

Mobilization Is Not Elimination

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Abstract

This concept paper examines mobilization is not elimination. It develops an argument drawn from Terrain Medicine: Fasting Science, identifies the relevant biological or clinical mechanisms, and considers where that argument may fail. This is a narrative perspective, not a systematic review or an original clinical study.

The central problem

Weight loss mobilizes stored triglycerides and can alter distribution of certain fat-soluble environmental compounds. The book proposes that circulating burdens may rise when mobilization exceeds the body's ability to transform and excrete them. The concept is chemically plausible for some contaminants but cannot be generalized to all "toxins," especially heavy metals and infections whose kinetics differ. The central distinction is between movement out of storage and verified removal from the organism.

Mechanisms and causal architecture

Adipose tissue can partition some persistent lipophilic compounds. Lipolysis changes the lipid pool and may alter plasma concentrations depending on release, dilution by circulating lipids, redistribution and elimination. Higher blood concentrations after weight loss do not automatically prove increased toxic effect or net reduction of total body burden. Conversely, lower concentration does not necessarily prove successful clearance, because a compound may have redistributed. Hepatic metabolism and biliary or renal elimination are analyte-dependent, and enterohepatic circulation can prolong the residence of selected compounds.

A discriminating example

A rise in circulating concentration after weight loss could mean release from adipose stores, a change in lipid partitioning, altered metabolism or modified elimination. A lower concentration could mean excretion or redistribution. The direction of blood concentration alone therefore does not settle the beneficial-versus-harmful question. A strong concept paper teaches this ambiguity clearly.

Competing explanations and limitations

This model must not be used to interpret fasting headache, diarrhea, agitation or weakness as evidence of contaminant release. Such symptoms can indicate dehydration, inadequate intake, electrolyte disorders, medication effects or acute disease. Evidence supporting fasting as a broad heavy-metal detoxification treatment is lacking. Chelation, when indicated, is a separate medically supervised intervention with its own risks.

What evidence would change the interpretation?

A discriminating study of the concept would need named compounds, longitudinal lipid-adjusted measurements, estimated body burden where feasible, and actual excretion data. Without these distinctions, changing a blood concentration during fasting is not proof of benefit. Any association with symptoms would require independent clinical assessment.

Implications for medical interpretation

The public paper should insist on clear language: redistribution, biotransformation and excretion are not synonyms. That precision makes a provocative hypothesis scientifically usable.

Selected scientific reading

Longo & Mattson (2014), Fasting: molecular mechanisms and clinical applications, Cell Metabolism.
<https://doi.org/10.1016/j.cmet.2013.12.008>

Barabási, Gulbahce & Loscalzo (2011), Network medicine: a network-based approach to human disease, Nature Reviews Genetics.
<https://doi.org/10.1038/nrg2918>

Original source: Terrain Medicine: Fasting Science. All source books supplied by the author.

Conceptual research commentary. Not a peer-reviewed clinical study, original trial, systematic review, validated diagnostic instrument or treatment protocol. Consult qualified care for medical decisions.