

StaphWash™

Formulated to wash MRSA and other
Staph bacteria from skin

For use on skin

StaphWash Field Trial Results

as of May 20, 2007

Confidential, not for public disclosure.

This documentation is for use during the evaluation of a new product.

"The superbugs are here," says Martin J. Blaser, MD, president of the Infectious Diseases Society of America and the chair of New York University Medical School's department of medicine. "And it doesn't take a crystal ball to see that even more problems are coming."



Field Trials

In November, 2006, the manufacturer began field trials to evaluate StaphWash as an anti-bacterial skin cleanser.

It has been formulated for the following applications:

1. For an open lesion which may not be infected with bacteria, application of StaphWash is intended to PREVENT staph bacteria, including MRSA, from forming a colony at the site where StaphWash is applied and used as directed.

2. For a MRSA-infected lesion, StaphWash is formulated to attack the bacteria, and allow the lesion to heal in a normal manner.

StaphWash is not a drug. It is a skin cleanser. It uses six mechanisms of action to attack MRSA and other bacteria. It tingles a bit when applied to an open lesion, but the sting is less than what would be felt if isopropol alcohol were applied to the lesion.

What is a MRSA staph infection?

Community-Acquired Methicillin-Resistant *Staphylococcus aureus* (MRSA)

Skin Infections

Fact Sheet for Healthcare Providers

Staphylococcus aureus is a common etiologic organism in soft tissue infections and may be found on the skin of nearly 20% of healthy people. Over the past several decades, infections with methicillin-resistant *Staphylococcus aureus* (MRSA) among hospitalized patients have become common. Recently, reports of MRSA infections acquired outside of the hospital setting have increased nationally.

<http://www.ochealthinfo.com/epi/mrsa/providers.htm>



What is the cost when you have MRSA?

MRSA patients are four times more likely to die and stayed in the hospital two and a half times longer than patients without the antibiotic-resistant infection.

The report by the Pennsylvania Health Care Cost Containment Council is the first in the nation with statewide statistics on hospitalizations of patients with MRSA. The Pennsylvania agency found 13,722 patients with MRSA, based on 2004 data, the latest available. MRSA patients are four times more likely to die and stayed in the hospital two and a half times longer than patients without the antibiotic-resistant infection. Hospital charges for patients with MRSA were three times higher than charges for patients without the infections.

“The prevalence of MRSA in every hospital in the U.S. poses a very serious health risk to patients who are unwittingly exposed to these superbugs,” said Lisa McGiffert, Director of Consumers Union’s Stop Hospital Infections campaign.

Ref: http://www.consumersunion.org/pub/core_health_care/003679.html

NBC Today Report on MRSA

MRSA: Superbug Or False Alarm?

J. Scott Wilson, Staff writer

UPDATED: 10:04 am EST January 3, 2007

Methicillin resistant staphylococcus aureus, or MRSA, is present in the general population, is more easily transmissible than ebola and can be found in common places and situations. While it is treatable, MRSA is a bona fide superbug that shows no inclination toward disappearing.

What Is MRSA?

Staph is one of the most common skin bacteria. Approximately 25 to 30 percent of the general population is colonized by staph in the nose, meaning the bacteria are present but not actively causing any infection. According to Jennifer Morcone, a representative for the Centers for Disease Control and Prevention, some types of

staph have grown drug-resistant since the invention of penicillin and other antibiotics, making them more difficult to treat. MRSA is one of these resistant strains.

In a health-care environment, MRSA is a deadly threat. It infects surgical patients and anyone who has undergone an invasive procedure or has a weakened immune system. According to the CDC, MRSA in health-care settings commonly causes serious and potentially life-threatening infections such as bloodstream infections, surgical site infections or pneumonia.

It is an opportunistic infection, attacking those who are already weakened and making their situations worse. In other community settings, MRSA is less serious at its onset but can become very much so if ignored.

The first-line antibiotics, Morcone said, the ones originally used to treat staph and many other bacterial infections, have largely been rendered useless. Bacteria, like all living things, adapt to threats in their environment. Over the decades, they have to varying degrees become resistant to treatment. According to the CDC, approximately 1 percent of the general population is colonized with MRSA.

Methicillin is one of a class of antibiotics called beta-lactams, which also includes amoxicillin, penicillin and oxacillin. Newer, more powerful and expensive antibiotics must be used to combat MRSA, but according to Morcone it's critically important that the right drug, rather than just the most potent one, be used.

MRSA was once primarily found in health-care settings such as hospitals and clinics. In the last few years it has begun to show up in sports teams, prisons, military recruits, as well as other groups such as Native Americans and men who have sex with other men.

In Great Britain between 1992 and 2002, the percentage of staph infections that were methicillin resistant increased from 3 percent to 43 percent. According to the CDC, in the United States the percentage of all drug-resistant staph strains, including MRSA, increased from 2 percent to 63 percent of the total cases.

What Are The Symptoms?

MRSA is primarily a skin infection. It shows up in non-health-care-related cases primarily as pimples and boils, which may swell and become inflamed to the point that they require lancing by a doctor.

Very serious cases of MRSA can cause pneumonia and bloodstream infections, so it is important to seek medical attention if you have a skin infection that is red,

swollen, painful and has pus or other drainage. It may not be MRSA, but it's important to find out.

How Is MRSA Transmitted?

According to Morcone, MRSA is transmitted primarily through skin-to-skin contact. It is not airborne, so coughing and sneezing will not spread it. It can be carried on towels and clothing, so it's important to take simple cleanliness steps to keep yourself safe.

Frequent handwashing, especially after any activity involving close contact with others, is one of the best protections against infection. Avoid sharing towels and personal care items.

Wounds are open doors through the protective outer layers of your skin, so it is very important that open wounds be kept clean and covered with clean bandages that are changed frequently.

What Is The Danger?

Pandemic is a word that gets attached to diseases very frequently. Morcone said it does not apply in the case of MRSA. Because of the method of transmission, a widespread outbreak is considered highly unlikely by the CDC.

That does not mean there is no concern, however. More and more cases are appearing outside health-care settings, and raising public consciousness about the transmission and dangers of MRSA is one of the best ways to fight the spread.

MRSA Transmission between Cows and Humans

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Abstract

We isolated methicillin-resistant *Staphylococcus aureus* (MRSA) from cows with subclinical mastitis and from a person who worked with these animals. The bovine and human strains were indistinguishable by phenotyping and genotyping methods and were of a low frequency *spa* type. To our knowledge, this finding indicates the first documented case of direct transmission of MRSA between cows and humans.

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<http://www.cdc.gov:80/eid/content/13/4/630.htm>

Section 2

StaphWash Field Trial Results

as of May 20, 2007

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StaphWash is manufactured by Phillips & Co.

Contact: Tel. 501-888-3040

StaphWash Laboratory Test Results

StaphWash has been tested by a physician-professional microbiologist team in an independent university pathology laboratory. Experimental culture-study results showed that a single drop of StaphWash completely neutralized MRSA bacteria. These results were repeated in subsequent evaluations of StaphWash.

Laboratory culture-studies were done to evaluate the concentration-dependence of the effect of the primary active ingredient in StaphWash. At concentrations greater than 2%, the effect was virtually the same for all concentrations tested -- a single drop of StaphWash completely neutralized MRSA bacteria.

Laboratory culture-study evaluations of alternative products, including antibiotic products, were carried out. StaphWash compared favorably in these preliminary tests.

Clinical Results

StaphWash has been used in a clinical setting to clean bacteria-infected lesions. Lesions that would not heal in response to antibiotic treatment showed good progress after being cleaned with StaphWash. More information is provided later in this document.

A specific example of actual clinical results involved a patient who presented with an infection that was due to a form of enterococcus bacteria, based on a culture study. A second culture test was carried out to evaluate the effects of StaphWash. Two specimens were taken from the lesion. The specimens were taken from the discharge (liquid) and the two specimens were taken in an identical manner.

One specimen was treated with StaphWash; the other was not. Both specimens were sent to the lab. The lab report for the specimen not treated with StaphWash showed a bacteria colony count of 27 colonies. The report for the specimen treated with StaphWash showed a bacteria colony count of 2 colonies with a notation from the lab saying "scant growth."

The conclusion drawn from the culture test was that the application of StaphWash resulted in approximately 92.6% less bacteria. The bacteria growth from the specimen treated with StaphWash was only 7.4% as much as the growth from the specimen NOT treated with StaphWash.

Limitations of StaphWash

StaphWash is formulated to neutralize Gram-positive bacteria. Specifically, StaphWash is formulated to clean lesions that show signs of staph infections with methicillin-resistant staphylococcus aureus (MRSA). StaphWash is not formulated to clean lesions having Gram-negative bacterial infection.

Brian fought MRSA infection and his lesions healed quickly

Brian T. works in a pharmacy in Little Rock. He was diagnosed with MRSA on December 14, 2005. MRSA is a well-known staph infection that has evolved to become resistant to all forms of antibiotic treatments. It is systemic in nature, and usually interferes with normal healing of most skin lesions.

In mid-November Brian noticed inflammation around a scar from a previous MRSA-infected lesion. He used StaphWash on this new outbreak by applying the StaphWash topically. He noticed some drying of the area and the skin surface flaked away after 5 to 6 days after he began using StaphWash. That area looked much better two weeks after using StaphWash, and shows no signs of expanding in size or discoloration indicating continuing inflammation.

StaphWash is an anti-bacterial skin cleanser formulated to kill MRSA bacteria on contact. The use of StaphWash is intended to keep the MRSA from growing in skin lesions. MRSA bacteria causes infection and inflammation, and prevents normal healing of skin lesions. The successful application of StaphWash is expected to result in the lesion being dried up. Before using StaphWash, the lesion is typically red and inflamed. During the use of StaphWash, the tissue should return to a normal healthy-looking pink color. Normal healing of the lesion can proceed, with decreasing StaphWash application over time until healing is complete.

StaphWash is an experimental anti-bacterial skin cleanser, being evaluated by selected individuals who suffer from systemic MRSA staph infections. It does not treat the tissue or the body; the main purpose of StaphWash is to clean the lesion and prevent MRSA bacteria from growing in lesions.

Brian's next bout with MRSA-inflamed lesions followed a hunting trip. While hunting, he wore an Under Armor shirt for warmth. The Under Armor kept him warm, but the possibility of a warm skin surface, with some perspiring over an extended time period is suspected to be a contributing cause for the outbreak of lesions that followed. (See Note 1)

Note 1: Staph bacteria prefer warm, damp skin areas. Bacteria do not breed and prosper well in dry lesions or on dry skin.

After the hunting trip, Brian had approximately a dozen lesions that appeared on his skin from his hips to his armpits. These lesions showed the typical inflammation that occurs when MRSA bacteria is involved.

Brian's physician prescribed Bactrim ointment and also Bactrim oral medication, but these medications were not immediately effective in healing the new outbreak of lesions. According to the manufacturer of Bactrim, it is an antibiotic combi-

nation used to treat or prevent infections. Bactrim contains sulfamethoxazole and trimethoprim. Side effects that may occur while taking Bactrim medication includes dizziness, headache, loss of appetite, mouth sores or swelling of the tongue, nausea or vomiting and tiredness. StaphWash, by comparison, is a skin cleanser formulated to kill bacteria on the skin with none of the side effects (given above) which are listed by the manufacturer of Bactrim.

On 11/30/06, he decided to continue using the perscribed medications and use StaphWash on only a portion of the lesions. The goal was to observe the lesions and note any difference between the ones cleaned with StaphWash and the other lesions NOT cleaned with StaphWash. (See Note 2)

Note 2: StaphWash contains a surfactant which has been shown effective in chemically neutralizing partially-hydrophobic toxins and venom enzymes. To the extent that bacteria are partially hydrophobic, the surfactant adsorbs to the surface, thereby changing the bacteria's surface chemistry. This mechanism of action is intended to neutralize the staph bacteria and allow the skin to heal in a normal manner. Lesions NOT cleansed with StaphWash might be expected to heal at a slower rate, or perhaps become more inflamed as a result of the bacteria infection.]

He had 12 lesions ranging in size from just smaller than a dime to the size of a half dollar.

He continued using StaphWash on three of the smaller lesions, with one application of StaphWash per day on the lesions. This continued on Thursday, Friday, Saturday and Sunday (December 3). The StaphWash was applied after a hot shower, when the lesions were wet and oozing. He noticed that a few hours after the application of StaphWash, the lesions seemed dry and even somewhat "scaly." (See Note 3)

Note 3: StaphWash uses gentle abrasion to achieve more-effective cleansing action. Sodium carbonate and calcium carbonate with small concentrations of silicon dioxide are used for gentle abrasion to physically remove protective films which can harbor bacteria.

On December 3, Brian noticed that the three lesions being cleansed with StaphWash appeared to be much improved. The spots appeared to be less inflamed, and the color had begun to return to a healthy-pink color. This was particularly true for one of the troublesome lesions on his skin near the armpit. It was obvious to him that the three lesions being cleansed with StaphWash were healing at a

much more rapid rate than the other lesions.

Based on these observations, Brian made a decision on December 3; he decided to use StaphWash on ALL 12 of the lesions.

Brian's next report on his progress was on December 6. He noted that all of the lesions were healing. He said "This stuff is definitely helping. I'd tell people to buy it and try it." (See Note 4)

Note 4: StaphWash was not offered for sale in 2006. It was provided free of charge to anyone with systemic MRSA during field trials.

On December 11, Brian reported that "ALL the spots are drying up, and they ALL look good." He noted that "all the middles are gone," meaning that all of the lesions that previously had puss pockets were now healing, and there was no current signs of weeping or puss leakage from any of the lesions.

He had been applying StaphWash two times daily since December 6 (for the past 5 days). He reported that the drying effect was entirely adequate, and that the surface of the lesions appeared to be slightly "crusty" in appearance. (See Note 1 and Note 3 for an explanation of why this is a desired result.)

Brian sometimes feels a "needle prick" feeling when he turns or moves in a way that perhaps puts some pressure on the lesions. The cause of this occasional feeling is not known for certain, but it probably is related to a slight stretching of the thin skin as the lesions heal.

His lesions seemed to be bacteria free, based on the light pink color of the healing tissue. As of December 11, he could not locate any sign of redness or inflammation, including swelling, that would normally be associated with an infected lesion.

When asked for his bottom-line opinion about whether the StaphWash had been a factor in his healing process, he said, "The healing was fast after I started using the StaphWash. I've been through this before I had StaphWash, and I know the healing definitely would have been slower without it. Before StaphWash, when I was using only antibiotics, the healing was much slower."

He considered himself to be virtually healed, with no additional follow-up required.

On December 11, 2006, Brian gave his permission for this information to be disclosed without restriction.

Jimmy Watson's success using an anti-bacterial skin cleanser to fight MRSA and allow rapid healing of lesions

Jimmy Watson is an auto mechanic in Little Rock. He suspects that his first MRSA infection happened about four years ago, when he had a lesion under his arm, in the armpit area. Because it was slow to heal, he sought medical attention. He was treated using antibiotics and a salve for use in his nostrils. Eventually, the lesion healed.

But, he continued to have problems with infected lesions until recently when he got a definite diagnosis. On November 30, 2006, his physician, Dr. Joseph Nelson at Baptist Heath in Bryant, Arkansas, diagnosed his condition as a MRSA staph infection. On the following day, December 1, 2006, the diagnosis was confirmed.

THE LARGER LESION — His physician lanced one lesion on November 30. That lesion was approximately 1 inch in diameter. It was located on his wrist.

THE SMALLER LESION — When Jimmy showered that day, he noticed another lesion developing on the skin in the groin area. It quickly developed into a hardened knot, in the form of a circular spot about 1/4 inch in diameter. The lesion was obviously infected, as indicated by a red, inflamed appearance with a small “puss pocket” in the center of the lesion.

THE USE OF STAPHWASH -- He began using StaphWash on Friday, December 1. (See Note 1)

Note 1. StaphWash is formulated to function as an anti-bacterial skin cleanser. StaphWash allows normal healing of skin wounds and lesions after MRSA and other bacteria, including other staph infections have been cleansed.

Jimmy began using it on the day his friend Joyce had received StaphWash from her friend Jennifer.

He decided to leave the larger lesion untreated, and use StaphWash on the smaller lesion. He applied it three times during the course of the day and noticed that there was a mild burning sensation when StaphWash was applied to the open lesion. (See Note 2)

Note 2. StaphWash contains chlorine. Chlorine-based disinfectants have been proven effective as a MRSA bacteria killer. The EPA has registered a chlorine dioxide product for use as a disinfectant on skin and on hard, non-porous surfaces and instruments,

including those used in hospitals and other medical settings. Under normal use when applied to an open lesion, StaphWash will cause a sensation similar to how eyes burn a bit when exposed to swimming pool water treated with chlorine. This burning feeling is usually less than the sting felt when isopropol alcohol is applied to an open lesion.

The next day (Saturday), he applied StaphWash three times, and noticed some changes. The first change was that the knot had diminished in size. He had to “feel for the knot,” because it was much less prominent than it had been on the previous day.

The second change that he noticed was that the skin area seemed to be drying up a bit. (See Note 3)

Note 3: StaphWash is formulated to promote drying of the lesion, because staph bacteria prefer warm, damp skin areas. Bacteria do not breed and prosper well in dry lesions or on dry skin.

On the following day (Sunday), he applied StaphWash two times and continued to notice changes. The most obvious change was that the knot had diminished and it was no longer a hardened mass.

The next change was that the lesion appeared less inflamed, and the discoloration of the skin had diminished. No scab had formed on the lesion during the application of StaphWash. He noticed that the underlying skin had begun to appear more healthy, with a “healthy pink” color, and the lesion showed slight signs of peeling. (See Note 4)

Note 4: StaphWash uses gentle abrasion to achieve more-effective cleansing action. Sodium carbonate and calcium carbonate with small concentrations of silicon dioxide are used for gentle abrasion to physically remove protective films which can harbor bacteria.]

On the next day (Monday), he applied StaphWash twice and noticed a definite improvement in skin tone. The lesion was a light-pink color; the tissue color normally associated with non-inflamed, non-infected healing. (See Note 5)

Note 5: StaphWash contains a surfactant which has been shown effective in chemically neutralizing partially-hydrophobic toxins and venom enzymes. To the extent that bacteria are partially hydrophobic, the surfactant adsorbs to the surface, thereby changing the bacteria's surface chemistry. This mechanism of action is

intended to neutralize the staph bacteria and allow the skin to heal in a normal manner.

On Tuesday (December 5), he continued to apply StaphWash and when asked whether it was helping him, his friend Joy said “Jimmy swears by it now.”

Jimmy refers to StaphWash as “Jennifer’s stuff.”

The account given above was reviewed by Mr. Watson’s designate on December 6, 2006 and found to be correct on all points.

Jimmy’s next report was received on December 11. The report was very positive, and he was very pleased with the results obtained using StaphWash.

He was “doing wonderful.” The lesion in the groin area (the smaller lesion) was gone. It was completely healed, with no scab or other remnants of the former lesion. He thought the reasons that this lesion healed so rapidly were (1) StaphWash was used in the very early stage, before the lesion developed into a larger infection; (2) this lesion was the smaller of the two lesions; and (3) the smaller lesion had not been surgically treated, so it had less trauma history.

The larger lesion, on his wrist, was much improved and healing rapidly. The tissue was a healthy-looking pink color where the puss pocket had been. The depression, presumably due to the surgery to lance the infected lesion, was healing and looked good.

When asked for his opinion about whether the StaphWash had been helpful, he replied, “I believe it works!” Referring to the effect of StaphWash on the MRSA-infected lesions, he said “It stopped it.”

He considered himself to be virtually healed, with no additional follow-up required.

This was a successful outcome, but when MRSA is in the body, it can be systemic. When this is the case, there presently is no cure. Antibiotics usually don’t “end the problem for life.” In this case, there usually are future episodes of skin lesions that can become inflamed because of bacterial infection. When this happens, it is a good idea to begin using StaphWash at the very first sign of an inflamed area on the skin, so that bacteria can be prevented from forming a colony and developing into a fully-developed boil.

This account was approved as correct by Mr. Watson’s designate on December 11, 2006. Permission was given for this information to be used without restriction, including the use of his full name.

Nan P and her bouts with MRSA and pressure sores

Nan is a retired school teacher living in Kingston, Oklahoma. She was diagnosed with MRSA in April 2006. She had been treated for lesions by her physicians using antibiotics and hyperbaric oxygen treatments. She experienced healing of the lesions during the months that followed.

Another lesion appeared in November 2006. This lesion was most likely a pressure sore caused by physical inactivity. She was seen by her physician on November 22. Because this lesion presented another opportunity for MRSA bacterial infection, she was treated with Minocycline (100 mg) oral antibiotic medication. She also was treated with Clobetasol propionate (0.05%) topical ointment. Other medications, including Silvasorb, Laprox and zinc oxide treatments were used as well.

Minocycline is a member of the tetracycline family of antibiotics. It has a broader spectrum than the other members of that family of antibiotics. It has been used to treat certain strains of MRSA infection. One of the great advantages of Minocycline is the inability of bacteria to become resistant to it when used to combat existing highly-resistant bacteria including MRSA.

Several types of antibiotic medications, including tetracyclines, work by inhibiting the action of certain enzymes. Bacteria use these building-block enzymes to produce proteins from which new bacteria DNA is formed. When these building blocks have been removed, the reproduction of bacteria is prevented. Over time, the existing bacteria will die but new cells won't be able to take their place and the bacterial population will dwindle. It is likely, therefore, that Minocycline also inhibits the action of other enzymes which have nothing to do with the reproduction of bacteria. This could explain why the drug is being used (in effect as an immunosuppressant) to treat MS.

RELEVANT SIDE EFFECTS of minocycline: A number of patients who had taken Minocycline appeared to be suffering from a form of depression or Chronic Fatigue Syndrome. Minocycline is known to cause a Serum-Sickness-Like Reaction. This is a type of delayed allergic reaction, in which the immune system interprets the antibiotic as a foreign threat, as if it were animal protein.

As noted above, Nan also was treated with clobetasol propionate (0.05%) topical ointment. Clobetasol propionate comes in ointment and emollient cream presentations. It is a very high potency topical corticosteroid that should not be used with occlusive dressings. It is recommended that treatment should be limited to

2 consecutive weeks and therapy should be discontinued when adequate results have been achieved.

POSSIBLE SIDE EFFECTS of Clobetasol propionate: Published possible side effects of this drug include Acneform eruptions, Allergic contact dermatitis, Burning sensations, Cracking and fissuring of the skin, Cushing's syndrome, Dryness, Erythema, Folliculitis, Hypertrichosis, Hypopigmentation, Itching, Irritation, Millaria, Numbness of fingers, Perioral dermatitis, Pruritus, Secondary infections, Skin atrophy, Skin maceration, Stinging, Striae and Telangiectasia.

Nan is a long-term MS patient. She was diagnosed with MS in 1987. Because of the progression of MS, she is not physically active. The lesion, located on skin surface on the buttock, has received limited exposure to air as a result of her spending much time in a sitting position. The slightly inflamed area measured approximately 5 inches x 6 inches, with an open lesion approximately 1/4 inch in diameter.

NAN'S EXPERIENCE WITH STAPHWASH: She had access to StaphWash near the end of her hyperbaric oxygen medical treatments but she only used StaphWash twice during one day and noticed some drying of the skin near the lesion. StaphWash promotes some drying of the lesion to discourage bacterial colony formation. Nan did not realize that this was a desired effect, so she discontinued using StaphWash when she noticed the dry skin.

Later, in November 2006, when another lesion appeared in the same area, Nan decided to use StaphWash on a trial basis. Other than the chlorine-induced sting when applied, StaphWash has no known undesirable side effects. It is not a drug. It is an anti-bacterial skin cleanser. It can be used frequently for best effect; overdose is not a problem.

During the first three days, she noticed a sting when the StaphWash was applied to the open lesion. But after the third day, as healing progressed the sting was no longer noted during the use of StaphWash.

The beneficial healing that was experienced prior to December 10 can not be credited to StaphWash alone, because a broad mix of treatments were being used, including oral antibiotics and a range of topical applications as noted above.

After five days of StaphWash application, the lesion appeared to be healing, based on a reduction of the redness and discoloration. Because of this initially-encouraging result, she requested more StaphWash from the manufacturer on December 10. On that date, she decided to use StaphWash as the only topical application for the next few days as a trial evaluation.

After December 10, conclusions about the effectiveness of StaphWash will be more clearly identified.

On December 14, Nan reported that the large area (4" x 5") had been dark red only two days earlier (On the evening of December 12), but the color had improved and the area seemed less inflamed by the following morning (December 13).

SUCCESS AFTER ONLY 10 DAYS OF USING ONLY STAPHWASH: From December 10 through December 20, Nan's lesions were cleaned with StaphWash on a regular and frequent basis. The lesions seemed to heal in a healthy manner.

DISMISSED BY HER PHYSICIAN: She saw her Physician, Dr. Hill, on Wednesday, December 20. During the medical examination, she was told that the skin "looks fine" and "nothing else needs treatment at this time." She was dismissed by her physician and asked to return if needed in the future. She was pleased that she was not required to repeat IV antibiotics and hyperbaric oxygen treatments for months. Her bottom-line reaction was "HooRay!"

THEN ANOTHER LESION DEVELOPED: On Christmas day, she travelled to visit friends and relatives. She was sitting either in the car or in a wheelchair for approximately 8 hours. This caused considerable stress on the skin area previously troubled by pressure spot lesions. The result was that another lesion appeared at the end of the day.

StaphWash was immediately used to clean the lesion. On the first day, she reported tingling when the StaphWash was applied. Then, on the second day, less tingling was noted, followed by the third day when no tingling was noted. On December 29, her sister reported that the healing of the lesion had progressed rapidly, and was on the way to being back to normal.

Note: This account was approved (as accurate) by Nan on December 11, 2006. Permission was given for this information to be disclosed without restriction.

Dale C and his experience using StaphWash

Dale is an automechanic in Little Rock, Arkansas. Although he has not been medically diagnosed as a MRSA patient, he did develop an inflamed lesion on December 25, 2006. The lesion was on his arm, and formed a knot about the size of a half dollar. The lesion was inflamed (redish color) and it was weeping with the production of a transparent fluid. He was given StaphWash, and began using it soon after the lesion developed.

On December 27, Dale reported that the “red was mostly gone.” The size of the lesion had decreased to the size of a quarter, and the mass associated with the knot had decreased in size. He was sure that it was improving and healing.

A SUCCESSFUL RESULT: On January 2, he reported that the swelling had been considerably reduced, and the lesion had decreased in size to about 1/4 inch in diameter. The lesion still showed some signs of drainage of both a transparent and a slightly yellow color. Dale considered this lesion to be healing at a good rate. Dale had not been taking antibiotics, so the healing is believed to be due to the body’s natural tendency to heal and in this case, the healing is believed to be assisted by the use of StaphWash to attack the bacterial infection

GUESSING ABOUT THE CAUSE OF HIS LESIONS: Although undiagnosed, his lesions are suspected to be MRSA, because his coworker, “JW,” has been diagnosed as a MRSA patient. Dale and JW work closely together, offering the possibility of transfer of the MRSA bacteria from one person to another.

When MRSA is in the body, it can be systemic. When this is the case, there presently is no cure. Antibiotics usually don’t “end the problem for life.” In this case, there usually are future episodes of skin lesions that can become inflamed because of bacterial infection. When this happens, it is a good idea to begin using StaphWash at the very first sign of an inflamed area on the skin, so that bacteria can be prevented from forming a colony and developing into a fully-developed boil.

But, by January 2, Dale had noticed some smaller spots on his legs. He began cleaning those spots with StaphWash at the very first sign of a skin lesion, so that bacteria can be prevented from forming a colony and causing a fully-developed boil.

By January 15, Dale’s lesions had healed and he reported a successful outcome.

StaphWash used to successfully cleanse boils

Anita G. works and resides in Little Rock, Arkansas. Anita works in close proximity to a co-worker who was diagnosed with MRSA that had manifested as a skin lesion.

Anita has not been diagnosed with MRSA but she developed the signs and symptoms that she recognized from having seen the bacterial infection on the arm of her co-worker. A lesion appeared at the junction of her buttock and her groin. Anita's lesion first became prominent on January 1, 2007. It started out as a knot. It grew in size and developed into a full-fledged boil by January 3, 2007.

Since Anita's friend had used StaphWash to successfully help with the healing, she began applying StaphWash to the affected area.

The lesion became larger and the skin broke open. The lesion was about the size of a silver dollar. Anita applied StaphWash 3 times each day. By the second day, the soreness had subsided and the size of the lesion was noticeably smaller.

Cleansing with StaphWash was successful in allowing normal healing of this lesion.

A separate boil appeared next to the first lesion. Anita applied StaphWash when she first noticed this second lesion. She continued application for three days and was continuing the use of StaphWash when interviewed on January 15, 2007.

Anita G says, "I am a true believer in StaphWash."

StaphWash was successful with Joyce

Joyce C. lives in Little Rock. Her friend is a diagnosed MRSA patient at the Baptist Health Clinic in Bryant, AR. She had been a caregiver for her friend during his struggle with lesions that were slow to heal because of the MRSA bacterial infection.

On December 26, 2006, Joyce developed a lesion that soon developed into the same kind of lesion that she had seen on her boyfriend. She strongly suspected that she had a MRSA bacterial infection.

THE PROBLEM -- Her lesion was on the back of her leg, at the juncture of the buttock and the thigh. The lesion began as a small red area approximately 1/4 inch in diameter. It developed over a period of two days and opened to reveal a clear discharge, which was followed by a white discharge. At the point of maximum inflammation, the lesion reached the size of a half dollar and was very red and inflamed looking near the center of the lesion where the opening had developed.

The lesion developed into a knot; a hard-tissue area under the opening. The white discharge had a distinctive and strong odor that she considered very offensive. Because of the copious discharge, she kept the lesion covered and changed the bandage frequently.

Because of the discomfort when sitting, she had difficulty driving for a period of 3 to 4 days.

THE SOLUTION -- She began using StaphWash at 4 hour intervals and began to notice the first signs of healing within a day or two.

On day-2 and day-3 of the StaphWash applications, she noticed very minor peeling of the skin at the lesion site. At this stage she noticed definite signs of early-stage healing of the lesion based on the change in color of the lesion and surrounding skin.

On day-5, the discharge had ceased and the lesion began to lose some of the red color associated with the inflammation.

On day-6 of the StaphWash applications, the lesion was noticeably smaller, and the skin color had faded to a more healthy-looking pink. The signs of inflammation were very much reduced. The discharge had ceased by this time. Following day-6, she no longer needed to cover the area with a bandage. "After day-6, I didn't use the patch any more," she said.

On January 11, 2007, Joyce reported that the skin on and around the lesion were “back to skin color” and the lesion had completely “healed over.” The healing had progressed to the stage where she no longer felt any tingling caused by the application of the StaphWash.

CONCLUSIONS -- Joyce believes “the StaphWash was definitely what I needed.” When asked whether she would use it again if needed she replied, “If you never had one of these sores you don’t understand what it is like. I don’t care how much it costs, I’d buy it.”

On January 11, 2007, Joyce gave her permission for this account to be used publicly.

StaphWash was successful for George, a diagnosed MRSA patient

George E. is a 48-year-old resident of San Diego County, California. He has skin that is sensitive, with a history of reactions to poison ivy, bee stings and what was suspected to be spider bites.

BACKGROUND — Several months before this report, he had a suspected bite or sting on his left arm that developed into two infected lesions, side by side. He was seen in the local emergency room, and treated for a staph infection with necrosis (dying tissue). The attending physician's opinion was that the staph infection could have been carried by whatever bit or stung him. A culture was taken, but George never learned if the diagnosis was confirmed, or if the staph was of the MRSA type.

After cleaning, the two wounds left a quarter sized hole in his arm, below a smaller opening at the surface. After treatment, the holes in his arm healed normally, with scarring.

MRSA PROBLEM — In early December, 2006, George received two bee stings on his right hand. He developed lesions; this time more confined to the skin surface, but spreading. He counted more than a dozen lesions located at various points on his body including his hand, wrist, arm, nose and even one on the bottom of one foot. In mid-December he sought medical attention and was treated with two antibiotics. Cultures were taken for evaluation. George was diagnosed with MRSA bacterial infections, and informed of this on December 28, 2006, as part of his 10-day follow up medical examination.

THE SOLUTION AND THE HEALING — He received StaphWash on December 26. This was provided to him as part of a national field test, sponsored by the manufacturer, to evaluate the effectiveness of StaphWash when used to attack MRSA bacteria that prevents natural healing of skin lesions.

He used StaphWash on some lesions and not on others. He reported a difference which was favorable for the lesions receiving the StaphWash applications. For example, he had one lesion that started as a small infection on the nose. He used **ONLY** StaphWash on that lesion and experienced rapid healing which left no scars or other visible after-effects. This lesion was invisible to the physician on his follow-up visit, 2 days after applying StaphWash to the wound.

”One thing I noticed is that the healing was smoother and less crusty for the spots that were cleaned with StaphWash. The appearance of the other lesions did not heal as fast, or look as smooth during the same time frame,” he said.

On January 7, after the other lesions had mostly healed, he began using StaphWash on his largest lesion; a spot on his wrist that had crusted over many times but did not heal like the others. “Because it was large, I applied 4 drops of StaphWash,” he said. “Two days later, the crust was gone, and the area became a nice pink color like the others,” he said.

On January 11, George reported a successful outcome. “All of the spots are healing nicely or have already healed. All of the spots have lost their red color and have returned to a nice pink color,” he said. When asked if, in his opinion, StaphWash had benefited him, he said, “It definitely helped.”

On January 11, 2007, George gave his permission for this account to be used publicly, pending editing to ensure that this is a factual and objective account of his experience with MRSA and StaphWash. On Thursday, January 18, George provided additional information by email so that this account could be shared publicly for the benefit of others who are dealing with MRSA.

Physician's report of successful use of StaphWash

Dr. D used StaphWash to clean the skin lesion on his patient, Charles T. in Russelville, AR.

Charles is 72 years old, and has a history of bacterial infection problems. Skin injury tends to be a recurring problem because he is a diabetic with a compromised healing ability.

THE PROBLEM — Charles was dismissed from the hospital with a bacterial infection that was not healing. The lesion was the size of a half dollar, and it showed signs of tissue loss from the bacterial infection. The discharge from the lesion was a thick yellow fluid (pus). The lesion, including the surrounding area, was inflamed. The patient felt discomfort and soreness in the region near the lesion. Conventional treatments, including treatment for the bacterial infection, were being continued at home, following the patient's dismissal from the hospital. The infection was due to a form of enterococcus bacteria.

LAB TESTS AND RESULTS — Charles was examined again on Monday, January 8, 2007. The lesion had the same characteristics that had been noted previously.

A culture test was begun to evaluate the bacteria and the effects of StaphWash. Two specimens were taken from the lesion. The specimens were taken from the discharge (liquid) and the two specimens were taken in an identical manner.

One specimen was treated with StaphWash; the other was not. Both specimens were sent to the lab.

The lab report for the specimen not treated with StaphWash showed a bacteria colony count of 27 colonies. The report for the specimen treated with StaphWash showed a bacteria colony count of 2 colonies with a notation from the lab saying "scant growth."

The conclusion drawn from the culture test was that the application of StaphWash resulted in approximately 92.6% less bacteria. The bacteria growth from the specimen treated with StaphWash was only 7.4% as much as the growth from the specimen NOT treated with StaphWash.

THE TURN-AROUND — Because conventional treatments were not successful, Charles' physician decided to treat the infected lesion with StaphWash.

The lesion was on Charles' back, between his shoulders. Because of the difficulty in reaching the lesion, Charles relied on a caregiver to apply StaphWash directly to the infected area 5 times daily, beginning January 8, 2007.

The patient was seen again the next day (1/9/2007) and the lesion was seen to be much improved. The discharge had ceased, and the opening had begun to heal. The opening was shrinking in size and had reached a smaller diameter. The opening was approximately the size of a pencil eraser.

One day later, on January 10, Charles was seen again in Dr. D's office. The opening showed no drainage, and the wound was judged to be healing with good progress.

The next day, on January 11, Dr. D noticed that the wound opening showed continued healing with a granulated texture. The patient reported that the soreness had gone away. When speaking about the case, Dr. D characterized the lesion as having shown a "vast improvement" during the three days that StaphWash had been applied.

Below are photos of the erythema. Erythema is the term used to describe redness of the skin caused by dilatation and congestion of the capillaries, often a sign of inflammation or infection.



Initial Moment StaphWash treatment was started -- Day 1



48 hours after starting StaphWash treatment

The photographs above were taken by Dr. D for the purpose of documenting

the progress of the treatment using StaphWash. (The cosmetic version of this product is called Staph-Wash.) The following is the email text from Dr. D, explaining the photographs:

“Here are the only picture I have of the skin lesion. The first day was poor quality as I did not use the camera’s close-up feature; however, you can see how bad the lesion looked. The area that was draining was 3 cm in diameter and the area of the erythema was 4.5 cm in diameter.

The second picture shows the edges of the wound healing well and the over-all appearance of the wound is much improved.”

On January 18, 2007, Dr. D recorded this account on videotape, to be used publicly for the purpose of disclosing a successful outcome with the use of StaphWash to clean the bacterial infected lesion that had not responded to conventional treatment with antibiotics.

On January 25, Dr. D saw the patient again. The healing process had shown very good progress. Dr. D said, when referring to the patient, “He was so excited. He had been using a mirror to apply the StaphWash himself. The wound had a small scab over it and was completely healed.”

Physician’s second report of successful use of StaphWash

Dr. D used StaphWash to treat his daughter in mid-January, 2007. She had developed blisters on her feet from skating, and one of the blisters became inflamed.

The inflammation was assumed to be a bacterial infection, although no culture was taken.

Dr. D used StaphWash to clean the lesion and the area around the inflamed area.

The inflammation was quickly stopped, and the lesion healed in a normal manner with no further signs of bacterial or other infection.

On January 18, 2007, Dr. D recorded this account on videotape, to be used publicly for the purpose of disclosing a successful outcome with the use of StaphWash.

On January 25, Dr. D reported that “My daughter’s wound has totally healed.”

Biology teacher and skin lesions

Betty R, age 65, is a retired biology teacher who has studied skin lesions, including her own difficult-to-heal lesions. She lives in Idabel where she taught at the middle school and at the higher learning center before her retirement.

NOVEMBER 2006 -- She developed a wart-like growth in front of her left ear, in the hairline. The growth was removed by Dr. Y, a dermatologist in Texarkana in November, 2006. When the bandage was removed, she noticed that the surgical site was inflamed. Soon, probably because of hand-to-skin contacts, she developed several lesions on different parts of her body.

MORE LESIONS -- She had lesions on her shoulder, on her chest, stomach and the back of her legs. She noted tunneling (a hole in the center of the lesion) which is characteristic of staph infections. She saw her home-town physician, Dr. W and she returned to Texarkana and was seen in the emergency room for treatment of the lesions.

MEDICAL TREATMENT -- She was treated with a range of medications, including antibiotics. She treated the lesions with Polysporin, Bactriban, Sulfa drugs and other medications that were prescribed for her lesions. She had only limited success, with some lesions healing slowly and other lesions developing and remaining as open sores. Betty was not aware of any culture tests that could have been done to provide a definitive diagnosis for the kind of bacterial infection causing her skin lesions. Methicillin-Resistant Staphylococcus aureus (MRSA) was the suspected cause, but no firm diagnosis was given to Betty.

BETTY'S DISCOMFORT -- For more than two months, she wore turtleneck tops and clothing that concealed most of the open lesions. "I have not hugged my kids and grandkids since before Thanksgiving; more than two months," she said. "This is depressing, and only adds to the other problems in my life including the loss of my husband and other family during the past four years," she said.

FEBRUARY 2007 -- Betty was enrolled in the StaphWash field trials on Wednesday, February 7, 2007; approximately 2 1/2 months after her skin lesions had begun. She was given StaphWash with the recommendation to use this skin cleanser every four hours for a few days until she could determine whether it was helpful in allowing the body to heal in a normal manner.

FEBRUARY 14, 2007 -- Betty reported that her lesions were better, but she was not sure if the StaphWash or the Polysporin had been responsible. By this time, she had used all the StaphWash and was using only the Polysporin. She commented that using the StaphWash every four hours was difficult because each application required approximately half an hour. She was offered more StaphWash but she felt that she was getting better and did not need anything else for the time being.

Girl, age 10, had multiple lesions with MRSA infection

Mariah H lives in Arkansas with her mother, Teresa, and her father, Chris. Teresa owns a business, a loan closing service, and she is a member of NNA with Certification. She suspended her professional work at the beginning of 2007, to provide full-time care for Mariah. Mariah was enrolled in the StaphWash field test on February 14, 2007.



FEBRUARY 14 -- Mariah was confined to a wheelchair, was on oxygen, and had recently lost weight rapidly, from 96 pounds to a current weight of 57 pounds. (Normal weight for a 10-year-old child is in the range of 65 to 70 pounds.) She is fortunate to be receiving excellent in-home care, because her mother is a registered medical assistant. Mariah was enrolled in the StaphWash national field test because of multiple skin lesions, including the large bacteria-infected lesion described in more detail below.

MEDICAL HISTORY -- Prior to using StaphWash, Mariah had been treated with Silvia Gel , Lanaseptic, Bactroban and Accuzyme. Wound #1 (described below) was being cleaned and dressed daily. Her physician described wound #1 as a pressure wound of the type often seen in nursing homes. Because of her allergies,

Mariah was not being treated with antibiotics during the time she used StaphWash. She is allergic to penicillin and most other antibiotics.

One aspect of this case is that Mariah offers the rare opportunity to evaluate the effectiveness of StaphWash in the absence of antibiotic treatment. Because of this, any improvement can be attributed to the use of StaphWash, and NOT a combination of StaphWash and antibiotic treatment.

MRSA-INFECTED LESIONS -- On February 14, Mariah had 3 skin lesions, all assumed to be the result of Staph infection.

The first lesion appeared in mid-December, about one week before Christmas, 2006. The lesion was located on the back of the leg in the region of the buttock on the right side; a common location for so-called “pressure sores” that result from sitting long periods of time in one position. The lesion grew and became an open lesion. By February 14, the lesion had opened and showed signs of infection from the skin surface down to the bone. It was being dressed and treated with a Wound-Vac application. The lesion covered a skin surface area of approximately 4” x 4.5” and was producing discharge as part of the indications of inflammation.

The second lesion appeared on the back of the right leg near the junction of the buttock and the thigh. By February 14, it was showing signs of inflammation, including redness, but it had not yet developed into an open lesion.

The third lesion appeared on the inside of Mariah’s thigh, at the junction of the right leg and the groin. On February 14, this lesion was the size of a pencil eraser and showed signs of inflammation.

On February 14, Mariah’s mother assessed the situation as critical. The largest lesion had not responded to medical treatment and all three lesions seemed to be getting worse. Her physician had given a prognosis that was not encouraging. Last-resort treatments were being considered and planned, including the use of magots to consume the dead tissue caused by the Staph bacteria.

PLAN TO USE StaphWash -- Extensive conference-call discussions were held with Teresa, the distributor and the manufacturer of StaphWash. The mutually-agreed plan of action was:

1. Teresa volunteered to establish and report photographs of the progression of the appearance of the lesions.
2. StaphWash was planned for use at 4-hour intervals on all three skin lesions.
3. Because of Mariah’s unusual allergy history, a test patch on healthy skin was

planned so that any possible allergic reaction to StaphWash could be quickly detected. [StaphWash has no known side effects, but people with unusual allergies can be allergic to anything, including cosmetics, lotions, and soaps that normally have no effect on most people. Because of this, a proactive “allergy watch” approach was planned to ensure that continued use of StaphWash could be beneficial without resulting in any unexpected allergic skin reaction.]

4. The manufacturer provided cell phone contact information to Mariah’s mother for 24/7 use in the event that any discussion was desired by the family. Local telephone contact information was provided so that Mariah’s family could contact the distributor, if desired.

5. The family planned continued medical attention through the wound care center at St. Vincent Hospital, where Mariah had been receiving care prior to the time when StaphWash was first used to clean Mariah’s lesions.

FIRST REPORT OF IMPROVEMENT -- On February 16, Teresa was contacted as a follow-up to the first use of StaphWash for Mariah. She had some good news to report. One of the lesions was an open lesion when StaphWash was first used on February 14. She reported that the lesion was now closed, after only 48 hours of StaphWash use.

SUCCESS AFTER 5 DAYS -- On February 19, Mariah’s mother reported good results.

The first lesion showed good improvement. Before StaphWash application began, the lesion covered a skin surface area of approximately 4” x 4.5” and was open “to the bone.” After 5 days of StaphWash application the lesion was showing regranulation, the process of healing. Also, of major significance was the observation that there was almost no redness and no appearance of inflammation of the skin around the edge of the lesion. The lesion appeared to be progressing rapidly toward healing and regrowth of tissue.

The second lesion was located on the back of the right leg. By February 19, it was showing no signs of inflammation and no redness. The skin had returned to a smooth surface, and appeared to be normal, with a slightly white color. In summary, after 5 days of StaphWash application, the lesion appeared to have returned to normal.

The third lesion was located on the inside of Mariah’s thigh, at the junction of the right leg and the groin. Before use of StaphWash, this lesion was the size of a pencil eraser and showed signs of inflammation. By February 19, this lesion showed no signs of moisture or discharge; the skin had returned to a smooth texture; and the

color was a healthy pink.

Her nurse visited Mariah on Monday, February 19. When observing the skin lesions, the nurse said “This is **SO much improved** since I saw it last week!”

On February 19, Mariah’s mother wrote, “I want to truly THANK YOU for allowing us to be a part of this adventure. It has been such a blessing to us as a family. I am most thankful for the product. The product is all you claimed it would be and I feel blessed that it helped Mariah in such a time of need.”

On February 19, Mariah’s mom gave permission for this account to be used publicly. She also offered to participate in activities planned to announce StaphWash as a new product for cleansing Staph infected skin lesions.

Mariah’s mother provided an update on 3/25/07. In the month between 2/19 and 3/25, Mariah had a surgical procedure to clean the worst and deepest of the three lesions (the lesion referred to earlier in this report as the FIRST LESION. Also, it was determined that this lesion was being affected by conditions that went beyond a Staph infection. The diagnosis received was Osteomyelitis, a condition characterized by a bacterial infection in the bone. The lesion was being treated with a wound vac which was being changed three times each week. At 8-hour intervals she was being given IV antibiotics of two kinds -- Vancomycin and Merrem. StaphWash was also being used on this most-difficult of lesions, and there was some good news. The lesion had begun to granulate (healing progress).

SUMMARY AND CONCLUSIONS -- In closing this field test report, the use of StaphWash can be summarized as follows:

1. The use of StaphWash on the FIRST LESION was helpful, but did not result in rapid healing. This lesion was affected by conditions that went beyond a Staph infection of a skin lesion. Before StaphWash was used, the infection had progressed deep into the tissue, to the bone. The diagnosis was Osteomyelitis. Osteomyelitis is an acute or chronic bone infection, usually caused by bacteria. The infection that causes osteomyelitis often is in another part of the body and spreads to the bone via the blood. In children, the long bones are usually affected. Bone infection can be caused by bacteria or by fungus. When the bone is infected, pus is produced within the bone, which may result in an abscess. The abscess then deprives the bone of its blood supply. Chronic osteomyelitis results when bone tissue dies as a result of the lost blood supply. Chronic infection can persist intermittently for years.

The lesion was being treated with IV antibiotics of two kinds -- Vancomycin and Merrem. Merrem/Meronem (meropenem) is an ultra-broad spectrum injectable antibiotic for a wide variety of serious infections, including meningitis and pneumo-

nia.

StaphWash was also being used on this most-difficult of lesions, and there was some good news on March 25th. The lesion had begun to granulate (healing progress) following an extended and complex medical treatment.

2. The use of StaphWash marked the turn-around and the progression of healing for the SECOND LESION. Continued use of StaphWash resulted in the skin area being able to heal naturally and rapidly.

3. Similarly, the use of StaphWash marked the turn-around and the progression of healing for the THIRD LESION. Continued use of StaphWash resulted in the skin area being able to heal naturally and rapidly.

Mariah's pediatrician took special note of the total healing that had occurred with the SECOND lesion and the THIRD lesion (described earlier). He asked Teresa (Mariah's mother) about the history of those lesions and the causes for the rapid and complete healing that had occurred. Teresa explained, "those lesions healed because of the use of StaphWash, a product that is not yet on the market, so you don't know about it." After a thorough physical examination of the healed skin, **the physician said, "StaphWash? Whatever it is, it did a good job."**

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Eyelid infection -- I've tried everything and nothing seemed to work until I tried your Staff Wash. It is wonderful!

I wanted to let you know your StaphWash for ACNE has done wonders for my eyelids! For several years I have been getting sties on my eyelids. Most sties fill up with a liquid type substance similar to a blister; where you can lance them and they will go away. Mine are the type that fill up with a "cheese like" consistency and must be cut out by an eye doctor. My doctors have given me everything from topical ointments to antibiotics to try and prevent them from reoccurring. The doctor has stated it might be caused by a viral infection...but I really don't know.

When my stress level goes up...they seem to appear more often. I can usually tell when they are going to appear as the lid will start itching and cause discomfort. I started using the StaphWash for ACNE on the eyelid with a Q-tip. I put a drop on a sterile Q-tip and apply to the eyelid. It sooths the itching immediately and it has stopped the sties from forming. I am very impressed with your product. Like I've stated before...I've tried everything and nothing seemed to work until I tried your StaphWash for ACNE. It is wonderful!



Sherrie S.

Thank you so much for letting me try your product! I am a walking, talking billboard and will share this information with others who suffer with acne and staff infections. As you know I am a skin care specialist and will have many opportunities to pass this information on.

Take care and God bless,
Sherrie S.
April 7, 2007

5-day recovery from MRSA reported by Jennifer

Jennifer F is a school teacher in McCurtain County, Oklahoma. Her husband was diagnosed with Staph infection. Her pharmacist recommended that her husband use StaphWash on the skin lesion.

The lesion had developed to the stage of a boil, and his physician had lanced it as part of the medical treatment for the Staph infection.

5 DAY RECOVERY — StaphWash was frequently applied to the lesion, beginning after the lesion had been lanced. After only five days following the surgical procedure (and after five days of StaphWash use), the patient was seen by the surgeon as part of a follow-up medical appointment. According to Jennifer, the surgeon “was amazed that it looks as good as it does.”

The physician made favorable comments about the results and about StaphWash, saying “it was probably some good stuff.”

Jennifer reported some comparison information. “I compared the recovery time with someone else that had the same Staph-infection condition that my husband has. He said that it would take a good 2 1/2 to 3 weeks to recover.”

FEBRUARY 5, 2007 — Jennifer said “I am convinced that this wash did help the healing process. Even though the staph infection is not totally gone yet, it is well on its way.”

“I personally have not ever had Staph infection, but I watched my husband suffer and I know that this is something that I never ever want to have. I am thankful for the samples that I received for my husband and I think that if you have Staph infection, you will want StaphWash. It will cut down on the time that you have a staph infection.”

SUMMARY AND CONCLUSIONS -- Following the successful recovery, there was some question about which kind of bacterial infection might have been the cause of the problems, based on the physician’s opinion. Even with this degree of uncertainty, the physician made favorable comments about the results and about StaphWash, saying “it was probably some good stuff.”

###

Los Angeles man, wife and daughter acquired MRSA and used StaphWash

Joe U. works for a film company in Los Angeles. His Staph infection began with a scrape on his hand that rapidly developed into an infection. His physician diagnosed the infection as a MRSA bacterial infection based on a culture test.

Joe's wife also tested positive for MRSA based on the results of a nasal culture, but did not develop bacterial infections (skin lesions) as of the time Joe was enrolled in our national field test to evaluate StaphWash.

Joe's daughter, Lola, is 5 years old. She developed MRSA which began with a skin lesion on the nose. She was being treated with sulfa drugs at the time the family was enrolled in the field test.

The skin lesion on his hand was followed by another lesion on his back near the waist band. The lesion on the back grew to the size of a golf ball.

Joe was treated with Kevlex, Bactrin, Ribansis and surgery before requesting StaphWash on March 26, 2007.

The StaphWash product was used to treat Lola's lesion on her nose.

The following photos show the progression from Day 1 through Day 5 of treatment with StaphWash.



Day 1





Day 5

Joe's report on April 4th was, "Here are three photos of my 5 1/2 year old daughter Lola. Day one was the day we recieved the StaphWash and day 5 was after three applications."

"It was very successful. These photos are in order of use on the small occurrence on her nose."

"Thank you so much, we have had no recurrances so far."

###

Cindy's ACNE improved quickly when she used StaphWash



Cindy C operates a real-estate business. ACNE can be a problem for anyone who deals with the public on a regular basis.

ACNE HISTORY -- Although she had no problems with ACNE as a teenager, she began to have “ACNE spots” as an adult. These spots appeared as small cysts and other minor skin irregularities.

ENROLLMENT -- Her husband, Larry, is a health enthusiast. He learned of StaphWash when shopping for sports nutrition products. At that time, StaphWash was not for sale because the national field test for this product was being conducted. He obtained samples of StaphWash and provided these samples to Cindy.

RESULTS -- On April 25, 2007, Cindy reported that she had tried several samples of StaphWash on her ACNE spots, with good success. She had tried “clear color” samples and “blue color” samples. She reported the best success with the blue color samples. *[Note: The blue color additive improves the electrolytic quality of the StaphWash liquid, making it more effective. This has been established in controlled in-vitro laboratory tests.]*

The first time Cindy used StaphWash she reported, “good results in 1 to 2 days.” She noted that, “it dried up the ACNE spots quickly.”

She has continued to use StaphWash from time to time when her ACNE symptoms occur; each time with good results.

Cindy gave permission for this account to be used publicly, as part of our StaphWash national field test report. On 4/27/2007, she wrote, “This looks good. You may use this in your reports.” /s/ Cindy Cole

###

Tyra used StaphWash to obtain success after receiving conventional medical treatment

Tyra B develops contracts for race tracks and travels extensively as part of her work. Her experience with a Staph infection has been a long, painful experience that has at last seen a turn-around and improvement resulting from the use of StaphWash.

She had knee surgery at Baylor hospital in Dallas and subsequently developed a lesion in her nose. She has been under the care of eight physicians in her attempts to seek treatment to stop the loss of tissue that resulted from the continuing expansion of the lesion. Her description of the long-term result is that, “the inside of the left nostril was almost destroyed.”

DIAGNOSIS -- In July 2006, she was diagnosed with a Staph infection in her nose. The lesion was inside the nasal cavity and did not respond to conventional treatment.

CONVENTIONAL MEDICAL TREATMENT -- In October 2006, she moved from Dallas to Little Rock where she sought treatment at the University of Arkansas (UAMS). By this time, her lesion had resulted in a loss of tissue that was so extensive that reconstructive surgery, at a cost of \$15,000 was being considered. Her physician could not perform the surgery until the bacterial infection could be cleared up, because surgical intervention would only provide more opportunity for the bacteria to colonize and expand. By this time, the lesion was “a raw sore” as she described it, and it often would bleed, even at night during sleep.

STAPHWASH RESULTS -- Her brother, Gary B, learned of StaphWash from a friend and obtained samples for Tyra to use and evaluate. Tyra was enrolled in the StaphWash national field test in April 2007.

She used StaphWash in two ways: First she applied it with Q-tip. Later, she learned that if she use a small section of surgical sponge she could put a couple of drops of StaphWash on the sponge and leave it in the nasal cavity when at home or when sleeping.

“Healing began quickly after I began using StaphWash,” she said. When interviewed on April 25, 2007, she described the improving condition of her nose as:

“The bleeding has stopped; there is no more bleeding.”

“The healing has continued to progress since I began using StaphWash.”

“The healing has resulted in some re-growth of tissue; the tissue in that area is thicker than it was.”

Physician's review of StaphWash examples

Field test results reported in this document, and other relevant information was reviewed by a physician having an interest in the use of StaphWash.

The following are examples which were provided by the physician in summary format.

The examples below were reviewed and summarized by Dr. C.

Example 1

Testing was conducted at a pathology laboratory certified for microbiology testing by a physician and a microbiologist. A double blind, randomized controlled experiment was conducted to evaluate the surfactant compounds against bacteria in Petri dishes.

Bacterial strain: Two well characterized strains of methicillin-sensitive *Staphylococcus aureus* (MSSA) and methicillin-resistant *Staphylococcus aureus* (MRSA) were used. Specifically, experiments used ATCC 29213 (MSSA) and ATCC 43330 (MRSA), both beta-lactamase positive strains, which represent greater than 90% of the respective strains in the American population.

Petri dish preparation: A sterile cotton swab (American Scientific Products, McGraw Park, IL) was dipped into the cultures and used to swab the entire surface of 150 X 15 mm Petri dishes containing 75 ml of standard Mueller-Hinton agar. Two Petri dishes were inoculated with ATCC 29213 (MSSA) and two Petri dishes with ATCC 43330 (MRSA). One Petri dish of each group (MSSA and MRSA) was set aside as the controls. The other two Petri dishes (MSSA and MRSA) were divided up in quadrants, and each quadrant was labeled B, C, D or E.

StaphWash is usually prepared with a surfactant concentration of 2% to 4%. To evaluate a wider range of surfactant concentrations, cleanser compositions were prepared as follows: A surfactant solution and a stock solution were mixed in various ratios to produce four skin cleanser solutions having four different surfactant concentrations of 0.5%, 1%, 2% and 8%, by volume. The amount of other ingredients in each of the four skin cleanser solutions was less than 1% concentration by volume.

Cleanser Testing: Four samples of the cleanser with the four different concentrations of the surfactant (0.5%, 1%, 2% and 8%) were placed into four separate, unmarked bottles. Each bottle was randomly labeled (B, C, D, or E), and the microbiologist conducting the study was unaware of any difference between the solutions.

Application: Holding each bottle vertically, the microbiologist added a single drop from each bottle (B, C, D, or E) to the corresponding quadrant of the labeled Petri dish. All four Petri dishes were placed in an incubator overnight at 37 degrees Celsius, and examined 20 hours later. Petri dishes were compared to the corresponding controls, and zones of inhibition were characterized by the largest point of diameter of the circle or oval.

Results: The solution with the lowest surfactant concentration, 0.5%, showed no difference between the controls, while the 1% and 2% concentrations inhibited approximately 50% of the colony forming units (CFUs). The 8% concentration

showed clear inhibition of the bacteria in a large circle of approximately 40 mm in diameter.

Example 2

The same protocol as described in Example 1 above was used to test various concentrations of the surfactant compound against the MRSA strains and revealed a clear trend, with higher concentrations of the surfactant causing larger zones of inhibition [range from zero (control) to 42.3 mm (14.80% concentration)]. Inhibition zone diameters shown in the table below were averaged over three repeated experiments.

Diameter of Zone of Inhibition (mm)	Surfactant conc. (vol. %)
42.3	14.80%
41.7	4.90%
39.3	4.00%
39	6.50%
37.3	3.30%
35.3	2.30%
34	9.30%
33.7	2.50%
32.7	2.80%
No Change	1.00%
No Change	0.00%

Example 3

Four cleanser compositions were prepared and tested in the manner described in Example 1, except that each cleanser contained a different surfactant. Four control compositions containing only the surfactants were also prepared and tested in a similar manner.

All four cleansers evaluated in this example showed definite effectiveness as anti-bacterial and anti-septic agents. Each of the four surfactants proved effective when mixed with water only and still greater efficacy in the presence of chlorine.

A 5% solution of surfactant in the stock solution (containing chlorine) was as effective as a 10% concentration of the surfactant in water (a solution lacking chlorine).

Example 4

Addition of 5% dye by volume to a solution containing surfactant and chlorine dramatically improved the effectiveness of the cleanser as an anti-bacterial agent. The zone of inhibition increased 66% (from 62 mm to 80 mm diameter) when 5% (by volume) ionic dye was added.

Example 5

Action against Gram-positive bacteria such as *Enterococcus*: A 68-year-old man with long history of diabetes was admitted from his hospice care home to an acute care facility hospital secondary to an infected decubitus ulcer (bedsore). This patient's sacral ulcer tested positive from culture swab for *Enterococcus*, a common Gram-positive bacterium for infecting bedsores. Immediately upon admission, the patient was placed on antibiotics (ciprofloxacin). Over the next five days, the 4 cm open, oozing ulcer with erythematous margins and discharging pus showed signs of worsening. On day five, the treating physician directly cultured the wound again with two cotton swabs. Cotton swab #1, the control, was placed directly in the sealed container based on hospital protocol. Cotton swab #2 was placed into the sealed container, with one single vertical drop of StaphWash cleanser solution. Both swabs were sent to the lab and a count of colony-forming units (CFUs) was ordered. Forty-eight hours later, the culture of cotton swab #1 (the control) exhibited 22 CFUs, while the culture of cotton swab #2 had only two CFUs.

Moreover, the patient's ulcer showed marked improvement within 24 hours of the first application of StaphWash. There was sufficient resolution (decreased erythema, lower induration, skin color improvement from red to pink, and decrease pus discharge) of the ulcer over the next four days for the patient to leave the hospital.

Example 6

Action against *Mycobacteria*: A 39-year-old female with four month long history of an infection on the posterior aspect of her right ring finger was treated. The infected areas were culture positive for mycobacteria marinum, with symptoms of infection resulting in a 4 cm long patchy zone of erythema, induration, and oozing from the wound. After failing two full courses of oral antibiotics, over the previous four months, the patient was given a third round of antibiotics, this time Clarithromycin, after her finger's condition had worsened. After eleven days of antibiotics and no change in symptoms, the patient applied two drops of StaphWash into the wound three times per day where a 5 mm biopsy had broken the skin, and

applied gentle abrasion as directed. Within 24 hours of the first application, the wound showed marked improvement in the overall signs of infection. Within 72 hours, the area of the open skin lesions had a continued decrease in induration, erythema and signs of infection. The patient's symptoms ultimately improved with the combination of antibiotics and StaphWash.

Example 7

Goat and other farm animals are very susceptible to infections. Often, if a bad infection occurs, the animal will be separated and sacrificed. A goat (with an ophthalmic infection resulting in large greenish discharge from both eyes for three weeks) was treated with StaphWash. The cleanser was squirted into the eyes of the goat for two days. Within 24 hours, the goat's eye infections had improved, and the goat was able to see out of one of the eyes. The treatment was continued for five days resulting in the full resolution of the goat's symptoms.

Example 8

Five patients with confirmed MRSA positive infections by their doctors were treated with StaphWash by direct topical application on the surface of their skin and open lesions. Within 24 hours, three of the patients improved such that their areas of skin erythema, induration and open lesions appeared more normal. All five patient's infected area showed complete resolution of his or her acute symptoms within five days of starting the treatment.

Example 9

A patient with a 12 month history of culture positive MRSA returned from a hunting trip with a dozen skin lesions on his skin from his hips to axillary region. The patient was started on oral and topical sulfamethoxazole and trimethoprim combination antibiotics, with no change in symptoms. On day 6 of the antibiotics, patient applied StaphWash on the skin of three of the 12 lesions, and experienced marked improvement over the first 24 hours and by the fourth day patients three lesions had returned to a healthy pink color. He then applied StaphWash to all twelve lesions, and after seven days of subsequent cleanser treatment, combined with the continuation of his antibiotic regiment, showed all the lesions dried up with a healthy fleshy skin toned appearance.

Example 10

A 35 year old male patient was diagnosed by a physician with MRSA skin infection, with two active 1 cm and 4 cm skin lesions. The patient applied StaphWash on the small 1 cm lesion three times per day with concomitant application of gentle abrasion while leaving the larger lesion alone as the control. Within one day, the smaller lesion had dried and patient reported in the appearance and feel of the infection under the skin as well, reporting less inflammation. After ten days the smaller lesion had turned a healthy flesh toned color with no scab or other remnant, and complete resolution. On day five, the patient began using the cleanser on the larger lesion, and this larger lesion, which had been unchanged compared to the healing of the small lesion, showed immediate improvement after the application of StaphWash, with similar course of action as the smaller lesion.

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staphWash™

Formulated to cleanse MRSA
and other Staph bacteria from skin

Keep your skin healthy!

Consistently kills 100% of bacteria
that cause Staph infections
in controlled in-vitro testing.



Alcohol free. Patent pending.
“Take it to the people”



100% guaranteed when used as directed.

BENEFIT: StaphWash™ contains a cleanser for use on skin that is specifically formulated to remove MRSA and staph bacteria.

DIRECTIONS FOR USE: Use this product as a cleanser by gently rubbing it on skin with a clean Q-tip. Repeat process every 4 hours or as needed.

MECHANISMS OF ACTION: (1) Contains a skin cleanser. (2) Contains chlorine and other oxidizing agents for bacteria control. (3) Contains an anti-bacterial surfactant to wash away dirt and oil films which can harbor bacteria. (4) Formulated to slightly dry the skin. (5) Uses gentle abrasion to achieve more-effective cleansing action.

INGREDIENTS: Water, sodium hypochlorite (antiseptic cleanser), surface reactive agents (oil and dirt cleanser), trace amounts of calcium carbonate, sodium carbonate and silicon dioxide (gentle abrasion), and a proprietary blend for color. Contains no alcohol. Contains no animal products.

CAUTION: For external use only on skin. Keep out of reach of children. Eye irritant. Do not swallow or inhale. Ask a physician before use if you have unusual allergies to any ingredients listed above. When using this product, in the event of unexpected side effects, discontinue use, cleanse the area with water and see a physician. No harmful effects are known to result when used as recommended.

NET WEIGHT: Approximately 3 gm. **NET VOLUME:** Approximately 3 mL.