CFS/ME, FM: THERAPEUTIC TEST AND FIRST TREATMENT SCHEME FOR PATIENTS WITH CHRONIC FATIGUE AND BRAIN FOG TO ASSIST THE DIAGNOSIS OF PERSISTENT CLOTS AND HYPOPERFUSION.

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CFS/ME, FM:

THERAPEUTIC TEST AND FIRST TREATMENT SCHEME FOR PATIENTS WITH CHRONIC FATIGUE AND BRAIN FOG TO ASSIST THE DIAGNOSIS OF PERSISTENT CLOTS AND HYPOPERFUSION.

For patients with Chronic Fatigue Syndrome, Myalgic Encephalomyelitis, Fibromyalgia, Persistent Symptoms of COVID, Chronic Lyme, Herpesvirus, EBV, Bartonella, Babesia, Enterovirus, Coxsackievirus, HPV, Gulf War Disease, Alzheimer's and, other Diseases that present Chronic Fatigue and Brain Fog.

Aguirre-Chang, Gustavo and Trujillo Aurora. ResearchGate. October 23, 2021.

BACKGROUND

The symptoms of Chronic Fatigue and Brain Fog are associated more frequently with Endothelial Dysfunction and less Blood Flow.

Chronic Fatigue Syndrome (CFS) affects many people, and often in addition to fatigue, patients present with various neurological symptoms known collectively as Brain Fog.
Several studies have been published in which it is evidenced that, both in Chronic Fatigue Syndrome (CFS) and in the so-called Brain Fog, there is less blood flow and / or long-term dysfunction (inadequate functioning) at the level of the cells that make up the walls of blood vessels (endothelial cells and pericytes) *[1-4]*.

Subgroup of CFS/ME associated with Endothelial Dysfunction and Persistent Clots.

Our approach is that Chronic Fatigue Syndrome and Myalgic Encephalomyelitis (CFS/ME) include several Subgroups according to their pathophysiology and the causes that originate the symptoms, and most of the cases of CFS/ME correspond to a Subgroup in which there is an inadequate functioning of the blood vessels, more specifically a dysfunction of the endothelial cells, which in a high percentage is accompanied by a lower blood flow and a state of long-term hypercoagulability, with the presence of persistent clots that are attached to the vascular walls and also circulating intravascularly.

Other Subgroups of CFS/ME.

There are other Subgroups within CFS/ME, such as that associated with Dysbiosis, SIBO or alteration of the Intestinal Microbiota, a situation in which D-Lactate is increased. There are also Subgroups associated with Vitamin depletion (especially B complex) and Subgroups associated with decreased hormones (especially thyroid and adrenal).
It should be taken into account that patients with CFS/ME can frequently present symptoms associated with several of the Subgroups of CFS/ME, being frequent that they present at the same time Endothelial Dysfunction, Dysbiosis or SIBO, and vitamin B complex depletion

Endothelial dysfunction and persistent clots cause tissue hypoperfusion.

Long-term dysfunction of the blood vessel walls and the presence of persistent clots causes a decrease in the perfusion of fluids from the bloodstream to the cells and tissues, which is called tissue hypoperfusion, which implies a lower contribution to cells and tissues of:

- Oxygen (generating cellular hypoxia).
- Vitamins.
- Nutrients.
- Hormones.

- Other substances.

Long-term tissue hypoperfusion affects the normal functioning of organs and systems, especially those that require a greater supply of oxygen and nutrients, which are mainly the musculoskeletal system, the brain and the lungs.

Endothelial Dysfunction, Persistent Clots, and Hypoperfusion are not detectable with routine exams.

The inadequate functioning of endothelial cells (endothelial dysfunction) and tissue hypoperfusion cause various organs and systems to not respond adequately when they are required, but it is a problem in the functioning that usually does not produce obvious tissue damage This is why most of the ancillary tests that are ordered routinely tend to be normal, such as X-rays, CT scans and routine laboratory tests.

Persistent Clots as a Cause of Hypoperfusion and Hypoxia.

We have suggested that the main cause of tissue Hypoperfusion and cellular Hypoxia is due to the presence of persistent clots, which are characterized by having a high fibrin content *[5,6]*. On the one hand, adhered or fixed clots, as they are covering the wall of the blood vessels, create a layer or wall that reduces the perfusion of oxygen and substances from the blood to the tissues, and on the other hand, hypercoagulability and clots to Intravascular level they generate a slow blood flow which leads in the same way to a lower supply of oxygen, nutrients and other substances to the different tissues of the organism

Persistent bioclots as a refuge for viruses and other microorganisms.

We have also explained that viruses and other organisms that cause persistent intracellular infections take refuge in persistent clots that are high in fibrin *[7,8,9,10]*. Because these clots perform similar functions to Bioflims, we have named them Bioclots.

SYNDROMES AND PERSISTENT INFECTIONS PRESENTING CHRONIC FATIGUE AND BRAIN FOG.

There are several syndromes and a set of chronic or persistent symptoms that present Chronic Fatigue and Brain Fog.

The most frequent and well-known are named below:

- Chronic Fatigue Syndrome (CFS).
- Myalgic encephalomyelitis (MS).
- Fibromyalgia.
- Persistent symptoms of COVID, Long COVID, Chronic COVID or Long haulers.
- Gulf War Syndrome or Disease.
- Chronic depression.
- Alzheimer's disease and dementias.
- Psychosis and Schizophrenia.

On the other hand, several chronic diseases caused or associated with Persistent Intracellular Infections, present Chronic Fatigue and Brain Fog.

The most frequent and known are:

CHRONIC OR PERSISTENT VIRAL INFECTIONS:

- Infections caused by viruses of the Herpesviridae family:
  - Herpes simplex 1 and 2 (HSV-1, HSV-2).

  - Herpes zoster (VVZ).
  - Epstein-Barr virus (EBV).
  - Cytomegalovirus (CMV).
  - Herpesvirus 6 and 7 (HHV-6 and HHV-7).
  - Herpesvirus 8 (HHV8) or Kaposi's Sarcoma virus.
  - Other viruses in the family.
- Persistent infection by SARS CoV-2 (Chronic COVID, Long COVID, Long haulers or Persistent COVID).
- Enterovirus.
- Coxsackievirus.
- Human Papillomavirus (HPV).
- Human parvovirus B19.
- Nile virus infection and others.

BACTERIAL INFECTIONS AND BY OTHER MICROORGANISMS:

- Chronic Lyme disease (caused by the bacteria Borrelia burgdorferi and Borrelia mayonii).
- Bartonellosis (caused by the gram-negative bacteria Bartonella).
- Babesiosis (caused by the protozoan Babesia).
- Ehrlichiosis and Anaplasmosis (caused by bacteria of the rickettsiae family: Ehrlichia and Anaplasma).
- Other Rickettsiosis (they are intracellular pleomorphic bacteria).
- Chronic Chagas disease (caused by the Trypanosoma cruzi parasite).
- Mycobacterial diseases and others.

In all these Syndromes and Persistent Infections that present Chronic Fatigue and Brain Fog, there may be endothelial dysfunction, persistent clots and tissue hypoperfusion, for which we recommend D-Dimer analysis and Venous Blood Gas Measurement, and the application of the Therapeutic Test and First Treatment Scheme to aid in the diagnosis of Persistent Clots and Hypoperfusion.

D-DIMER ANALYSIS FOR THE DIAGNOSIS OF PERSISTENT CLOTS.

D-dimer is a breakdown product of fibrin, which is the main component of persistent clots. It is generally accepted that the normal value is less than 0.5 ug/ml.

The D-dimer is considered a sensitive test, and it rises within a few hours of initiating the breakdown of clots.

Elevated D-dimer in CFS/ME.

If an elevated D-dimer is identified in a patient with CFS/ME and Brain Fog, it is interpreted that there is the presence of clots.

The higher the D-Dimer is, it is interpreted that the breakdown of a greater number of clots is taking place.

Normal or slightly increased D-dimer in CFS/ME.

It should be clear that the D-dimer does not measure the formation of clots, what it measures is the decomposition or fibrinolysis of the clots present in the body.

So, if there are persistent clots, and the CFS/ME patient is not taking any medications, supplements, or foods with anticoagulant or fibrinolytic effect, the D-dimer may turn out to be normal or only slightly increased.

MEASUREMENT OF VENOUS BLOOD GASES TO ASSIST THE DIAGNOSIS OF HYPOPERFUSION.

A simple, accessible and inexpensive test, which serves as an aid to the diagnosis of tissue Hypoperfusion, is the Venous Oxygen Saturation (SvO2 or Sat vO2) blood test, for which it is required to request the patient a Measurement of Venous Blood Gases, since SvO2 is part of this auxiliary test.

Venous Blood Oxygen Saturation (SvO2) is also known as Venous Oxygen Saturation or Mixed Venous Saturation.

SvO2 tells us what is the level or amount of oxygen in the blood when it returns to the heart. A low SvO2 value may indicate a lower intake (supply) or higher demand (consumption) of oxygen. When there is tissue hypoperfusion, the supply of oxygen to the tissues by the blood is decreased, and this is associated with a decreased SvO2.

However, it must be taken into account that several patients with CFS/ME may have normal SvO2.

Lactate (or Lactic Acid) and Pyruvate.

They are other tests that are recommended to perform, since their elevation is correlated with a state of cellular hypoxia.

THERAPEUTIC TEST TO ASSIST THE DIAGNOSIS OF PERSISTENT BIOCOAGULES AND HYPOPERFUSION.

If a patient with persistent clots is given medications or supplements with fibrinolytic, anticoagulant and/or antiplatelet effects, these will cause the clots to break down, which in turn will cause a significant elevation of the D-dimer.

Taking into account the aforementioned, we have developed a Therapeutic Test to aid in the Diagnosis of Persistent Bioclots and Tissue Hypoperfusion.

Objectives of the Therapeutic Test for Persistent Bioclots and Hypoperfusion.

This Test has the following objectives and utilities:

1) Identify a significant elevation of the D-dimer, which would have the utility of supporting the existence of persistent clots.
2) Identify a significant improvement in the Symptoms associated with Hypoperfusion, which would have the utility of supporting the existence of tissue Hypoperfusion, which is often caused by endothelial dysfunction, presence of clots and less blood flow.
3) Identify a significant improvement in Venous Oxygen Saturation (SvO2), which would have the utility of supporting the existence of tissue hypoperfusion and cellular hypoxia, and that these findings were associated with a hypercoagulable state and the existence of persistent clots.

Sequence of activities to follow for the application of the Therapeutic Test.

For the application of this Therapeutic Test for Persistent Bioclots and Hypoperfusion, the following sequence of activities should be followed:

1) Evaluate the patient to identify if there are symptoms of Hypoperfusion and / or Hyperlactacidemia. In addition, you are instructed to suspend any medication, supplement, herb or food with an effect on clotting for at least 3 days before starting the Therapeutic Test.
2) Perform analysis of: D-dimer, Venous Blood Gases and Lactate.
3) Apply the Therapeutic Test for Persistent Bioclots and Hypoperfusion.
4) Evaluate the therapeutic response based on the clinical improvement (from 1 to 10

points) of the symptoms associated with Hypoperfusion and/or Hyperlactacidemia.
5) Perform control analysis (at least D-Dimer analysis should be performed).
6) Obtaining test results based on control analyzes.

MEDICATIONS AND SUPPLEMENTS INCLUDED IN THE THERAPEUTIC TEST FOR PERSISTENT BIOCLOTS AND HYPOPERFUSION.

Included in this Therapeutic Test are 2 medications or nutritional supplements that have the effect of contributing to the breakdown of clots.
And as a third drug, an H2 receptor blocker is included in order to reduce the risk of gastrointestinal bleeding by reducing acid production in the stomach. In addition, H2 blockers reduce inflammation due to mast cell hyperactivity and dysfunction.
So, in a generic way, this Therapeutic Test includes:

1) A drug or supplement with antiplatelet and/or anticoagulant effect.
2) A supplement that has fibrinolytic effects.
3) An H2 receptor blocker.

Table 1 shows the names of the medications or supplements included in this Therapeutic Test.

Table 1
THERAPEUTIC TEST AND FIRST TREATMENT SCHEME FOR PATIENTS WITH CHRONIC FATIGUE AND BRAIN FOG TO ASSIST THE DIAGNOSIS OF PERSISTENT CLOTS AND HYPOPERFUSION

1. **ACETYLSALICYLIC ACID (ASA) or LYSINE ACETYLSALICYLATE.**
   Alternatives that do not require a prescription: Taxifolin, Garlic, Naringin.
   Alternatives that require a prescription: Clopidogrel, Dipyridamole or Apixaban.
2. **LYSINE or SERRAPEPTASE (no prescription required).**
   Alternatives: Bromelain, Lumbrokinase, Nattokinase or Pentoxifylline.
3. **FAMOTIDINE.**
   Alternatives: Cimetidine or Nizatidine.
   Alternatives that do not require a prescription: Baking Soda (Sodium Bicarbonate), Andrews Salt or similar.

ADDITIONAL INDICATIONS:

- **If there are symptoms associated with an increase in Histamine, Allergies or MCAS, include an H1 Blocker: Rupatadine, Cyproheptadine, Diphenhydramine, Hydroxyzine or Desloratadine.**
- **Diet low in Arginine and Histamine and high in Lysine and Vitamin D. Avoid coffee, sodas, caffeinated or lactated drinks.**
- **If the patient presents an inflammatory reaction of the Herx type that cannot be tolerated, it is recommended to: suspend the medications in numbers 1 and 2, give Antimicrobial Medications and evaluate the response to the medications.**

SUGGESTED DOSAGE FOR THERAPEUTIC TEST.

Doses vary according to the patient's body weight. We have considered 3 groups of patients according to their body weight:

1) From 56 to 75 kilos, or 124 to 166 lbs, the most frequent group (see Table 2).
2) From 76 to 95 kilos, or 167 to 210 lbs (see Table 3).
3) From 45 to 55 kilos, or 99 to 123 lbs (see Table 4).
4) From 96 to 125 kilos, or 211 to 276 lbs (see Table 5).

Tables 2 to 5 describe in detail the doses of the drugs or supplements included in this "Therapeutic Test".

Table 2

THERAPEUTIC TEST AND FIRST TREATMENT SCHEME FOR PATIENTS WITH CHRONIC FATIGUE AND BRAIN FOG to assist the diagnosis of Persistent Clots and Hypoperfusion

SUGGESTED DOSAGE FOR PATIENTS WITH BODY WEIGHT BETWEEN 56 TO 75 KILOS (124 to 166 pounds).

N°	Medication/Supplem	DAY 1	DAY 2	DAY 3	DAYS 4, 5, 6	DAY 7
1	ASA (Aspirin)* or	300 mg per day. For 100 mg TB, 1 TB is indicated at breakfast, lunch, and dinner. If they are 81 mg TB: 1 TB at breakfast, 2 at lunch and 1 at dinner. For 325 mg TB: 1 TB is indicated at lunch.				RESULTS ACCORDING TO CLINICAL IMPROVEMENT, D-DIMER AND SvO2:
	LYSINE ACETYLSALICYLATE	1000 mg per day. For Sachets of 500 mg, 1 Sachet is indicated at breakfast and dinner. If they are 1000 mg sachets, 1 is indicated at lunch. For 900 mg ampoules, 1 a day is indicated.				
	Alternatives:					
	CLOPIDOGREL	1 TB of 75 mg per day			1/2 TB of 75mg/d	
	TAXIFOLIN	between 50 to 60 mg a day (1 mg/kg/day), in 2 or 3 doses a day				
	NARINGIN	500 mg at 9 am and 9 pm (1000 mg daily).				
	GARLIC	1000 mg at breakfast, lunch and dinner (3000 mg daily)				
	DIPIRYDAMOLE	1 TB of 75 mg at 7.30 am, 4 pm and 11 pm (away from food).				
	APIXABAN	7.5 mg at 9 am and 5 mg at 9 pm				
2	L-LYSINE or	500 mg at least 1 hour before breakfast (7 or 8 am) at 4pm and 11 pm (1500 mg a day)		500 mg at 7 am, 11.30 am, 5 pm and 11 pm (2000 mg daily, take away from food)		The result is POSITIVE if there is: a) Clinical Improvement of Chronic Fatigue and Brain Fog of 3 out of 10 points, or more (30% or more improvement); and/or b) D-dimer rises more than 30%; and/or c) Venous Oxygen Saturation (SvO2) improves significantly. The result is NEGATIVE if there is no clinical improvement in fatigue, the D-dimer does not rise, nor does the SvO2 improve significantly.
	SERRAPEPTASE	20 mg or 40000 SU at 11 am and, 10 pm (away from food)		40 mg o 80000 at 11 am and, 20 mg at 10 pm (away from food)		
	Alternatives:					
	BROMELAIN	500 mg at 8 or 9 am only		500 mg at 11 am and at 10 pm (1000 mg daily)		
	LUMBROKINASE	20 mg at 11 am and 10 pm (away from food)		20 mg at 7 or 8 am, 4 pm and 10 pm (60 mg daily, away from food)		
	NATTOKINASE	1 capsule at 11 am and 10 pm (away from food)		2 capsules at 11 am and, 1 capsule at 10 pm (away from food)		
	PENTOXIFYLLINE	400 mg at 9 am only		400 mg at 9 am and 9 pm		
3	FAMOTIDINE	20 mg at 7 or 8 am, 3 pm and 10 pm				
	Alternatives:					
	CIMETIDINE	400 mg at 10 am and 10 pm				
	NAZITIDINE	150 mg at 10 am and 300 mg at 10 pm.				
	BAKING SODA or Andrews Salt	1/2 tsp 11am 1/2 tsp 10pm	1/2 tsp 11am 1/2 tsp 10pm	1/2 tsp 10pm	1/2 tsp 10pm	
	ADDITIONAL INDICATIONS:					
	Avoid coffee, sodas, caffeinated or lactated drinks. Diet low in Arginine and Histamine, and high in Lysine and Vitamin D.					
	If there are symptoms associated with increased histamine, allergies or MCAS, include an H1 Blocker: Rupatadine 10 mg daily; Cyproheptadine 4 mg 10am and 8 mg before bedtime; Diphenhydramine 25mg at 10am and 50mg before bed; Hydroxyzine 25 to 50 mg before bedtime					
	If the patient presents an inflammatory reaction of the Herx type that you cannot tolerate, it is recommended to: suspend the medications listed in numbers 1 and 2, give Antimicrobial Medications and evaluate response to the medications.					

Table 3

Therapeutic Test and First Treatment Scheme for patients with Chronic Fatigue and Brain Fog to assist the diagnosis of Persistent Clots and Hypoperfusion

SUGGESTED DOSAGE FOR PATIENTS WITH BODY WEIGHT BETWEEN 76 TO 95 KILOS (167 to 210 pounds).

N°	Medication/Supplem	DAY 1	DAY 2	DAY 3	DAYS 4, 5, 6	DAY 7
1	ASA (Aspirin)*	300 mg per day. When TBs are 100 mg: 1 TB at breakfast, lunch, and dinner. If the TBs are 81 mg: 1 TB at breakfast, 2 at lunch and 1 at dinner. If the TBs are 325 mg: 1 TB at lunch.		600 mg per day. When TBs are 100 mg: 2 TB at breakfast, lunch, and dinner. If the TBs are 81 mg: 2 TB at breakfast, 3 at lunch and 2 at dinner. If the TBs are 325 mg: 1 TB at lunch and dinner.		RESULTS ACCORDING TO CLINICAL IMPROVEMENT, D-DIMER AND SvO2:
	LYSINE ACETYLSALICYLATE	1000 mg per day. For Sachets of 500 mg, 1 Sachet is indicated at breakfast and dinner. If they are 1000 mg sachets, 1 is indicated at lunch. For 900 mg ampoules, 1 a day is indicated.		1500mg daily. For 500 mg Sachets, 1 is indicated at breakfast, lunch and dinner. If they are 1000 mg, 1 at breakfast and 1/2 at dinner. For ampoules of 900 mg 1 is indicated at 8am and 8pm.		The result is POSITIVE if there is: a) Clinical Improvement of Chronic Fatigue and Brain Fog of 3 out of 10 points, or more (30% or more improvement); and/or b) D-dimer rises more than 30%; and/or c) Venous Oxygen Saturation (SvO2) improves significantly. The result is NEGATIVE if there is no clinical improvement in fatigue, the D-dimer does not rise, nor does the SvO2 improve significantly.
	Alternatives:					
	CLOPIDOGREL	1 TB of 75 mg per day. It is suggested to take it at 9 am.				
	TAXIFOLIN	between 75 to 90 mg a day (1 mg/kg/day), in 2 or 3 doses a day.				
	GARLIC	1000mg at breakfast and lunch, 2000mg at dinner (4000mg/day)				
	NARINGIN	500 mg at 9 am and 9 pm (1000 mg daily).				
	DIPIRYDAMOLE	2 TB of 75 mg at 7am; 1 TB 4 pm and 11 pm (away from food).				
	APIXABAN	7.5 mg at 9 am and 5 mg at 9 pm				
2	L-LYSINE or	500 mg at least 1 hour before breakfast (7 or 8 am) at 4pm and 11 pm (1500 mg a day)		500 mg at 7 am, 11 am, 3 pm, 6.30 pm y 11 pm (2500 mg daily, take away from food)		
	SERRAPEPTASE	20 mg or 40000 SU at 11 am and, 10 pm (away from food)		40 mg o 80000 at 11 am and, 20 mg at 10 pm (away from food)		
	Alternatives:					
	BROMELAIN	500 mg at 8 or 9 am only		500 mg at 7 am, 4 pm and at 10 pm (1500 mg daily, away from food)		
	LUMBROKINASE	20 mg at 11 am and 10 pm (40mg/day, away from food)		20 mg at 11 am and 10 pm (80 mg daily, away from food)		
	NATTOKINASE	2 capsules at 11 am and, 1 capsule at 10 pm (away from food)				
	PENTOXIFYLLINE	400 mg at 9 am only		400 mg at 7 am, 3pm and 10 pm.		
3	FAMOTIDINE	40 mg at 10 am and 10 pm				
	Alternatives:					
	CIMETIDINE	400 mg at 10 am and 800 mg 10 pm				
	NIZATIDINE	150 mg at 10 am and 300 mg at 10 pm.				
	BAKING SODA or Andrews Salt	1/2 tsp 11am 1/2 tsp 10pm	1/2 tsp 11am 1/2 tsp 10pm	1/2 tsp 11am 1/2 tsp 10pm	1/2 tsp 10pm	
	ADDITIONAL INDICATIONS:					
	Avoid coffee, sodas, caffeinated or lactated drinks. Diet low in Arginine and Histamine, and high in Lysine and Vitamin D.					
	If there are symptoms associated with increased histamine, allergies or MCAS, include an H1 Blocker: Rupatadine 10 mg daily; Cyproheptadine 4 mg 8am and 3pm, and 8 mg before bedtime; Diphenhydramine 25mg at 10am and 50mg before bed; Hydroxyzine 25 to 50 mg before bedtime (according to tolerance) for no more than 10 days.					
	If the patient presents an inflammatory reaction of the Herx type that you cannot tolerate, it is recommended to: suspend the medications listed in numbers 1 and 2, give Antimicrobial Medications and evaluate response to the medications.					

Table 4

Therapeutic Test and First Treatment Scheme for patients with Chronic Fatigue and Brain Fog to assist the diagnosis of Persistent Clots and Hypoperfusion

SUGGESTED DOSAGE FOR PATIENTS WITH BODY WEIGHT BETWEEN 45 TO 55 KILOS (99 to 123 pounds).

N°	Medication/Supplem	DAY 1	DAY 2	DAY 3	DAYS 4, 5, 6	DAY 7
1	ASA (Aspirin)*	200 mg per day. When TBs are 100 mg, 1 TB is indicated at breakfast and dinner. If the TBs are 81 mg, 1 TB is indicated at breakfast, 1 at lunch and 1 at dinner.				RESULTS ACCORDING TO CLINICAL IMPROVEMENT, D-DIMER AND SvO2:
	LYSINE ACETYLSALICYLATE	500 mg per day. For Sachets of 500 mg, 1 Sachet is indicated at lunch. If they are 1000 mg 1/2 is indicated at lunch. For 900 mg ampoules: 1/2 a day is indicated.		1000 mg per day. For Sachets of 500 mg, 1 Sachet is indicated at breakfast and dinner. If they are 1000 mg, 1 is indicated at lunch. For 900 mg ampoules: 1 a day is indicated.		The result is POSITIVE if there is: a) Clinical Improvement of Chronic Fatigue and Brain Fog of 3 out of 10 points, or more (30% or more improvement); and/or b) D-dimer rises more than 30%; and/or c) Venous Oxygen Saturation (SvO2) improves significantly. The result is NEGATIVE if there is no clinical improvement in fatigue, the D-dimer does not rise, nor does the SvO2 improve significantly.
	Alternatives:					
	CLOPIDOGREL	1 TB of 75 mg per day.		1/2 TB of 75 mg per day.		
	TAXIFOLIN	between 40 to 50 mg a day (1 mg/kg/day)				
	NARINGIN	500 mg at 9 am.		500 mg at 9 am and 9 pm.		
	GARLIC	1000 mg at breakfast and dinner (2000 mg daily)				
	DIPIRYDAMOLE	1 TB of 75 mg at 11 am and 10 pm (away from food).				
	APIXABAN	5 mg at 8 am and 2.5 mg at 10 pm				
2	L-LYSINE or	500 mg at least 1 hour before breakfast (7 or 8 am) and at 5 pm (1000 mg a day)		500 mg at 7 am, 11.30 am, 5 pm and 11 pm (2000 mg daily, take away from food)		
	SERRAPEPTASE	20 mg or 40000 SU at 11 am and, 10 pm (away from food)				
	Alternatives:					
	BROMELAIN	500 mg at 11 am only		500 mg at 8 or 9 am and, at 8 or 9 pm (1000 mg daily)		
	LUMBROKINASE	20 mg at 11 am only (away from food)		20 mg at 11 am and 10 pm (40mg/day, away from food)		
	NATTOKINASE	1 capsule at 11 am and 10 pm (away from food)				
	PENTOXIFYLLINE	200 mg at 9 am and 9 pm		400 mg at 9 am and 200 mg 9 pm		
3	FAMOTIDINE	20 mg at 10 am and 10 pm				
	Alternatives:					
	CIMETIDINE	200 mg at 10 am and 400 mg at 10 pm				
	NIZATIDINE	300 mg at 10 pm				
	BAKING SODA or Andrews Salt	1/2 tsp 11am 1/2 tsp 10pm	1/2 tsp 10pm	1/2 tsp 10pm	1/2 tsp 10pm	
	ADDITIONAL INDICATIONS:					
	Avoid coffee, sodas, caffeinated or lactated drinks. Diet low in Arginine and Histamine, and high in Lysine and Vitamin D.					
	If there are symptoms associated with increased histamine, allergies or MCAS, include an H1 Blocker: Rupatadine 10 mg daily; Cyproheptadine 8 mg before bedtime; Diphenhydramine 25mg to 50mg before bed; Hydroxyzine 25 to 50 mg before bedtime (according to tolerance).					
	If the patient presents an inflammatory reaction of the Herx type that you cannot tolerate, it is recommended to: suspend the medications listed in numbers 1 and 2, give Antimicrobial Medications and evaluate response to the medications.					

Table 5

Therapeutic Test and First Treatment Scheme for patients with Chronic Fatigue and Brain Fog to assist the diagnosis of Persistent Clots and Hypoperfusion

SUGGESTED DOSAGE FOR PATIENTS WITH BODY WEIGHT BETWEEN 96 TO 125 KILOS (211 to 276 pounds).

N°	Medication/Supplem	DAY 1	DAY 2	DAY 3	DAYS 4, 5, 6	DAY 7
1	ASA (Aspirin)*	300 mg per day. When TBs are 100 mg: 1 TB at breakfast, lunch, and dinner. If the TBs are 81 mg: 1 TB at breakfast, 2 at lunch and 1 at dinner. If the TBs are 325 mg: 1 TB at lunch.		600 mg per day. When TBs are 100 mg: 2 TB at breakfast, lunch, and dinner. If the TBs are 81 mg: 2 TB at breakfast, 3 at lunch and 2 at dinner. If the TBs are 325 mg: 1 TB at lunch and dinner.		RESULTS ACCORDING TO CLINICAL IMPROVEMENT, D-DIMER AND SvO2:
	LYSINE ACETYLSALICYLATE	1500mg daily. For 500 mg Sachets, 1 is indicated at breakfast, lunch and dinner. If they are 1000 mg Sachets, 1 is indicated at breakfast and 1/2 Sachets at dinner. For ampoules of 900 mg, 1 is indicated at 8am and 8pm.				The result is POSITIVE if there is: a) Clinical Improvement of Chronic Fatigue and Brain Fog of 3 out of 10 points, or more (30% or more improvement); and/or b) D-dimer rises more than 30%; and/or c) Venous Oxygen Saturation (SvO2) improves significantly. The result is NEGATIVE if there is no clinical improvement in fatigue, the D-dimer does not rise, nor does the SvO2 improve significantly.
	Alternatives:					
	CLOPIDOGREL	1 TB of 75 mg at 9 am and 9 pm		1 TB of 75 mg per day, at 9 am.		
	TAXIFOLIN	between 80 to 120 mg/day (maximum 1 mg/kg/day) in 2-3 doses a day				
	GARLIC	1000 mg at breakfast, 2000 mg lunch and dinner (5000 mg daily)				
	NARINGIN	500 mg at 9 am and 9 pm		500 mg at 8 am, 4 pm and 11 pm		
	DIPIRYDAMOLE	2 TB of 75 mg at 7 am and 4 pm, and 1 TB at 11 pm (away from food).				
	APIXABAN	10 mg at 9 am, and 5 mg at 9 pm				
2	L-LYSINE o	500 mg at 7 am, 11.30 am, 5 pm and 11 pm (2000 mg daily, take away from food)		1000 mg at least 1 hour before breakfast (7 or 8 am) at 4pm and 11 pm (3000 mg a day)		
	SERRAPEPTASE	40 mg o 80000 at 11 am and, 20 mg at 10 pm (away from food)				
	Alternatives:					
	BROMELAIN	500 mg at 11 am and at 10 pm (1000 mg daily, away from food)		500 mg at 7 am, 4 pm and at 10 pm (1500 mg daily, away from food)		
	LUMBROKINASE	20 mg at 7 or 8 am, 4 pm and 10 pm (60 mg daily, away from food)		20 mg at 7am, 40 mg at 4 pm and 10 pm (100mg/day, away from food)		
	NATTOKINASE	2 capsules at 11 am and, 1 capsule at 10 pm (away from food)		2 capsules at 11 am and 10 pm (away from food)		
	PENTOXIFYLINE	400 mg at 9 am and 9 pm		400 mg at 7 am, 3pm and 10 pm.		
3	FAMOTIDINE	40 mg at 10 am and 10 pm				
	Alternatives:					
	CIMETIDINE	800 mg at 10 am and 10 pm				
	NAZITIDINE	300 mg at 10 am and 10 pm				
	BAKING SODA or Andrews Salt	1/2 tsp 11am 1/2 tsp 10pm	1/2 tsp 11am 1/2 tsp 10pm	1/2 tsp 11am 1/2 tsp 10pm	1/2 tsp 10pm	
	ADDITIONAL INDICATIONS:					
	Avoid coffee, sodas, caffeinated or lactated drinks. Diet low in Arginine and Histamine, and high in Lysine and Vitamin D.					
	If there are symptoms associated with increased histamine, allergies or MCAS, include an H1 Blocker: Rupatadine 10 mg daily; Cyproheptadine 4 mg 8am, and 8 mg 3 pm and before bedtime; Diphenhydramine 25mg at 10am and 50 to 75 mg before bed; Hydroxyzine 50 to 75 mg before bedtime (according to tolerance) for no more than 10 days.					
	If the patient presents an inflammatory reaction of the Herx type that you cannot tolerate, it is recommended to: suspend the medications listed in numbers 1 and 2, give Antimicrobial Medications and evaluate response to the medications.					