusions.
The Logic at the basis of scientific theories has got its own dynamism justified by strong laws that must be totally respected.
Proven the existence in biological systems of non-local reality, next to the local one, it was necessary and inevitable first of all to hypothesize psychokinetic diagnosis, afterwards confirmed by an enough long experience.
Following the 4-dimensions non-local reality, according to which two space dimensions (surface) and two time dimensions (T1 and T2, past and future which cancel out in the present) exist (1, 8, 15, 18-29), and considering the conclusions of my previous article regarding the influence of the Mind on the precise space collocation of an object, I could confirm the possibility of psychokinetic diagnosis, mentally placing in time, past and future, both examiner and examinee, according to a productive suggestion of Simone Caramel, above mentioned.
As the reported paradigmatic examples prove, examples which are expression of the consistency of many other data collected up till now, I feel authorized to claim that psychokinetic diagnosis can be applied on a subject mentally placing in time the location of the diagnosis. Obviously the subject must have mitochondrial physiological activity in order to produce the necessary conditions to have the entanglement.

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Psychokinetic Diagnostics. Mind, Matter and Energy-Information.

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Introduction

With the help of Biophysical Semeiotics, before 2007 not yet Quantum Semeiotics, I have observed for the first time a very large number of facts which weren't explainable through the knowledge of traditional physiology and biology, due to the wrong belief that the reality of biologic systems was only "local" (1-3). In order to comprehend following arguments regarding Mind-induced modifications on both Matter and Energy Information, readers have to pay accurate attention on 3 fundamental facts:

A) Manual lymphatic draining of one breast (= Simulated Sucking Test, on my website www.semeioticabiofisica.it) provokes a meaningful increase of the local vasomotion (= microvessels fluctuation, owing to the improved perivascular condition or periangium) with following increase of the histangic oxygenation: in a healthy woman the latency time of the basal breast-gastric aspecific reflex is 9,5 sec., but rises up to 19 sec., in doing so doubling the basal value after the lymphatic draining (= reduction of interstitial "free water" and consequently increase of the local viscosity). "Simultaneously" this improvement involves also the oxygenation of the contralateral breast! On the contrary, no oxygenation improvement is observed in other biological systems.

B) The application of the NIR-LED (Near Infra Red-Light Emitting Diode) on the skin projection of the heart, stimulating the mitochondrial breathing activity, as for the first time I have proved from the clinical point of view (4), statistically causes a meaningful rise of the myocardial oxygenation: in a healthy subject, regardless his/her age, gender and race, the basal latency time of the heart-gastric aspecific reflex is exactly 8 sec. Owing to the effects of the NIR-LED the latency time (LT) rises to 16 sec., once more the LT doubles. Simultaneously, with the application just started, also the oxygenation of the fingertip doubles: the LT of the finger-gastric aspecific reflex goes from the basal value of 8 sec. to 16 sec. (1-3)

C) The rhythmic touch of a joint, for instance the right knee (also the application of the NIR-LED on that joint) causes type I, associated, microcirculatory activation "in loco" and a bigger contribution of matter-energy-information to the local parenchyma (= the "flow-motion" appears immediately accentuated). Simultaneously the oxygenation of the contralateral knee and of all the other joints increases, doubling the basal value.
In the same way the stimulation of the tragus of an ear simultaneous provokes the same microvascular effects, just mentioned, in the contralateral ear.
On the contrary in this experimental condition no modification of the tissue O2 or other tissues is noticed (1-20).

It is unavoidably necessary to emphasise that nervous correlations, reflexes are based on, which could explain these facts, don't exist; the only satisfactory explanation of these instantaneous microvessel modifications at a distance is represented by the theory of the non-local reality, founded on the embryogenesis.
In fact, in all these examples reported and of course in many others that are not mentioned here for reasons of space, the answer "at a distance" to a physical stimulation shows itself exclusively in those tissues who are made up of cells with the same origin, according to the so-called old "embryologic memory".

In my opinion semeiotics-biophysical data, today also quantum, which we briefly referred to, can offer a solution to problems up till now open, such as the

mechanisms of action of the homeopathic therapy and the results of the antiplatelet and vasoprotective therapies with the administration of acetylsalicylic acid in "minimum" dosage in the face of the number of platelets and endothelia (1-20).

Key concepts: from No-Local Reality to the basis of Psychokinetic Diagnostics

Thanks to the partnership with my precious friend Paolo Manzelli, who coined the definition of Quantum Biophysical Semeiotics, I could prove the existence of a non-local reality, parallel to the local one, in biologic systems. The favourable consequences of this discover in terms of both clinical diagnosis and research are now well-documented in Literature (1-15).
In local reality, characterized by a 4 dimensions space/time matrix (3 D/S and 1 D/T), the EI (energy-information) is notoriously "conveyed" through expenditure of time and energy (1-20).
On the contrary, non-local reality, present in biological systems next to the other (ibidem), is characterized by "simultaneity" of information, as a consequence that the matter (particle) is localized, but not the wave which represents its vector and can maybe transiently originate the entanglement with other waves. In the book "Quantum Reality" by Nick Herbert, the author states that the non-localization of the particles would explain their "simultaneous" communication unmediated by fields or other phenomena experimented with reference to Euclid's space/time structure; this is precisely because in a world three-dimensional in space and mono-dimensional in time it is accepted that Information as well as Energy and Matter have to be transmitted between two locations, A and B, according to a Cartesian coordinate system. Therefore the "Simultaneity" of events is considered totally fortuitous and phenomena of simultaneity of Information like telepathy or empathy are considered devoid of any possible scientific explanation. It follows that our traditional definitions of space and time are once again questioned, as it had already happened with the relativity theory and quantum mechanics.
The non-local model of reality can even help the theoretical physics to include many events observed in Biology when the Biophysical Semeiotics wasn't enriched by the precious contribution of the quantum physics, so leaving those events without a real explanation until 2007.

Following Lory's Experiment (7-11, 17-20), it was born the Psychokinetic Diagnosis which allows the doctor to diagnose diseases in a far patient away hundred and thousand kilometres as long as the patient is known to the doctor, directly or indirectly through photos, videos or other means and that the exchange of information occurs in a loving state of mind: if the doctor "hates" the patient, no quantum entanglement, which makes possible the communication and the psychokinetic diagnosis, becomes established between the two (6, 9, 11, 16-18).

From the above remarks, it is understandable how mind alters matter: if thinking of it the doctor stimulates any patient's trigger point a local increase in pressure occurs as I have widely demonstrated already in my previous works, above mentioned. Just one example (6), the doctor applies a mental "intense" pressure on any point of the patient's precordium: the doctor's stomach doesn't "simultaneously" modify its volume, meaning that the Gastric-aspecific Reflex is absent, that is the Negative Caotino's Sign (21, 22).
To demonstrate that the digital pressure has "really" stimulated the heart trigger point by means of psychokinetics, it is the doubled latency time of the heart-gastric aspecific reflex (NN = 8 sec when medium-intense pressure is applied) on both patient and doctor evaluated after 5 sec. from the first manoeuvre, proving the Cardiac Preconditioning (23-25).

Experimental Evidence: Mind modifies both Matter and Energy-Information at the basis of the Quantum Entanglement in the Space Dimension.

On 26th July, 2010 I write the following mail to my dearest friend Simone Caramel, the greatest expert in the world of Quantum Biophysical Semeiotics:

«Dear Simone,

I am happy that YOU will write on my behalf the article on Diabetes I have been asked by Rana Ashour, Editorial Office, Experimental Diabetes Research, Hindawi Publishing Corporation Experimental Diabetes Research: they are a serious publishing house!
[…]

I tell you an interesting experiment of few minutes ago, to report to Chris (Simone's wife and expert in psychokinetic problems, Ed!): the door to my daughter and grandchildren's room was shut, to open it would mean the possibility to wake them up. Children are ANGELS only when they are asleep!
At this point I applied the Psychokinetic Diagnosis to the problem and I tried to visit Luigino "localizing him precisely in that particular space". No contact, no entanglement!!!
While writing I stopped to visit you sit on the rocking chair close to my computer: no contact!
Please explain it to me….
I think that local and non local realities, what is implicit and what is not, finite of Man-creature and INFINITE of God-creator, etc. are definitely separated, but not like Leibnitz's monads or Kant's phenomenon and nounmenon.
The important thing is that I enjoyed myself: my grandchildren and daughter were NOT in the room… the room was empty when I opened the door!

Bye

Sergio».

After this first experiment many others followed, which confirmed the influence of the doctor-observer's mind in modifying both matter, as once again proved here-above, and energy information at the basis of Psychokinetic Diagnosis. If the doctor lovingly thinks about the patient known to him at least visually, located in any position in space, – independently from the direction of the antero-posterior axis of the skull to the direction SW, EW, or any other – a link becomes established (quantum entanglement) made of the energy vibrations of doctor and patient, irradiating towards all the directions of the universe, allowing the necessary information exchange (7-11, 17-25).
However, if the doctor follows the above instructions, but placing his experimental subject in a precise spatial point (e.g. the living room, which can be wrong being the subject in the kitchen in that moment) the quantum entanglement doesn't take place and the psychokinetic diagnosis is not possible, due to the lack of the information exchange between the two.
This experiment confirms what was previously observed in old researches and talked about in many articles (7-11, 17-25); what provokes the quantum entanglement at the basis of psychokinetic diagnosis is the mind: by analogy only tuning our radio on a set frequency, or wavelength, it is possible to listen to the messages of a specific radio station.

Conclusive scientific note.

From my friend Simone Caramel, poet and scientist as it was usual in the old Greek literary period, I received an interesting answer, which suggests further developments of Medicine:

«Dear Sergio,
It is a very interesting experiment, because as it works in space (given the real localization), you can for amusement find out what happens in time (that is to visit a person as he/she was yesterday or a month ago) or how it will be in the "future" (according to the present initial conditions).
A hug and Good Night!!

Simone»

About the mind influence on quantum phenomena at the basis of Psychokinetic Diagnosis related to time we will talk in an upcoming article. At the moment I only wish to report my reply to my ingenious friend on the same day 27th July, 2010:

«Dear Simone
Your suggestion of trying in time (the experimental patient must BE alive, obviously, otherwise there is no vibratory energy, ATP!) the mind influence on quantum phenomena worked: I visited my grandson at 11am: NOTHING to report. Then immediately I visited Luigino placing both of us at 1pm: clear signs of flu (26-28), later confirmed at 2pm, even if he seems ok. […]
In the end, interesting were the results of the objective exam on Luigino with the Psychokinetic Diagnosis at 2pm, but mentally placing both, doctor and patient, at 8am: I didn't observe any of the characteristic signs of the flu viral infection!
A hug
Sergio Stagnaro»

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NEW RENAISSANCE IN MEDICINE.

Stagnaro Member Since: 2010-07-20 Category: Biology

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Introduction.

As there are numerous ways of thinking, exist also different, useful methods which can modify doctor's clinical practice, and Medicine (1). Among them the results evaluation, even in relation to other colleagues, strategies that stimulate innovation responsibility, educational measures, a.s.o. To go deep into such interesting topic, reader is adviced to go back to Trisha Greenhalgh intriguing and excellent paper (2).
Moreover, it is well know that "medical class around the world suffered a brain-washing, since university professors and physician's orders aimed to convincing doctors that there is one, and only one, method of examining patient. Our rituals at the bed side would undergo to a critical examination, as medical therapy and drugs; and so it would be necessary for all other profession aspects" (3).
To comprehend the paramount aid of the original semeiotics, i.e., Biophysical Semeiotics, in solving old medical problems, as the crisis of patient-doctor relation as well as the utilization of the results of medical researches in day-to-day practice, I invite readers to go back to my earlier papers (4, 5). In addition, to deep the knowledge of descussed arguments, reader may visit my web site, HONCode 233736, www.semeioticabiofisica.it, my Page in italian site www.katamed.it, as well as tha articles in http://piazzetta.sfera.net, Professione Medica e www.clicmedicina.it.
In front of a patient who presents with whatever disorder, doctor must remember the authoritative statement of D.L. Sacketet al. in their interesting paper analyzing all parts of a question (6). Firstly, we have to define precisely the subject of clinical question, i.e., answering to this question: "What type of patient is this?" (7); secondly, it is necessary to define exactly the best treatment in favour of the patient; finally, forcast the course of disease, monitoring it on the base of reahed results.
The SPBM can be defined as the medicine based on the exact knowledge of both function and stracture of patient's biological systems, actual result of the interaction between its genotype (i.e.,biophysical-semeiotic constitutions) and environment, assessed with the aid of Biophysical Semeiotics, from psychical and physical view-point.
In this article, I illustrate the SPBM contribution in modifying practical application of medicine, particularly its new way of applying the guide lines, now really hindered and descussed, referring to a patient with acute pain in upper right abdominal quadrant, as an example.

Guide lines: clinical application from the Single Patient Based Medicine view-point.

Notoriously there is a great discussion on guide lines, and the difference between physician's and NHS manager view-points is really great (2). The firsts, a part a small minority which is not tied to the establishment, are adverse to guide lines, that are evaluated positively by the seconds.
First of all, it is correct to give readers a definition, sufficient for our subject, of the value of guide lines as regards both diagnosis and therapy. It seems to be acceptable the following definition: "The guide lines are statements expressed in an orderly way, which help doctor in taking decision about suitable therapy under a well-defined situation" (8).
Surely, beside supporters of both EBM and clinical application of guide lines, do not fail essential questions and adverse argumentations of the doctors who

are contrary to their excessive use. On this subject, probably is right who maintains that: "there is the fear that, in absence of evidences applicable with certainty under a particular situation, doctor could be obliged by guide lines to use evidences really not surely appropriate, gathered probably in a different group, in an diverse geographyc area, in another period, and by means of a similar, but not identical treatment. This is termed evidence biased medicine" (9), i.e., medicine of erroneous evidence or medicine based on errors, in opposition to EBM.
The first therapeutic action consists notoriously of diagnosis and I wish to invite reader to make a reflexion about the application of guide lines at this level, ameliorated by SPBM.
Let us consider, e.g., the behaviour suggested to doctor in case of acute pain in upper right abdominal quadrant. Every experienced physician, learned in physical semeiotics, helped, or not, at the bed side by EBM, knows in a perfect way the diagnostic iter to perform clinically in such as case.
It is unavoidably necessary to consider the large number of disorders in numerous biological systems (lung, liver, gall-bladder, pancreas, kidney, digestive tract, in particular appendix, muscle-skeletric apparatus, a.s.o.) to make rapidly the correct diagnosis and differential diagnosis; to this end a large variety of algorhytms are available.
Single Patient Based Medicine: Acute pain in upper right abdominal quadrant.

Aiming to outlining SPBM revolutionary aspect in clinical carrying out diagnostic iter, as example we consider a young who presents with persistent pain in upper right abdominal quadrant.
Without underestimating the objective, and undeniable importance of EBM, the scientific preparation and doctor's experience, SPBM suggest to proceed first of all in the knowledge, precise as possible, of "this" individual, unique, i.e., having no like or equal, involved by whatever clinical phenomenology.
Before analyzing the original diagnostic procedure, it is necessary to state that very often the patient do not show any clinical symptomatology (apart from the disorder which probably advices his (her) physical examination, of course), although such as individual, only apparently healthy, shows really biological, metabolic-biochemical and microcirculatory characteristics, typical of Grew Zone, or Pre-Morbid, Pre-Metabolic State, fully described elsewhere (10) (See web site www.semeioticabiofisica.it/microangiologia), recognizable in a "quantitative" way with the aid of Biophysical Semeiotics.
Doctor must get togheter A) patient's history (Tab.1), which plays a primary role in bed side diagnosis and differential diagnosis, and soon thereafter, as allows me to state a 46 year-long clinical experience, he B) has to examine the probable presence of different "Biophysical-Semeiotic Constitutions" by physical examination (V in the site: Constitutions: www.semeioticabiofisica.it,/semeioticabiofisica/constitutions.htm). In fact, it is easy to understand that a subject, without Oncological Terrain (See in the site), can never be involved by malignancy, as a patient negative for Diabetic Constitution (See in the site), surely will never suffer from diabetes mellitus. As regards this point, I remember some cases of DM onset, exclusively characterized by abdominal pain, caused by acute and serious failure of glucose metabolism: in the site, Diabetis Mellitus and in Piazzetta, URL http://digilander.libero.it/piazzettamedici/professione/professione.htm).
Only in presence of "variant type" metabolic syndrome, I described previously (11, 12), doctor may suspect that a patient is suffering fom renal or biliary stones, since such as gene-dependent dysmetabolic condition represents the conditio sine qua of lithiasis (See in the wite "Practical Aplications"). In absence of varint type of metabolic syndrome, doctor can exclude certainly lithiasic disorders.
At this moment of diagnostic procedure, it is adviceble D) assess patient's present antibody synthesis (13) (See in the site Appendicitis as well as Glossary). In fact, "chronic" antibody production allows to exclude , as regards differential diagnosis, infections (e.g., acute appendicitis), rheumatic diseases, cancer, obviously if the patient is involved by rheumatic and oncological (Oncological Terrain:

www.semeioticabiofisica.it,/semeioticabiofisica/oncological.htm)
constitution.
By contrast, "acute" antibody synthesis is allways associated with E) other numerous signs of infections-inflammations and/or, under above mentioned genetic conditions, of rheumatic diseases and/or solid or liquid malignancy, doctor must recognize promptly in a quantitative way: Rethiculo-Endothelial Hyperfunction Syndrome, in its three types, (14), increased hepatic synthesis of Acute Phase Proteins, blood-associated antibodies, Local and General Autoimmune Syndrome, a.s.o. (V. the cited site).
At this point of diagnostic process, data, gathered with the aid of Biophysical Semeiotics, are so precious and reliable to allow doctor to direct himself towards the precise diagnosis, assessing subsequently other important signs, useful and sufficient in making the proper diagnosis. (Tab.1).

PRATICAL APPLICATION OF SPBM.

Acute Pain in Upper Right Abdominal Quadrant

A. Patient's History.

B. Evaluation of Biophysical-Semeiotic Constitutions (Oncological Terrain)

C. Recognizing classic or "variant" Metabolic Syndrome

D. Evaluation of Antibody Synthesis

E. Evaluation of Inflammation Biophysical-Semeiotic Signs (RESHS, Acute Phase Proteins, blood-associated antibodies, a.s.o..)

FINAL DIAGNOSIS

Tab.1

To complete this paragraph, which can not obviously comprise SPBM application to all pathological conditions causing acute pain in upper right abdominal quadrant, is timely to remember that patient's history, age, type of pain, acute antibody synthesis also in the spleen, but with the unique exclusion of caecal appendix, high-located in upper right abdominal quadrant, direct doctor to the diagnosis of appendicitis, subsequently and promptly corroborated by means of numerous , aspecific and specific, signs of the original physical semeiotics (15, 16, 17) (See web sites
http://www.clicmedicina.it/pagine%20n%204/diagnosi%20semeiotica%20biofisica.htm-size 103kb,
www.semeioticabiofisica.it,/semeioticabiofisica/Documenti/Eng/Appendicitelavorogiorn% ,
http://digilander.libero.it/piazzettamedici/professione/professione.htm).
Advantages of applying Single Patient Based Medicine.

Diagnosed acute appendicitis (in high retrocecal site, under the liver, a.s.o.), doctor is able to evaluate the severity of disease, on the objective base of the particular biophysical-semeiotic phenomenology: specific and aspecific biophysical-semeiotic signs have "quantitative" value, allowing consequently objective therapeutic monitoring of the disease.
It is well known that appendicitis, apparently trivial in initial stage, rapidly causes severe peritonitis due to viscera perforation. In my opinion, paradigmatical is one case, I observed a lot of years ago: an young american girl, 16 years old, suffered in the recent past months from abdominal pain, lasting, localized in upper right abdominal quadrant, associated with dyspepsia; she recovered from such as disorder completely under efficacious treatment, not referred, and diet, prescribed by her physician in U.S.A. Recognized promptly her acute appendicitis, because of the severity of numerous biophysical-semeiotic signs, although the pain was not particularly intense, even during the known manoeuvres of the old, traditional physical semeiotics, I myself carried

the young patient in the night (11 h pm.) to our hospital, and, after our arrival, phoned to surgeon, at the moment away from the hospital, pressing the operation, who my friend colleague disagreed. However, he said: "One can not deny neither an appendicectomy nor a cigarette". During operation, my diagnose was corroborated: once the viscera was clamped, appendix wall suddenly perforated.
A 46 year-long clinical experience allows me to state that EBM and Single Patient Based Medicine, when associated, permit to achieve paramount successes, for instance, to exclude in a few seconds Oncological Terrain, and, therefore, a possible malignancy, bringing to the patients great relief, we never may forgett, satisfaction and prise to doctor and, respectively, to his prestige. Finally, from such application derives usefulness to HNS, due to the fact that unnecessary hospitalization, often lasting weeks or months, and sophysticated semeiotics (laboratory, XR- and images- departements, a.s.o.) are really expensive and very often justified.
Discussion and conclusion.

Nowadays one have to discuss more and more about guide lines, which are to be applied particularly in therapeutical field: diagnosis, however, must come allways before therapy. Clearly the guide lines for diagnosis and treatment of different disorders, realized by authrorities in a complete, synthethic, objective and hopefully independent way, are given by EBM. Guide lines, that one can define statements, expressed in an ordinate manner, which help doctor in bed side deciding the proper diagnosis and suitable therapies under a particular situation (17).
Independently of criticism, more or less constructive, really some times absurd, which derive from crass, a-critical acceptance, due to blinkered attitude of doctor, of a paradigm of EBM (2), theaching this theory has surely benefit by its practical application.
In my opinion, however, to reach further and remarkable advantages in clinical decision, therapy, in programming clinical researches, and to avoid useless procedures due to the ignorance of both biophysical-semeiotics constitutions and syndromes, it is unavoidable "also" utilize usefully SPBM, nowadays an useful reality thanks to Biophysical Semeiotics (10-17).
In this article the whole of suggestions of applying SPBM in case of acute pain localized in upper right abdominal quadrant, that complete numerous diagnostic algorhytms, well-known certainly to readers. Applying SPBM, in a contemporaneous and "rationalized" way, beside EBM and guide lines doctor can make a more rapid and proper diagnosis, and , then, an appropriate therapy and perform an effiicious therapeutic monitoring.
In conclusion, data of SPBM, rather than set themselves against EBM, complete EBM in the interest of patient, physician, and Health National Service.

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Diabetic Constitution-Dependent Inherited Real Risk.

Editors,
In my opinion, as far as diabetes is concerned, primary prevention is far better than therapy, as usually. In fact, it is well known that diabetes is a growing epidemics: I 2030, diabetics prevalence will be 366 milion. However, I'd like to state that with the aid of Quantum Biophysical Semeiotics, I've discovered the until now unknown, newborn-pathological, subtype a) oncological , and b), aspecific, type I, Endoarteriolar Blocking Devices in tissue, wherein does really exist the real risk of human common and severe diseases, as diabetes: 1° Convegno Nazionale "La Semeiotica Biofisica Quantistica ed il nuovo Rinascimento della Medicina" - Riva Trigoso - GE - 19-20 dicembre 2010. Hotel 4 Venti Via Vespucci, N 35, 16039 Riva Trigoso, (Genova) Italia.Tel. 0185/42336 - Fax 0185 458074,
organization: Simone Caramel, Cellulare: 39 338 8129030, Via Doberdò N° 3, 31020 Fontane di Villorba (Strada Ovest) (Treviso), simonecaramel@yahoo.it
http://www.quantumbiosystems.org/admin/files/QBS%202(1)%20250-281.pdf
Obviously that happens in individuals with defined Biophysical Semeiotics Constitutions, in our case, Diabetic "and" Dislipidaemic (Bibliography in the above-cited website) (1-6). Interestingly, e.g., in Diabetes Primary Prevention (PP), we need new clinical tools, aiming to lower the increasing number of patients, although the present, expensive screening:
http://www.semeioticabiofisica.it, Practical Applications: Diabetes, and Biophysical-Semeiotic Constitutions (1-7). For instance, in the normal Langheran's islets microcirculatory bed, there are exclusively "normal" type II (= in arterioles, according to Hammersen), but not type I (= in small arterioles) endoarteriolar blocking devices, i.e. EBD, of first and second classes, according to S.B.Curri (See http://www.semeioticabiofisica.it/microangiologia). In health, i.e., not involved by Diabetic Constitution, we cannot observe type I, newborn-pathological, EBD in above-mentioned biological system. On the contrary, in individuals involved by diabetic constitution as well as diabetic "Inherited Real Risk" and overt diabetes, of course, we observe with the aid of Quantum Biophysical Semeiotics also type I, newborn-pathological, subtype b) a-specific , EBD, facilitating the diagnosis and consequently diabetes primary prevention. In addition, the evaluation of Insulin Secretion Acute Pick Renal Test is significantly impaired, corroborating the clinical diagnosis (1-3) (See above cited- website, Practical Applications, and Glossary). Finally, an interesting clinical tool in recognizing diabetic constitution -dependent inherited real risk, as well as in diagnosing diabetes since early stages and diabetic monitoring proved to be bedside Biophysical- Semeiotic Osteocalcin Test (10) As a matter of fact, Pre-hypertension during Young Adulthood may be involved by Coronary Calcium Later in Life exclusively in presence of Inherited Real Risk of CAD, typical for individuals with lithyasic Constitution, present in about 50% OF ALL CASES OF Pre-Metabolic and Metabolic Syndrome (www.semeioticabiofisica.it; Constitutions and Bibliography). Considering the frequent association between hypertension and diabetes, more important, in my opinion based on 53-year-long clinical experience, is bedside recognizing diabetic predisposition, now-a-days possible since birth, utilising a lot of methods, different in difficulty, but all reliable. For the first time, from the clinical view-point, I have recently illustrated an original manoeuvre, based on a singular activity of osteocalcin, and reliable in bedside detecting diabetes in one minute, with the aid of a stethoscope (10). In fact, osteocalcin, a product of osteoblasts, among other action mechanisms, stimulates both insulin secretion and insulin receptor sensitivity. As a consequence, osteocalcin, secreted by above-mentioned bone cells during mean-intense lasting digital pressure – for instance – applied upon lumbar vertebrae, brings about increasing

pancreatic diameters, i.e., technically speaking, type I, associated, Langherans's islet microcirculatory activation, so that doctors assess pancreas size augmentation, which in health, lasts 10 seconds exactly (1-11). After that, pancreas diameters return to basal value for 3 sec. The second pancreas size increasing lasts 20 sec., and finally the third show the highest value: 30 sec. I terme such as clinical investigation. On the contrary, in case of diabetic constitution (3, 4, 11, 13) the first pancreas increasing persists normally (10 sec.), but both the second and the third are less than physiological ones (i.e., less than 20 sec. and respectively 30 sec.). In presence of intense inherited real risk of diabetes (6), such as impairment is greater. Finally, in case of diabetes the alteration is present already in the first evaluation, wherein duration appears less than 10 sec., inversely related with disorder seriousness. Subsequently, I have ascertained that Ronald's Manoeuvre result pathological already in individuals involved by both Diabetic Constitution and Inherited Diabetic Real Risk (1-11). Interestingly, not only in examining subject, but also in all others, even if kilometers way from him (her), according to Lory's experiment, based of no local realm in biological systems (12), pancreas show identical modifications, allowing doctors to made clinical diagnosis until now impossible (1-13).

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Siniscalchi's Sign: DM Bedside Diagnosis

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2010-12-24 08:49

Introduction

Despite screening measures adopted in the secondary prevention, at the moment there is no primary prevention because the traditional and pedantic Medicine ignores Quantum-Biophysical-Semeiotic Constitutions and the correlated Inherited Real Risks (1-9), such as of the diabetes, CVD and Cancer (Oncologic Terrain), pathologies that all the Authors consider ever-growing epidemics (1-5).
Next to Diabetes Mellitus, whose type 2 represents about the 50% of all the cases, arterial hypertension, glaucoma, osteoporosis, CVD, the several forms of dyslipidemia, and cancer (1-10) are generally diagnosed too late, only when the classic clinical and laboratory symptoms set in, "anticipated" and accompanied by harmful complications, often lethal, which notoriously manifest decades after the Congenital Real Risk, dependant of the correlated Constitution, expression of the potential disease (6-12).

These few exemplar FACTS underline the urgency in Medicine to proceed without any further delay towards the New Renaissance of Medicine (1), for the first time with the aid of primary prevention of Diabetes Mellitus, CAD, and cancer, three growing epidemics.
Recently, illustrating my Lecture at I National Meeting of International Society of Quantum-Biophysical-Semeiotics, Riva Trigoso (Genoa), I have announced a paramount clinical tool in the war against type 2 DM, Siniscalchis Sign (1). See also website http://www.sisbq.org

The war against diabetes: State of the Art.

On the 21st December, 2006 the General Assembly of the United Nations declared that diabetes mellitus is a threat for the whole world, designating the 14th November as World Diabetes Day.
In fact, this epidemic, ever-growing and unstoppable, is a serious threat to health, on the same level as infectious diseases like Aids, tuberculosis and malaria. The incidence and predominance of diabetes type 2 are growing in underdeveloped and developing countries.
For example, today in Italy diagnosed diabetics are two millions, without counting those who haven't been recognized ill, while the numbers of diabetics in the world is foreseen to rise from 171 millions in 2000 to 366 millions in 2030 (Nature Clinical Practice Endocrinology & Metabolism 2007, 3, 667).
To be carefully considered it is the number of adults with arterial hypertension, which affects the 70% of the diabetics, showing a double incidence compared with non-diabetics subjects, and it is foreseen an increase of the 60%, for a total equal to 1.500 millions in 2025.

Diabetic pathology is notoriously characterized by the fact that the affected body can't make use of the sugar present in the blood and it appears only in patients with Quantum-Biophysical-Semeiotic Congenital Real Risk.
Diabetes mellitus, both type I and type II, can damage heart, kidneys, eyes, nerves, peripheral arteries of the patients affected by the congenital real risks in the target organs (11-15). Without this pathological condition, dependant on the related constitution, the environmental risk factors, like diabetes, are "innocent spectators" (32).
In fact a long and successful clinical experience allows me to state that in the absence of this characteristic parenchimal congenital and microvascular alteration, the "micro vascular remodelling", all the environmental risks factors are not harmful, similarly to what happens in case of CAD (32).
This at last explains why only about the 50% of patients suffering from Metabolic Syndrome (11) is affected by diabetes type 2 as well as by the

regional and not systemic vascular damage, and the existence of several diabetics without lesions in the target organs!

I think that it is no longer possible to delay an honest stance on everyone's behalf, but especially the Government responsible for Health, Research and University, who must eventually consider the scientific discoveries in diabetology, accepted by Publishers of famous "peer-reviews", aimed to start a new and effective strategy against diabetes mellitus and other serious and common diseases, such as CVD and cancer "clinically" carried out on a large scale in a population "rationally" enrolled (1-22).
Although diabetes keeps being one of the most serious world epidemic, no world authorized Health Authority shows interest in modifying the expensive, obsolete, disastrous management enforced so far, paying the due attention and honest critic to original proposals, that proved effective in a long clinic experience, whose data are by now spread in a wide Literature (1-5, 24).

At the beginning of the third millennium no medical or surgical intervention exists, that can give complete recovering from diabetes. About the dangers of present use of stem cells, the day 11November, 2010, the Federation Argentina de Cardiologia, FAC, has posted in its Forum my comment, I have sent to the most prestigious peer-reviews of the world (Ask Google.com), wherein I referred to my earlier letter published on Washington Post website in 2007.
Furthermore only a small percentage of diabetics is kept under control in a satisfying way, if evaluated and monitored in the best possible way available today: the biophysical-semeiotic evaluation of hepatic PPARs (1-7).
In a few words, the so-called diabetic complications begin decades before leading to the diabetic syndrome, as allows me to state also Quantum Biophysical Semeiotics, showing that primary prevention is the best therapy ever!

Unfortunately up to this day primary prevention of diabetes has been realized in an expensive, limited, impractical, reductive, ineffective way, due to completely wrong principles on which it is founded, in the absolute preference for technology and neglecting a Medicine focused on Man, according to the spirit of the "Single Patient Based Medicine" (5, 7, 9).

The "screening" of Diabetes Mellitus is not synonymous of Primary Prevention
In the well-known magazine Diabetologia, considered rightly, in my opinion, the "Bible" for diabetologists, for example in the Volume 50, Number 11, November 2007, there is no article actually clinical, whose data can be cross-examined at the patient's bedside using a stethoscope.
In other words, the majority of articles published in that magazine, similarly to what happens in the others, report the conclusions of researches based on results from laboratories and sophisticated semeiotic instruments, among them genetic investigations that can only be performed in very few university centres and specialized institutes, and for this reason not applicable on a large scale of the population.
In spite of the progress, only apparently astonishing, of technology applied to diabetology, the paradoxical result is that today, during a physical examination, preferably at the patient's birth, no doctor and no diabetologist is able to clinically recognize and discern, in a quantitative way, the one with diabetic real risk, that is actually predisposed to diabetes mellitus, from the one who surely will never suffer from diabetes, even if he/she will live surrounded by several environmental risk factors.
Otherwise stated, the doctor who only knows the orthodox, academic, traditional physic semeiotics, based on the deterministic mechanics in the service of power, even having the use of state-of-the-art laboratories and sophisticated and expensive instrumental semeiotics, cannot "bedside" diagnose the diabetic constitution, the dyslipidemic constitution and the congenital Diabetic Real Risk, which represent the "conditio sine qua non" of the onset of diabetes (1-22, 31-35).
The consequences of what mentioned above, a striking example of Medieval Medicine, maidservant of Economy (23), are too evident to be only mentioned!

On the basis of a successful clinical experience of more than 50 years, without fearing refutations I state that the fight against diabetes mellitus, carried out on a very large scale with clinical methods, must necessarily be realised in ALL the individuals who are positive to diabetic "and" dyslipidemic constitutions, quickly recognizable with the help of a simple phonendoscope, and at the same time positive to the "Congenital Diabetic Real Risk" (1-22) (see also the open letter I sent to the former Minister Prof. G. Sirchia on May 2004!: http://www.clicmedicina.it/pagine-n-30/reale-rischio.htm).
In order to predict achievable objectives in a far-reaching enterprise like the primary prevention diabetes mellitus, more than relying on good intentions it is useful to carefully consider the logic held in it, associating the Medicine Based on the Obvious to the more pragmatic, realistic and practical Medicine Based on the Single Patient, which by now is accepted worldwide (5-14).
In the useless and expensive campaigns against diabetes so far fought, due to the irrational selection of the subjects to enrol, the term of primary prevention has been constantly, erroneously and silently substituted by screening (early recognition of a disease already in existence, but not diagnosed for years or decades, independently from the presence or seriousness of its "complications" already acting and from its well-known development).

I think that among the several reasons of the failing and wasteful prevention of diabetes carried on until now, the following facts lead a primary role:

a) The so-called diabetic, kidney, retinic, coronary, etc. "complications" show up decades and decades before the onset of the diabetic symptoms, both haematological (altered glycaemia on an empty stomach and/or post-prandial, high levels of glycosylated haemoglobin, pathologic OGTT, etc.), and clinic, according to the Angiobiopathy theory (31). It follows that the traditional diagnosis of diabetes, even when it seems early, is "always" inevitably late, done when by that time the target organs have already been damaged.

b) Stylish and precise enough evaluations of the alterations of the glycidic metabolism of the initials phases (e.g. hyperinsulinemic-normoglycemic clamping) CANNOT be used on a large scale for obvious economical and organizational reasons, contrary to the quantum-biophysical-semeiotic evaluation of PPARs (alfa) of the liver, the most precise method – to my knowledge – to monitor the gluco-lipidic metabolism (1-5).

c) Metabolic Syndrome, constantly anticipated by the Pre-Metabolic Syndrome, classic and variant, described in previous papers (11, 17), can be diagnosed by a phonendoscope since birth, that is when the Pre-Metabolic Syndrome and the so-called diabetic "complications" are present, but "potential" (5-10).

d) The term "screening", used arbitrarily as a synonymous of primary prevention by the Health Authorities and Doctors, is not correct at all. In fact, in this case we are not talking about primary prevention, carried out before the onset of a disease in individuals who are apparently healthy, but with congenital real risk, dependant on the relative pathology, but it is secondary prevention, carried out on diabetic patients, perhaps not yet diagnosed, but with the complications of the disease already in action. The tertiary prevention aims to contrast the progression of clinically present and advanced complications.

The nature of a prediction is scientific when can't escape, with the help of ad hoc theories, to falsification: I foresee that in future Diabetology based on Man, in the scrupulous respect of the "Single Patient Based Medicine" (5, 7-10), and accordingly in agreement with the spirit of the NEW RENAISSANCE of Medicine, the "clinical" diagnosis will play the leading role, quantitative of diabetic "and" dyslipidemic quantum-biophysical-semeiotic constitutions, diabetic congenital real risk, followed by the acknowledgement of Pre-Metabolic Syndrome and consequently of the Metabolic one in diabetic evolution and eventually of diabetes mellitus on a very initial stage (21, 31).

The five Stages of Type 2 Diabetes Mellitus

Since their births all diabetic individuals show quantum biophysical semeiotic signs typical of dyslipidemic "and" diabetic constitutions, and all the related, ICAEM- dependent, Inherited Real Risks, subsequently evolved first into pre-metabolic syndrome and after into metabolic under the negative influence of well-known environmental factors: sedentary lifestyle, tobacco smoke, overeating, a diet rich in saturated fats and carbohydrates, weight gain (BMI 25 or more), and so on (5, 7, 9-11, 13-15,17, 20). (Table 1)

Natural History of type 2 Diabeyes Mellitus

Stage 1 (individual's birth)
Diabetic "and " Dislipidemic Constitutions
Diabetic Inherited Real Risk (e.g. LATENT)

Stage II (under 10 years)
Abnormal synthesis of Perivascular GAGs by fibroblasts, pericytes, mioblasts, megacariocytes, a.s.o.; Amiline in the Interstitial Fundamental Substance, and so on. (Location: Capillaries, Small Arteries, Arterioles, AVA type II, group B, cutaneous, EBD, a.s.o.)

Stage III (Second decade of life)
IIR, Microalbuminurie, Initial ATS Plaques , a.s.o.

Stage IV (about third decade of life)
Prediabetes, overt microbascular Complications.
(OGTT, Iper-Insulinemic-Normo-Glicemic Clamping, Insulinemia)

Stadio V
Type 2 overt Diabetes

Tabella 1

In fact, it is evident that not "all" the individuals, even though obese and/or hypertensive, are at diabetes risk with different probabilities, obviously, as instead health authorities, both Ministers of Health and Instruction, university professors and also the General Practitioners keep – so it seems – thinking.

On the contrary, the individuals with diabetic "real risk" are all those who are positive to dyslipidemic "and" diabetic biophysical-semeiotic constitutions, inherited only from the mother, and associated to the diabetic Congenital Real Risk, measurable only with a simple phonendoscope, conditio sine qua non of diabetes type 2.

Quantum Biophysical Semeiotics allows physician, since birth, rationally and clinically to select "all" the individuals affected by dyslipidemic "and" diabetic constitutions, even latent, the only ones to enrol in the primary prevention because carriers of the diabetic congenital real risk (1-33).

Furthermore, for the first time the General Practitioner is able to monitor, clinically and objectively, the course of gluco-lipic congenital metabolic anomalies, recognizing the possible progression, slow and gradual, towards diabetes, favoured, but not caused, by the environmental risk factors: from the genetically directed alterations of lipidic "and" glucidic metabolism towards the Pre-Metabolic Syndrome first and, after, the Metabolic one, both absolutely lacking the traditional clinical symptoms, well recognized instead by Quantum Biophysical Semeiotics (21, 34, 35). (Table1)

As for the technical aspect, in the easiest way the doctor can recognize diabetic congenital real risk by an "intense" skin pinch at the level of the VI thoracic dermatome, which corresponds to the superior part of the epicondrium (= the area beneath the right and left costal arches).

In a healthy patient, “simultaneously” the gastric aspecific reflex is absent, appearing after 24 sec sharp (1-35)
On the contrary, in those patients who are predisposed to diabetes, the reflex appears “simultaneously”, showing an intensity inferior to 1 cm, while in the diabetic patient is 1 cm or more, in relation to the here beneath mentioned pathology.
In other words, interesting from the practical viewpoint, reflex intensity parallels the seriousness of the alterations of amorphous fundamental substance as well as glycemic metabolism impairment, which highlights the contemporaneous intense “in toto” ureteral reflex” (1)

Interestingly, from practical view point, the intensity of reflex is directly linked to the seriousness of the glucidic dysmetabolism.

Once diabetes has been recognized, potential or overt, the doctor proceeds to the quantum-biophysical-semeiotic evaluation of the glucidic metabolism, using several methods, all reliable but different in style and information (1-35).

A therapeutic important aspect is played by the war against overweight and obesity, which facilitate diabetes onset, obviously exclusively in individuals at inherited real risk.
As a consequence, doctors have to reach the goal of maintaining the real weight near to ideal weight at the best, i.e., conserving physiological BMI.

Schillaci’s Sign.

In health, lying down psycho-physically relaxed, in supine position with closed eyes to lower melatonin secretion, “intense” (24-28) cutaneous pintchig of VI thoracic dermatomere , i.e., trigger-point of pancreas (= the skin 3 cm. about below costal arch, at right or left), does not bring about “simultaneously” the gastric aspecific reflex, which occurs after exactly 24 sec., as after pancreas preconditioning (5, 12, 14) (Fig. 1).

Fig. 1
The figure shows centripetal lines, along which digital percussion has to be applied, gently and quickly, starting from outer areas and moving towards the bell piece of stethoscope. For further technical information, See www.semeioticabiofisica.it, Technical Page Number 1.

On the contrary, under identical experimental condition, illustrated above, in individuals involved by Diabetic Constitution, Diabetic Constitution-Inherited Real Risk, and overt Diabetes Mellitus, of course, “simultaneously” appears the gastric aspecific reflex (respectively of 0,5 < 1 cm. and 1 cm. or more, showing an intensity of about 3 cm in diabetes out of proper control.
Conclusions.

Based on a sclerotized Physiology, incapable of giving persuasive explanations of the several quantum-biophysical-semeiotic signs and of a Biology that disregards a non-local Reality next to a local one, Western Medicine only considers biological systems which are “static” and with a rigid metabolic balance and, according to Claude Bernard and Walter Cannon, intra-correlated only through nervous and vascular ways, arterial, venous, lymphatic.
In contrast with the blind ignorance of traditional Medicine, the physiological behaviour of biological systems is indeed that of a dynamic system far away from a fixed balance, where also the single cellular and sub-cellular structures vibrate in a stochastic, unpredictable, uncertain, chaotic way.
In addition, Western Medicine erroneously considers individuals born equal and “healthy” until the moment of the onset of the disease, according to a platonic-manichean vision, vainly underpinned with "ad hoc" hypothesis. Western Medicine is a giant with clay feet (30).

For all the above mentioned reasons, which surely don't exhaust my J'Accuse against the present Middle Ages of Medicine, maid of Economy, it now time of its Renaissance, on the basis of the discoveries done in the last 50 years and which brought to the foundation of Quantum Biophysical Semeiotics (33).
Regarding the present war against DM, based on the useless screening, unfortunately until now physician fight such as metabolic, complex disorder exclusively with therapy, however showing to be not able to bring under optimal control metabolic impairment.
Quantum Biophysical Semeiotic primary prevention of type 2 DM, providing an efficacious, reliable tool, as Siniscalchi's Sign, here illustrated for the first time, allows, easily and quickly, to recognize individuals at real risk of DM, to be enrolled in the original primary prevention.

* Mario Siniscalchi, my dearest Friend, Cardiologist in Neaple, skilled in Quantum Biophysical Semeiotics of hearth disorders.

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Bedside Diagnosing Ovarian Cancer Inherited Real Risk.

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"…… questo usa parole al vento.
Non sa di cosa parla!"

Silvio Garattini
mail 9 dicembre, 2010

_____

"Veritas Filia Temporis".

A Gellio. II sec. after Christ

Editor,

in my 55-year-long well established clinical experience, Quantum Biophysical Semeiotics proved to be a reliable and useful bedside tool in early detecting ovarian cancer, since its first stage, i.e., ovarian Cancer Inherited Real Risk, mainly overlooked – if not mocked – by physicians around the world, in individuals obviously with Oncological Terrain, (1) (website, www.semeioticabiofisica.it , Oncological Terrain) (1-3).
There is a general agreement among the Authors, that ovarian cancer I diagnosed to late in 75% of all cases, so that its prognosis is not good at all!
In my opinion, what accounts for the reason cancer is a growing health problem in developed as well as in developing countries, as CAD and type 2 Diabetes Mellitus, is that Medicine developments, especially in the field of physical semeiotics, continuously meet difficulties in spreading among General Practitioners all around the world.
As follows, a easy method, quickly to apply, which proved to be reliable in my long CLINICAL experience, is fully escribed.
In healthy woman, starting hopefully since birth, involved by Oncological Terrain, of course, lying down on supine position, psycho-physically relaxed, and with open eyes to reduce endogenous melatonin secretion, lasting, mean-intense hand pressure, applied on X thoracic dermatomere (= from the practical viewpoint, at right or left iliac fossa, which represent ovarian trigger-points), brings about aspecific gastric reflex (= stomach fundus and body dilate, while antral-pyloric region contracts), only after a latency time of exactly 8 sec.
The reflex lasts physiologically "less" than 4 sec., related to normal Microcirculatory Functional Reserve; it's really a paramount parameter value, since it parallels fractal dimension of related microvessell fluctuations (1-3).
Afterwards reflex disappears for > 3 < 4 sec. corrisponding precisely to fractal dimension of local microvessell fluctuation, corroborating the interne coherence of the theory.
On the contrary, in ovarian cancer, since its earliest stage of Inherited, Oncological Terrain-dependent, ovarian cancer "Real Risk", latency time could be jet 8 sec. (NN = 8 sec.), but reflex duration interestingly lasts 4 sec. or more (NN > 3 < 4 sec.), in relation to severity of underlying inherited oncological real risk.
Importanly, from differential diagnostic viewpoint, soon thereafter stomach contracts "pathologically": tonic Gastric Contraction (tGC), typical sign of cancer.
These parameter values parallell ovarian microcirculatory abnormalities, so-called "microcirculatory remodelling", based on newborn-pathological, type I, subtype a), oncological, Endoarteriolar Blocking Devices, I discovered (1- 2).

More precisely speaking, reflex latency time becomes shorter than the normal 8 sec. in inverse relation to the tumour stage.
In addition, in day-to-day practice, biophysical semeiotic "ovarian preconditioning" is very useful and reliable: exactly 5 sec. after the basal manoeuvre, illustrated above, when ovarian Microcirculatory Functional Reserve is activated, doctor performs the described test a second time: in health, where tGC. is always absent, all parameters values improve in a clear-cut manner, latency time raising to 16 sec., i.e., doubled value.
On the contrary, in patients at inherited real risk of ovarian cancer, they either persist unchanged or increase not significantly in relation to the severity of ovarian, inherited cancer "real risk".
Finally latency time worsens significantly in case of overt ovarian cancer, even in initial stages of its evolution. Such as sign, easy to perform and reliable at the bed-side, is really useful in both ovarian cancer clinical primary prevention and diagnosis, among a large variety of other remarkable biophysical-semeiotic signs (1-10).
In addition, as I described previously (1-8), malignancies occur on the base of a genetically transmitted mitochondrial cytopathology, I named Congenital Acidosic Enzyme-Metabolic Histangiopathy, conditio sine qua non of Oncological Terrain. Such as inherited abnormalities of psycho-neuro-endocrine-immunological system is mainly transmitted by mother. Therefore, it is a distressing non-sense, or at least uselessly expensive, for instance, to ask if patient's mother is, or was, involved by ovarian cancer, as well as assess oncological biomarkers and newly discovered mutated genes level in women (and men, of course!) without Oncological Terrain and/or whatever Cancer Real Risk. Doing such as clinical research, physician can avoid the overlooked epidemics, I termed Psychological Jatrogenetic Terrorism
According to Psychokinetic Diagnostics, in healthy women, since birth, "intense" digital pressure, applied on above-mentioned trigger-point is not "simultaneously" accompanied by gastric aspecific reflex.
On the contrary, in women at ovarian cancer inherited real risk, and in those involved by overt cancer, even in initial stage, “simultaneously” appears gastric aspecific reflex, immediately followed by characteristic tonic Gastric Contraction, showing parameter intensity correlated with the seriousness of underlying disorder.

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Raggi's Sign. Bedside diagnosing Bone Marrow Disorders.

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Introduction

The definition of Quantum Biophysical Semeiotics – QBS - was coined by my friend Paolo Manzelli (1) (See Bibliography in the site www.semeioticabiofisica.it).
The use of quantum mechanics evolution applied to biology, has finally illuminated the nature of complex pathogenic mechanisms underlying several QBS signs, after a long wait for a satisfactory explanation that the reductive deterministic mechanics has not been able to provide because of his limited world view, considered to be formed only by Matter and Vibratory Energy ignoring completely the Energy-Information (2-4).

In previous articles I have clinically shown that in biological systems it does exist the non local reality next to the local one, in which different is the nature of the transmission of Energy-Information, this transmission present in truth only in the second case where there is consumption of energy and of time in information processing (1-4). In contrast, in the non-local reality, characterized by a matrix space / time, but with four-dimensional and 2DS 2DT, based on "Entanglement Theory", the information is simultaneous transmitted by resonance and is made without any transfer.

"This is for example when two simultaneous actions occurring at the same time, as when a firecracker explodes at a distance while others shine resonance firecrackers quite distant, but it has been possible to transfer any of sparks" (Manzelli, personal communication).

The use of these new concepts of Quantum Biophysics in Medicine proved to be of essential importance in-depth understanding of many signs, syndromes and QBS tests, and especially in the diagnosis, in the therapeutic monitoring, in research, as evidenced now by a considerable literature (1-45).

This article describes the Raggi’s sign that allows the doctor to rule out a bone lesion in a second, including the metastases, which are notoriously difficult to diagnose.

Quantum Biophysical Semiotics of bone lesions.

In health, the mean-intense digital pressure, applied directly on a biological system, or, far more frequently exercised indirectly through the stimulation of related trigger points, causes the middle ureteral reflex, typical of Endoarteriolar Blocking Devices, Type II, physiological and ubiquitous (5-14).

The “intense” compression in the lower third of the radius and of ulna, between the thumb and other fingers of the hand, actives the microcirculation

simultaneously, depending on the type I, associated, both locally and throughout the remainder of the skeletal system, for example, in various bones of the skull and lumbar vertebrae, explained by quantum entanglement (1-4, 14, 29, 56).

In health, digital pressure of "light" intensity exerted on a bone, causes the oscillating upper and lower ureteral reflexes, i.e., vasomotion and vasomotion, which inform the way of being and functioning of local small arteries and arterioles, by Hammersen, or vasomotility, and respectively the nutritional capillaries, or vasomotion, allowing to observe the "simultaneous" intensification of the characteristics fluctuations of ureteral reflex in experimental conditions referred to above.
It follows that the medium-intensity stimulation of a small part of a bone simultaneously provides information on the whole biological system, as is the case for all other tissues (1-4, 14, 29, 56).

In fact, in health, if the bone stimulation is of medium intensity, after a latency time of exactly 8 seconds, appears the gastric aspecific reflex whose duration is less than 4 seconds, expression of the effectiveness of Microcirculatory Functional Reserve, a great diagnostic significance parametric value, which disappears for the duration of> 3 sec. <4 sec., corresponding to the fractal dimension of the micro-vascular chaotic deterministic dynamics.

The triad of information has led Paolo Manzelli to a wider general reflection on the new "quantum-biophysics," based on the formation of entanglement between quantum particles, electrons and atoms in a "sharing" system of space-time, which produces simultaneous communication of pure information between systems.

However, for this to happen in biological systems must have a sufficient energy level, unavoidable condition for the realization of non-local reality, which provides the normal mitochondrial respiratory activity.

In the presence of an mitochondrial alteration, even if functional one, as is the Congenital Acidosic Enzyme-Metabolic Histangiopathy (5-9, 44-46), out-of oxidative phosphorylation in these intracellular organelles, the non-local reality becomes just local reality with local increase in EM (pyruvic acid converted to lactic acid) and reduction of energy-information, represented by ATP.

Raggi’s Sign.

In health, "intense" stimulation of the bone - the pressure above the lower third of the radius and ulna has got a very practical use - shown above, is not accompanied "simultaneously" by the gastric aspecific reflex. (Fig. 1).

Figure 1
Gastric aspecific reflex

In contrast, in the presence of a bone lesion, whatever its nature, inflammation, fibrosis, rheumatic, vascular, neoplastic, etc.. "simultaneously" to the stimulation is observed the gastric aspecific reflex, whose intensity correlates with the severity of the underlying disorder: a positive Raggi’s Sign.

Interestingly, in the presence of bone cancer, primary or metastatic, the reflection is immediately followed by the typical tonic Gastric Contraction (5, 47 - 49).

At this point, having established the bone pain, the physician should proceed with the investigation of the bone location, diagnosing the exact nature, based on awful number of signs, part of them specific, provided by the Quantum Biophysical Semiotics.

The following experimental evidence supports the above-referred statements.
In health, Raggi's Sign is negative.
However, if it exerts intense pressure on any point of the bone system - excluding the joint tissue, useful but for the provocation of rheumatic-gastric reflex (5, 47-49) - continued for at least thirty seconds, so as to induce pain in underlying tissue with release of cytokines and significant changes in the local micro-circulatory blood flow, the Raggi's Sign becomes transiently positive, without being followed by the Tonic Gastric Contraction of course, characteristic of cancers and rheumatic diseases, in case of involvement of sinovium.

Conclusions.

Since 2007, Quantum Biophysical Semeiotics was greatly enhanced and made more effective by the contribution afforded by quantum physics, both in terms of clinical research, and on that of the daily practical application, so that the boundaries of his domain had a great expansion. .

It is well known, for example, that so far the clinical diagnosis of bone metastases or perivascular epithelioid cell tumor (PEComa) was impossible for anyone.
In fact, it is very difficult clinical diagnosis, made out on the basis of reports of symptomatology for imaging, from laboratory and histology test.

Notoriously, the traditional physical semeiotics and symptomatology does not allow the medical finding of bone injuries of any kind, such as bone cysts, and tumors, malignant or benign, out of the arteries not palpable, i.e., localization in internal tissues.

It has recently been reported in world literature that PEComa show an increasing incidence in a variety of anatomical locations. The locations of these lesions are often more widely the uterus and the retro-peritoneum. These tumors are part of a large family that includes, among others, angiomyolipomas, and the linfangiomiomatosi miomelanociti clear cell tumors of the falciform ligament, also known as PEComa-NOS.

There are about fifty known cases of these cancers.

However, based on personal experience with the Quantum Biophysical Semiotics, I am authorized to state that in the future can be detected for much more numerous cases on the condition that doctors around the world will be able to use the original semiotics, which allows faster the generic diagnosis of malignant vascular tumor, whose precise diagnosis will be made in a timely manner in subjects rationally selected on the basis of several clinical signs of malignancy.

As for the easiest method to use, just remember that "mean to moderate" digital pressure, applied directly over a bone, for example, the radio, allows to learn

the way of being of the stimulated bone segment through the numerous signs and QBS maneuvers known to readers as: gastric aspecific reflex, followed by tonic Gastric Contraction, complete SIRSI, Domenichini Sign with duration of 4.5 sec. (Glossary), an increase of Acute Phase Proteins, Acute antibody synthesis, local microcirculatory activation type II, dissociated, etc.

On the contrary, if the stimulation exerted on any bone segment is "intense", it causes associated microcirculatory activation, type I, in bones, EV (ATP) increases and thus an higher EI, pure and catalytic energy: the reality in the biological system is both local and non-local one.

For the phenomenon of resonance, a possible bone lesion at a distance is "simultaneously" stimulated, producing a number of reflections (gastric aspecific reflex followed by tonic Gastric Contraction just in case there is cancer), depending on the nature of the disease itself.

Raggi's Sign is based on this scientific knowledge, subject of this article, which allows to exclude just in one second the presence of metastases, as shown by the paradigmatic case I described above: a young Italian woman, but living in Hamburg, made in surgery two years before for a cancer of the rectum to nerve cells, which was diagnosed by CT scan to check bone "a suspected metastatic lesion of the sacrum".

She turned to me via the Internet, of course, understandable in the grip of anxiety and despair, cause the psychological jatrogenetic terrorism. The psychokinetic diagnosis made before August, 15th, 2010, was of probably benign lesion scar of post-traumatic nature, and it was correctly confirmed by a PET survey two months later PET! (50).

The psychokinetic diagnosis was able to recognize in just a second the presence of a bone lesion, indicating the nature of the tumor or nonspecific nature. Then the doctor will locate the alteration and accurately diagnose the cause based on the many signs provided by the Quantum Biophysical Semiotics.

* Dedicated to the friend Dr. Raggi Francesco, Specialist in Hygiene and Preventive Medicine in Terni - Italy, an expert in NIR-LED Treatment.

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The New War against Five Stages of type 2 Diabetes Mellitus

According to WHO competent Authorities, there were in 2010 250 milion of diabetics, and they will be 366 milion in 2030, indicating that type 2 DM is today's growing epidemics (1-16).
In my opinion, as far as diabetes is concerned, primary prevention, especially when initiated in the first two stages among the five of th natural history of the disease, is far better than therapy, as usually.
Unforunately, Diabetic "and" Dislipidemic Constitutions, conditio sine qua non of type 2 DM, are nowadays overlooked by the majority of physicians all around the world (12-14). A long well westablished clinical experience allows me to state that with the aid of Quantum Biophysical Semeiotics, physicians can quickly and easili bedside recognize the "microcirculatory remodelling", based on newborn-pathological, subtype a) oncological , and b), aspecific, type I, Endoarteriolar Blocking Devices in tissue, wherein does really exist the inherited real risk of human common and severe diseases, as diabetes (12-16).
Obviously that happens in individuals with defined Biophysical Semeiotics Constitutions, in our case, Diabetic "and" Dislipidaemic, according to Joslin(1-6, 12-16).
To realize on vast scale Diabetes Primary Prevention (PP),enrolling exclusively individuals at Inherited Real Risk, we need new clinical tools, aiming to lower the increasing number of patients, because the present, expensive screening has failed (14). For instance, in the normal Langheran's islets microcirculatory bed, there are exclusively "normal" type II (= in arterioles, according to Hammersen), but not type I (= in small arterioles) endoarteriolar blocking devices, i.e. EBD, of first and second classes, according to S.B.Curri (See http://www.semeioticabiofisica.it/microangiologia). In health, i.e., not involved by Diabetic Constitution, we cannot observe type I, newborn-pathological, EBD in above-mentioned biological system. On the contrary, in individuals involved by diabetic constitution as well as diabetic "Inherited Real Risk" and overt diabetes, of course, we observe with the aid of Quantum Biophysical Semeiotics also type I, newborn-pathological, subtype b) a-specific , EBD, facilitating the diagnosis and consequently diabetes primary prevention. In addition, the evaluation of Insulin Secretion Acute Pick Renal Test is significantly impaired, corroborating the clinical diagnosis (1-3) (See above cited- website, Practical Applications, and Glossary). Finally, an interesting clinical tool in recognizing diabetic constitution -dependent inherited real risk, as well as in diagnosing diabetes since early stages and diabetic monitoring proved to be bedside Biophysical-Semeiotic Osteocalcin Test and Siniscalchi's Sign (10, 15, 16).
As a matter of fact, Pre-hypertension during Young Adulthood may be involved by Coronary Calcium Later in Life exclusively in presence of Inherited Real Risk of CAD, typical for individuals with lithyasic Constitution, present in about 50% OF ALL CASES OF Pre-Metabolic and Metabolic Syndrome (www.semeioticabiofisica.it; Constitutions and Bibliography). Considering the frequent association between hypertension and diabetes, more important, in my opinion based on 53-year-long clinical experience, is bedside recognizing diabetic predisposition, now-a-days possible since birth, utilising a lot of methods, different in difficulty, but all reliable. For the first time, from the clinical view-point, I have recently illustrated an original manoeuvre, based on a singular activity of osteocalcin, and reliable in bedside detecting diabetes in one minute, with the aid of a stethoscope (10). In fact, osteocalcin, a product of osteoblasts, among other action mechanisms, stimulates both insulin secretion and insulin receptor sensitivity. As a consequence, osteocalcin, secreted by above-mentioned bone cells during mean-intense lasting digital pressure – for instance – applied upon lumbar vertebrae, brings about increasing pancreatic diameters, i.e., technically speaking, type I, associated, Langherans's islet microcirculatory activation, so that doctors assess pancreas

size augmentation, which in health, lasts 10 seconds exactly (1-11). After that, pancreas diameters return to basal value for 3 sec. The second pancreas size increasing lasts 20 sec., and finally the third show the highest value: 30 sec. I terme such as clinical investigation. On the contrary, in case of diabetic constitution (3, 4, 11, 13) the first pancreas increasing persists normally (10 sec.), but both the second and the third are less than physiological ones (i.e., less than 20 sec. and respectively 30 sec.). In presence of intense inherited real risk of diabetes (6), such as impairment is greater. Finally, in case of diabetes the alteration is present already in the first evaluation, wherein duration appears less than 10 sec., inversely related with disorder seriousness. Subsequently, I have ascertained that Ronald's Manoeuvre result pathological already in individuals involved by both Diabetic Constitution and Inherited Diabetic Real Risk (1-11). Interestingly, not only in examining subject, but also in all others, even if kilometers way from him (her), according to Lory's experiment, based of no local realm in biological systems (12, 15), pancreas show identical modifications, allowing doctors to made clinical diagnosis until now impossible (1-15).

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Bedside Diagnosis of Lung Cancer Inherited Real Risk

Sirs,
in my opinion, ascertaining 26 gene mutation aiming to recognize individuals "possibly" at risk of lung cancer is expensive and impossible to perform on vast scale! From the clinical viewpoint, to prevent lung cancer I suggest another methof. Easily and quickly to apply on very larga scale, aiming to detect individuals at Inherited Real Risk! (1-6) Our pivotal goal in reducing lung cancer incidence and mortality, is bedside Diagnosing in humans Lung Cancer INHERITED Real Risk, which represent its initial Stage, now-a-days possivle thanks to Quantum Biophysical Semeiotics (7).
Fortunately, the overlooked Baserga'sign, I described in earlier article (1), proved to be useful in bed-side recognizing iron-deficiency syndrome. In fact, due to iron deficiency, erythropoietin can not stimulate bone-marrow, as it happens in healthy subject, originating the "classic" biophysical semeiotic Baserga's sign. In a few words, in health, lying down in supine position, psycho-physically relaxed with open eyes to prevent melatonin secretion, mean-intense digital pressure applied upon middle line of sternal body, brings about gastric aspecific reflex after a latency time of exact 10 sec., indicating that bone-marrow activity is normal, according to my Angiopathy theory (1-4).
On the contrary, after stimulation of renal erythropoietin secretion by pinching lateral abdominal skin lasting 15-20 sec., the second evaluation shows a statistically significant lowered latency time: 6 sec. precisely, due to bone-marrow increased microcirculatory activity. Notoriously, exclusively in presence of normal iron tissue level, endogenous erythropoietin can act on bone marrow. In fact, in iron deficiency syndrome, the lowering of sternum-gastric aspecific reflex, i.e., Retyculo-Endothelial System Hyperfunction Syndrome (RESH) (2, 3), is clearly compromised, in inverse relation to the seriousness of underlying iron deficiency
Interestingly, in lung cancer (e.g. adenocarcinoma), I observed a "variant" form of the Baserga'sign. Really, as hypothesis 0, I suspected that stimulating cutaneous pulmonary trigger-points, related to lung cancer even in the initial stage of Cancer, i.e., Inherited Oncological Real Risk (1-6) by digital pressure, could provoke the output of tumour cell products, which in turn stimulate bone-marrow, at the moment partially suppressed in its function. According to Max Born, a new theory must be "mad" enough to be true.
In health, mean-intense digital pressure, applied on skin projection area of diverse lung lobes (= stimulation of pulmonary trigger-points), brings about gastric aspecific reflex after exactly 8 sec. latency time (lt), and the basal latency time of Rethiculo-Endothelial System Hyperfunction Syndrome (2-6) persists identical, under the same condition, when the stimulation of lung trigger-points lasts about 15-20 sec.
In fact, the latency time (lt) of sternum-aspecific gastric reflex, i.e., RESH (= mean-intense digital pressure applied upon the middle line of sternal body, and/or iliac crests) persists identical to the basal one: lt 10 sec., also after stimulating the trigger-points of healthy lung for about 15-20 sec., indicating absence of erytropoietin-like substance secretion from lung (or every biological system, of course).
On the contrary, in case of lung cancer "inherited real risk" (6, 7) and overt lung cancer, of course, under the same condition (= mean-intense digital pressure, applied precisely on disorder cutaneous projection area, lasting 15-20 sec.), one observes a significant reduction of RESH lt, lowering from 10 sec. to 6 sec., in relation to the seriousness of underlying disorder.
In addition, in presence of lung cancer "inherited real risk", characterized by the presence of newborn-pathological, type I, subtype a), oncological, Endoarteriolar Blocking Devices (6, 7), interestingly, basal lt. of lung-aspecific gastric reflex may result normal (i.e., 8 sec.), but reflex

duration is pathologically more than 4 sec. (NN lower than 4 sec.: parameter value of paramount diagnostic importance, correlated with local Microcirculatory Functional Reserve), and finally follows the pathological tonic Gastric Contraction, absent under physiological conditions, and typical of oncological disease.
In presence of overt lung cancer, even in initial stage, latency time of lung-gastric aspecific reflex lowers significantly (NN = 8 sec.), reflex duration is increased (more than 4 sec.), followed, without delay, by "pathological" tonic Gastric Contraction (tGC)
I suggest such as biophysical-semeiotic signs as worthy of attention, although further investigations are necessary. In fact, what referred represents, so I think, a paramount clinical tool in lung cancer primary prevention as well as in the war against pulmonary malignancy.
While lung carcinoma causes patient's death, all authors are agree with, there is well based hope that Inherite Real Risk of lung cancer may be successfully treated, as it happens under similar pathological conditions (e.g., breast cancer, colon cancer, prostate cancer, a.s.o.) treated with proper, mediterranean diet, Coniugated-Melatonin, personalized applications of LLLT and/or NIR-LED, CellFood (Eurodream), bioflavonoids, a.s.o., analogously to primary prevention therapy of type 2 Diabetes Mellitus (8-12).
In conclusion, also regarding lung cancer, Primary Prevention Prevention is far better than therapy, as my well established CLINICAL experience demonstrates.

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Di Bella's Oncological Terrain and Insomnia.

Introduction.
Living organisms have notoriously evolved internal timekeeping mechanisms to synchronize behaviour and physiology with the cycles of day and night. These biological clocks have been found in a lot of organisms, as fungi, fruit flies, hamsters, and humans. The biological clock of humans is found in the brain. There is a general agreement that in such event an important role is plaid by the path of light input to the suprachiasmatic nucleus (SCN), a collection of neurons that regulates our circadian rhythms. The SCN contains several cell types and several different peptides (including melatonin, somatostatin, vasopressin and vasoactive intestinal peptide) and neurotransmitters, and it interacts with many other regions of the brain, especially epihysis.
In a fascinating article, Authors have demonstrated that the hormone melatonin phase shifts circadian rhythms generated by the mammalian biological clock, the hypothalamic suprachiasmatic nucleus (SCN), through activation of G protein-coupled MT2 melatonin receptors (1). The pretreatment with physiological concentrations of melatonin in rat decreased the number of MT2 melatonin receptors expressed in mammalian cells in a time and concentration-dependent manner. Furthermore, MT2 melatonin receptors were internalized upon pretreatment with both physiological and supraphysiological concentrations of melatonin (1). In rats, the recovery process was partially protein synthesis dependent. Furthermore, exposure to physiological concentrations of melatonin for a time mimicking the nocturnal surge (8 h) desensitized functional responses mediated through melatonin activation of endogenous MT2 receptors (1).
The authors conclude that in vivo the nightly secretion of melatonin desensitizes endogenous MT2 melatonin receptors in the mammalian SCN, thereby providing a temporally integrated profile of sensitivity of the mammalian biological clock to a melatonin signal (1).

The Human Suprachiasmatic Nucleus

In mammals, the controlling clock component that generates a 24-hour rhythm is the suprachiasmatic nucleus (SCN), located in the hypothalamus. The SCN produces a signal that can keep the rest of the body on an approximately 24-hour schedule, but in individuals negative for Di Bella's Oncological Terrain (2-10), as I am going to demonstrate for the first time in this article.
Even in the absence of external time cues, humans maintain a sleep-wake rhythm very close to 24 hours. Typically an organism's circadian system is made up of components that receive environmental input, that generate the 24-hour rhythm, and that mediate rhythmic output to all the tissues of the body. In mammals, the controlling clock component that generates a 24-hour rhythm is the suprachiasmatic nucleus (SCN), located in the hypothalamus. SCN signal can keep the rest of the body on an approximately 24-hour schedule.
However, because the internal clock's period is not exactly 24 hours, environmental cues—most importantly, light—are required to reset the clock each morning and keep the organism synchronous with the external world. Notoriously sunlight represents a signal that can reset neurons in the SCN.

At the moment, Authors agree with the statement that light enters the eye activating neurons in the retina, and converting photons to electrical signals. The retinal neurons transmit the electrical signals from the retina via long axons in the optic nerve. Along the way is the optic chiasm, where the optic nerves from the left and right eye meet and cross. At the optic chiasm, visual information continues toward the back of the brain, where it is processed into images that we can consciously perceive. The neurons carrying information to the

SCN, however, take a different path. They exit the optic chiasm and turn upward, toward the SCN, so called because it is located above the chiasm.

However, with the aid of Quantum Biophysical Semeiotics (See my website www.semeioticabiofisica.it and www.sisbq.org), I have demonstrated that in biological systems, beside local realm, weherin transmission happens by losing time and energy, as above described, according to classic physics, there is also no-localm realm, characterized jet by a four dimensional space/time, but showing 2 T/D and 2 S/D: the information is "simultaneous" in the space and synchronous in the time, whitout losing energy since its mechanism nature is cathalitic,according to quantum biophysics (11-21).
The SCN is a small, paired, wing-shaped structure, located at the base of the brain, exactly in the hypothalamus. Within each side of the SCN is a network of up to several thousand neurons, normally synchronized with the activity of its neighbours.
Inside a single SCN neuron, the protein product of a biological clock gene turns off production of more protein, forming a negative feedback loop. Even in the absence of external time cues, humans maintain a sleep-wake rhythm very close to 24 hours. Typically an organism's circadian system is made up of components that receive environmental input, that generate the 24-hour rhythm, and that mediate rhythmic output to all the tissues of the body.
The SCN produces a signal that can keep the rest of the body on an approximately 24-hour schedule, as above refered. However, because the internal clock's period is not exactly 24 hours, environmental cues—most importantly, light—are required to reset the clock each morning and keep the organism synchronous with the external world, by regulating tissue level of melatonin.
Light enters the eye and activates neurons in the retina that convert photons to electrical signals, but especially in the first phase, according to Quantum Biophysical Semeiotics, through "simultaneous" information of some occipital brain regions, as demonstrates the following clinical evidence.
When an healthy individual opens his (her) until before closed eyes, brain occipital circonvolutions show "simultaneously" microcirculatory activation, according to type I, associated, physiological (3, 22-25).
Further information reader may find in the websites http://www.semeioticabiofisica.it/microangiologia/, and www.sisbq.org.
Unfortunately, regarding retinal in-put transmission to the brain, physicians all around the world continue to think erroneously that the unique way of energy transmission is the retinal neurons transmission of the electrical signals from the retina via long axons in the optic nerve. Along the way is the optic chiasm, where the optic nerves from the left and right eye meet and cross. At the optic chiasm, visual information should contune toward the back of the brain, where it is processed into images that we can consciously perceive, losing time and energy. The neurons carrying information to the SCN, however, take a different path. They exit the optic chiasm and turn upward, toward the SCN, i.e., above the chiasm. All that happens really in the second phase of visual perception.
In a few words, such as transmission is firstly "simultaneous", according to non local realm of biological systems, I have demonstrated in earlier articles (11-21), and secondly it happens as generally admitted, losing time and energy (13,19,20).
Role of hormones and neurotransmitters in SCN functioning.
A major function of the SCN in mammals is thought to be to generate biological rhythms with a period of about 24 hours, and these circadian rhythms are normally related to the light-dark cycle. They underly daily rhythms of activity and of hormone secretion. The involvement of the SCN was first shown by experiments in which damage to the SCN in animals resulted in abnormal activity rhythms.
In all mammals many physiological processes are governed by circadian rhythms; for example the secretion of many hormones, such as melatonin, follows a 24-hour cycle.
Specialized neurons in the ventrolateral SCN have the ability for light-induced gene expression. If light is turned on at night, a singular componen of SCN relays this information throughout the entire SCN, as demonstrates clinical

evidence: in a few second, local microcirculatory activation disappears, followed by basal microvessel fluctuations (3-5, 26)
The SCN receives notoriously information via the optic nerve. However, neurons in the dorsomedial SCN can generate a 24-hour rhythm of activity that can persist even in constant darkness. The SCN sends information to other hypothalamic nuclei and the pineal gland to modulate body temperature and the production of hormones such as cortisol and melatonin.
The SCN is one of four nuclei in the brain that receive nerve signals directly from the retina, the other three are the lateral geniculate nucleus (LGN), the superior colliculus, and the pretectum.
The LGN passes information about color, contrast, shape, and movement on to the visual cortex and itself signals to the SCN. The superior colliculus controls the movement and orientation of the eyeball. The pretectum controls the size of the pupil.
However a key feature of a true circadian pacemaker, such as the SCN, is that it can produce rhythms with an approximate period of 24 hours even in the absence of any change in light. True circadian rhythms thus persist when animals are maintained in constant light or constant dark. Thus light cues do not themselves determine the rhythm, they just entrain the rhythm, keeping it locked to the light-dark cycle.
Insomnia and wakefulness are related to other important disorder, including Di Bella's Oncological Terrain.
Epidemiologic studies indicate that disturbances in sleep and wakefulness predict the presence of current, and the emergence of future, psychiatric impairments, including depressive, anxiety, and substance use disorders (27).
At the end of the life cycle, a predictive value for disturbed sleep was demonstrated for individuals above the age of 55 by Authors (28) who presented data from 140 patients suffering from major depression disorder (MDD) consecutively visiting in a family practice setting over the course of 6 months and 140 controls, matched with respect to age and sex.
In these aged patients, improvement in mood was correlated with increased sleep quality in both depressed and nondepressed patients. However, other lifestyle indicators were not.
Young and colleagues added to the database supporting the predictive value of insomnia in psychiatric morbidity in a cross-sectional study of 49 older adults (ages 50-89) with bipolar disorder; 60% reported a history of suicidal ideation (29). Positive correlates for suicidal ideation included white race, prominent sleep difficulties in the depressed phase, and younger age.
Taken togheter, these data extend the predictive value of disturbed sleep in the psychiatric disorders to younger and older age spectra, obviously only in those individuals involved by Constitutiond-Dependent Inherited Real Risks (3, 4, 48).

For the first time, based on a sufficiently long, well established, clinical experience, I emphasise suprachiasmatic nucleus disturbances, evaluated with Quantum Biophysical Terrain, as a typical sign of Di Bella's Oncolgocal Terrain.
As a matter of fact, among the principal neurotransmitters involved in conveying photic information to the SCN have been identified glutamate, and PACAP. Light stimulation of the retina results in direct secretion of glutamate from the Rethino Hypothalamic Tract (RHT) into the ventral VIP-containing part of the SCN (30, 31). Glutamate as a transmitter at RHT/SCN synaptic connections plays an important and critical role in mediating photic regulation of circadian rhythmicity. RHT terminals innervating the SCN show glutamate immunoreactivity associated with synaptic vesicles which confirms the role of glutamate as a neurotransmitter (32,33).
Different types of glutamate receptors were identified and localized in the SCN using in situ hybridization and immunocytochemistry (35).
My principal interest here is to underly the central role plaid in SCN disturbaces by melatonin as well as somatostatin, two paramount components of Di Bella's Oncological Terrain, conditio sine qua non of cancer onset in SCN in bith function and disturbances (2-4,10,22).
Melatonin, the so-called darkness hormone, proved to be of great importance in the functioning of the SCN, as demonstrate the following experimental evidence: "symultaneously" to eye closure, physician observes microvessel activation of

epyphysis and after one sec., also the activation of SNC microcirculation, according to type I, associated (2-4, 22).
In my clinical researches, among the most important target of melatonin in humans, there is the SCN, as it contains the highest density for melatonin receptors (4, 10, 22, 36).
A double effect of melatonin in the SCN, namely, an immediate effect and long term effect, has encouraged its worldwide use against the ill effects of jet lag. Acceleration of sleep initiation in humans at circadian phases when the SCN would normally stimulate waking is another reported action of melatonin (37).
In terms of long term effect, melatonin can phase shift and amplify circadian rhythmicity of the SCN. Melatonin application has been found to be useful in synchronizing the endogenous circadian rhythms not only in people who suffer from jet lag, but also in blind individuals, patients with dementia, and shift workers (38).

In spite of the experimental evidence favouring a very important role for melatonin in the circadian timing system, the exact role of melatonin has not been demonstrated clearly. Melatonin and seasonal rhythms are intimately related in mammals, and this has been well documented (37-40). The retinohypothalamic-pineal (RHP) axis is comparable in animals and humans. In both animals and humans melatonin is secreted exclusively at night. The RHP is capable of detecting changes in night length to make proper adjustments for the duration of nocturnal melatonin secretion so that animals can use this melatonin message to trigger seasonal changes in behaviour (41).
I have demonstrated the central role of Melatonin in the pathogenesis of Di Bella's Oncological Terrain (2-4, 22, 23).

A second neurotransmitter lowered typically in Di Bella's Oncological Terrain is somatostatin (SST). SST producing neurons of the SCN are located in both the core and shell portions and form a distinct peptidergic neuronal group. The shell portion of the SCN, which is likely to be involved in the regulation of overt rhythms, projects within the SCN through SST fibres. Aging effects of SCN neuropeptide expression, like the circadian profile of peptide expression, may be species specific as far as the SCN is concerned. Synapse of SS fibres on VIP and AVP neurons and presence of SST receptors in the SCN is suggestive of a regulatory role for SST on other peptidergic neurons. An inhibitory modulating role of SST on VIP rhythmicity has been demonstrated (42). Increase in SST immunoreactivity could explain the observed VIP decrease with aging, and, if enhanced SST immunoreactivity reflects a release deficit, this may lead to reduction in inhibitory action.
One must remember that VIP, a gut polypeptide, has been identified as one of the main neurotransmitters of SCN neurons and participates in SCN function. In addition, VIP signalling through its receptor serves two important functions in the SCN, namely, circadian rhythmicity in a subset of neurons and maintenance of synchrony between intrinsically rhythmic neurons. This may also mean that VIP-expressing neurons themselves are circadian pacemakers in the SCN for establishing and synchronizing rhythmic activity (42).
From the above remarks, I am allows to state that in individuals involved by Di Bella's Oncological Terrain, characterized by lowering of both melatonin and SST, the first plays the central role in SCN disturbances.

Regarding the link between neurotransmitters and some human disorders, researchers have started to identify the role of the SCN in a lot of disease conditions. SCN dysfunction, particularly in terms of neurotransmitter content, has been associated with several chronic diseases such as hypertension, diabetes, and depression (43, 44).
An awful number of observations strongly suggest that a changed SCN may precede the development of hypertension. There is also evidence that circadian disturbances may be detected prior to the development of diabetes or hypertension (45, 46) Further evidence that the functionality of the biological clock may be affected in humans by diseases such as depression and hypertension has been provided by numerous Authors.

According to my clinical experience, all researches are fundamentally biased, since the majority of Authors ignore Quantum Biophysical Semeiotic Constitution (45).
A 55 year-long clinical experience allows me to state that the Authors, overlooking these predispositions to related disorders, cannot correlate neurotransmitters alterations with a lot of disorders, like SNC dysfunction and psychiatric diseases, hypertension, and diabetes.
In fact, these disorders can occur exclusively in presence of the related Quantum Biophysical Constitutions (2-8, 23-25, 48).
In the course of efficacious therapy, e.g., with selective serotonin reuptake inhibitors, both neuronal and cerebral evoked potentials, now-a-days assessed at the bed- side with the aid of Quantum Biophysical Semeiotics in reliable way, have to ameliorate clearly (49, 50).
In addition, under identical condition, cerebral microcirculatory functional reserve improves statistically (2-8, 10, 23-25), when bedside assessed with the aid of SPBM, i.e. "Single Patient Based Medicine" (24, 48, 49).

Melatonin Deficiency: the Link between Insonnia, Night Shift and Cancer.

In a large literature, the link between night shift, insomnia and cancer are largely described, although till now Authors mainly ignore the existence of Di Bella's Oncological Terrain, I suggested since a decade as a the condition sine qua non of malignancy (2-10).
In 2001, in a large, and interesting prospective cohort study of shift-work and breast cancer, the risk of breast cancer was statistically significantly elevated in postmenopausal women who worked for 30 or more years on rotating night shifts, compared with those who never worked at night. (51)
A few years later, in 2009, it was reported that women in Denmark, who developed breast cancer after many years of working night shifts, received compensation despite only limited research supporting the link. Out of 78 cases notified to the national board of industrial injuries in Denmark, 38 have received compensation through their employers' insurance schemes.
All of the women had worked night shift patterns for at least 20 years and were otherwise at low risk – they had low alcohol consumption and no family history of breast cancer. The Danish decision was based on a ruling by the International Agency for Research on Cancer (http://www.iarc.fr/) in December 2007 which stated that "shift-work that involves circadian disruption is probably carcinogenic to humans."
Despite Oncological Terrain was overlooked, other experimental studies have indicated the majority of totally blind people whereby melatonin is never suppressed by light exposure since most totally blind women are not receptive to light, could be protected from cancer through this mechanism.
Richard Stevens, Ph.D., cancer epidemiologist at the University of Connecticut Health Center, Farmington, Conn., and colleagues published a study in the British Journal of Cancer that found breast cancer risk decreased by degree of visual impairment, from moderate low vision to totally blind. "It was initially thought that blind women might have a greater risk of developing breast cancer because some studies have reported that they have earlier menarche and delayed child-bearing age, both of which have been seen to increase the risk of breast cancer in women," R. Stevens said. "Yet these women have been found to have a lower risk of developing the disease." They concluded that this suggests a dose-response relationship between visible light and breast cancer risk (52).

Conclusion.

The results of my research, emphasising the insomia as another sign of Di Bella's Oncological Terrain, need certainly to be further corroborated on a sufficiently large scale. However, on the base of their concordance, my results allow to state that Melatonin deficiency is the link between insomnia and Di Bella's Oncological Terrain.

As a consequence, in the treatment of insomnia, physicians have to prescribe drugs, as well as physical therapy (e.g., patches emitting energy concordant with biological systems, as epiphysis and SCN), aiming to normalize melatonin tissue level in diencephalic hypothalamic nuclei and epihysis, utilizing therapy able to transform Oncological Terrain into its "residual" variant, which prove to be no dangerous (51).
To insomnia therapy with drugs and physical treatment normalizing melatonin tissue level, I shall dedicate a next paper.

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Bedside Detecting Oesophagus Inherited Oncological Real Risk .

I find really interesting the article "Dysphagia and an oesophageal stricture; not always cancer"K J Woittiez, W R ten Hove, J T M van der Heyden.
However, such as diagnosis is facilitated enormously if physicians could know Quantum Biophysical Semeiotics (www.semeioticabiofisica.it, www.sisbq.org).

In my view, based on 55 year-long clinical experience, doctors around the world have to know new and more efficacious screening types for malignancies, easy to perform on very large scale and reliable in ascertain also oesophagus cancer Oncological Terrain-Dependent, "inherited real risk" in well defined site of the oesophagus, or cancer initial stage in individuals always involved by oncological terrain, of course (1).

In fact, nowadays a new bed-side preventive medicine can be applied by all general practitioners worldwide in an efficient and practical manner (1-9) (See my site www.semeioticabiofisica.it, Biophysical-Semeiotic Constitutions, as well as Practical Applications
http://www.semeioticabiofisica.it/semeioticabiofisica/Documenti/Eng/Ernia%20Jatale_eng.doc).
As a matter of fact, nowadays, physicians, who knows the progresses of physical semeiotics, can recognize since birth clinically individuals at "inherited real" risk of malignancy, both solid and liquid, including their precise location (1, 2).
In following, I describe briefly an original physical sign, reliable in recognizing "inherite real risk" of oesophageal cancer, and thus usefull in primary preventing it, as well as in bed-side early detecting oesophagus Cancer, i.e. since very early stage, including Cancer "in situ" (1).
In health, lying down on supine position and psycho-physically relaxed with open eyes (=to lower melatonin secretion), a lasting cutaneous pinch at the level of oesophageal thoracic dermatomere, at right or left, brings about gastric aspecific reflex (in the stomach both fundus and body dilate, while antral-pyloric region contracts = tissue acidosis; see above-cited site, Technical Pages, n° 1), after a latency time (lt) of 8 sec.
The reflex lasts less than 4 sec. (paramount parameter value, which parallels local Microciirculatory Functional reserve) and then disappears for >3 < 4 sec., which informs on fractal dimension of local microvessel fluctuations. All parameters values are interesting from diagnostic point of view.
On the contrary, in case of oesophageal Cancer, even in initial stage, lt is < 8 sec., reflex duration 4 sec. or more and finally the entire stomach, soon theafter the reflex, contracts: Gastric tonic Contraction (GtC). This is a "pathological" parameter, typical of malignancy.
All parameters values, indicating local oesophageal micorcirculatory abnormalities (1-7), are in relation to the severity of underlying malignancy.
For instance, lt. becomes shorter than the normal 8 sec. in inverse relation to the exstension of tumour. Very useful and reliable (I perform it during physical examination, i.e., in every case, routinely) is the biophysical semeiotic "preconditioning" of oesophagus: after 5 sec. exactly of interval after the basal performance,doctor applys this method a second time (interval must be 5 sec. precisely, due to oesophageal microcirculatory functional reserve (MFR) activation):
in health, where there isn't GtC., all parameters value ameliorate significantly: e.g., latency time results 16 sec., i.e., a doubled value.
On the contrary, in oesophageal cancer, since first stages (even "in situ" cancer), as well as in "inherited real risk" of cancer, they worsen clearly or persist identical in latest case (1-11) .

Finally, thanks to Quantum Biophysical Semeiotics, in health, "intense" digital stimulation of a SINGLE oesophageal trigger-point, for instance the cutaneous pintschingat the immediately above sternum, aloong the middle line, does not cause "simultaneously" stomach modification, allowing doctors to exclude oesophagus disorder of whatever nature in less than one second!
On the contrary, in case of oesophagous Inherited Oncological Real Risk or overt cancer, since its initial stage, we observe above-illustrated stomac size changes, followed by characteristic tonic Gastric Contraction.
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Kidney Disease Inherited Real Risk. 2011-03-05 14:47

To rightly evaluate possible beneficial action of renin-angiotensin blockade in preventing kidney diseases, physicians have to know as well as bedside recognize kidney disease inherited real risk (1-8). In fact, such overlooked congenital real risk represents the "condition sine qua non" of kidney disorder, different in nature.

As a consequence, renin-angiotensin blockade must be happen in individual properly enrolled, because kidney disorders will never occur in absence of renal inherited real risk. In addition, it is generally admitted that early diagnosis is the conditio sine qua non of the best therapeutic results. Unfortunately, renal disorders, including cancer, and other less common disorder of urinary tract are mainly recognized later, since for years or decades they are silent from the clinical view-point. The following easy manoeuvre plays a central role also in recognizing renal inherited real risk. In health, "light-moderate" persisting stimulation by cutaneous pintching of renal trigger-points, i.e., VIII-X thoracic dermatomeres (= lateral abdominal quadrants), after exact 8 sec. latency time, brings about aspecific gastric reflex: in the stomach, both fundus and body dilate, while antral-pyloric region contracts: www.semeioticabiofisica.it. Reflex duration lasts LESS than 4 sec.: such as parameter value, paralleling local Microcirculatory Functional Reserve, plays a paramount role in bedside excluding Renal Cancer, as well as all other kidney diseases, even in its first stage of inherited real risk, characterized by newborn-pathological, type I, subtype a) oncological, and b) aspecific Endoarteriolar Blocking Devices (6-8). On the contrary, in individual involved by Inherited oncological or aspecific Kidney Real Risk, including urinary way cancer, the identical stimulation causes aspecific gastric reflex, showing normal latency time (NN = 8 sec.), BUT its duration is 4 sec. or more, i.e. pathological.

Really, these two parameter values are inversely and respectively directly related to the seriousness of underlying disorders. Immediately there after, in oncological real risk only, one observes tonic Gastric Contraction, typical of tumoural lesion: Pollio's Sign.

Interestingly, when renal trigger-points stimulation is "intense", due to non local realm of biological system (8-10), all components of urinary tract are "simultaneously" stimulated: in health, reflex latency time raises from 8 sec. to 16 sec., because locally free energy is increased, due to type I, associated, microcirculatory activation (3-7). Interestingly, in subject involved by both Oncological Terrain and Inherited Oncological Real Risk in whatever part of urinary system (kidney, urinary bladder, and prostate), "intense" stimulation of a UNIQUE trigger-point causes "simultaneously" intense aspecific gastric reflex, immediately followed by great tonic Gastric Contraction: Pollio's Sign, which surely will play a paramount role in RC as well as in urinary tract malignancies primary prevention. Subsequently, physicians will localized tumoural lesion with the aid of a lot of biophysical-semeiotic signs (1-7).

Pollio's Sign. In memory of my dear friend, Fabrizio Pollio MD, brilliant gynaecologist surgeon, dead at age of 34 years for renal cancer.

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Functional Decline in Aging and Co Q10 Deficiency Syndrome.

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In following, I would like emphasise briefly the central role of these quantum-biophysical-semeiotic-Constitution-Dependent, Inherited Real Risk of Brain also in aging people disease occurrence,especially if Co Q10 deficiency is present.

In my opinion, bedside quantum-biophysical-semeiotic diagnosis of Co Q10 deficiency syndrome, I have described earlier (1-5), and the topic of above-cited Letter to Editors, could be very helpful in risk stratification to predict functional decline in Older Adults.

In fact, I have demonstrated that doctors can clinically recognize with the aid of a stethoscope subjects involved by Ubidecarenone deficiency, even initial and symptomless, causing damage of tissues due to the increase levels of free radical (1-5).

Moreover, in my 55-long clinical experience, such as diagnosis, made clinically for the first time, proved to be really efficacious and reliable in avoiding dangerous administration of statine to individuals without clinical symptomatology, even involved by ubidecarenone deficiency, notoriously worsened by anti-cholesterolemic drugs.

In addition, physicians are able to recognize since birth whatever Constitution-Dependent Inherited quantum-biophysical-semeiotic Real Risk, including oncological, diabetic, and Alzheimer Disease one (5-8), based on microvascular remodelling, characterized by newborn-pathological, type I, subtype a), oncological, and b) aspecific Endoarteriolar Blocking Devices, which predispose to the related disorders.

Finally, only individuals with inherited cerebral quantum-biophysical-semeiotic Inherited Real Risk (5) may be involved by functional decline, like Alzheimer Disease (8), particularly in presence of Co Q10 deficincy syndrome.

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