

NEXT STEPS FOR **TOUGH** TREATING SIBO

MASTERCLASS SUMMIT + RESEARCH UPDATES

Peptides for SIBO with Dr. Farshid Sam Rahbar

Shivan Sarna: What a treat! Hi, I'm Shivan Sarna. And I'm here with Dr. Sam Rahbar and Dr. Allison Siebecker. And we're going to be talking about peptides today and the possibilities—fingers crossed—of their impact on SIBO and a variety of other topics that Dr. Rahbar specializes in. So let's just get started.

Welcome! Everybody is talking about peptides.

Dr. Allison Siebecker: Well, I wanted to hear what Dr. Rahbar had to say because I know you've been using them. I'm not sure what you've been using them for. So let's find out!

Can you just start by telling us a little bit about what peptides are and how you found out about them?

Dr. Farshid Sam Rahbar: Right! It actually is an interesting story. We've used peptides in our practice for many years. I think my first encounter with the BPC-157, which is a 15-amino acid peptide, goes back to 2011.

At that time, I met with an PhD from Croatia that worked originally with Dr. Sikiric in Zagreb on this peptide. And this was presented as a post-dissertation in the American Gastroenterological Association National meeting, a standard, traditional GI meeting. And this is where we met. We did an informal study. And I kind of learned they were doing a lot of healing fistulas in rats, he presented findings. He's feeding these rats with enterocutaneous fistulas. And by feeding them BPC-157, they had a faster healing of the fistular tracts.

That became very interesting. I said, "Look, maybe this peptide has a healing effect on surfaces."

And I continued. Since then, I've learned this peptide has been used for many other types of surface healing, including joints and soft tissue. It's not just limited to the gut.

Back in 2017, I gave a presentation at the American Academy of Anti-Aging, this is the GI module. Right after that, I flew to Zagreb, and I met with Dr. Sikiric who showed me his lab. And the research on this goes back to the 1990s. My question to him was had he been thinking about this. And he mentioned to me that they realized there was a peptide around the ulcers, in each of the ulcers, that the body was creating as part of the healing process. They were able to purify that. And then, he used it for a variety of injuries—for the nerve, injuries to the vascular system, cirrhosis, gallbladder.

There were numerous publications on this—they're not very clinical about it, but basic science research. There are a lot of publications about this.

In 2019, I met with the two doctors in San Diego, I went down and met them, they had eight additional abstracts in that meeting. It was an update to that research they did. By then, we had used BPC-157 probably over 500 times. By now, we're probably close to about 900 patient prescriptions in the way that I have used it.

I might recall maybe one or two patients who said, "Well, I think this doesn't agree with me. I've got some dizziness." And I'm not sure why, but we can't argue. You can't have everybody be satisfied with all products. And one person had said, "Oh, I got bloating from it." And that's all because a peptide of 15 amino acid usually doesn't cause fermentation and bloating.

But I said, "Okay, we'll do something else. I will switch us to a subcutaneous injection." And to this day, this patient does use the subcutaneous form of the BPC-157 which helped to reduce his overall body pain—the muscle pain, the joint pains. So it does have this anti-inflammatory effect that we sort of keep it as a backup.

When I spoke to Sikiric himself, he said that the majority of his research was based on the oral form with the animals. So I looked at his lab. He basically poured this in the water of the rats and the mouse in the study. And they looked at the effects and the clinical outcomes on those animals.

But we think it's safe because it's only 15 amino acids. It's generally in the stomach juice. And it has a healing effect on surfaces. So for gastritis, for ulcers, for esophagitis, it seems to have some role.

It also seems to neutralize the effect of the pepsin in the wrong place. So for some of the patients who have gastroesophageal reflux disease, or they may have, we may ask them to use the peptide closer to bedtime by opening the capsule and taking it with a little sip of water, so it would coat the lining.

Now, I don't have obviously publications for all of these. But I did find one article from Sikiric from 1990. And it took a week for our librarian to find this article, but I needed that reference in my presentation at the A4M. And it was about the use of BPC-157 for esophagitis where they put this stricture of the esophagus, exposed it to the acid, and one of them was prepared with BPC prior to that. The injury to the esophagus was remarkably less with the BPC. So it's something that seems to be safe in order for us to introduce that to our patients.

Anyhow, the BPC, at the beginning was in the form of a prescription. We had to order it from a special place. Unfortunately, that lab is not capable of providing this. But since then, there are lots of resources that have become available that will provide this without the prescription as a nutraceutical in a product. If you do a search online, you can see all the resources that come up.

Shivan Sarna: Dr. Rahbar, is this one of the brands that is a viable source?

Dr. Farshid Sam Rahbar: *Integrated Peptides*, exactly. That's what we're currently using.

Shivan Sarna: Okay, okay. And what is the dosage that you're currently using? And are people with SIBO noticing a big difference? And what would that difference be?

Dr. Farshid Sam Rahbar: So, even though there may be some information on the BPC that it may have antibacterial properties, I personally am not quite convinced of that phenomenon. And I don't use it just for SIBO. I use it when I believe there is, in SIBO, an associated leaky gut or increased intestinal permeability as manifested by food reactivity and histamine problems and so forth.

So, BPC is not my go-to in a SIBO scenario... just what else is associated with SIBO or the gut dysbiosis in general.

I forgot what the question was.

Shivan Sarna: Yeah!

Dr. Allison Siebecker: The dose... the dose...

Shivan Sarna: The dose...

Dr. Farshid Sam Rahbar: The dosing, thank you. The dosing, to be cost-effective, I usually use one capsule a day which is 500 micrograms. You

can go up to about four capsules a day. But obviously, it becomes costly. I think generally speaking, it's one to two capsules a day. They could be taken together or at separate times.

I personally like it to be taken on an empty stomach—however, realizing that the BPC, it's part of the intestinal juice and gastric juice, there's more problems taking it with food conceivably. But I think if you take it before you eat—maybe you time it in the morning (you wake up, it's the first thing)—then you guarantee that it is in, and you don't have to worry about it.

Shivan Sarna: Have you tried it nasally up the nose?

Dr. Farshid Sam Rahbar: Yeah, there is one laboratory in the US that use an intranasal version of it. We have not found that approach—

It may have some role as an anti-inflammatory in the recovery of the nasal mucosa. But I'm not really sure why one would use it as an intranasal if one could swallow it. It's a little bit counterintuitive for me to try to put it in the nose. Maybe it would be a replacement for the injectable form because of its absorption.

But I don't see any problems with trying it to see if the systemic inflammation can be reduced so long as the excipients that were used to prepare this as a nasal spray is not a big problem for the patient.

Dr. Allison Siebecker: How much does it cost? Shivan, you have that bottle there?

Shivan Sarna: I can't remember.

Dr. Farshid Sam Rahbar: It's probably less than \$200 nowadays for 60 capsules. I don't know the exact dollar amount of that.

Dr. Allison Siebecker: That's pretty spendy.

Dr. Farshid Sam Rahbar: Yeah, it is expensive, yes.

Dr. Allison Siebecker: ...especially if someone is doing maybe two a day. So then the question is do you think the benefit is enough to justify that cost in your experience of what you've used it for?

Dr. Farshid Sam Rahbar: I can say that the demand as patient requests has been very high on our part. We don't provide this more than a month's supply. But we looked at the number of times patients will return requesting additional refills. And the majority of the patients, probably 70% to 80%, has shown interest. That's all I can say. It's not a prospective study. It's not something that you put a little bit of money into it.

Again, within one to two months, generally, they'll be able to say if it's something they'd like to continue with.

My patients also understand this is expensive. Nobody is oblivious to that fact. So unless people have a sense that this is of some value to them, I don't think they would be coming back to ask for it.

Dr. Allison Siebecker: That's actually very helpful to know. I thought something you said was so interesting, that it's generated in the stomach juice. And I wonder if somebody has low hydrochloric acid production, would BPC also be lower? Could that be part of something that's occurring for people?

Dr. Farshid Sam Rahbar: It's a great question. I am not sure of that answer. Hypothetically, the answer is yes. And that's why, when you supplement, you would see benefits on that one.

But we can also say that maybe the low amount could be relative. Maybe they do need additional amount, and the body is not capable of producing that. However, I've not seen specific research on hypochlorhydria to say if that's the case or not.

I mean, there aren't too many labs that would do a research on BPC. If you see something like this, it should be coming from Sikiric's lab in Zagreb.

Dr. Allison Siebecker: Well, what you've said that it's used for so far is amazing. I mean, just when you started out with fistulas... you know, fistulas can lead to SIBO. That can be a risk factor for SIBO... I mean, for just tying it to

people who have SIBO. And also, pain, there's a lot of body pain as well as GI in SIBO as reflux of course. And then, leaky gut...

I mean, these are rather ubiquitous problems in SIBO. So I can see why there's been such an interest... all these really good uses.

And you said you've used it on, gosh, 900 patients maybe? What else are you using it for?

[14:00]

Dr. Farshid Sam Rahbar: Nine hundred patient prescriptions. Some patients could've returned. I don't know the exact number. But I'd say probably at least half the number of the patients .

Dr. Allison Siebecker: Yes, so what else are you using it for besides those indications?

Dr. Farshid Sam Rahbar: I mean, generally, the main scenario that I use it for is when there's evidence of intestinal injury. Now, it could be inflammatory bowel disease. We do have some animal data on ulcerative colitis. And when you think about inflammatory bowel disease or Crohn's or colitis, many of these scenarios, the inflammation for example could be colon. But the driver of the inflammation, the problem might be arising from the small bowel.

If you think about what then helps to improve intestinal permeability, this is a great thing to add in generally.

[15:00]

In our patient population, we also check for evidence of endotoxemia as a marker for leaky gut. And the endotoxin, which is lipopolysaccharide, the LPS, is in very small amounts. So it's not so easy to measure that in the blood in the human body.

A group of researchers from Finland had a study that LPS can be associated with fatty liver, pre-diabetes and diabetes risk. And so, it would be of interest to see whether we can actually just measure that. However, I realize of course, for example, who has that test, but they won't do it on human secretions.

Now, having that in mind, the LPS, if it's present in the circulation, it may be associated with an antibody. With a lot of that, I would start to look at the antibody effect against the LPS. And the amount of antibody formation, we can get a sense of what is the magnitude of the "leaky gut" or the intestinal permeability.

And we have an objective marker in the use of BPC, among other things, to be able to make healing effective.

Dr. Allison Siebecker: I have one more dosing question. It sounds like it's after about a month of use that someone can get a sense if it's helping them or you can get a sense of that. Is that about how long you'd give it?

Dr. Farshid Sam Rahbar: Yeah, I usually have patients take it for one to two months before we decide if this is not beneficial for them. And that is hard to know. But we do this among other things that we do.

For example, you can't just take BPC and have a SIBO that is ongoing. We can't have a scenario with fungal and a very active dysbiosis and fermentation and just take BPC. I don't think that's going to quite work. You almost want to do this as part of a protocol.

But many patients, as you know, have mast cell activation problems. They react to numerous things. And occasionally, this, among omega-3 and zinc and glutamine in some other scenarios, it can be used to create some level of control of the intestinal integrity before we move and attack, and try to do the clean-up process.

[18:00]

Dr. Allison Siebecker: Oh, that's interesting... like you'd almost use it before and then during your killing phase?

Dr. Farshid Sam Rahbar: Exactly, exactly.

Shivan Sarna: What about injections of the peptides, have you ever experimented with that? Taking a pill is so much easier.

Dr. Farshid Sam Rahbar: Yeah... I mean, the injectable is definitely more expensive. And it currently is not readily available. I am sure if you search, you're going to find some places. But all the websites where they sell them, they do have a disclaimer on them that this is not for human use. However, they have to do that. Either they become a pharmaceutical or some other type of company. They have to have a relationship, so that's the way it's presented.

But I'm positive that some conditions are using the injectable. For some of our patients—I've used it in one patient and I don't believe you need to go to Canada, probably available in the US.

Shivan Sarna: That makes sense. I don't know if you've said it before, but it bears repeating... exactly what is a peptide?

Dr. Farshid Sam Rahbar: A peptide is a form of a protein with a limited amino acids number—generally, we can say maybe less than 50 amino acids that are put together. And in the case of the BPC, it's 15. So obviously, when the numbers go high, it becomes a protein. Meat is a form of protein with numerous peptides and amino acids attached to each other.

Dr. Allison Siebecker: That's protein.

Dr. Farshid Sam Rahbar: Like a mini-protein...

Shivan Sarna: Right! No, that makes sense. That makes sense.

This is very exciting, the possibilities. I mean I have skin issues with my SIBO. So when I did take my first bottle of this, I did really feel good about it. I probably should've continued, but I was kind of pill-fatigued at the time. But I do feel like it did make a difference for me in retrospect.

Dr. Allison Siebecker: And what did it do for you, Shivan? Do you remember?

Shivan Sarna: I was with you at the SIBO Conference. Remember that? I was just like, "I don't know what it's doing, but I really like it." I just got this energetic hit from it. I know that sounds woo-woo everybody. There you go! That's what happened.

I do try to listen to my intuition. I have it for a reason. And then, I work with these great practitioners.

Dr. Rahbar, it sounds like people can get it through your office if they're your patients. And I bought my first bottle at a trade show. So can people just reach out to Integrated Peptides and order it, or do they need to go through a physician?

Dr. Farshid Sam Rahbar: You know, I actually don't know exactly what their procedure and policies are. It is a nutraceutical product. So I won't be

surprised if they can just purchase it. However, I do recommend you use this under the supervision of a physician or practitioner who has experience with it.

Dr. Allison Siebecker: And besides the BPC-157, are there other peptides you're using in your practice?

Dr. Farshid Sam Rahbar: Yes. We have now introduced the Tb4 fragments—Tb4 plus thymosin beta-4. And the fragment, it stands for a fragment of a Tb4.

The size of the Tb4 is about a tenth of the size of the original molecule which is the thymosin beta-4. And thymosin beta-4 is about 44 or 45 different amino acids. So with the Tb4 fragmented, it's a much smaller molecule with less chance of causing other side effects than sometimes people do with bigger molecules.

But the area that seems to be very fascinating with the Tb4 fragment and maybe some other thymus peptides is the anti-inflammatory effect it has which seems to be in perfect combination when one uses them with the BPC.

Now, I have one patient in Europe and one patient in the US. I can't think of anybody who took Tb4 fragments and said, "Oh, I want to have more of this. This was so nice." But these two patients clearly reported improvement in their food sensitivities.

So this is something that we're new to, but we're keeping it in mind. I do believe it's safe to use it as it works more as an immune balancer—trying to balance the TH1 and the TH2 balance. Particularly the TH2 activity in allergies, it tends to kind of calm it down.

And this particular patient, for example, I have in Europe, we have treated her for some gut dysbiosis, some fungal scenarios. But this was also part of the protocol that she was using. And she mentioned to me that, for the first time, she's able to go out and eat without worrying—which is very common in patients who have had Lyme disease and tick-borne disease. They tend to have significant environmental and food sensitivities.

Dr. Allison Siebecker: That's very exciting!

Dr. Farshid Sam Rahbar: I know, thank you.

Dr. Allison Siebecker: Any other peptides you're using?

Dr. Farshid Sam Rahbar: There will be other peptides. I will mention some names for you. I think the DSIP which is the deep sleep-inducing peptide for improving the sleep pattern. There may be some anti-inflammatory effect . These are additional peptides that I also am picking up momentum on.

[25:00]

I learn this by talking to colleagues. Sometimes, and it's not like everybody knows what's going on with this. And obviously, if it's simple and it's safe and it's affordable, it's worth giving it a try. Obviously, the safety profile is very important.

Now, the one other peptide which we have had lots of experience with is oxytocin. Oxytocin is not something that somebody has not heard about beyond the effect that it has on affection and maybe water retention and so forth. It seems to have a healing effect on the gut.

And the data on this was presented in the same conference in 2017, the A4M Conference by Dr. Lindsey Berkson who's another colleague that I've talked to. They have had a few scenarios where she tried the oxytocin. She shared her experience with using oxytocin, for example, in a patient with Crohn's disease.

When I looked this up, it appears to me that oxytocin may help to reduce stomach acidity. For somebody who has gastroesophageal reflux disease, and they may be hyperchlorhydric, which is not uncommon—I have to say that it is actually more common than low stomach acid. We've probably done over 200 Heidelberg tests here in my practice. It is a rare scenario where there'd be low stomach acid. A lot of people are more in the high stomach acid profile.

That's a side story that I don't know what to go into...

Dr. Allison Siebecker: That's actually extremely interesting because you run the Heidelberg test.

Dr. Farshid Sam Rahbar: Yeah... we have a lot of experience with this and I cannot really say, "Oh, everybody walking into the office has a low stomach acid." I would say a big caution with giving betaine—especially, you could be setting up SIBO because you're introducing hydrogen as a substrate, and it may add to the problem especially for methane-producers.

So, with that background, I would say the oxytocin is probably for people who have intractable SIBO. And this is available on Amazon, an intra-nasal product.

But I think you can titrate this before meals and see if reflux-type symptoms improve.

They may also have an effect on gastric motility. It's very interesting. We found some literature that low oxytocin may be associated with reduced gastric integrity. And if that's the case, then you can improve basically some of the stomach motility. And it's something that people can get, the spray in the nose. You can buy it on Amazon without a prescription.

Do we have a lot of details? No. But again, if it's safe, it's not too expensive, and it's not too risky, it may be worth a personal trial, especially when we're getting stuck in a clinical scenario.

Dr. Berkson also presented some information about the healing effects on the intestinal lining. I don't remember all the details . It seems to work with the estrogen receptor somewhat. And maybe you should interview her and see. Shivan. She also has a lot of podcasts that's out there which is nice to listen to.

Dr. Allison Siebecker: That's actually helpful for people listening. We can go and listen to her podcast.

[30:00]

Dr. Farshid Sam Rahbar: Dr. Berkson.

Dr. Allison Siebecker: This is just amazing, all these that you're telling us. I thought oxytocin was classified—well, I mean it's a hormone. Are you saying that we can't get the nasal spray without the prescription?

Dr. Farshid Sam Rahbar: Yes, absolutely... 10 parts, 10 units, I think it comes in 10 units. If you go more than 80 units a day, there's the possibility of water retention, hyponatremia. I think you do one spray in each nostril before meals. And again, this should be done under the supervision of a physician. I don't think anybody should take this as part of this presentation as a recommendation. But I've had a lot of patients who've tried that.

Dr. Allison Siebecker: Well, thank you so much for telling us all about peptides. Now, I know there's another amazing topic you have to share. And this is some clinical detective work you've been doing associating methane

and yeast. And we'd just love to hear what your hypothesis is and what you've been finding.

Dr. Farshid Sam Rahbar: Right! I mean I did give a presentation on this with Dr. Nirala Jacobi. It was almost an hour long. So I would invite everybody to listen to it. There are a lot of details over there. I would like to give you a snapshot of it. This Sunday, I did it with another physician, a naturopath in Australia. We sort of discussed the same thing. He suggested an observation.

But the part that is fascinating for me is why methane-producing archaea should produce methane in the proximal duodenum in levels of 1500? Why would you ever see a patient at that high level of methane in the duodenum?

Archaea are anaerobic. So they cannot really survive in an oxygen environment.

And the other one, fungus, loves oxygen. Fungus can be present with or without oxygen. But generally speaking, it likes oxygen.

It would be the perfect match! If you have fungal overgrowth in an area of the gut, you make it ready for the methane... which means, clinically, if you treat the methane without addressing the fungus, we would not substantially be addressing the underlying problem.

We started to look at evidence of fungus in the clinical picture. And this is something that, usually, in textbooks, they talk nothing about. This is not

recognized as an entity unless the fungus is invasive. I know Dr. Satish Rao talked a little bit about it at the conference. And it may be getting more attention.

But this subject is not new to us. We have dealt with this for the last 10 years. And we understand the clinical picture of yeast. And once one recognizes the risk factors, it becomes even more obvious in scenarios in the clinical picture of yeast as a main cause of fermentation.

Typically, we check the stool. And it's amazing that, in my observation, if I went back over my charts, probably 80% to 90% of the time, I see evidence of fungal growth in the stool. So we generally use labs that they grow this—not just within any lab. Genova does it. But I think their threshold is a little bit higher than Doctor's Data. And we do that with that lab. I don't have any preference, one lab over another. But I'd like to see if there's any evidence of fungal growth.

The interesting part is that some of the fungi that they grow in the stool, they were not *Candida albicans*. They were a type of fungi—I do have difficulty saying these long Latin names. They're hard to memorize obviously. I have to do a little research to see what these things are, the very recent findings. I said, "Oh, this is an opportunistic fungi you see in the hospital setting on chemotherapy or somebody who had a transplant." I said, "Look, how do you get opportunistic fungi showing up in somebody's stool?"

And the lab may call this in the normal range if it's only 1+. But I say the lab doesn't know the story of the patient. I have never seen a man having had fungus in the stool. I'm looking for an incident of a variety of symptoms before they even get blood culture.

The presence of the fungal growth in the stool is important. But we commonly see an association—

If you look at Genova, they may see that *Methanobrevibacter smithii* is pushing on the right side. But if you do a blood test, you see their number is above 10, there seems to be a correlation.

Now, having this in mind, I did a search on one. And I think I've sent you the article on that one. I said, "How do you grow archaea in the laboratory... hopefully?" I found one article, one bright PhD, that said, archaea, they have different methods to grow them.

This type of archaea—there are all different types of archaea. They have different culture mediums. So this guy who used the wrong culture medium, they didn't grow all of them. So I read through the methodology. And I read what's in that substrate growing these things here. And they're using fungi as a method, apparently creating an anaerobic environment. So, maybe that's what it is. And that's why I'm putting the pieces together.

So generally speaking, when I see somebody with methane, I'm also looking for fungals. And I can tell you, if I'm looking for fungus, I'm also looking for a cause of persistence of fungus. That's why I always say one has to think like an onion with layer one, layer two, layer three...

Why would fungi stay with us on an ongoing basis? In many of these patients, either they have evidence of stealth infections and/or they have evidence of mold toxins.

In California, I always say our regulations are very good for earthquakes. They are not good for cracks in the walls of Californian homes. And I think a lot of homes are water-damaged. And in susceptible people, the presence of the mold may be similar to that, in that maybe some of this will reside in their sinus cavities or in their gut. We see the evidence of the toxins more shown in the urine. And that may be another area one has to start to address to be able to break up the hierarchy that is developed within patients with methane SIBO.

I hope that was not too long.

Dr. Allison Siebecker: It was perfect! It was amazing. I've been so intrigued. Yes, thank you. I'm so intrigued with this ever since you wrote to me about it six or more months ago. I just think it's an amazing premise and is very important for all of us to consider that if somebody has hard-to-get-rid-of

methane, we should look to see if they have yeast. And we might not be able to get rid of their methane unless they get rid of their yeast.

And if we are having trouble getting rid of their yeast, we need to look at these other factors like mold and chronic hidden infections. That's the two you were saying, right?

Dr. Farshid Sam Rahbar: Exactly! That's it. I mean, we should also include heavy metals. I think that's important. And I do have one child recently who had very severe SIBO. I'm talking about hydrogen in the hundred in a 6-year old. And interestingly, the urine shows evidence of metal. The metal test, it shows high levels of metals.

And these are things that we don't hear about. But we need to start to see how our body relates to the environment. And we need to learn more environmental medicine and the chemicals that we're constantly dealing with.

The next area of interest that I've developed through discussions will have similar content, but the subtleties are going to be different. And it's going to be about microbiome disruptors. I think this is what we need to think about... what disrupts the microbiome?

And that is in harmony with endocrine disruptors which came from the pesticides and other things.

But now that we're doing more environmental toxicity and chemical exposure, I think we need to think about what disrupts the microbiome because SIBO is really a form of a disordered microbiome disruption, that something is not allowing it to go back to its previous scenario.

Shivan Sarna: Absolutely! Just off the top of your head since we have just a few more minutes, some of the other microbiome disruptors you just mentioned are like medication, I think my microbiome gets disrupted when I drink softdrinks. What are some other things? Of course, environment toxins and mold... what are some other things that you're observing that would be microbiome disruptors?

Dr. Farshid Sam Rahbar: I mean, beyond stress (which is a major factor), lack of sleep, late eating (too much, too late, too fast), sugar substitutes, alcohol and drugs, antibiotics...

Beyond these, we need to understand the environmental chemicals. This is one of those areas that, when we come as an outsider, you read all these chemicals with long names—first, you have to learn the names, and then relate to their personality.

[40:00]

The two that really had been a stand-out for us, one is the BPA, the bisphenol-A because more and more (and we know that can exist in many

ways); and the other one is glyphosate or the RoundUp which shows up quite frequently in the urine samples. It's very important.

I do not have any patient who does not have glyphosates. The only thing is how much. And I think this would be another microbiome disruptor to consider.

Shivan Sarna: Of course...

Dr. Farshid Sam Rahbar: ...and the metals, heavy metals.

Shivan Sarna: Heavy metals, of course.

Dr. Rahbar, thank you so much.

Dr. Farshid Sam Rahbar: Thank you! Thank you for inviting me. I appreciated it!

Dr. Allison Siebecker: Thank you so much!

Shivan Sarna: Dr. Siebecker, thank you for introducing me to Dr. Rahbar many years ago. I appreciate it. And that makes me think... anybody who meets you, Dr. Rahbar, is going to want to be your patient (just like I wanted to be your patient, just like I am your patient).

If someone wanted to be your patient, are you doing telemedicine these days? How can people get a hold of you? What's what?

Dr. Farshid Sam Rahbar: I mean, our website has all the information. If one needs to contact us, you do it by our form where we have our email. We still are going to accept new patients. And we also do telemedicine.

Personally, I like to meet the patient at the first visit, in the practice, that connection the first time is very valuable.

However, we have been still quite successful working with patients across the globe now—in many ways, using telemedicine technology.

Shivan Sarna: It's very exciting! What is the name of your website again?

Dr. Farshid Sam Rahbar: LIntegrativeGI.com.

Dr. Allison Siebecker: Thank you, Dr. Rahbar.

Shivan Sarna: Thank you.