

# Complex treatment of urogenital disorders using bioresonance

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## Foreword

Ladies and gentlemen  
Mr and Mrs Brugemann

After 14 years of clinical work in the field of physiotherapy/physio-science, in 1988 I was confronted with a new challenge: the treatment of conditions and complaints in the fields of gynaecology, urology, proctology, and psychology. Complaints such as urinary incontinence, faecal incontinence, constipation, impotence, prostate disorders, sexual diseases and problems in pregnancy were at the time taboo and called for great sensitivity when it came to their rehabilitation. The complexity of the matter resulted in my founding the specialist field "Urogenital Rehabilitation" in Switzerland. Treatments consisted by and large of pelvic floor exercises, biofeedback, electro stimulation "TENS" (Transcutaneous Nerve Stimulation) and intravaginal and intra-anal palpation. In 2003 I learned about the biophysical treatment option using Bicom bioresonance, which I have been using successfully ever since in my urogynaecological and complementary medical practice. Since 1999 I have been self-employed. My practice, which was initially established in Lucerne and Stans, moved to St. Moritz in the beautiful Upper Engadin valley in 2012.

## 1 Urogenital rehabilitation

The term "urogenital rehabilitation" is derived from two specialisms, urology and the specialist medical field covering the organs responsible for urinary elimination and urine formation.

## 2 Clinical pictures and their treatment forms

"Urological rehabilitation" consists of a broad spectrum of clinical pictures. And their treatment options are just as extensive. In this work I am focusing therefore on a small number of therapeutic measures within the framework of bioresonance.

### 2.1 Urinary incontinence: the disease no one likes to talk about

Bladder weakness is extremely common and can be described as a truly widespread condition. Worldwide more than 200 million people are affected. In Switzerland bladder weakness is one of the most widespread health problems. According to estimates, at least 400,000 people of every age are sufferers in our country. With increased life expectancy we may safely assume that in the future more and more people will suffer from bladder weakness (Swiss Society for Bladder Weakness, 2013). The following types of urinary incontinence can be differentiated:

#### 2.1.1 Clinical pictures of urinary incontinence

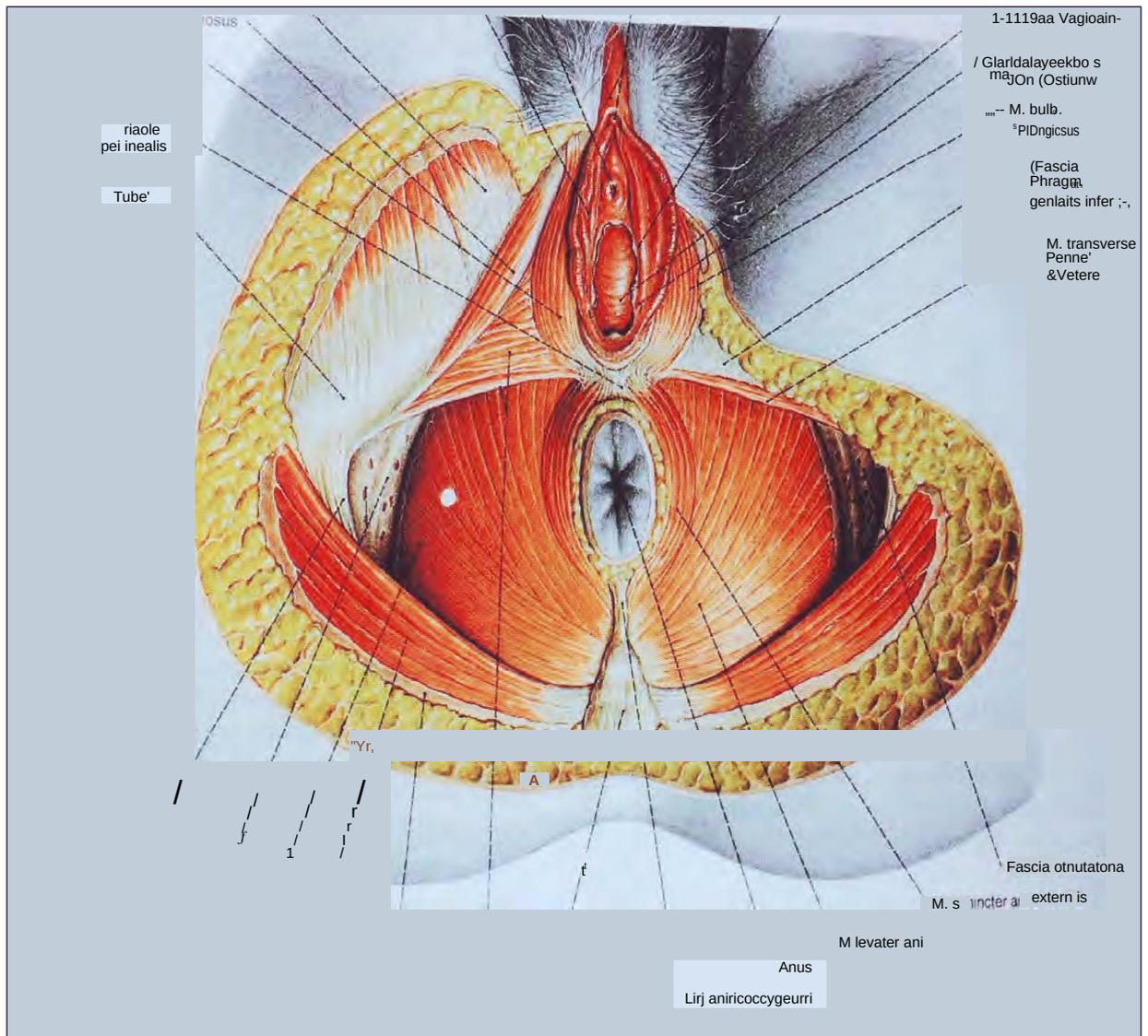
##### Stress incontinence / incontinence during physical activity

With this form of incontinence, which mainly affects women, there is an involuntary loss of urine during sudden physical exertion such as coughing, sneezing, laughing or lifting heavy loads. The quantities of urine lost can vary from 5 to 30ml per episode. The extent to which people are affected by the physical inconvenience, and each individual's differing sensitivity threshold for impaired quality of life, will vary depending on social circumstances.

The cause of this type of incontinence is a weakness in the pelvic floor muscles (pfm). A weakness in the pelvic floor muscles can be triggered by difficult births, forceps delivery, breech presentation, untrained pushing during labour, very rapid onset of labour, pfm trauma, tears in the M. transversus perinei superficialis and profundus, and a tear in the Centrum tendineum perinei (Chakra 1).

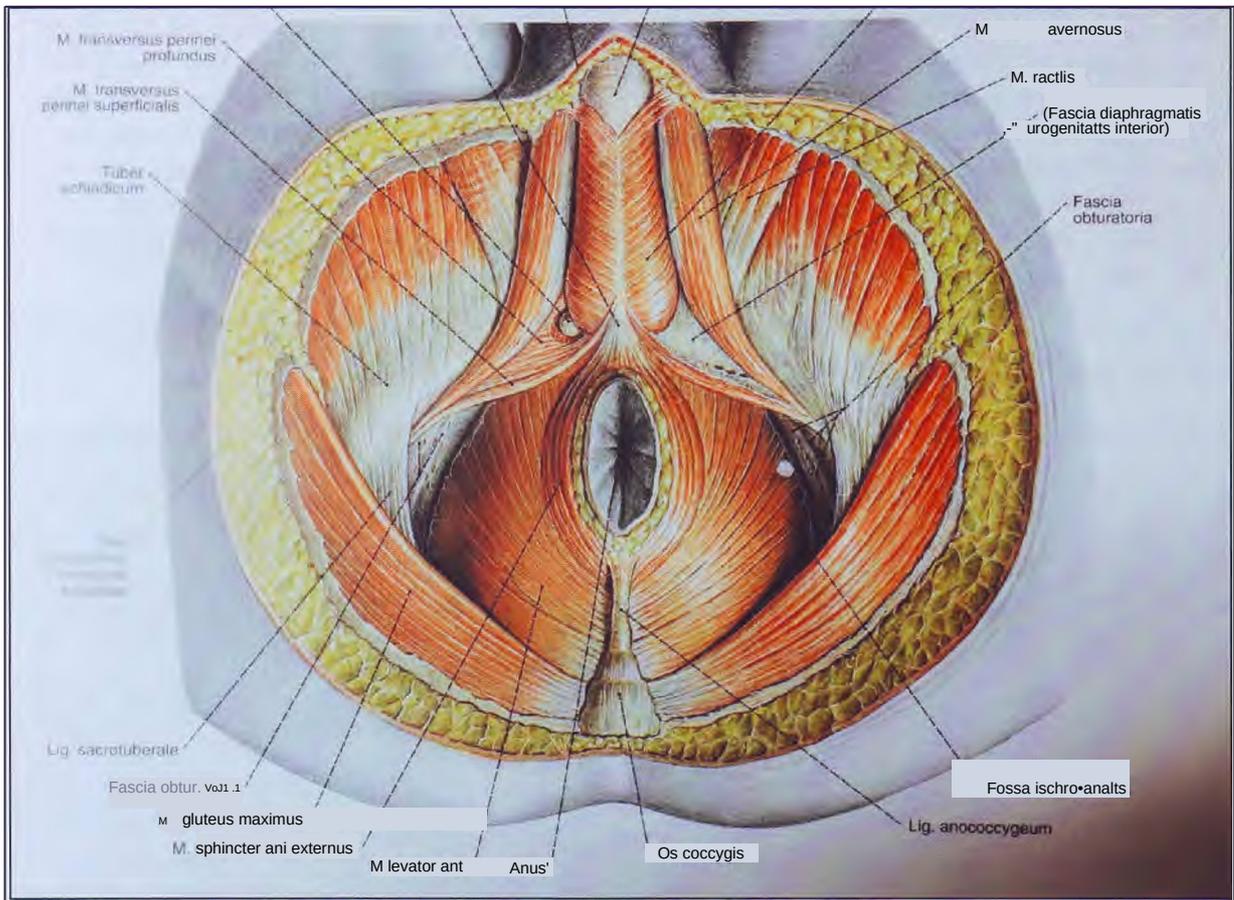
Collagen connective tissue weakness, age and weakness from inactivity, oestrogen deficiency and the menopause are other factors impeding the functionality of the pelvic floor muscles (pfm) especially the M. levator ani and the M. sphincter ani externus with the following possible consequences — loss of continence, cystocele, rectocele, prolapse, pain and social withdrawal.

### Female pelvic floor muscles



Atlas of Anatomy: Frank Netter (1989), Thieme Verlag

## The male pelvic floor muscles



Atlas of Anatomy: Frank Netter (1989), Thieme Verlag

### Reflex incontinence

Reflex incontinence can be caused by diseases or injuries to the central or peripheral nervous system. Here, the corresponding nerve paths in the central nervous system, which are responsible for emptying the bladder, are interrupted. The bladder and sphincter muscle function can no longer be coordinated and controlled voluntarily.

### Overflow incontinence

Overflow incontinence is the most frequent form of bladder weakness in men. Compared with other forms of incontinence, it is not a disorder of urine retention but a disorder related to emptying the bladder. It can be a consequence of prostate enlargement (prostate hyperplasia) or a bladder tumour. The urethra becomes

increasingly constricted because of the demand on space on the urethra from the prostate gland and as such no longer allows a normal flow of urine during urination. Drops of urine escape and there is an urge to urinate with frequent urination (as many as 20 times in 24 hours). Frequent night time urination is significant with small amounts of urine (5-20ml/per miction).

### Irritable bladder (hyperactive bladder)

This form of incontinence is triggered by over-excitability of the bladder muscle (M. detrusor). The classic symptoms are frequent trips to the toilet during the day (pollakisuria), and often at night too (nykturia). In this case there is a strong and uncontrollable (imperative) urge to urinate and an involuntary and spontaneous loss of larger quantities of urine.

The causes for this are frequent urinary infections (cystitis), chronic inflammatory diseases, affliction with parasites, Candida, restricted retention capacity of the bladder because of bladder stones, tumours, cysts and hormonal changes. Also a urethral stricture (narrowing of the urethra) as occurs in male prostate hyperplasia, can lead to a reactive thickened and hyper excitable bladder muscle.

Overexcitability of the bladder muscle can however also have an idiopathic origin or be a consequence of an underlying neurological disease such as Parkinson's disease, multiple sclerosis, diabetes mellitus or dementia. The underlying cause in such cases is considered to be damage to the neural control of the peripheral nerve fibres. The M. detrusor and the M. sphincter urethrae externus (of the bladder) can no longer be controlled involuntarily (nerve root: spinal segments S2 —S4).

#### Cystitis (Inflammation of the bladder)

Uncomplicated acute cystitis is a disease of children and women. Men are usually only affected in connection with diseases of the bladder (tumour, stone) or prostate gland (obstruction). Typical acute cystitis in woman arises because of an increase in microbes in the urethra or also after sexual intercourse (so-called honeymoon cystitis). Factors which favour the situation are reduced immunity of the urethra mucous membrane (hormonal influences, chronic inflammation, radiation, immunodeficiency) as well as residual urine, foreign bodies or stones.

Symptoms of acute cystitis are the frequent urge to urinate producing small quantities of urine, pain and/or burning sensation when passing water. Visible blood (macrohaematuria) may occur, together with the above-named symptoms. Acute cystitis is a bacterial condition, usually the result of infection with the Escherichia coli (E. coli) bacterium, part of normal intestinal flora.

Interstitial cystitis affects older women and in time, because of structural changes to the bladder wall, leads to reduced bladder capacity. The aetiology is unknown. Besides autoimmune processes and neurogenic factors, it is known that infectious pathogens such as Chlamydia, ureaplasmas and mycoplasmas, gardnerella and viruses play a part. Since these germs occur in urethral syndrome, it is this that should be treated primarily. In rare cases symptomatic therapies are indicated for interstitial cystitis, such as bladder stretching, (controlled miction straining and miction analysis) and treatment with medication. (Urology clinic, Berne University Hospital (*Inselspital*) 2013).

#### 2.1.2 Treatment approach

In my practice I take a detailed medical history for each patient, do a biophysical status, a physical examination and keep a miction diary.

In Appendix 5.1 you will find the "Urogynaecology" medical history sheet, which the patient fills out before the first consultation.

In Appendix 5.2 you will find the "Urogynaecological Diagnosis Sheet". If you are unable to carry out the vaginal/ anal examinations yourself, have a doctor provide you with information on the relevant parameters.

In Appendix 5.3 you will find an information sheet on avoiding urinary tract infections, which will help you to give the appropriate recommendations to the patient.

Appendix 5.4 provides a template for a miction diary.

It is urgent that a record of miction be kept in the case of all bladder problems for several days over a 24 hour period. Information about drinking habits is also imperative with respect to bioresonance therapy and the transmission of biophysical information.

*Testing and therapy procedures* are carried out *using the BICOM optima*.

### 3 Fundamental therapeutic procedures with bioresonance

#### Testing

	Test set	Program no.
1	According to the CTT 5 element test sets	192
2	Stresses: Viruses, parasites, bacteria, mycosis, heavy metals	191
3	Tumours	1 92
4	Food intolerances, allergy	1 70, 998
5	Urine, secretions, thrush, faeces, ejaculate	192, 191
6	Medicines	170, 171, 998
7	Acid/base with test strips	

#### Treatment systems

##### 1. Basic therapy based on conductance reading

##### 2. Treatment of blockages

	Programs	Program no.	Program series no.
2.1	Tissue		10026
2.2	Energetic		1002
2.3	Sacrum/coccyx	221.2	
2.4	Temporomandibular joint	530.2, 570.9, 3054.0	
2.5	Scars	900.2, 910.5	

*It is imperative during initial treatment not to forget scar interference elimination for navel, tonsillectomy, episiotomy, Caesarean section and vasectomy scars! Apply bioresonance oil in the output cup and rub in to the appropriate area.*

##### 3. Toxin eliminating organs

	Programs	Program no.
3.1	Kidney	480, 481, 482
3.2	Lymph	930, 830, 610
3.3	Uterus/prostate gland	934, 970, 900
3.4	Lung	423, 210, 211
3.5	Toxin elimination	3036.0, 970.5

#### 4. Therapy for pathogenic substances following testing

	<b>Programs</b>	<b>Program no.</b>
4.1	Candida according to Dr Rummel	937.0 or 191
4.2	Viruses	191
4.3	Bacteria	191
4.4	Parasites*	191
4.5	Patients' own correlates**	191, 192

\* Enterobius vermicularis and Schistosoma haematobium

\*\* after individual testing

#### 5. Urine therapy

To relieve and calm the bladder in the case of cystitis irritable and hyperactive bladder.

	<b>Programs</b>	<b>Program no.</b>	<b>Program series no.</b>
5.1	Treatment with intrinsic urine	506.0	
5.2	Treatment with intrinsic urine specifically*	491, 492	
5.3	Bladder candida treatment specifically*	927	
5.4	Irritable bladder (fresh urine in the input cup)		10126

\* Note: Patient's own fresh urine: mixed with a pinch of copper sulphate, (1d1 +/—) urine in the input cup, square electrode on the bladder connected to the red output cable.

\*\* Nystatin/Multilind suspension and Mycolog ointment in the input cup, square electrode on the bladder connected to the red output cable.

#### 6. Additional indicated therapy sequences

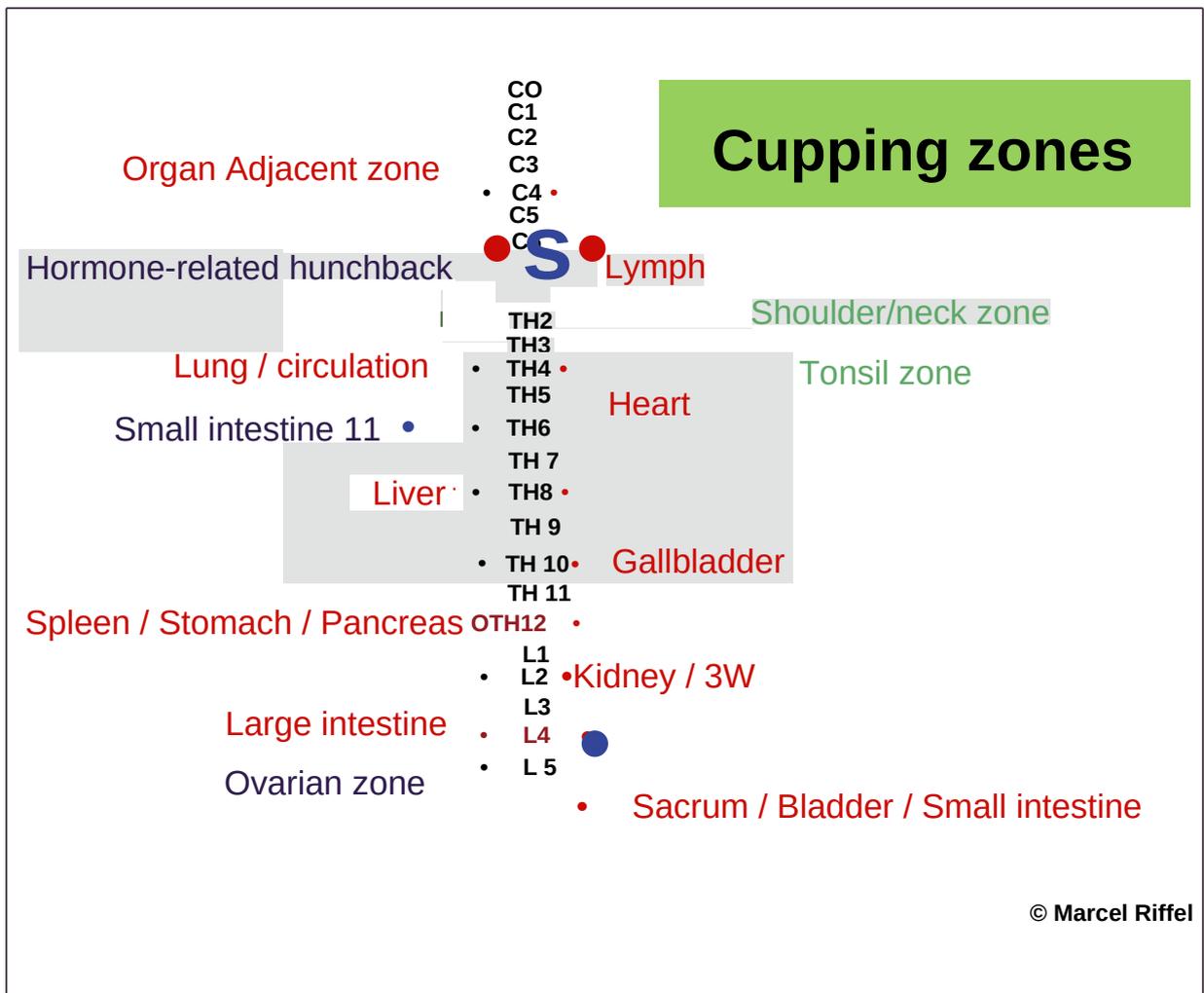
	<b>Programs</b>	<b>Program no.</b>	<b>Program series no.</b>
6.1	Hormonal disorders*		10070
6.2	Rheumatic pain		10129
6.3	Nerve calming		10110
6.4	Shock treatment		10147
6.5	Metabolism therapy		10159
6.6	Radiation stress		10160
6.7	Sterility		10158
6.8	Potency difficulties	Special program, see Regumed manual	
6.9	Lack of energy		10045
6.10	Urinary tract problems		30005
6.11	Tissue, acute	922.2	
6.12	Tissue, chronic	3040.0, 925.0	
6.13	Tissue, regenerating	3040	

\* Tip: Hormone ampoule with native progesterone and oestradiol (Dr. med. Rohrer), oscillate in channel 2 after amplification.

## 7. Manual measures

	Measure
7.1	"Hot Roll" on the sacroiliac, lumbar vertebral dermatomes / Head's zones, cervical neck zones (hormone-related hunchback) / thoracic trigonum (see cupping table)
7.2	Moor mud/paraffin hot pack on both feet and lumbar vertebral region
7.3	Cupping: bloody-dry (see cupping zones) in combination with bioresonance program no. 136 (urine or blood in the input cup).

## Cupping zones



Marcel Riffel (2009)

### 3.2 Erectile Dysfunction (Impotence)

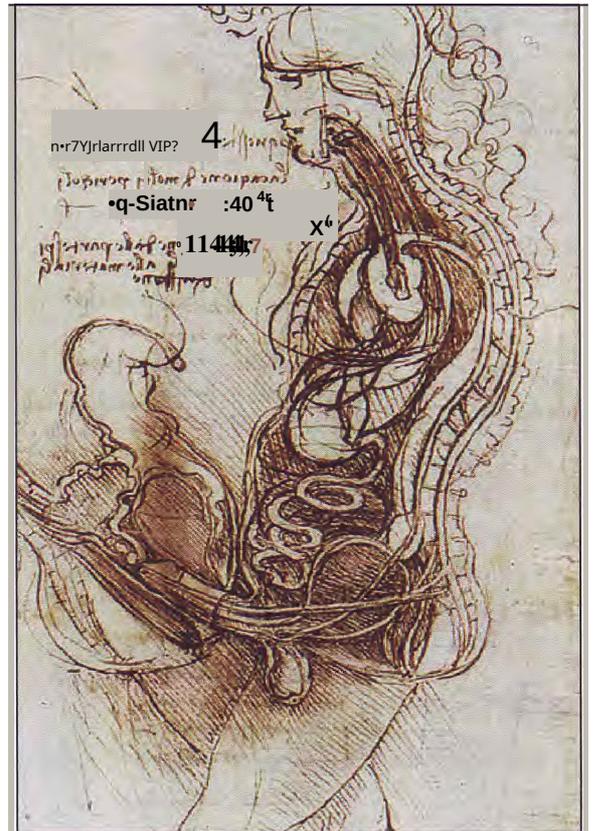
When a man wants to but can't.

#### 3.2.1 Clinical picture

Erectile dysfunction (ED) is the inability of a man to achieve an erection for sexual intercourse, to penetrate the vagina and be able to successfully complete sexual intercourse. Results of a survey in the USA from 1987-1989 (the "Massachusetts Male Ageing Study") have shown that more than 50% of all American men aged between 40 and 70 complained of erectile dysfunction with varying degrees of severity, with 34% of respondents reporting severe or moderate dysfunction. Erectile dysfunction poses a problem worldwide and affects highly developed industrial countries just as much as so-called civilised countries. Erectile dysfunction occurs much more frequently in diabetics, patients with high blood pressure, coronary heart disease, raised cholesterol and who have a heavy nicotine consumption. While it was believed earlier that erectile dysfunction is due to psychological reasons in more than 90% of cases, it is now known through modern investigative procedures that organic factors are responsible in the majority of all impotent men (60-80%) for their "failure" in bed and in particular disorders of the circulation in the erectile tissue underlying what is often generalised vascular disease. In this context, various authors, only in the last few years, have demonstrated that incidence of erectile dysfunction is very often associated with a concomitant disease of the coronary arteries (impending myocardial infarction) while the patient is often unaware of this disease since up to this point in time it has not produced any clinical symptoms. (Key term: Erectile dysfunction = endothelial dysfunction; Prof. Dr. med. Hartmut Porst, Urologist, Hamburg, 2012).

### **Human Anatomy**

Leonardo da Vinci



#### 3.2.2 Treatment approach

##### **Testing**

See Chapter 1.1.2

##### **Treatment systems**

See Chapter 1.1.2 for the first four steps.

1. Basic therapy based on conductance reading
2. Treatment of blockages
3. Toxin eliminating organs
4. Therapy for pathogenic substances following testing.

## 5. Specific erectile dysfunction

	Programs	Program no.	Program series no.
5.1	Tissue process, acute	922.3	
5.2	Tissue process, chronic	923.2	
5.3	Circulation disorders	3031.0, 504.0	
5.4	Shock		10147
5.5	Potency difficulties	Special program, see manual company Regumed	
5.6	Depression	Special program, see manual company Regumed	
5.7	Venous system impairment		10172
5.8	Vital capacity		10178

*Oscillate medication* to encourage potency: *Viagra, Levitra*, medicinal mushrooms (*Lentinula edodes = Shiitake* and *Ganoderma lucidum = Ling Zhi, Reishi*), *drugs brought in by the patient, testosterone in the input cup. Alternatively tested in channel 2 for intensity* and oscillated on to resonance drops, chip, globuli.

## 6. Manual measures

Tens (Transcutaneous and intra-anal electrostimulation) 1-10 Hz, comfortable intensity.

### **3.3 Induratio penis plastica (IPP)**

#### **3.3.1 Clinical picture**

Induratio penis plastica involves dorsal, ventral or lateral curvature of the penis with chronic disease of both areas of erectile tissue, leading to scarring (plaques). Although the disease was first described in detail in 1743 by the French surgeon Francois de la Peyronie, there has to date been little or no research into the causes.

At the present time there is general agreement among experts that Peyronie's disease involves a multifactorial disease process, i.e. a number of factors may lead to manifestation. There is much evidence that repeated unnoticed micro-injuries to the dense white membrane (the tunica albuginea) covering the erectile tissue or the partition (septum) of the erectile tissue, can trigger induratio penis plastica. In the corresponding segments of erectile tissue involved, there is a so-called build up of

plaque in the connective tissue layer with nodular induration of the tissue. This is similar to and comparable with Dupuytren's contracture of the hand, where "shrinkage" is seen at the site affected, i.e. bending of the joint. With early diagnosis and treatment surgery can be avoided (Prof. Dr. Hartmut Porst, Urologist, Hamburg, 2012).

#### **3.3.2 Treatment approach**

##### **Testing**

See Chapter 1.1.2

##### **Treatment systems**

See Chapter 1.1.2 for the first four steps.

1. Basic therapy based on conductance reading
2. Treatment of blockages
3. Toxin eliminating organs
4. Therapy for pathogenic substances following testing.

## 5. Specific induratio penis plastica (IPP)

	Programs	Program no.	Program series no.
5.1	Tissue process, chronic	923.2	
5.2	Circulation disorders	3031.0, 504.0	
5.3	Shock		10147
5.4	Scars	910.3, 927.3, 341.4, 900.2, 910.5	
5.7	Skin treatment	350.4, 351.2	
5.8	Carpal Tunnel syndrome	301.3, 519.3, 928.0	

The area to be treated on the penis is rolled with the roller electrode applying gentle pressure to produce a massaging effect. The patient can also carry this out himself.

For *hyperaemisation* of the penis, especially in the plaque-forming region, oscillate via channel 2 potency *enhancing drugs* on resonance oil (see Impotence). The oil should be massaged well into the plaque regions on a daily basis.

Alternatively it is recommended to oscillate via channel 2 stored substances, musculoskeletal system, symptom complex: Dupuytren's contracture.

With regard to treatment frequency, I treat chronic complaints once a week. For more acute cases such as painful urinary tract infections 2-3x a week. In principle my patients always come for a minimum of 6 to 20 treatment sessions.

Since patients find the treatments to be extremely pleasant and the success of the

therapy is very quickly noticeable, my patients very often consult me after successful therapy on other 'health-related' matters.

A real advantage of bioresonance therapy compared with conventional treatment is its pleasant application, the work with the patient's own frequency patterns, substrates and the organ-related therapeutic procedure.

### **4 Closing word**

The field of urogenital diseases and their treatment is extremely complex.

I hope I have succeeded in raising awareness of this important and often taboo area of medicine and its ethics.

The use of bioresonance therapy is a valuable instrument in helping and healing these sensitive conditions.

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## 5 Appendix

### 5.1 Urogynaecology Medical History Sheet

How long have you been leaking urine?	Years, months, week (please underline the applicable) <input type="checkbox"/> I do not leak urine
<i>Please only answer the next 4 questions if you leak urine</i>	
In what situation(s) do you leak urine?	<input type="checkbox"/> coughing <input type="checkbox"/> sneezing <input type="checkbox"/> laughing <input type="checkbox"/> walking <input type="checkbox"/> jumping <input type="checkbox"/> exercise <input type="checkbox"/> sitting <input type="checkbox"/> lying Other:
Please estimate the quantity of urine leaked:	<input type="checkbox"/> drops <input type="checkbox"/> dribbling <input type="checkbox"/> large quantities <input type="checkbox"/> don't know
How often do you leak urine?	<input type="checkbox"/> seldom <input type="checkbox"/> only if cold <input type="checkbox"/> daily <input type="checkbox"/> U several times a day <input type="checkbox"/> continually
Do you leak urine without noticing immediately?	<input type="checkbox"/> no <input type="checkbox"/> only at night <input type="checkbox"/> only during the day <input type="checkbox"/> day and night
How often do you empty your bladder during the day?	Every _____ (hours, minutes) <input type="checkbox"/> very variable
How frequently do you have to go to the toilet at night because of an urgency to urinate?	_____ times
How quickly do you have to get to the toilet when you have the urge to urinate?	<input type="checkbox"/> I can wait more than an hour <input type="checkbox"/> within approx. 1 hour <input type="checkbox"/> within 30-60 minutes <input type="checkbox"/> 0 within 5-15 minutes <input type="checkbox"/> I cannot wait
Have you ever had cystitis?	<input type="checkbox"/> no, never <input type="checkbox"/> yes, when _____ <input type="checkbox"/> approxim. _____ infections a year
Have you ever had burning when passing water	<input type="checkbox"/> yes <input type="checkbox"/> no
How is your urine flow?	<input type="checkbox"/> strong, normal <input type="checkbox"/> weak <input type="checkbox"/> interrupted flow (stuttering)

## 5.2 Urogynaecological Diagnosis Sheet

Name, first name, date of birth \_\_\_\_\_

Weight \_\_\_\_\_ kg      Height \_\_\_\_\_ CM

### Gynaecological findings

	0	1	2	3
Cystocele level				
Urethrocele level				
Rectocele level				
Desc. uteri/stump				

### Paravaginal defect

no

yes, right side

yes, left side

yes, both sides

### Cystourethral transition

mobile

immobile

scarred

Other: \_\_\_\_\_

### Trophic

good

slight atrophy

severe atrophy

### Testing

0	=	no palpable contraction
1	=	barely detectable contraction
2	=	detectable but weak contraction
3	=	easily palpable contraction without resistance
4	=	easily palpable contraction against slight resistance
5	=	easily palpable contraction against strong resistance

### Stress test

Urine leakage lying

no

drops

'dribbling'

gush

miction

Urine leakage standing

no

drops

'dribbling'

gush

miction

### Pad weight test

(300ml bladder filling, 10 x coughs while standing, 10 x jumping actions, 10 x coughing while crouching / 1 minute handwashing)

Weight difference: Stress test: \_\_\_\_\_ g "hand-wash test": \_\_\_\_\_ g

Date: \_\_\_\_\_ Signature of tester: \_\_\_\_\_

© G. Schar, Frauenklinik Aarau 7/2004

### 5.3 Information Sheet Avoiding Urinary Tract Infections

#### Information Sheet

#### Avoiding repeated urinary tract infections.

Dear Patient,

You are suffering from repeated bladder infections. These infections usually occur because intestinal bacteria reach the urethra via the vagina and from the urethra get into the bladder causing an infection with the typical symptoms. Typical symptoms are a burning sensation when passing water, frequent urge to urinate, bladder pain and bad-smelling urine or urine leakage. It is normal for intestinal bacteria to occur near the vagina and the urethra. But in your case there appears to be a localised lowered resistance in the urethra or bladder so that bacteria there cannot be removed by the body on its own. By changing habits you may be able to improve your defence against infection and prevent the bacteria from entering the bladder.

The following changes in habits and measures are advisable (the steps applicable to you are marked with a cross):

#### Treatment program

- Fluid intake of at least 2 litres a day
- Urination after intercourse
- Caution when using spermicides for contraception (vaginal suppositories, certain condoms coated with spermicides)
- Hygiene measures: Wash around the anus after each bowel movement. Always wipe backwards away from the vagina
- Treatment of a vaginal infection: \_\_\_\_\_
- Hormonal treatment: \_\_\_\_\_
- Cranberry juice (Schloer, 3 dl a day) or Cranberry Extract (2 dl a day)
- Antibiotics treatment :
  - Furadantin ret. Dose \_\_\_\_\_ Duration \_\_\_\_\_
  - Bactrim \_\_\_\_\_ Dose \_\_\_\_\_ Duration \_\_\_\_\_
  - Noroxin \_\_\_\_\_ Dose \_\_\_\_\_ Duration \_\_\_\_\_
  - Colloidal silver Dose \_\_\_\_\_ Duration \_\_\_\_\_

We hope you will be successful using the proposed measures.

St. Moritz, \_\_\_\_\_Your personal physician \_\_\_\_\_

## 5.4 Miction diary

Date: \_\_\_\_\_ lsmall      cup (1dl)      mug (2dl)      small glass (2dl)      large glass (3dl)

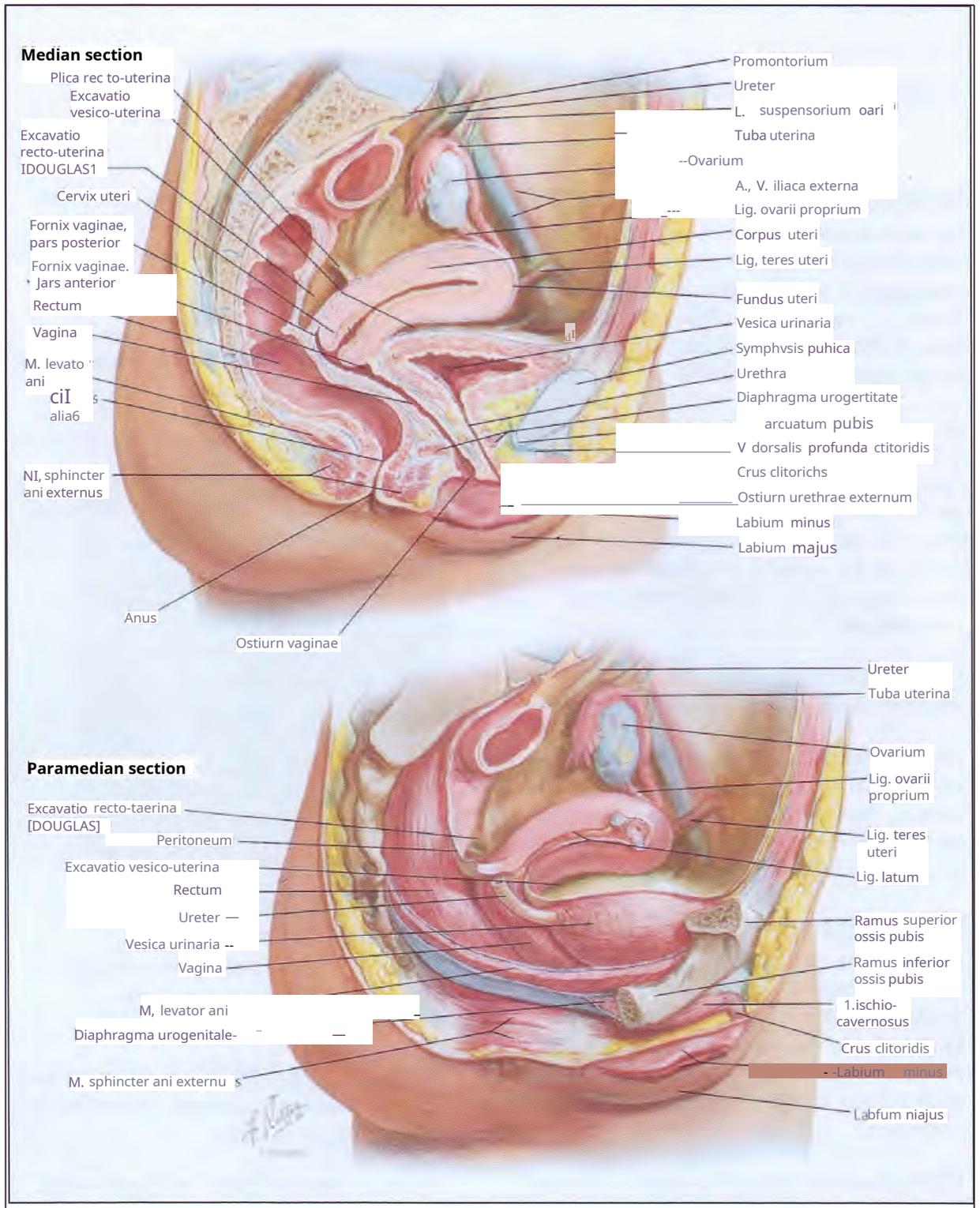
Time	Quantity (see above)	Urine qty in ml	Sudden urge to urinate?		Involuntary urine leakage	
			yes	no	a little*	a lot*
		please enter qty	please	tick	please	tick

<b>Total</b>						

\* a little = a few drops,    \* a lot = change of clothing or pad is necessary

(Pfizer AG, 2006, Zurich)

## 5.6 Pelvic viscera and perineum in women



Atlas of Anatomy: Frank Netter (1989), Thieme Verlag