Dr Georgiou's HMD Protocol Video Transcript

SLIDE 1 - INTRODUCTION

Hello fellow colleagues and welcome. My name is Dr George Georgiou, a naturopathic and holistic medicine practitoiner, as well as the researcher and inventor of the HMD Protocol.

Before we begin, I want to ask a few simple questions.

- How often do we see clients who suspect heavy metal toxicity, but their symptoms are complex, sensitive, or difficult to interpret?
- How do we know when detox support is appropriate — and when we need to slow down, prepare the body, or investigate further?
- And most importantly, how do we support detoxification in a way that is structured, responsible, and safe for the individual in front of us?

This presentation is designed to give practitioners a clear, practical overview of the HMD® Heavy Metal Detox Protocol — not as a "quick detox" concept, but as a practitioner-guided approach that considers testing, mineral status, exposure history, drainage support, monitoring, and patient sensitivity.

We'll look at the research background, the clinical reasoning behind the protocol, and how to communicate HMD® responsibly with clients — without overpromising, and without encouraging people to push through reactions unnecessarily.

My aim is to make this practical, balanced, and easy to apply in clinic.

So let's begin by looking at the bigger picture: why heavy metal detoxification needs to be approached with intelligence, caution, and proper practitioner guidance.

I will "disappear" from the screen so that you can concentrate and enjoy the slides, and hope to have further contact with you all in the near future.

SLIDE 2 – WHAT THIS 20-MINUTE SESSION COVERS

In this short 20-minute session, I want to give you a clear and practical roadmap for using HMD® responsibly in clinical practice.

We'll start by looking at why heavy metals still matter. Many clients come in with complex, overlapping symptoms, and toxic metal exposure can be one of those hidden factors that is easy to miss.

Then we'll look at the gap between testing and action. A test result is useful, but only when it leads to a structured plan that considers the person's overall health, mineral status, drainage, and sensitivity.

From there, I'll explain the core logic of the HMD® Protocol: mobilize, bind, and drain. This is really the foundation of a safer detox approach.

We'll also touch on the research background behind HMD®, and how to translate that into practical clinical takeaways.

Then we'll cover implementation: how hair mineral analysis, monitoring, safety checks, and follow-up can help practitioners use the protocol more confidently.

And finally, we'll look at language — how to explain HMD® clearly and responsibly to patients and colleagues without overclaiming.

The goal is simple: to give you credible, practical, evidence-aware tools that you can use with confidence in your own practice.

SLIDE 3 – HEAVY METALS ARE NOT ONLY AN INDUSTRIAL ISSUE

This slide sets the scene for why heavy metals still deserve our attention in clinical practice.

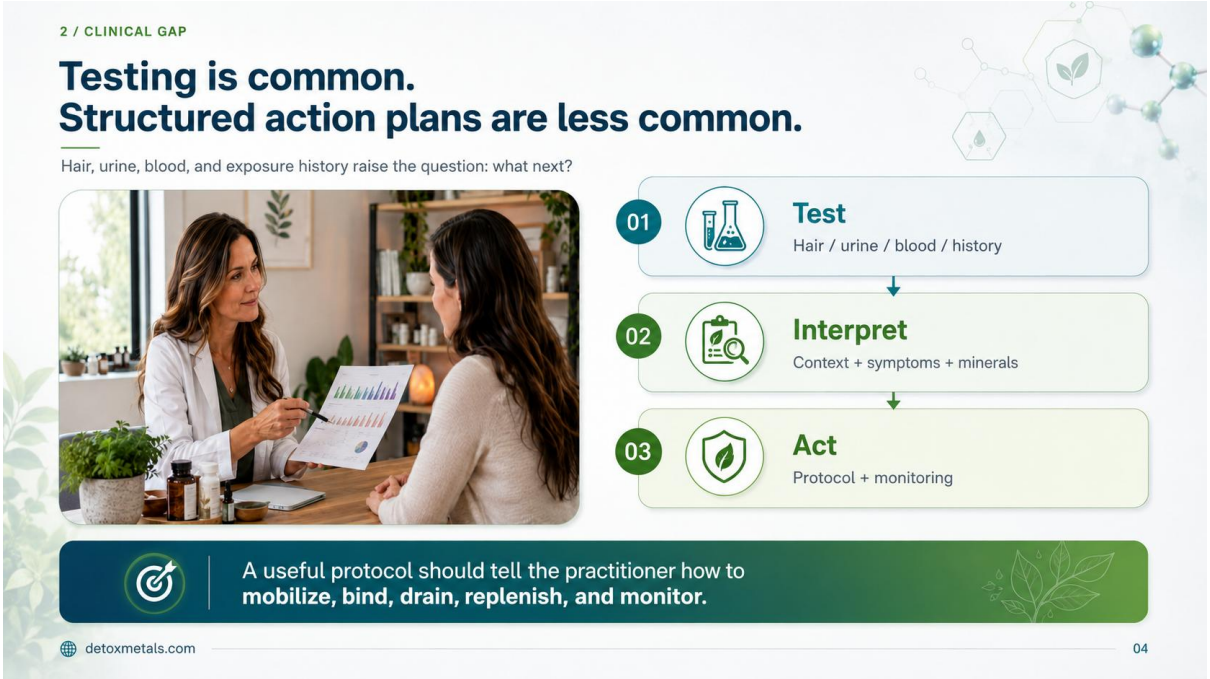
We often think of heavy metals as an industrial problem, but exposure today can come from many everyday sources — food and seafood, water and old plumbing, dental or cosmetic products, occupational exposure, hobbies, pollution, dust, old paint, and even some supplements.

The important point is that these exposures are often low-level and repeated over time. They may not create obvious, dramatic toxicity, but they can still become clinically relevant, especially in chronic or complex cases.

On the right, you can see the main routes of accumulation: ingestion, inhalation, skin absorption, and then storage in tissues. Metals such as mercury, lead, cadmium, and arsenic may affect different organs and systems, which is why symptoms can be vague and non-specific.

So the practitioner message here is simple: don't guess from symptoms alone. A good exposure history, combined with appropriate testing, can help reveal whether toxic burden may be one hidden layer in the patient's overall picture.

SLIDE 4 – TESTING IS COMMON, STRUCTURED ACTION PLANS ARE LESS COMMON



This slide highlights a very common clinical gap.

Many practitioners are already testing — whether that's hair, urine, blood, or a detailed exposure history. But the real question is: what happens next?

A result on its own does not automatically become a useful protocol. It needs interpretation. We need to look at the wider picture — symptoms, mineral status, exposure patterns, sensitivity, and the patient's ability to eliminate.

That's why this simple three-step framework is so important: test, interpret, then act.

First, we gather the data. Then we place it into clinical context. Only then do we build a protocol with monitoring and safety checks.

The key message is that a useful detox protocol should not just tell us what to remove — it should guide us on how to mobilize, bind, drain, replenish, and monitor responsibly.

SLIDE 5 – INTRODUCING DR GEORGIOU'S HMD PROTOCOL

Now we're introducing Dr. Georgiou's HMD® Protocol.

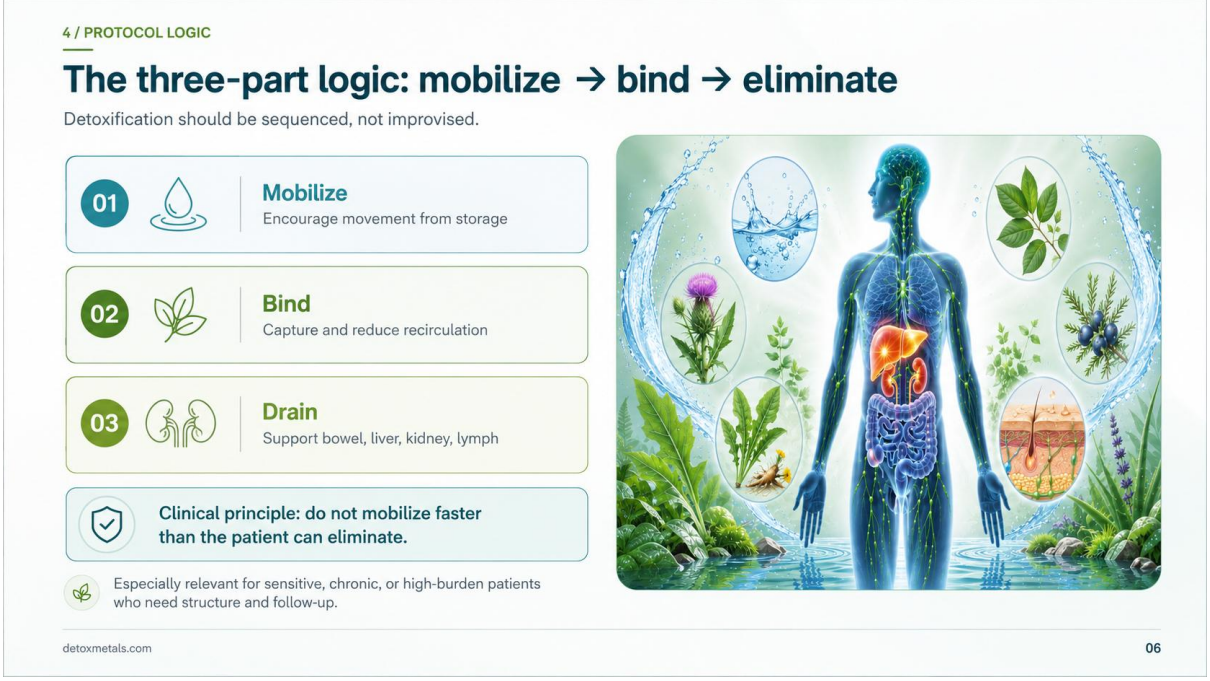
The important point here is that HMD® is not being presented simply as another general detox product. It is positioned as part of a structured, practitioner-guided protocol built around mobilization, binding, drainage, and follow-up.

The research background is also worth noting. The published HMD® materials report three years of research involving 350 metal foundry workers, using double-blind, placebo-controlled testing.

So clinically, the key idea is this: HMD® should be used thoughtfully, with proper assessment, careful wording, and appropriate monitoring.

Rather than making broad claims, we can explain it as a natural protocol designed to support the body's detoxification process within a responsible clinical framework.

SLIDE 6 – THE THREE PART LOGIC – MOBILIZE – BIND – ELIMINATE



This slide explains the **Three-Part Logic of the Protocol**: **mobilize, bind, and eliminate**.

The key message is that detoxification should be sequenced, not improvised. We don't want to simply "stir things up" in the body without making sure the patient can safely process and remove what is being mobilized.

First, we **mobilize** — encouraging movement from storage areas, where toxic metals may have accumulated over time. They may be stored in tissues, bound to proteins, or associated with cellular and intracellular compartments. A meaningful detox strategy therefore needs to address mobilization — the process by which metals are encouraged to move out of deeper storage and into routes where the body can eliminate them. The intracellular chelator is the HMD product, which is key.

Second, we **bind** — helping capture those mobilized toxins so they are less likely to recirculate.

And third, we **drain and eliminate** — supporting the bowel, liver, kidneys, and lymphatic system so the body has clear routes of exit.

Clinically, this is especially important for sensitive, chronic, or high-burden patients. The principle is simple: **do not mobilize faster than the patient can eliminate**.

That's why structure, monitoring, and follow-up are so important when using any detoxification protocol responsibly.

SLIDE 7 – THE 3 PRODUCTS IN THE HMD PROTOCOL

This slide shows the three products that make up the HMD detox protocol, organized around the clinical sequence: **mobilize, bind, and drain**.

The first product is **HMD Daily Wellness Support**, which is designed to support the mobilization phase. Its key ingredients include chlorella growth factor, coriander or cilantro, and a homeopathic chlorella pyrenoidosa homaccord. This is the part of the protocol aimed at helping mobilize toxic metals from tissues.

The second product is **HMD Chlorella**, which supports the binding phase. Chlorella is used here as a nutrient-rich binding support, naturally containing chlorophyll, vitamins, minerals, amino acids, and essential fatty acids. Clinically, this step is important because mobilization should be paired with gut binding support.

The third product is **HMD Lavage**, which supports the drainage and elimination phase. It contains botanicals traditionally used to support liver, kidney, lymphatic, and elimination pathways, including dandelion root, milk thistle, burdock, red clover, turmeric, hydrangea, and uva ursi.

So the protocol is not just one product doing everything. It is a structured three-part approach: first mobilize, then bind, then drain. For practitioners, this helps make detoxification more organized, more clinically logical, and easier to monitor.

SLIDE 8 – HOW HMD DIFFERS FROM SIMPLE BINDERS

Here I want to make an important distinction between a simple binder and the HMD® Protocol.

Many practitioners already use binders. Chlorella, charcoal, clay, modified citrus pectin, alginates, silica, zeolite, and fibre are all commonly discussed.

But a binder is not the same as a chelator or mobilizing agent.

A binder generally works in the gut. It may help capture toxins, bile metabolites, or metals that are already present in the intestinal tract or outside the cell.

This can be very useful. But it does not necessarily mean the binder is reaching deeper tissue compartments or mobilizing metals from intracellular spaces.

The HMD® Protocol is positioned differently.

It is not simply "take chlorella." It is based on the HMD® formula designed to mobilize toxic metals, with binding and elimination support built around that process.

This distinction is important for practitioners.

If a patient has mild gut-level exposure, a binder alone may be enough. But if the goal is deeper toxic metal reduction, then we need to think in a more structured way: mobilize, bind, drain, replenish, and monitor.

SLIDE 9 – RESEARCH PROGRAMME – WHAT PRACTITIONERS SHOULD KNOW

Let us now look briefly at the research background.

The published HMD research summaries describe a **randomized, double-blind, placebo-controlled trial programme** involving **350 metal foundry workers**.

These were adult male workers aged 18 to 60, exposed in a metal foundry environment, and they were allocated to different groups using natural substances or combinations to assess their chelating potential.

The research was reportedly conducted over a three-year period, using pre- and post-analysis of samples including urine, faeces, and hair - **ICP-MS** analysis in US labs was used for samples during the study period.

The key point for practitioners is that the research did not simply test one popular natural chelator in isolation.

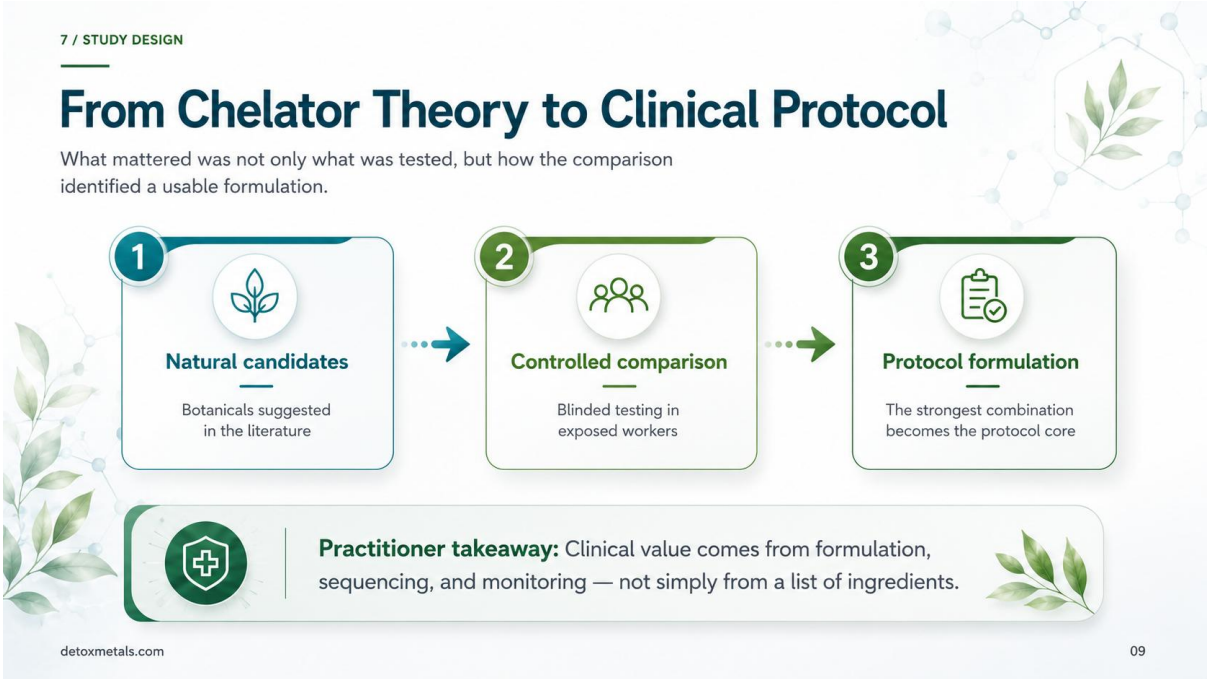
It evaluated a number of natural substances and combinations that had been suggested in the literature to have heavy metal chelating activity. The goal was to see what actually worked under a controlled trial design.

The HMD research page also lists several publications, including work on natural heavy metal chelators and the development of HMD® as a natural oral heavy metal chelator.

When speaking professionally, I think it is important to frame this carefully. We should say: "The published HMD materials report double-blind, placebo-controlled research in 350 metal foundry workers." That is accurate and appropriately cautious. We should not overstate beyond the data.

But we should also recognize that for a natural heavy metal detox formulation, this level of human research is unusual and worth the attention of practitioners.

SLIDE 10 – FROM CHELATOR THEORY TO CLINICAL PROTOCOL



This slide shows the shift from chelator theory into a usable clinical protocol.

The important point is that the research was not just asking, 'Which natural ingredients might help with heavy metals?' It was asking a more practical question: which formulation works best when tested in a controlled way?

The process began with **natural candidates** — botanicals and compounds already suggested in the literature for heavy metal support.

The next step was **controlled comparison**, where these candidates were tested in exposed workers. This is important because it moves the conversation beyond theory and into observed results.

From there, the strongest combination became the basis for **protocol formulation**. In other words, the protocol was built from what appeared most useful in the comparison, rather than simply choosing ingredients because they sounded promising.

For practitioners, the key takeaway is that clinical value does not come from a random list of detox ingredients. It comes from formulation, sequencing, and monitoring.

So this slide helps frame HMD as a structured clinical protocol, not just a collection of natural chelators.

SLIDE 11 – FOUR TAKEAWAYS FROM THE RESEARCH STORY

On this slide, I want to bring the research back into clinical decision-making. There are four practical takeaways here.

First, **formulation matters**. Natural chelators are not all the same, and we should avoid treating them as interchangeable. The specific ingredients, their binding properties, and how they behave in the body can make a meaningful difference.

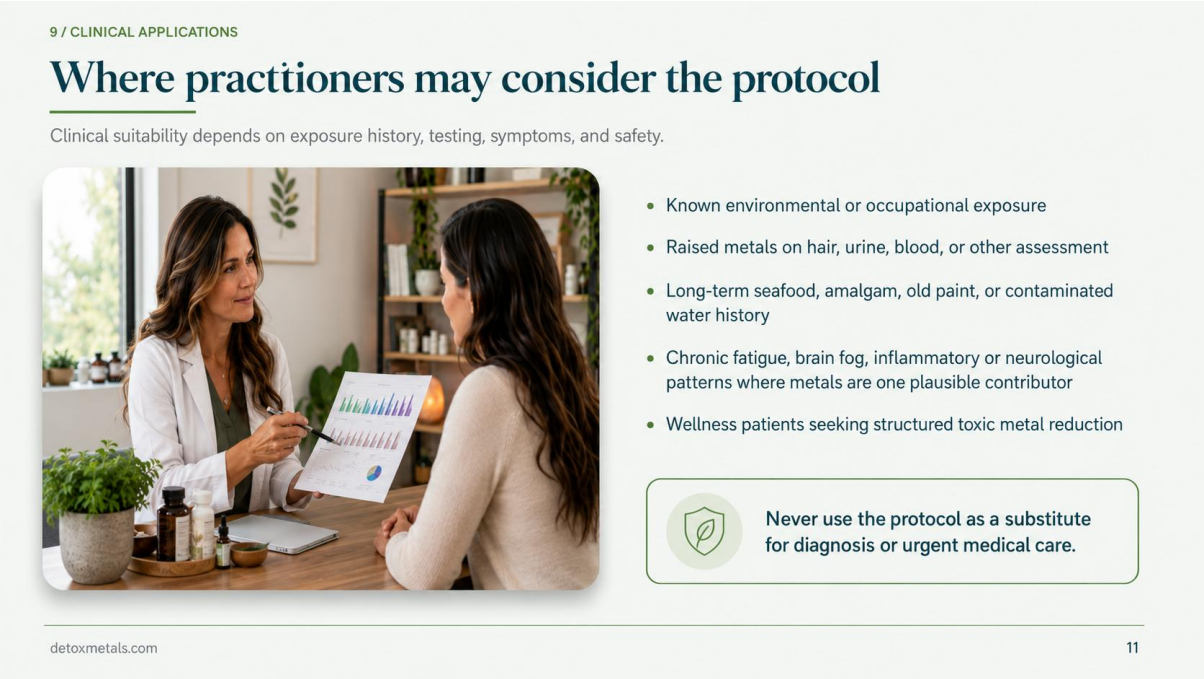
Second, **synergy matters**. In this research story, the benefit is not just about one compound working alone. It is about the combination and the ratio. That is clinically important, because small changes in formulation may change the effect.

Third, **population matters**. The study involved a high-exposure group, so we need to interpret the findings within that context. These results are especially relevant when we are thinking about patients with a known or suspected higher toxic metal burden.

And finally, **monitoring matters**. Natural does not mean careless. Even when using botanical or nutraceutical approaches, we still need proper assessment, clinical judgment, and follow-up. That includes watching symptoms, supporting elimination pathways, and using testing when appropriate.

So the practical message is this: when we translate research into practice, we should look beyond the headline result. The formulation, the synergy, the patient population, and the monitoring strategy all influence how safely and effectively we apply the evidence."

SLIDE 12 – WHERE PRACTITIONERS AY CONSIDER THE PROTOCOL



Now, the key question is: where might practitioners consider using this protocol in real clinical practice?

The first point is that suitability should never be based on one factor alone. We are looking at the full picture: exposure history, testing, symptoms, clinical presentation, and safety.

This may be considered in patients with a known environmental or occupational exposure, for example people exposed through work, contaminated environments, or long-term contact with potential sources of toxic metals.

It may also be relevant when testing shows raised metals, whether that is through hair, urine, blood, or another appropriate assessment method. The testing gives us a clearer starting point and helps avoid guessing.

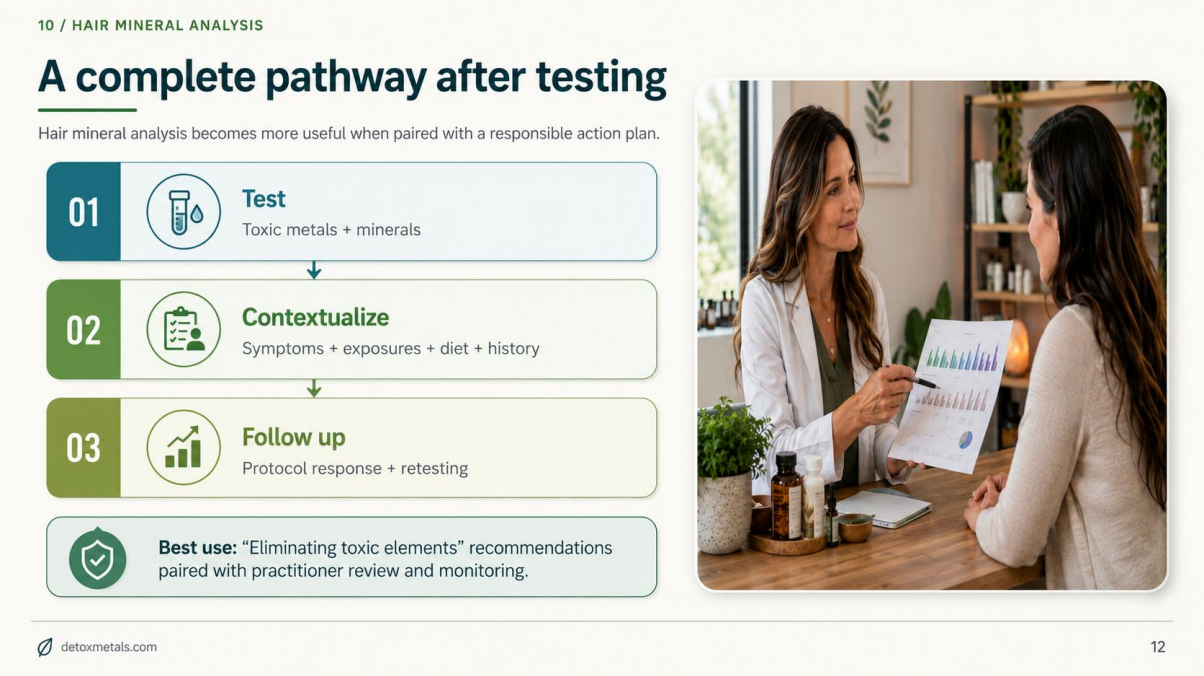
We should also think about long-term exposure patterns, such as high seafood intake, dental amalgams, older paint exposure, or a history of contaminated water.

Clinically, some patients may present with chronic fatigue, brain fog, inflammatory patterns, or neurological symptoms where toxic metals could be one plausible contributor. Not the only explanation, but one piece worth considering.

And finally, there are wellness-focused patients who are looking for a structured way to reduce toxic metal burden, provided they are suitable and properly monitored.

The important safety message is this: this protocol should never replace diagnosis, investigation, or urgent medical care. It is a clinical tool to be considered thoughtfully, within a broader assessment and care plan."

SLIDE 13 – A COMPLETE PATHWAY AFTER TESTING



Here we're looking at what happens after hair mineral analysis, because testing is only useful when it leads to a responsible action plan.

The first step is test. Hair mineral analysis can give us information about toxic metals as well as essential minerals. But the result itself is not the full clinical picture.

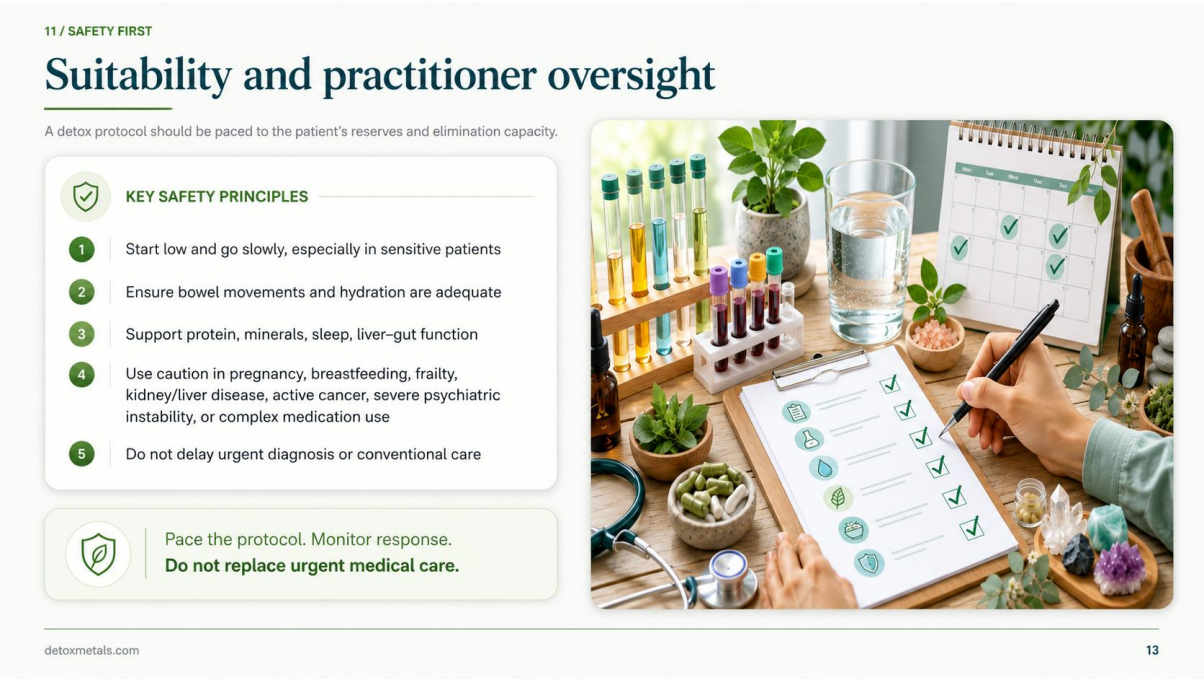
The second step is to contextualize. We need to interpret the findings alongside the patient's symptoms, exposure history, diet, lifestyle, and overall health background. For example, the same result may mean something different in someone with occupational exposure compared with someone who has no clear exposure history.

The third step is follow up. Once a protocol is introduced, we want to monitor the patient's response, track changes in symptoms, and consider retesting where appropriate. This helps us see whether the plan is working and whether it needs adjusting.

The key message is that hair mineral analysis should not be used as a stand-alone tool. Its best use is when recommendations for eliminating toxic elements are paired with practitioner review, clinical judgment, and ongoing monitoring.

So, the pathway is simple: test, interpret in context, then follow up responsibly."

SLIDE 14 – SUITABILITY AND PRACTITIONER OVERSIGHT



Before we think about any detox protocol, safety has to come first. The goal is not to push the body harder, but to pace the protocol according to the patient's reserves and elimination capacity.

The first principle is to **start low and go slowly**, especially in sensitive patients. Some people tolerate mobilization and detox support well, while others need a much gentler approach.

Second, we want to make sure the basics are in place: **regular bowel movements and adequate hydration**. If elimination is poor, symptoms can flare and the patient may feel worse rather than better.

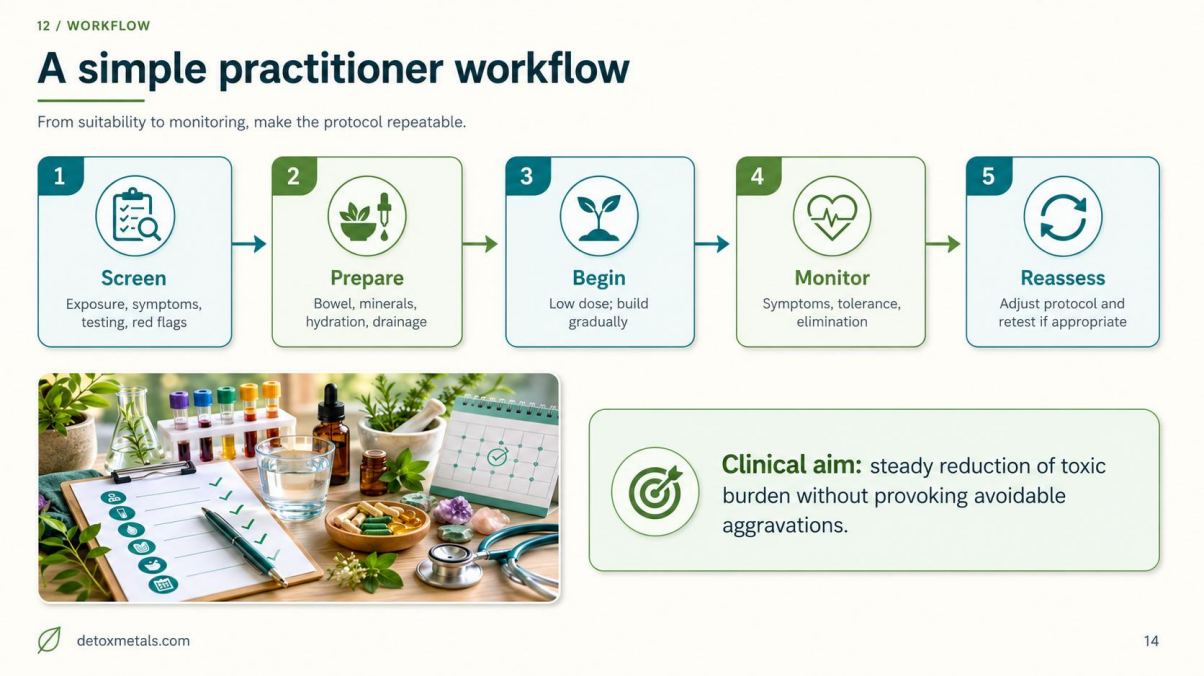
Third, we need to support the foundations: **protein, minerals, sleep, and liver–gut function**. These are not optional extras. They are part of making the protocol more tolerable and clinically responsible.

Fourth, there are situations where we need extra caution, including pregnancy, breastfeeding, frailty, kidney or liver disease, active cancer, severe psychiatric instability, or complex medication use. These patients require careful judgment, and in some cases this protocol may not be appropriate.

And finally, we should never delay urgent diagnosis or conventional care. If a patient has red flag symptoms, this is not a replacement for medical investigation.

So the key message here is simple: pace the protocol, monitor the response, and keep safety at the centre of clinical decision-making."

SLIDE 15 – A SIMPLE PRACTITIONER WORKFLOW



This slide gives us a simple practitioner workflow, so the protocol becomes structured, repeatable, and safer to apply.

We start with **screening**. Before beginning, we want to look at exposure history, symptoms, test results, and any red flags. This helps us decide whether the protocol is appropriate, and whether the patient needs further medical evaluation first.

Next, we **prepare**. This means making sure the basics are working: bowel movements, minerals, hydration, and drainage pathways. Preparation is important because detoxification is not just about mobilizing metals; it is also about helping the body eliminate them.

Then we **begin**. The principle here is low dose and gradual progression. We do not need to rush. For many patients, especially sensitive patients, slower is often better.

The fourth step is to **monitor**. We are watching symptoms, tolerance, bowel function, hydration, energy, sleep, and overall response. This is where practitioner oversight becomes very important.

Finally, we **reassess**. Based on the patient's response, we can adjust the protocol and consider retesting when appropriate.

So the clinical aim is steady reduction of toxic burden without provoking avoidable aggravations. In practice, that means screening carefully, preparing well, starting gently, monitoring closely, and adapting the plan as the patient responds.

SLIDE 16 – MANAGING SENSITIVITY AND DETOX REACTIONS

This slide focuses on managing sensitivity and detox reactions, because the right pace matters just as much as the right product.

Some patients will tolerate detox support very well, but others may react quickly, especially if they have poor elimination, inflammation, gut issues, mineral depletion, or a highly sensitive nervous system.

The first step is to **reduce the dose or pause** if symptoms become disproportionate. A strong reaction is not proof that the protocol is working better. It may simply mean the patient is being pushed beyond their current capacity.

Next, we need to **check the foundations**. Are they constipated? Are they hydrated? Are they eating enough protein? Do they have adequate mineral support? These basic factors often determine whether the patient can tolerate the process.

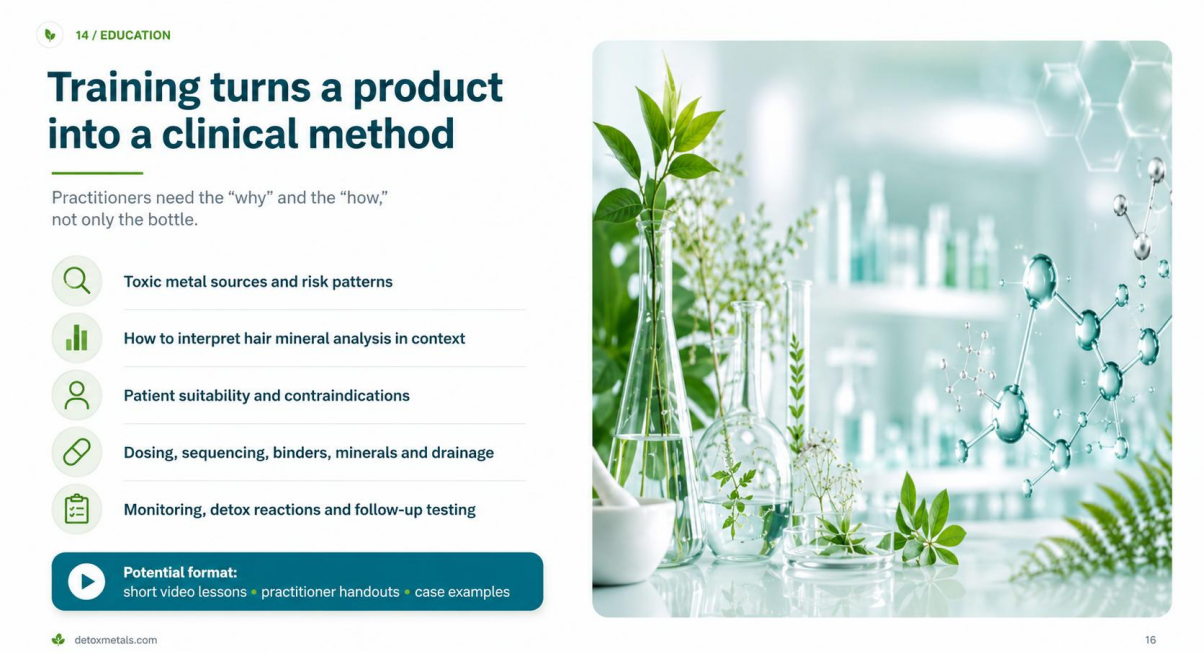
We also need to **differentiate detox discomfort from red flags**. Mild, temporary changes may occur, but severe, unusual, or escalating symptoms need proper clinical assessment and should not be dismissed as detox.

Binders and drainage support can be used strategically, but they should be matched to the patient rather than applied aggressively.

And finally, follow-up is essential. We do not want patients feeling they have to "push through" reactions on their own.

The key message is this: a dramatic reaction is not the goal. A stable patient is much easier to support safely, and a slower, steadier protocol is often the more effective clinical choice.

SLIDE 17 – TRAINING TURNS A PRODUCT INTO A CLINICAL PROTOCOL



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SLIDE 18 – A PRACTICAL, RESEARCH-INFORMED TOOL FOR NATUROPATHIC PRACTICE

To close, the main message is that this protocol can be viewed as a practical, research-informed tool for naturopathic and integrative practice.

Heavy metals may be one part of a patient's total toxic burden, especially when there is a clear exposure history, relevant symptoms, or supportive testing.

But testing on its own is not enough. Hair mineral analysis, or any form of assessment, becomes more useful when it is paired with a clear protocol, clinical interpretation, and follow-up.

The HMD protocol offers a structured **mobilize, bind, and drain** approach. That structure is important because it gives practitioners a more organized way to support toxic metal reduction, rather than relying on random or isolated interventions.

At the same time, practitioner oversight is what keeps the process safer and more individualized. We need to consider suitability, pace the protocol appropriately, monitor reactions, and adjust based on the patient's response.

So the practical takeaway is simple: test intelligently, support elimination, and monitor carefully.

For practitioners, the next step is to review the research, consider practitioner access, and build protocol literacy so this can be applied with confidence, caution, and good clinical judgment.

SLIDE 19 – SCIENTIFIC RESEARCH ON HMD

To close, I want to highlight the scientific references behind the HMD protocol and the wider discussion around natural heavy metal chelators.

These three publications by Dr. Georgiou provide the foundation for the research story we have been discussing.

The first reference, published in the *British Naturopathic Journal* in 2007, introduces the use of a natural heavy metal chelator in paediatric cases.

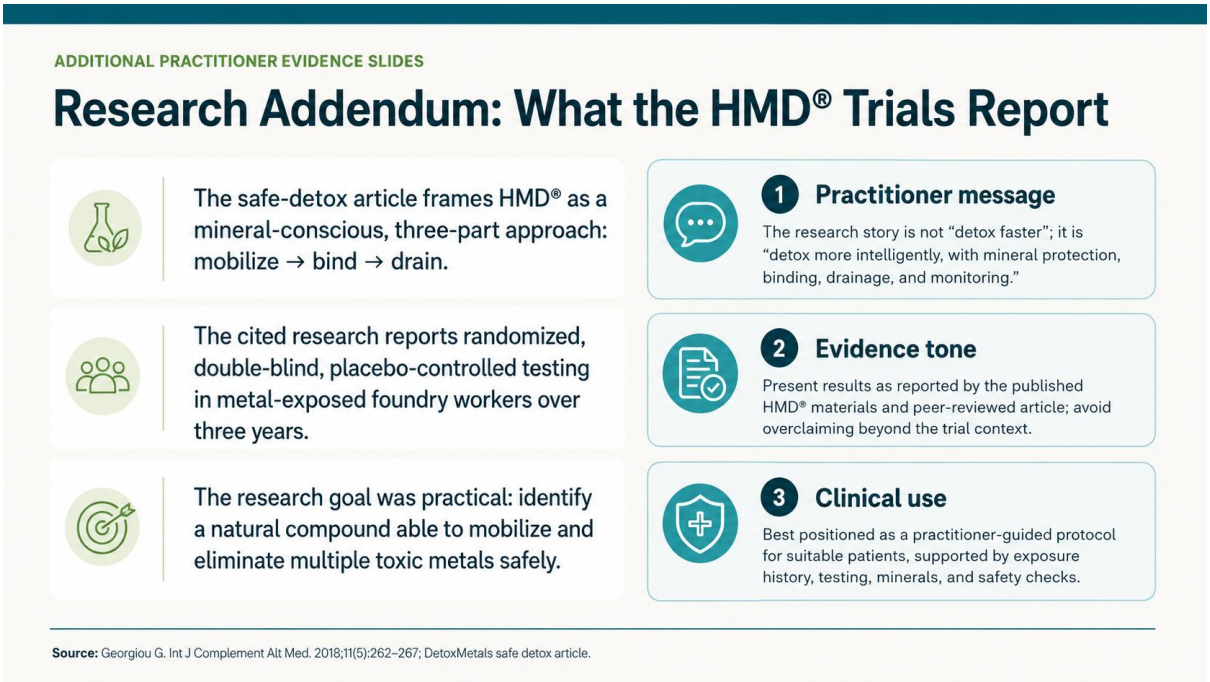
The second, also from 2007, asks an important clinical question: do natural heavy metal chelators actually work? That paper helps frame the rationale for looking beyond single ingredients and considering practical clinical outcomes.

The third paper, published in the *International Journal of Complementary & Alternative Medicine* in 2018, focuses more directly on testing what works in natural heavy metal chelation.

For practitioners, the purpose of this slide is simple: these references give you a starting point for reviewing the evidence yourself. They should be included in the practitioner handout, course page, or video description so clinicians can follow up, read the source material, and make informed decisions.

So the takeaway here is that HMD is not being presented only as a product, but as a protocol with a published research background that practitioners can review, question, and apply responsibly.

SLIDE 20 – RESEARCH ADDENDUM: WHAT THE HMD TRIALS REPORT



This addendum summarizes what the HMD trials report.

The key idea is that HMD is framed as a **mineral-conscious, three-part approach**: mobilize, bind, and drain. So the clinical message is not simply 'detox faster.' It is more about detoxifying more intelligently, with attention to mineral protection, binding support, drainage, and monitoring.

The cited research reports randomized, double-blind, placebo-controlled testing in metal-exposed foundry workers over a three-year period. That gives the discussion a practical clinical context: these were not just theoretical concerns, but people with meaningful occupational exposure.

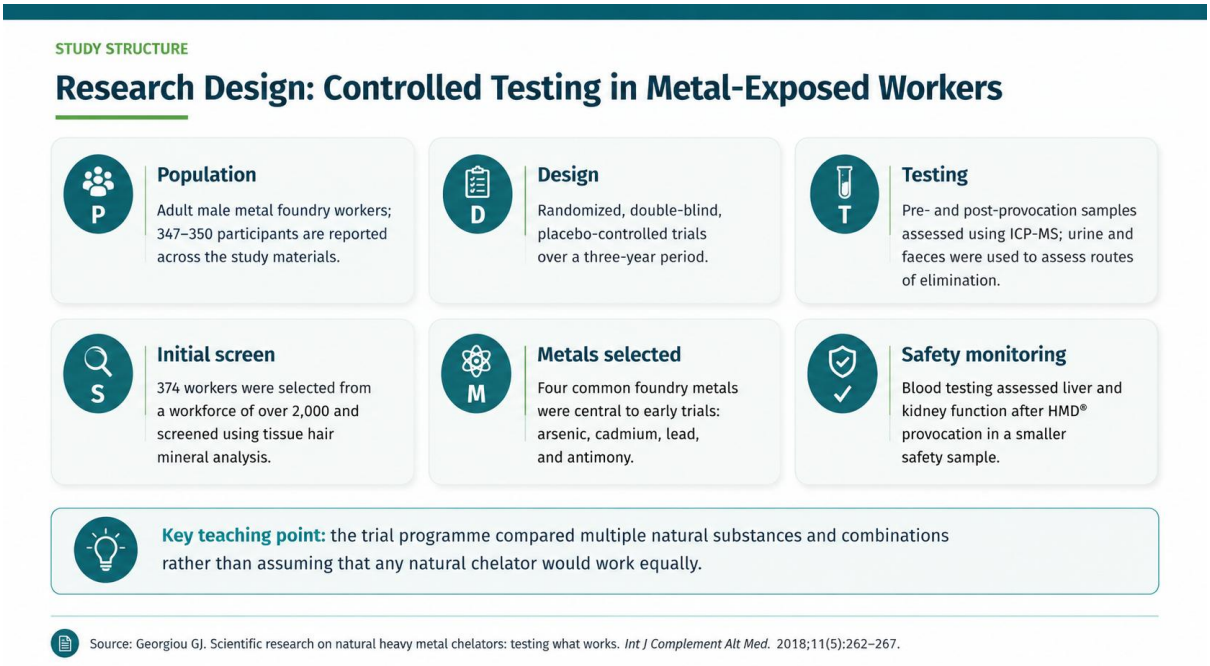
The research goal was also practical: to identify a natural compound that could help mobilize and eliminate multiple toxic metals safely.

For practitioners, the tone matters. We should present the findings as reported in the HMD materials and the published article, without overclaiming beyond the trial context.

Clinically, this positions HMD best as a practitioner-guided protocol for suitable patients, supported by exposure history, testing, mineral awareness, and safety checks.

So the takeaway is this: the research story supports a structured and monitored approach, not aggressive detoxification. The goal is intelligent reduction of toxic burden while protecting the patient's overall resilience.

SLIDE 21 – RESEARCH DESIGN: CONTROLLED TESTING IN METAL-EXPOSED WORKERS



This slide looks at the research design behind the HMD trials, specifically the controlled testing carried out in metal-exposed workers, at a cost of about $1 million.

The population was adult male foundry workers, with around 347 participants reported across the study materials. An initial screening process selected workers from a larger workforce of over 2,000, using tissue hair mineral analysis to help identify relevant exposure patterns.

The study design is important. These were reported as randomized, double-blind, placebo-controlled trials conducted over a three-year period. So the aim was not just to make a theoretical claim, but to compare outcomes in a controlled way.

The testing included pre- and post-provocation samples, assessed using ICP-MS. Urine and faeces were used to look at routes of elimination, which is clinically relevant because detoxification is not only about mobilizing metals, but also about whether the body is actually eliminating them.

The early trials focused on four common foundry-related metals: arsenic, cadmium, lead, and antimony.

Safety monitoring was also included, with blood testing used to assess liver and kidney function after HMD provocation in a smaller safety sample.

The key teaching point here is that the trial programme compared multiple natural substances and combinations. It did not assume that all natural chelators work equally. For practitioners, that reinforces the importance of formulation, testing, safety monitoring, and clinical context.

SLIDE 22 – WHY HMD BECAME THE LEAD COMPOUND

This slide explains why HMD became the lead compound in the reported trial programme.

The main point is that the final compound was not based on one ingredient working alone. It combined three elements: chlorella growth factor, coriander or cilantro tincture, and a homeopathic chlorella pyrenoidosa homaccord.

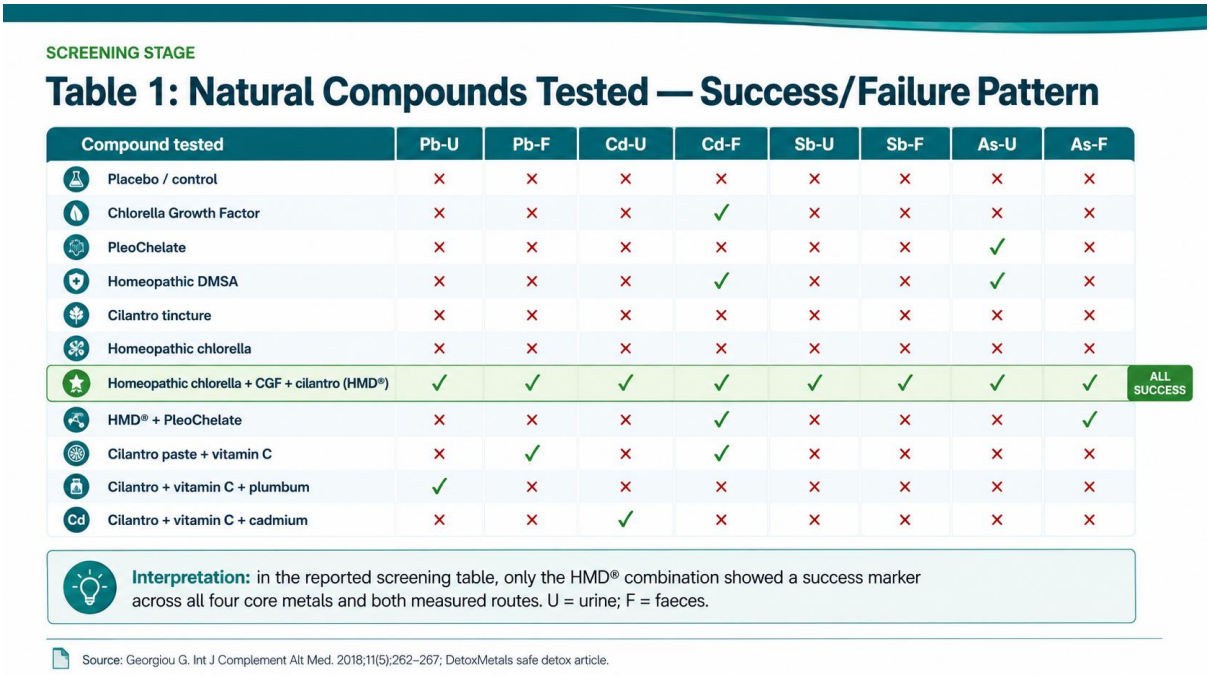
In the screening stage, individual ingredients appeared to show limited or selective activity. Some may have shown activity with one metal or one elimination route, but not across the wider pattern being tested.

The reported strength of the HMD formulation was the combination. The trial materials suggest that the blend showed a synergistic effect, which is why formulation became such an important part of the research story.

Clinically, this is where the mobilize, bind, and drain concept comes in. The aim is not only to mobilize toxic metals, but also to support binding in the gut and encourage safe drainage and elimination.

For practitioners, the takeaway is that the protocol was selected because of reported multi-metal mobilization across the trial programme. So again, the emphasis is on a structured formulation and a guided protocol, rather than assuming that any single natural chelator will produce the same result.

SLIDE 23 – NATURAL COMPOUNDS TESTED – SUCCESS/FAILURE PATTERN



SCREENING STAGE

Table 1: Natural Compounds Tested — Success/Failure Pattern

Compound tested	Pb-U	Pb-F	Cd-U	Cd-F	Sb-U	Sb-F	As-U	As-F	
Placebo / control	×	×	×	×	×	×	×	×	
Chlorella Growth Factor	×	×	×	✓	×	×	×	×	
PleoChelate	×	×	×	×	×	×	✓	×	
Homeopathic DMSA	×	×	×	✓	×	×	✓	×	
Cilantro tincture	×	×	×	×	×	×	×	×	
Homeopathic chlorella	×	×	×	×	×	×	×	×	
Homeopathic chlorella + CGF + cilantro (HMD®)	✓	✓	✓	✓	✓	✓	✓	✓	ALL SUCCESS
HMD® + PleoChelate	×	×	×	✓	×	×	×	✓	
Cilantro paste + vitamin C	×	✓	×	✓	×	×	×	×	
Cilantro + vitamin C + plumbum	✓	×	×	×	×	×	×	×	
Cilantro + vitamin C + cadmium	×	×	✓	×	×	×	×	×	

Interpretation: in the reported screening table, only the HMD® combination showed a success marker across all four core metals and both measured routes. U = urine; F = faeces.

Source: Georgiou G. Int J Complement Alt Med. 2018;11(5):262–267; DetoxMetals safe detox article.

This slide breaks down the screening-stage results from the research, where different natural compounds and combinations were tested across several toxic metals and elimination routes.

The table compares markers for lead, cadmium, antimony, and arsenic, looking at both urine and faeces. So it is not just asking whether a substance can mobilize a metal, but also whether that metal appears to be moving through measurable elimination pathways.

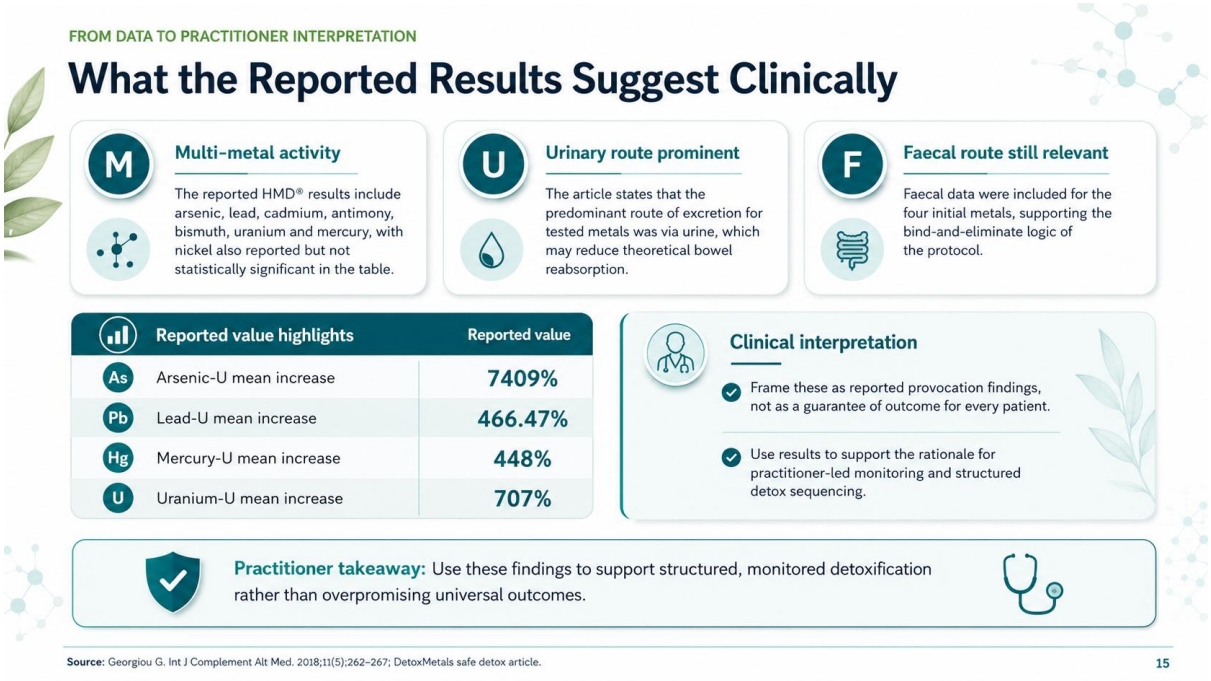
What stands out is the success and failure pattern. Several individual compounds showed limited or selective activity, but they did not perform consistently across all the core metals and both routes.

The highlighted row is the HMD combination: a homaccord of chlorella, chlorella growth factor, and cilantro. In the reported screening table, this was the only combination showing success markers across all four core metals and both measured routes.

For practitioners, the teaching point is important: we should not assume that all natural chelators work the same way. The evidence presented here supports the idea that formulation and combination matter.

So clinically, this reinforces the rationale for using a structured protocol rather than relying on a single ingredient. The goal is coordinated mobilization, binding, and elimination, with monitoring to make sure the patient is tolerating the process safely."

SLIDE 24 – WHAT THE REPORTED RESULTS SUGGEST CLINICALLY



This slide helps us move from reported data into practical clinical interpretation.

The first point is **multi-metal activity**. The reported HMD results include several metals, including arsenic, lead, cadmium, antimony, bismuth, uranium, and mercury. Nickel was also reported, but not as statistically significant in the table.

The second point is that the **urinary route appeared prominent**. According to the data, urine was the main route of excretion for the tested metals. Clinically, that may be relevant because it could reduce the concern of metals being reabsorbed through the bowel.

At the same time, the **faecal route still matters**. Faecal data were included for the first four metals, which supports the bind-and-eliminate logic of the protocol.

The highlighted values show notable reported increases for arsenic, lead, mercury, and uranium after provocation. But these should be framed carefully. They are reported provocation findings, not a guarantee that every patient will have the same response.

For practitioners, the real value is in how we use this information. These findings support the rationale for structured detox sequencing, practitioner-led monitoring, and individualized patient care.

So the takeaway is simple: use the data to support a responsible clinical framework, not to overpromise universal outcomes."

SLIDE 25 – MERCURY TRIAL AND SAFETY MONITORING

This slide focuses on the mercury trial data and the safety monitoring reported in the article.

In the mercury elimination table, the pre-test value is reported at 12.62%, while the post-test value after HMD provocation is reported at 448%. So, within this small mercury trial group, mercury elimination appeared to increase substantially after the protocol was used.

But the important point is that efficacy is only one part of the clinical picture. We also need to look at safety.

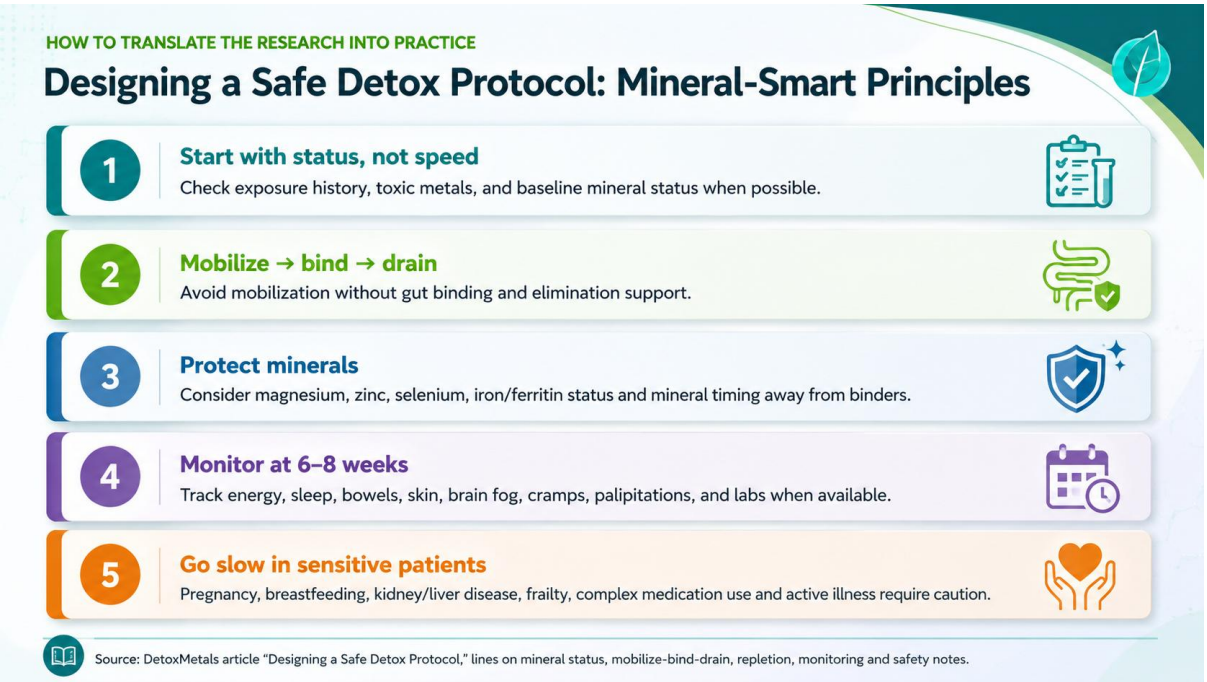
The second table reports liver and kidney function markers in a smaller safety sample. These included creatinine, bilirubin, urea, ALT, and AST. The article notes that although some changes were observed, they did not exceed pathological parameters in this small group.

From a practitioner perspective, that supports a gentler safety profile in the reported cohort, but it does not remove the need for caution.

We still need proper patient screening, attention to kidney and liver health, medication review, hydration, bowel function, and follow-up monitoring.

So the key takeaway is this: the reported data suggest a substantial increase in mercury elimination after HMD provocation, while liver and kidney markers remained within reported ranges. Clinically, that supports the rationale for the protocol, but only when it is used with appropriate practitioner oversight.

SLIDE 26 – DESIGNING A SAFE DETOX PROTOCOL: MINERAL-SMART PRINCIPLES



This slide brings the research into practical protocol design, with a focus on mineral-smart detox principles.

The first principle is to **start with status, not speed**. Before moving quickly into detoxification, we want to understand the patient's exposure history, toxic metal picture, and baseline mineral status where possible. This gives us a safer starting point.

Second, we need to follow the sequence: **mobilize, bind, and drain**. Mobilizing metals without adequate gut binding and elimination support can make patients more reactive, so the protocol should always support the full pathway.

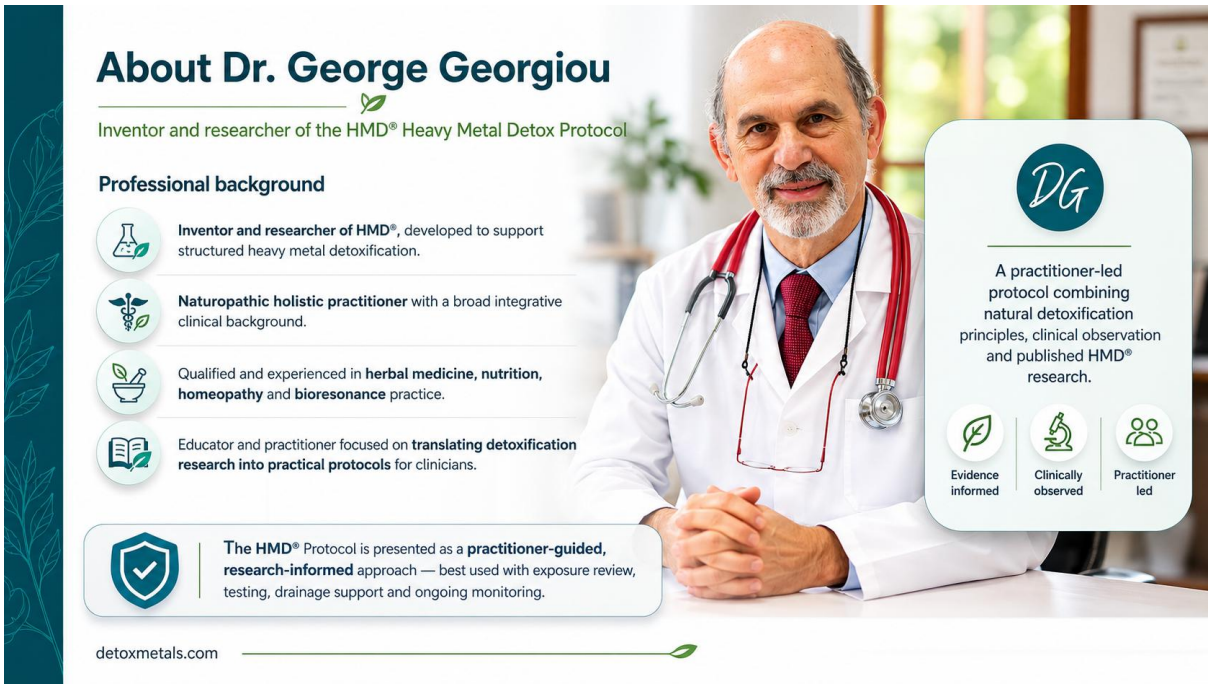
Third, we need to **protect minerals**. During detoxification, minerals such as magnesium, zinc, selenium, and iron or ferritin status may need attention. Timing also matters, because minerals should often be taken away from binders so they are not unintentionally reduced.

Fourth, we monitor around the **six-to-eight-week mark**. This is a useful point to check energy, sleep, bowels, skin, brain fog, cramps, palpitations, and lab markers when available.

And finally, we go slowly in sensitive patients. Pregnancy, breastfeeding, kidney or liver disease, frailty, complex medication use, or active illness all require caution and individualized judgment.

So the clinical message is this: a safe detox protocol is not about pushing harder. It is about assessing first, protecting minerals, supporting elimination, and adjusting the pace to the patient.

SLIDE 27 – ABOUT DR GEORGE GEORGIOU



This slide gives some background on Dr. George Georgiou, the inventor and researcher behind the HMD Heavy Metal Detox Protocol.

Dr. Georgiou developed HMD as a structured approach to heavy metal detoxification, with the aim of combining natural detoxification principles, clinical observation, and published research.

His professional background is broad and integrative. He is presented here as a naturopathic holistic practitioner with experience in herbal medicine, nutrition, homeopathy, and bioresonance practice.

A key part of his work has been education: translating detoxification research into practical protocols that clinicians can use in a more structured and responsible way. He is the author of 23 books on holistic medicine, as well as many research publications.

The important point for practitioners is that HMD is not being presented as a casual detox product. It is positioned as a practitioner-guided, research-informed protocol, best used with exposure review, testing, drainage support, and ongoing monitoring.

So this slide helps frame the protocol within the experience and clinical philosophy of its developer: evidence-informed, clinically observed, and practitioner-led.

SLIDE 28 – NEW COURSE: HEAVY METAL TOXICITY

This slide introduces an upcoming practitioner education course on **Heavy Metal Toxicity**, scheduled to launch in **September 2026**.

The aim of this course is to give practitioners a more complete, research-informed framework for understanding heavy metal exposure, testing, detoxification, and clinical decision-making.

The course will review cutting-edge research, but the focus will be practical. We want practitioners to be able to translate the science into safe, structured, patient-specific protocols.

A major part of the training will be clinical application: how to assess exposure history, interpret testing, identify suitability, and design a protocol that is appropriate for the individual patient.

Safety and monitoring will also be central. That includes mineral protection, sequencing, contraindications, sensitive patients, detox reactions, and follow-up strategy.

The course will also include tools for practice, such as protocol frameworks, practitioner handouts, and case-based learning, so clinicians can apply the material with more confidence.

So the message for practitioners is: this is not just a theory course. It is designed to build protocol literacy, improve clinical decision-making, and support a safer, more informed approach to heavy metal toxicity.

SLIDE 29 – THANK YOU FOR LISTENING

Thank you for listening.

The main message I want to leave you with is that practitioner-led protocols make detoxification safer, clearer, and more individualized.

Heavy metal detox is not something we should approach casually. It works best when there is proper assessment, a clear protocol, attention to elimination pathways, and ongoing monitoring.

For practitioner access, you can visit **detoxmetals.com** and open the **Practitioner** section. There, you'll find the HMD packs developed specifically for health practitioners, along with clinical education and structured support for patient protocols.

The goal is to help practitioners move beyond isolated detox products and toward a more complete clinical framework: understanding exposure, testing intelligently, supporting minerals and drainage, and adapting the protocol to the patient in front of you.

So, as you take this information forward, remember the core principle: detoxification should be guided, monitored, and individualized.

Thank you again for your time, and I encourage you to visit **detoxmetals.com**, explore the Practitioner section, and continue building your confidence in safe, research-informed heavy metal detoxification.

Contact Dr Georgiou directly on: admin@docgeorge.com

https://detoxmetals.com