

# An Iridological Investigation in 50 Confirmed Cases for Possible Correlations Between *Candida albicans* Overgrowth, Candidiasis and Structural Markings

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## Introduction

It has been postulated that certain structural markings or pigmented signs like a central heterochromia, of various colourations, attest to the probability or, even, confirmation that systemic overgrowth from the intestines of *Candida albicans* and the diagnosis of Candidiasis is present. This train of thought has evidenced that the central heterochromia “spills out” from inside the pupillary zone (intestinal reflexes) over the collarette (intestinal integrity) and into the ciliary zone, thus reflecting the systemic overload and fungal proliferation of *Candida albicans*; and the myriad of resultant and related physical and mental symptoms. It has been suggested that lacunae or crypts within the internal border of the collarette also relate to Candida overgrowth.

As far as I can ascertain these suggestions are maintained in many schools of Iridology training throughout North America and in the UK, through the Internet by authors such as the Coltons. Diametrically opposed, these theories are not postulated or even considered throughout mainland Europe, Russia or other continents.

## Method

Medical diagnostic confirmation of *Candida albicans* overgrowth in patients is difficult to achieve in the UK. The condition can be often overlooked. In the alternative medical field it has to be said that *Candida* can be a misdiagnosis for other conditions; and without any tangible proof *Candida albicans* overgrowth can and often is overdiagnosed. I have seen this many, many times in practice.

To help overcome and at least limit any possible ‘practitioner-bias’ or subjectivity, only patients with a confirmed diagnosis from what can be considered standard medical testing procedures, such as stool cultures examined for evidence of *Candida albicans* overgrowth and presence of elevated levels of IgG antibodies to *Candida* through serum samples. In addition to this, five cases confirmed via Vega Test and Tongue Diagnostics were admitted to the study group.

## Materials

Bilateral examination from 20x to 56x magnification of the patient's irides and pupils took place via iris microscope and fibre optic lighting system, in accordance with a system of iris analysis forwarded by myself. 35mm transparency images at each magnification were captured.

## Study Group

All patients attended at a private clinic. The accepted study group consisted of 47 adult females with age ranges from 17 to 68. Nine of the group were taking or had previously been prescribed Hormone Replacement Therapy, 32 were taking or had taken oral contraceptives. 42 of the group had taken antibiotics in the past two years. 10 members of the group were taking corticosteroid medications, predominantly for asthma.

The male group was aged 26 to 44. All 3 of the male group have taken recurrent antibiotics and *Zantac* over the previous three years. One of the male groups was taking steroid-based medication.

## Candidiasis

*Candida albicans* is indigenous to a healthy gut. An intestinal tract with mucosal integrity and a balanced immune system maintains the *Candida albicans* symbiotic relationship with ourselves. Various influences have been shown to impair mucosal integrity, depress immune responses and proliferate fungal overgrowth. Many of these are highlighted in Kitty Champion's excellent paper included in this Volume; but I would like to reiterate and add to this by listing some of the possible causes of this pathway to Candidiasis that is often experienced.

Practitioners need to be aware of the influences of oral contraceptives, Injectable contraceptives like Depo provera, antibiotics (particularly a history of recurrent usage), corticosteroids (including steroid inhalers), Monosodium glutamate, Geopathic Stress (see p.?? Volume 3 & 4, AIRJ), Diabetes mellitus, Iron-deficiency anaemia, dental amalgam fillings or root canals, high sugar intake, alcohol, sexually-transmitted diseases and low hydrochloric acid in the stomach (due to antacids, or ulcer medications).

## Symptoms

Various symptoms can accumulate to form the bigger picture of Candidiasis. These can include hypoglycaemia, Vulval itching, vaginal soreness, white vaginal discharge, blackened furred tongue, recurrent cystitis, PMT, anxiety, psoriasis, acid reflux, chronic fatigue, anal itching, breathlessness, reduced libido, fungal infection of skin or nails, muscular aches, abdominal bloating, poor memory, numbness, oral thrush,

intestinal cramps, depression, impaired immunity and food cravings for sugar.

Vaginal secretions can be changed by oestrogen in the contraceptive pill. This leads to a vaginal tissue climate very conducive to *Candida albicans* overgrowth. This can develop as far as the fallopian tubes causing inflammation and blockage, which could cause sub-fertility or even in some drastic cases, complete infertility.

Optimal liver performance is vital for resistance against *Candida* overgrowth. Not only is the liver responsible for various immune responses and functions, but it also filters and organises both endogenous and exogenous hormones, in addition to the metabolism, storage and release of Zinc and Essential Fatty Acids, plus, what is probably most well known, the detoxification of alcohol. As suggested by Murray and Pizzorno in the *Encyclopaedia of Natural Medicine* "The toxins of *Candida* absorbed from the gut are filtered from the blood by the liver. Impaired detoxification mechanisms of the liver are thought to be responsible for the high sensitivity to chemicals in individuals with *Candida albicans* overgrowth. Symptoms of chronic Candidiasis occurring outside the gastro-intestinal tract, such as Psoriasis, PMS, etc are a very strong indication that the liver is not filtering the blood sufficiently."

## Therapeutics

As highlighted in Kitty's paper there is often an urgent need to withdraw from antacids, HRT, oral contraceptives and in some cases steroid-based medication, as long as this isn't life threatening and under correct support. Dental amalgam fillings and root canals have to be assessed correctly and may require removal or replacement. Refined sugar and refined flours, in addition to MSG have to be eliminated from the diet.

Endocrine and immune integration have to be harmonised through numerous protocols, with particular emphasis on adrenal gland support, blood sugar balance and probiotic supplementation.

Nutritional requirements need to be met and I often find we need to check for signs of the following deficiencies: zinc, beta-carotene, vitamin C and Essential Fatty Acids. I have found that a diet temporarily high in Avocado, Seaweeds, Almonds and Coconut (due to its high Caprylic acid content, which is a naturally occurring anti-fungal - fatty acid) can be highly beneficial, combined with probiotic supplementation, such as *L.acidophilus*, *L.bulgaricus* or *B.bifidus*. Garlic, ginger, Cinnamon, Turmeric, Rosemary, Thyme, Oregano and Horse Radish culinary herbs, spices and oils are all active against renegade *Candida*. In fact Garlic has been proven to be more potent as an anti-fungal agent than Nystatin. Horse Radish was proven active against *Candida* and as a potent anti-fungal in trials published in 1957 in the UK.

Herbal medicines I have found beneficial either as singulars or part of individual formulae include: *Tabebuia impetiginosa cortex*, *Hydrastis radix*, *Berberis vulgaris radix*, *Mahonia aquifolium radix*, *Usnea spp*, *Olea europea folia*, *Angelica sinensis radix*, *Vitex agnus castus*, *Lamium album*, *Glycrrhiza glabra radix*, *Centella asiatica folia*, *Coleus forskohlii folia*, *Echinacea purpurea folia*, *Lentinus edodes*, *Zanthoxylum clava-herculis*, *Vaccinium myrtillus fructus*, *Filipendula ulmaria herba*, *Schisandra chinensis* and/or *Carduus marianus*.

As pessaries Tea Tree (*Melaleuca alternifolia*) and *Calendula* oils are impressive and can stem the tide. Topically for nails and skin outbreaks both these oils can be used in addition to Jojoba oil (*Simmondsia*) and *Sempervevium* for Vulval itching, nail infection and oral presentation.

Homoeopathically Pulsatilla or Sulphur also achieved good results.

### **Iris Signs and Markings from 50 Confirmed Candidiasis Cases**

<b>Gross Constitutional Type</b>	<b>Cases</b>	<b>% Correlation</b>	<b>Central Heterochromia Present</b>	<b>% Correlation</b>
<b>Lymphatic</b>	23	46%	9	18%
<b>Mixed Biliary</b>	16	32%	8	16%
<b>Haematogenic</b>	11	22%	0	0%
<b>Total</b>	50	17	0	0

### **Pigment Analysis of 17 Central Heterochromia Present in the Study Group**

<b>Pigment Type</b>	<b>No. of Cases</b>	<b>% Correlation</b>
<b>Straw-yellow</b>	3	18%
<b>Brown</b>	3	18%
<b>Reddish-brown</b>	4	23%
<b>Orange-brown</b>	3	18%
<b>Orange</b>	4	23%

## Inner Pupillary Border Diameters

Measurement scale in microns according to Dr V. DiSpazio

Diameter	No. of Cases	% Correlation
Hypertrophy	14	28%
Atrophy	10	20%
Normal	17	34%
Partial Atrophy	6	12%
Mixed IPB	3	6%

## The Presence of an Axis

Axis Type	No. of Cases	% Correlation
Immune Axis	7/50	14%
Stress Axis	11/50	22%
Depression Axis	4/50	8%
Thyroid Axis	5/50	10%

## Pupillary Dynamics

Pupil Type	No. of Cases	% Correlation
Mydriasis	16	32%
Miosis	6	12%
Anisocoria	1	2%
Hippus	4	8%
Normal	23	46%

### Collarette Integrity

Collarette Type	No. of Cases	% Correlation
Zig-Zag	23/50	46%
Restricted/Contracted	7/50	14%
Distended	19/50	38%
Romheld Syndrome	2/50	4%
Hypertrophy (Complete)	8/50	16%
Hypertrophy (Partial)	4/50	8%
Atrophy	7/50	14%
Local Indentation(s)	18/50	36%
Frontal Indentation	4/50	8%
Bridge	9/50	18%
Koch's Sign	1/50	2%

### Significant Lacuna

Lacuna Type	No. of Cases	% Correlation
Numerous Lacuna/Crypts at Internal Collarette Border	8	16%
Adrenal Lacuna	21	42%
Leaf Lacuna	32	64%
Thyroxine Lacuna	10	20%
Stairstep Lacuna	18	36%
Beak Lacuna	7	14%
Rhomboid Lacuna	31	62%

## Miscellaneous Iris Signs

Sign Type	No. of Cases	% Correlation
Transversals (Liver)	16	32%
Radii Solaris	17	34%
Brushfield Spots	8	16%
Mammilations	6	12%
Contraction Furrows (over 5x concentric rings)	37	74%
White Radials	31	62%

### Discussion of the Iris Markings

Initially what jumps out to the casual observer is how few central heterochromia were recorded in the study group. Seventeen in total, of which 8 were present in Mixed Biliary constitutional types. In the Mixed (eye colour) Biliary Type you would expect to see prominent numbers of central heterochromia. In relation to pigmentation of the CH, no particular clear colour dominance emerged.

Secondly, we should note that numerous lacuna/crypts located at the internal collarette border in the intestinal reflexes carried a 16% correlation; whereas Adrenal lacuna (with 42% correlation), Leaf lacuna (a staggering 64% correlation) and Rhomboid lacunae (at a high 62%

correlation). Both Adrenal and Leaf lacuna are attached to the collarette, Rhomboid lacunae are largely apparent in the ciliary zone.

Studies of Pupillary dynamics and the IPB were revealing in the fact that normal diameters of both dominated, although there were high correlations for the study with mydriasis and a Hypertrophic Inner Pupillary Border. Perhaps both of these together with the Adrenal and Leaf lacuna illustrate the endocrine impact in many Candidiasis cases. The iris illustrates the predisposition to endocrine dysfunction, when an individual takes a steroid or oral contraceptive, the inner milieu is fertile for such adversity and impaired systemic adaptability ensues. Although the predominance of normal pupillary functions obviously disputes this.

Collarette integrity is a major landmark by any conceivable iridology standard. In this study zigzag collarettes, distended collarette and collarette with local indentations occurred most frequently. The book *Immunology and Iridology* carries further details, but again the endocrine immunological status and response potential can be assessed here. As

with all the signs in the study, there is such an abundance of different types, a complete typical iris picture is hard to piece together.

According to this pilot study, however, as a generalisation to form an iris "e-fit" a typical individual with Candidiasis can expect to exhibit the following qualities within the iris structure:

Normal to mydriatic pupil diameter, normal to hypertrophic IPB, zigzag collarette; possibly distended with adrenal and leaf lacuna attached, along with a possible Stress Axis. Multiple rhomboid lacuna and contraction furrows in the ciliary zone. Together with a liver transversal (emphasising the importance of hepatic function in Candidiasis and autoimmune endocrine imbalance) and numerous white radials. The iris is a Lymphatic Type.

## **Conclusion**

We can conclude from the results of this, albeit small, iris studies that a central heterochromia or multiple crypts/lacuna at the internal collarette border do not necessarily illustrate the presence of *Candida albicans* overgrowth. These particular signs convey a low significance and lack confidence in the overall analysis. In Iridology we must be more than willing to open up our investigations, theories and claims to greater scrutiny. For the correct data to emerge we must discard subjectivity, and even our ego, and approach with a sceptical, but open mind. With this study it is very difficult to form any confirmation with clarity. We can only assume that drug deposits and fungal infections cannot be assessed from iris and pupillary analysis.