Abstract

Background: Ebola Virus Disease (EVD) has ravaged three countries in West Africa. The mortality rate is extremely high, and it is perceived not only as threat to all of Africa but to the entire world. There is no known treatment to date other than administration of convalescent blood or experimental monoclonal antibodies, which both often fail. Ozone therapy (OT) has been in clinical use for decades and has been found to have physiological effects, which should directly inactivate the virus itself, as well as modulate its damaging effects. We present the scientific background and the possibility of ozone therapy as a cure or prevention for EVD in five consecutive patients.

Materials and Methods: Ozone therapy administration by a combination of direct intravenous gas administration, rectal gas administration and ozonized water was administered to three patients with known acute EVD, one with apparent acute infection, and one case of extremely high risk. Ozone was administered for up to ten days despite fast total remission of symptoms. Vitamin C and glutathione supporting supplements were administered.

Results: Four symptomatic patients, three with test positive EVD confirmation and one (who suffered Ebola contaminated needle stick contamination three days earlier) without lab confirmation all remitted symptoms within 2-4 days and fully recovered. All four ill cases had an immediate recovery course upon initiation of therapy. The single case of non-symptomatic high-risk exposure treated preventively did not develop symptoms.

Conclusion: Ebola virus may have a very narrow window of redox infectivity capacity, which can be easily exploited with OT. OT may be a useful modality in EVD and other viral diseases and should be immediately studied to save lives that might otherwise be lost.

Key words: Ebola, Hemorrhagic Fever, ozone therapy, oxidation, virus, antiviral therapy

Introduction

A Filovirus of several strains, commonly known as Ebola, causes hemorrhagic fever (EVD). Incubation ranges 2-21+ days. Ebola virus enters dendritic cells shutting down their immune system alerting alarms. While unchecked, it replicates wildly, infecting and damaging critical organs, inclusive of liver and kidneys. The cells explode releasing new viruses and debris. This can result in a cytokine storm (Tisoncik et. al., 2012), characterized by massive capillary leakage and tissue destruction. Then, the immune system may do more harm than good (Amarasinghe, 2014). Mortality is extremely high (60% in the current Zaire species outbreak).

WHO reported that the current Ebola epidemic ravaging parts of West Africa is the most severe acute public health emergency seen in modern times (Watson, 2014). To date, there is no known proven effective treatment” (Choi and Croyle, 2013). A recent JAMA editorial proclaimed need for “utmost urgency” of fast tracking promising vaccines (Giesbert, 2015). Effective treatment is emergently needed.

Ozone kills bacteria in easily reachable concentrations nearly instantly (Leusink and Kraft, url) and some 100 times faster than chlorine containing disinfectants (decontaminants) (Oregon State Univ., 2011).

Nikola Tesla patented the first commercial medical ozone generator in 1896. In World War I, German physicians disinfected wounds with O3. Nikola Tesla was a pioneer in applying ozone to medical conditions. Velio Bocci, MD of Italy investigated OT’s immune effects. He published results first in a series of studies (over 175) in peer reviewed medical journals, now found succinctly in his book “Ozone, A New Medical Drug” (2011), which details ozone’s many mechanisms to help many medical conditions including: 1) immune system modulation balancing its inflammatory/anti-inflammatory cytokines, 2) increase in production of RBC oxygen releasing 2,3 DGP (also reported by Viebahn-Hansler, 2003), and improved rheology properties of blood (increased RBC flexibility) 3) elevation of key anti-oxidant enzymes such as SOD, and increased glutathione. Cuban ozone researchers have independently verified these findings (Menendez, et. al., 2008).
Medical OT induces vasoprotective prostacyclin production (Schulz, et. al., 2012). OT increases muscle (Clavo, et. al., 2003) and tumor oxygenation (Clavo, et. al., 2004) in humans studied by direct polarographic electrode measurement. Additionally, ozone protected against hepatic ischemia free radical reperfusion injury (Perralta, et. al., 1999).

Cuban researchers found that OT preconditioning inhibits TNF-alpha production during endotoxic shock. In addition OT exerts influence on the antioxidant-prooxidant balance for preservation of cell redox state by stimulating endogenous antioxidant systems (Zamora, et. al., 2005).

Many viruses require reduced sulfhydryl groups on their lipid envelope glycoproteins for cell entry. Mirazimi’s group speculated on the richness of disulfide bonds in viral glycoproteins as a factor for infectivity. Studying Cytomegalovirus (CMV) they found the virus requires sulfhydryl groups to infect cells (Mirazmi, et. al., 1999). If the thiol groups were oxidized, CMV lost infectivity. When thios were chemically re-reduced (by dithiothreitol), the virus regained 65% infectivity. Reflecting on the reduction of “critical” disulfide bonds for vaccinia virus cellular entry, Markovic, et. al., (2004) found that protein disulfide isomerase inhibitors limited HIV-1 entry into T cells.

Ozone inactivates many viruses including polio, Norwalk, coliphage MS2, hepatitis A and others (Kekez and Sattar, 1997; Shin and Sobsey, 2003; Herbold, et. al., 1989; Emerson, et. al., 1982).

Ebola appears no different. Studies by Sanders et al. have been able to determine the disulfide-bond map of the Ebola glycoprotein and, as a result, have proposed that reduction of the disulfide bond between the two subunits of the Ebola glycoprotein complex, GP1 and GP2, “is a critical step in the entry of Ebola virus into cells” (Sanders Lab, url).

Ozone, in vitro, instantly oxidizes reduced sulfhydryls to disulfides as shown in the chemical reaction below:

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\text{SH} + \text{SH} + \text{O}_3 \rightarrow \text{S-S} + \text{H}_2\text{O} + \text{O}_2.
\]

While ozone itself lasts only microseonds in blood, the reaction of ozone and blood lipids leads to the production of more stable but still highly reactive oxygen species (such as peroxides), which would react similarly, and perhaps mimic the pro-oxidant mechanism of immune system defense.

Aerobic cells are designed for redox shuttling and oxidant stresses. Viruses lack repair capacity. Shut out of the cell (inactivated), they cause no damage, but remain antigenically intact for immune response. However, aerobic mammalian cells can and do quickly repair membrane oxidation effects. One repair pathway activates the hexose-monophosphate shunt, which, incidentally, produces 2,3 DGP.

Finally, intravenous oxygen gas has been administered in significant volumes for decades in Europe. Numerous papers have reported beneficial effects on several physiological parameters. Regelsberger observed a general improvement in oxygen availability, eosinophilia, which can be valued as an increase in undetermined cellular immunological resistance. “Furthermore, rheological qualities of the blood as well as diuresis are improved, the release of oxygen into the tissue is increased, and the blood pH is normalized” (Schmidt, 2002). Intravenous oxygen gas in human volunteers induces eosinophil generated 15-LOX-1, a powerful anti-inflammatory enzyme, believed to be a key factor in inflammatory modulating effects of IV oxygen gas (Chaitidis, et. al., 2004).

Rowen has been using OT to treat virus and bacterial infections (outpatient setting) since 1986. He recruited Dr. Howard Robins, who refined a very inexpensive and relatively medical waste free technique of ozone administration- direct intravenous gas administration (DIV). DIV administers an oxygen/ozone gas mixture intravenously using a 27g winged infusion set. The clinician sets an ozone concentration up to 55 mcg/cc. (Approximately 98% O_2 and 2% O_3). Great care is taken to prevent “air”, which is 79% nitrogen gas and can cause an embolus, from entering the body. There are no reports in the worldwide literature, even after decades of use, that intravenous oxygen gas causes embolism. Desaturated venous blood is “thirsty” for it.

A protocol (Rowen-Robins Method) for EVD was developed inclusive of oral vitamin C, and a supplement supporting recycling of glutathione (Thiodox®, Allergy Research Group).
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Rowen and Carew visited the Freetown Hastings Ebola Center and taught the method on 10/24/2014. The staff acknowledged a current 60% EVD mortality rate, considered, among the best results in Sierra Leone. For unknown reasons Ministry of Health authorities suddenly forbade the administration of OT on patients at the center while the educational session was in progress. Since all confirmed cases of Ebola suffered mandatory quarantine, it became extremely difficult to locate and treat cases outside this mandate. However, four cases did arise from within the facility amongst front line providers. These managed to receive OT. We now report these four case results. The first case, who was not tested, had an accidental needle prick from Ebola contaminated blood three days earlier. All patients executed informed consents.

Materials and Methods

“DIV” ozone indicates direct intravenous ozone gas at 55 mcg/cc at a volume between 20-40 cc. “Rectal ozone” indicates ozone gas administered rectally at a concentration of 36 mcg/cc and volume between 150-350 cc. “Ozone water” was made by bubbling ozone gas at approximately 70 mcg/cc into water for 15 minutes. Administration volume was 300-500 cc, and administered orally. All cases were provided nutritional supplements Thiodox® and Buffered Vitamin C® (donated by Allergy Research Group). Thiodox dose: one twice daily. Vitamin C: four to eight grams daily during the days of ozone treatment.

Case Reports

Case 1 – Physician SK, 28, male, at the Hastings Ebola Center in Freetown jabbed himself with a contaminated needle. He was fearful to get an Ebola test, knowing if positive he would have been forcibly picked up and placed in quarantine and denied OT, which he feared would cost him his life. He was a physician Rowen and Carew had trained in OT at Hastings. He received 20 cc of DIV on October 23, 2014 as part of the training. The following is his verbatim and signed report edited only to remove names. What appears in brackets is editing by the authors for accuracy.

14th November: Needle prick in the red zone while trying to cannulate an EVD positive patient. This patient was in the recovery ward with no complaint and symptoms. She had done the blood (test) but it came positive and was waiting for the second specimen to be taken. The needle went through the PPE and pricked me a finger length anteriorly above the wrist. I was wearing Tyvek (the thinnest PPE). The prick happened just above the margin of the gloves, making me more exposed. Had it gone through the gloves, as in the case of another doctor, it wouldn't have penetrated the skin.

15th November: No symptoms, but planning to start OT.

16th November: No symptoms- feeling fine. Called Dr. Carew and went to see him. DIV [30 cc, 55 mcg/cc] done [one session]. [He also received 500 cc ozone water]. Was given Vit. C, Thiodox, colloidal silver. I was also given the ozone machine, couldn't use it - gas leak.

17th November: Fever at night, loss of appetite, bowel movements (unusual) and urge to empty my bowel. The urge was very strong. I tried to suppress it. I took ciprofloxacin, paracetamol, doxycycline, drank ORS. Couldn't sleep because of fever and the urge. I went after midnight to pass stools and I felt some comfort. The stool was not watery but not too hard (it was very soft). I came and slept.

18th November: Loss of appetite in the morning and weakness. Slightly febrile, muscular pain and joint (suppressible). Went directly to Blue Shield Ozone water only. Slight weakness. Appetite is much better. DIV done, started working again. Did rectal ozone.

20th November: For the first time I did rectal ozone 3 times a day [36 mcg/cc]. One DIV. Slight weakness. Slept well at night. My temperature was 37.1 degrees Celsius.

21st November: My appetite is improving, DIV and rectal [as before].


23rd November: No complaints. Ozone water but no DIV and rectal.

24th-29th November: Ozone water only.

SK fully recovered, resuming his duties within just days of commencement of therapy.

Case 2 - Physician MB, 35, male, had close personal contact (hug) with another physician after the latter initially tested negative for Ebola. However, within 2 days a repeat test (PCR) came positive on the other physician (who died shortly thereafter). MB subsequently developed typical Ebola symptoms (fever, abdominal pain, vomiting, appetite loss, and later diarrhea) within 3 days. He was placed in quarantine, but was offered and accepted OT administered by the recovered physician SK.

At the appearance of symptoms, he received 30 ml DIV. When PCR testing returned positive, he was given an additional 2 DIV administrations consisting of: 40 cc each, 12-16 hours apart, at 55 mcg/cc. He also drank 300-500 cc of ozonated water after the intravenous treatments. Within 4 days, all symptoms had cleared. A follow-up test for presence of Ebola virus was negative 2 weeks later. The government publicly announced this case as a complete Ebola recovery in a physician national, but did not mention he had received OT.

Case 3- SS, 25, male nursing student on the Ebola front line, who was present for the Rowen and Robins ozone training in October 2014. He documented exposure to Ebola via damaged protective gloves enabling an Ebola patient’s blood to come in contact with his skin. He also, without protective gear, cared for a friend, who later was confirmed to have EVD. On December 2, 2014, SS developed fever, malaise and headache. He received 2 DIV ozone gas injections of 20 and 30 cc respectively at 55 mcg/cc, and drank ozone water (100 cc) on 3 consecutive days. Upon testing positive for EVD, (PCR) he was taken to the Kerry Town Ebola treatment center where he was not permitted further OT. However, he had a complete and non-complicated recovery.

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Case 4 - IB, 24, male aid. Working in “red zone”. While bathing an Ebola patient, on or about November 24, 2014, he accidentally splashed body fluid contaminated water that went through his facemask and entered his eyes and mouth. Within 5-7 days, he developed progressive symptoms of extreme fatigue, body pains and vomiting. He started on anti-malarials. The next day, he informed the facility physician who immediately administered DIV ozone, 40 mcg/cc, 40 ccs. Within a few hours of the gas injection, almost all symptoms subsided. He also received two rounds of ozonated water (as in case 2). However, by then, he was about symptom free. His Ebola test proved positive (PCR) and he was placed in the treatment unit and prohibited from further DIV ozone. He did receive their usual treatment protocol consisting of D5W, Ceftriaxon (IV), Metronidazole (oral), Immunoboost (oral vitamin). He had an uneventful stay within the Ebola containment unit and was discharged in the first week of December.

Case 5 - GK was the female companion of a 67-year-old Sierra Leone senior physician who died of EVD. She had intimate contact with him at the time of his falling ill. Authorities placed her under home military quarantine (armed military guards), preventing any entry and exit, inclusive of anyone who might bring her OT. She was in great fear for her life and very much aware of OT, having urged her partner to accept it before he died. In the middle of the night she scaled a razor wire fence shredding her skin and evaded the guards. She arrived at Dr. Carew’s “Blue Shield” facility where she received: one DIV ozone treatment, and daily rectal ozone and ozone water for ten days. She also received vitamin C and Thiodox® twice daily. No symptoms developed.

An ozone-fogging device was deployed at Dr. Carew’s Blue Shield facility for decontamination and protection of Dr. Carew and all exposed to patients who were treated there.

Discussion

EVD has a progressively explosive downhill course from the time of symptom appearance. Typically, death occurs within a week or less in the majority of cases. In all our ozone treated cases, symptoms did not progress from the start of OT, and symptomatic patients were totally free of all symptoms, inclusive of fever, generally by day 3 of treatment.

Through December 2014, Sierra Leone lost 11 out of 13 national physicians diagnosed with confirmed or probable Ebola. Both survivors received OT and quickly recovered. Following Rowen-Robins’ mission, one senior physician was offered and refused OT. He received convalescent serum and was transferred to the USA and died only 2 days later. Another senior physician likewise refused OT opting for ZMapp. He died while it was thawing. (Source: public news wires). A third EBV positive physician, Hastings trained, requested OT. Authorities refused and quarantined him. He died within 3 days.

Both senior authors had expected rapid recovery with OT, but admittedly not this fast (within a few days and with limited treatments). Rapid recovery was expected because of the violent nature of EVD, and the known direct countering biological benefits/effects of OT. This merits further discussion.

Ebolas induced pathology includes rapid cellular entry, an explosion of viral particles into circulation, and rapid cellular re-entry perpetuating the cycle viciously. Then the repressed immune system “awakens” and pulls out all its weapons to do battle. But unfortunately, that battle results in a cytokine storm, wherein the immune system does more damage to the vascular system and tissues than does the virus. Death occurs due to capillary leaks, hemorrhage and organ failure.

Circulatory compromise – The final common denominator in any vascular insult is oxygen deprivation and resultant cellular injury and death. OT is known to improve rheological properties of blood, increase 2,3 DGP, shifting the oxyhemoglobin curve to the right and releasing more oxygen in tissues. Bocci, Menendez, and others have well demonstrated that OT enhances oxygen delivery and utilization. Ozone itself is oxygen. Clearly, in advanced EVD with vascular damage, tissues are starved of oxygen and energy production. Any oxygen delivery enhancement could potentially salvage cells that might otherwise die. Viral entry – The need for reduced sulfhydryl groups to enter cells, may be the Achilles heel for reversing the lethality of EVD (and other viruses). Sulfhydryl groups are key to activity of many cellular enzymes; aerobic cells may control enzyme activity by redox, providing means to activate/inactivate these enzymes. It appears from our cases EBV has a very narrow redox window, and that its envelope glycoproteins must be reduced as literature suggests. The symptomatic patients began a recovery essentially with the first oxidation (ozone) treatment. The senior authors did expect recovery, but within 5-7 days, considering the natural course of EVD. These symptomatic cases improved with the very first treatment. An oxidant stress to the blood stream carrying newly emerging viruses may be capable of oxidizing and inactivating sulfhydryl entry mechanisms. Such inactivated viruses will be incapable of entering the cell for further replication, while able to encourage healthy immune responses.

Gonzales et. al., (2014) reported on a case of another vicious virus now likely endemic in the USA. A man (54) developed high fever and severe arthralgia among other symptoms. He was positive for Chikungunya virus. After receiving two intravenous infusions of vitamin C, 100 grams each, he immediately began recovery and was clear of symptoms in two days. A second paper reported combined ascorbate and intravenous hydrogen peroxide on symptomatic cases of Chikungunya virus observing fast symptomatic relief (Marcial-Vega, et. al., 2015). This parallels our observations with ozone. Importantly, ascorbate in these doses has been found to undergo a newly discovered metabolism. The lab of Mark Levine at the National Cancer Institute research reported a heretofore-unknown effect of high levels of plasma ascorbate. “Pharmacologic ascorbate can act as a pro-drug for H2O2 formation, which can lead to extracellular fluid [accumulation of H2O2]” (Chen, et. al., 2005). Bocci, et. al., (1998) theorized that the key mediator in ozone’s beneficial effects is H2O2. Oxidation therapy was reported as far back as 1920 to dramatically cut the mortality rate of influenza pneumonia in the great epidemic of that time. British physician Oliver (1920), in India, took only hopeless cases and nearly halved the death rate with intravenous H2O2 therapy. In the 1940’s, ozone’s sister therapy, ultraviolet blood irradiation therapy, was used to rapidly resolve viral influenza (Miley, 1942) and polio (Miley and Christensen, 1944). We have nothing, even in today’s modern world, which compares. Cytokine storm - Ebola induces a cytokine storm. OT has been shown to significantly modulate TNF-alpha and inflammatory cytokines. Bocci has investigated and reported ozone as a cytokine inducer (Bocci, et. al., 1993). Bocci (personal communication to Rowen) called ozone the “ideal cytokine inducer”, inclusive of anti-inflammatory cytokines. EVD instigates pathologically high levels of NO. Ozone modulates NO (Bocci, et. al., 2007). The actual extraordinary rapid recovery of the treated patients suggests that all three mechanisms may be at play, particularly viral inactivation. Ozone easily oxidizes SH groups to S-S groups, which, according to literature, is expected to inactivate viral entry. Ozonides, reactive
Ozone therapy, a modality not well known or understood by conventional Western medicine, has performed as a safe and ideal therapy for EVD in all infected patients receiving it. EVD symptoms cleared within 2-4 days in all (four) symptomatic cases involving front-line health workers. No symptoms developed in a fifth extremely high-risk person. In contrast, two leading Sierra Leone physicians who contracted EVD and refused treatment both died, and one who requested, but was denied ozone treatment, also died, within weeks after our visit. DIV ozone is inexpensive, safe and leaves virtually no contamination. International organizations and governments would do well to immediately conduct a formal trial of this unique therapy for EVD, which could provide significant security, both for EVD prevention and treatment, and for dangerous front-line work.

Weaknesses of this report: We acknowledge that these cases were treated early (soon after symptoms developed). None were critically ill. Ozone benefits on late stage EVD remain unknown.

Conclusion

Ozone therapy, a modality not well known or understood by conventional Western medicine, has performed as a safe and ideal therapy for EVD in all infected patients receiving it. EVD symptoms cleared within 2-4 days in all (four) symptomatic cases involving front-line health workers. No symptoms developed in a fifth extremely high-risk person. In contrast, two leading Sierra Leone physicians who contracted EVD and refused treatment both died, and one who requested, but was denied ozone treatment, also died, within weeks after our visit. DIV ozone is inexpensive, safe and leaves virtually no contamination. International organizations and governments would do well to immediately conduct a formal trial of this unique therapy for EVD, which could provide significant security, both for EVD prevention and treatment, and for dangerous front-line work.

Dedicated to: Terri Su (Rowen), MD and Linette Robins, whose unselfish love and bravery sustained the mission’s hardships. And, to the staff at Blue Shield facility who were willing to place themselves in harm’s way for a greater good. And, to all the people of Sierra Leone who have endured unspeakable tragedy and suffered which continues even to this day of submission.

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Author contributions:

Dr. Rowen sourced the scientific references, drafted the manuscript, and compiled the transmitted information from Sierra Leone. Dr. Robins provided training, education and expertise in his method of ozone delivery and traveled together with Dr. Rowen to Sierra Leone. Dr. Carew coordinated all training in Sierra Leone, both didactic and practical, bringing in scores of health care professionals. Dr. Kamara coordinated difficult retrieval of information and results back from Sierra Leone. Additionally, he visited each of the named patients and subsequently deceased physicians at his own peril to offer the therapy and obtain informed consent. Dr. Jalloh was the supervisory physician to the treatment of case 2 and assisted with training at the Sierra Leone Ebola center.
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