Presomatic Syndrome

- disease in formation -

The term Presomatic Syndrome (PSS) refers to an early developmental phase of any process of *dis-ease*. It is the stage of illness formation characterised by mild functional disturbances, when routine medical tests still show no signs of discernible diagnosis. PSS manifests as a combination of mild, transient and non-specific symptoms and signs, which typically include: pain and aches, tiredness, insomnia, apathy, anxiety, depression, emotional conflicts; tendencies towards diarrhoea, constipation, indigestion or frequent urination. This complex and variable dysfunctional syndrome is successfully treated by Bioregulatory Medicine, since its open biological systems approach addresses both PNEI (Psycho-Neuro-Endocrine-Immune meta system) and Ground Regulating System. Such multi-targeted bioregulation prompts harmonious cellular signalling, which in turn strengthens one's overall health. Bioregulatory treatment of Presomatic Syndrome involves: re-hydration, re-mineralisation, detoxification and alkalisation of individual 'biological terrain'; improvement of oxygenation, circulation and innervations; manual release of restricted bodily parts; liberation of suppressed emotions, optimisation of cognitive processing and belief systems, as well as balancing of diet, microbiome, bioresonance and the flow of bioenergy. As conventional medicine does not treat non-recognised diseases, nor does it educate doctors how to medicate by means of a drug-free medical approach, this most common pathological condition that precedes all acquired diseases is usually blamed on stress and treated by tranquillisers - or it is simply overlooked and left therapeutically ignored.

PSS as the Last Preventative Call

Contrary to the meaning of prefixes and suffixes forming the words **patho**logy, **patho**physiology and **patho**histology, none of these medical sciences acknowledge the

archetypal evolution of the pathognomonic force, referred in medical literature as the '**Pathos'**. Yet, regardless of official diagnoses, this illness formative process or *dis-ease* process always has two distinctive phases of development: presomatic phase and a clinically detectable or somatic phase. Both presomatic and somatic stages of pathologic development also tend to evolve through different stages. Starting with bioelectrical, biochemical and psychological changes of early pathognomonic stages, this *dis-ease* process has a tendency to further progress towards dysfunctional, inflammatory, degenerative and malignant pathologies. The term Presomatic Syndrome was introduced by Dr Tatyana Bosh, MD - to define the **dysfunctional stages of any *dis-ease* formative process.** These are phases of an illness when physical manifestations of any specific allopathic disease are still absent, and medical tests usually show no significant results - regardless of numerous signs, tendencies or symptoms suggesting hyperfunction, hypofunction or even dysfunction present in various bodily parts. **Within the context of an evolving process of *dis-ease*, PSS represents the last preventative call - demanding immediate bioregulatory therapeutic measures.**

PSS as Precursor of All Acquired Diseases

PSS is a **state of preventative medical emergency**, where harmonious function of the psycho-physiological 'biological terrain' is disrupted or perturbed, with consequent involvement of compensatory mechanisms. Once physiological compensations fail or get exhausted, **somatisation** begins, which is the time when a specific disease becomes detectable.

Presomatic Syndrome symbolises a 'red light' - announcing that the button for manifestation of a disease has been switched on. The sufferer becomes a prime candidate to 'suddenly' develop a physical illness (somatic disease) - and yet she or he is completely unaware of it. Sadly, in a majority of cases the GP is not aware of it either, which is why this prime time for bioregulation of health is routinely lost. Along with it, the opportunity to prevent, minimise or slow down oncoming somatic disease also passes by, unrecognised and therapeutically neglected.

PSS is a **precursor to all acquired somatic diseases,** be they acute or chronic; dysfunctional, inflammatory, degenerative, benign or malignant. It represents a common denominator of a variety of seemingly unrelated pathologies, such as: flu, measles, dermatitis, arthritis, MS or cancer. Naturally,

PSS preceding a common cold radically differs from PSS that precedes acute colitis or cancer; where **specificity, intensity and persistency of each individual PSS define the nature of oncoming disease.** The relevance of a detailed understanding of this important illness-formative stage can not be emphasised enough since **- if PSS is therapeutically addressed, many diseases can be timely prevented.**

PSS as Hyper, Hypo and Dysfunction

During stages of a disease process characterised by functional disturbances, PSS **initially manifests as a hyper or hypo function** of various parts of the body-mind continuum. It is **usually a hyperfunction that sets in first**, while hypofunction tends to follow, once that specific part of the biological terrain gets exhausted.

Due to involvement of compensatory mechanisms or *homeostasis*, hyper and hypo functions **manifest mildly and sporadically at first**. Consequently, most PSS symptoms initially tend to come and go. The more these body signals for help are left ignored and compensatory mechanisms are worn down, the more the **symptoms increase in their frequency and intensity. In time, different symptoms start appearing too. These tend to be of a more dysfunctional nature, which is in sharp contrast to initial hyper or hypofunction.** For example, a tendency towards anxiety may induce diarrhoea, which in time tends to alternate with periods of constipation. If peristaltic movements are not timely regulated, e.g. by improvement of stress management; further progression of 'Pathos' frequently reaches a momentum when mucus or even blood may start regularly appearing in the faeces. Hence, once a threshold necessary for physical changes of tissues is reached, somatisation begins and becomes detectable by routine medical tests.

PSS's Meta-Systemic Origin

Unlike somatically developed diseases, Presomatic Syndrome is rarely, if ever, allocated only to one specific physiological organ or system. Due to its meta-systemic aetiology and involvement of PNEI - **it typically manifests as a mixture of symptoms from several disorderly physiological organs or systems.** As targeted tissue(s), organ(s) and/or organ system(s) begin to hyperfunction or to

hypofunction, a manifestation of seemingly unrelated symptoms and signs follow, including: backache, headaches, indigestion insomnia, frequent urination and mood swings. A typical and perhaps the most common PSS would involve experiencing muscular pains and aches, feeling of apathy and exhaustion, having frequent urges for urination and irregular bowel movements, bloatedness and cravings, while being dissatisfied with one's private or professional life.

PSS's Symptoms and Signs

Although PSS symptoms and signs may demonstrate a variable level of intensity, they can all be categorised in general as hyper, hypo or a dysfunction of various bodily parts, organs and systems. Some of the most typical presomatic manifestations are presented below, listed within their correlated physiological systems:

Psycho-Neurological Presomatic Symptoms: irritability, apathy, exhaustion, tiredness, tendency towards mood swigs, anxiety, depression, fearfulness or panic, ticks, insomnia, lack of purpose, etc; yet not fully developed picture of psychiatric or neurological diseases e.g. neurosis, psychosis, Parkinsons etc…

Endocrine Presomatic Symptoms: painful, irregular, sluggish or excessive periods, difficulties to conceive, excess or loss of libido, sugar level oscillation, subclinical hyperinsulinemia, sluggish metabolism etc; yet not fully developed uterine fibroids, sterility, diabetes, hypothyroidism, etc…

Presomatic Symptoms of Skin and Appendages: tendency towards very dry or very oily skin, isolated dry patches, dandruff, itchiness and spots, excess or lack of sweating; horizontal ridges, vertical ridges and white spots on the nails; yet not fully developed eczema, acne, etc…

Musculoskeletal Presomatic Symptoms: localised or generalised aches and pains, like headaches, neckaches, backache, etc; not yet developed sciatica, spondiloarthritis, etc…

Respiratory Presomatic Symptoms: stress related breathing difficulties, repeated spasmodic cough, pain and discomfort in the chest, frequent hiccupping and sighing, etc; not yet developed organic dyspnoea, bronchitis, bronchiectasis etc…

Cardiovascular Presomatic Symptoms: precordial aches and pains, palpitations, cold extremities, localised mild congestion and oedema, etc; not yet defined clinical picture of any allopathically established cardiovascular pathology.

Digestive Presomatic Symptoms: mild and repeated nausea, tendency towards diarrhoea or constipation; indigestion, bloatedness, cravings, pain and discomfort in the bowels, etc; oncoming but not yet allopathically detectable digestive pathology, further than nervous bowels or IBS is discernible.

Uroreproductive Presomatic Symptoms: pain and discomfort in the region, frequent urination, painful intercourse, etc; with no clear medicinal indications, and poor results when treated with conventional medications.

Sensory Presomatic Symptoms: tendencies towards mild dizziness, occasional tinnitus or nasal congestion; refractory anomalies, floaters and similar occasional visual disturbances etc; and again, no allopathic physically diagnosable lesions are found in the examined sensory apparatus.

PSS as Restriction of Biological Terrain

Regardless of differences in aetiology and clinical manifestation, **all acquired somatic diseases have a 'common denominator',** long before actual manifestations, which is – a need for change of one's habitual way of being and self-expression. Early common origin can be later physically traced as **variable presomatic symptoms and signs, and firmly established specific patters of physical tension.**

During early formative stages of the illness process, psychologically induced tension in musculo-connective tissues tends to progressively grow. Over time it frequently establishes **a very distinctive and specific pattern of restriction - Chronic Patterns of Restrictions (CPoR);** which irritates local nerves and compresses nearby blood and lymphatic vessels, organs and endocrine glands. All devitalised parts of the biological terrain become '*locii minoris resisteniae',* capable of orchestrating a variety of clinical symptoms.

CPoR is the corporal equivalent of PSS. It typically involves congested and stagnant lymph flow and disturbed cerebrospinal fluid fluctuation, soft tissues' entrapment of the vagus nerve, spastic lateral

neck muscles with consequently constrained thyroid and parathyroid glands and correlated hormonal imbalances (e.g. related to production of thyroxin or calcium metabolism); shallow breathing as a result of diaphragmatic hypertonicity, asynchronised peristaltic movement due to the spasm of visceral muscles etc. Those are just a few among many corporal restrictions typically found in PSS sufferers, at the time when their GPs and consultants are routinely considering those people to be 'well and healthy'.

PSS Pandemic

Facilitated by a stressful lifestyle, PSS is rapidly spreading, and it is already taking on pandemic proportions. Although it would be fair to say that PSS is currently the most common pathological condition in the world, it is unfortunately rarely treated or therapeutically approached, ether by conventional or alternative practitioners.

Allopathic Treatment of PSS

Although any 'official' disease may still be absent, cumulative impact of presomatic symptoms and signs can easily turn a PSS sufferer's life into misery. A majority of patients spend weeks and months, sometimes even years visiting their GPs; and describing their problems in a typically very detailed manner. Their GPs usually direct them to undergo various diagnostic procedures, frequently exposing them to x-rays and CT scans - only to conclude how healthy they actually are. These statements, contradictory to how they feel, bring additional frustration to PSS patients, **making them feel even more helpless**. Meanwhile, their problems are increasing while their health continues to deteriorate. This vicious circle commonly reaches a stage where PSS patients are unnecessarily treated with aggressive medication, such as steroids and tranquillisers; or become 'labelled' as hypersensitive, hypochondriacs or neurasthenics. Sadly, after loosing valuable time for bioregulation of disturbed homoeostasis and timely prevention, in a majority of cases somatic pathologies eventually 'set in'.

PSS is a very **frustrating situation for doctors** too. As much as they are aware of their patients' sufferings, and may even empathise deeply; conventional medical education simply does not equip contemporary doctors with an understanding of how to treat the 'non-diagnosable *dis-eases*'. Consequently, in dealing with patients suffering PSS doctors inevitably feel professionally frustrated to

a certain degree, being expected to successfully treat conditions that are neither specific, nor developed or persistent enough to be officially classified and diagnosed, which is a precondition for prescribing conventional therapy. Physicians are then faced with a dilemma whether to overmedicate by prescribing drugs that are not even fully indicated (risking possible iatrogenic side affects and legal actions); or whether to just keep on searching, in hope that diagnostic tests will eventually help differentiate whatever the condition could be. The second option also helps to hide professional frustration behind a wide range of diagnostic procedures on offer, which are then pursued long enough for a disease to eventually fully develop. This is when those patients are considered to be 'successfully and properly diagnosed', and their problems finally 'solved'.

Apart from this objective dilemma, PSS also faces doctors with a subjective dilemma – a psychological problem that arises in situations where they have to protect their professional integrity. PSS is a very challenging situation for the typical medical ego, which has been historically and socially conditioned towards 'over-inflation'. After generations of educational and social priming of physicians, identifying with the omnipotence of a 'God-like-figure', doctors are now called to therapeutically solve a relatively simple condition, for which they have never been trained. From this point of view, it doesn't come as a surprise that the majority of PSS symptoms are routinely blamed on stress, since stress offers an easy way out of this unpleasant situation. It provides doctors with an opportunity to preserve full professional integrity, without taking any curative action. Consequently, it is not uncommon practice for nothing to be done for therapeutic resolutions of PSS.

Regardless whether those patients are therapeutically neglected, referred to diagnostic investigations; put on palliative medication, such as tranquillisers or painkillers; diagnosed as hypochondriacs and neurasthenics; or perhaps just considered to be hypersensitive when stress is blamed for all their sufferings - the sad truth remains: **contemporary physicians are not able to cure PSS, as they are simply not trained to treat it.**

Alternative Treatment of PSS

After losing trust in conventional medicine, many PSS patients turn to complementary and alternative medicine (CAM) instead. Paradoxically, although no individual CAM discipline addresses PSS in its totality, alternative therapists are often more equipped to treat PSS, as majority of CAM disciplines are

principally self-regulatory (homeostatic) methodologies. This is probably the major reason behind increased popularity of alternative medicine in recent years. Unfortunately, many physicians still 'turn a deaf ear' to CAM therapies. In this silent war between allopathic and non-allopathic medical worlds, there is a tendency for the CAM movement to blame physicians' professional arrogance for a lack of co-operative work. On the other hand, a doctor's tendency to ignore professional opinions of CAM therapists is usually justified by **insufficient or inconsistent academic standards of CAM practitioners**.

Bioregulatory Treatment of PSS

The inability of a majority of CAM therapies to express their knowledge in customary medical terminology is overcome by Bioregulatory Medicine. It was established and run by **physicians experienced in CAM therapies** and medically eloquent enough to come forward with a coherent, scientifically justifiable and evidence based - drugless therapeutic proposal.

Bioregulatory Medicine is a multidisciplinary therapeutic approach that proposes **a health-centred system of preventative and regenerative medicine.** This new medical paradigm is in agreement with contemporary allopathic medical science, but **shifts the emphasis from treatment of diseases towards strengthening of patients' health**. It places medical sciences within the concept of Open Systems Theory and Systems Biology, suggesting a multifactorial therapeutic approach that matches an open-flow of bio-information within living systems. Its major therapeutic objectives are the **elimination of disruptions on physiological network systems, and the stimulation of self-regulatory mechanisms -** also known as homeostasis. The concept was postulated in the mid-nineties by Dr Tatyana Bosh, MD and Damir Shakambet MD.

One of the objectives of Bioregulatory Medicine is to explain and demonstrate a successful therapeutic modus operandi for the treatment of PSS. Patients suffering PSS **are re-hydrated, re-mineralised, nourished and detoxified appropriately; their restricted body parts are detected, manually released and restructured so that better oxygenation and innervations of the affected parts can take place; while their microcirculatory parameters are improved, along with pH status and regulation of the microbiome. At the same time, suppressed emotions are recognised, liberated and integrated in a more 'bio-economically' viable way, so as to adopt a more positive and**

psychological framework in dealing with stressful situations. This version of a **human MOT'** is based on specific bioregulatory therapeutic methodology, referred to as **Bioregulatory Psychosomatic Bodywork** (BPSB), which is frequently applied in conjunction with indicated homeotherapeuticals, nutritherapeuticals and herbotherapeuticals. BPSB is a multifaceted therapeutic approach specifically integrated to meet the needs of a patient's biological open system, and to deliver PSS sufferers back to health.

When PSS patients are approached as an open biological system, where cumulative impact of their health disruptors are recognised and eliminated, while affected aspects of health are timely therapeutically supported – it seems to be fairly easy to achieve optimal therapeutic results and restore one's health fully. Unfortunately, toxo-synergy of a multitude of health disruptors is rarely conventionally addressed, while the importance of facilitation of each health factors and their influence of harmonious allostatic interplay is routinely overlooked. Consequently, whenever PSS's multifactorial aetiology is ignored, while the condition is approached in a linear way of cause and effect like other 'standardised diseases'– it only turns into yet another incurable condition.

Dr Tatyana Bosh, MD; London 2010