The crises shorten: a real pattern across four flares

Within-subject clinical narrative (N = 1) — recovery duration collapses, the device held outside any attribution

Level of evidence : Within-subject clinical narrative (N = 1, 4 severe ulcerative-colitis flares, 2020 → 2026) — honest documentation of a pattern (decreasing recovery duration); NO data links the device to the course of the illness (firewall); no medical claim or advice; conflict of interest declared

Study type	Within-subject clinical narrative (N = 1), 4 severe flares — descriptive
Subject	The author himself — inventor of the technology (conflict of interest declared)
Observation	Recovery duration: ~2 months → 5 weeks → 9 days → a few days (2020 → 2026)
Illness	Ulcerative colitis (severe flares) — the subject's personal account
Substantiated mechanism	Muscle reserve (lean mass, metabolic buffer) — from training, not the device
Device	NO data links it to the course of the illness (firewall)
Status	Real pattern; multiple explanations; no medical claim or advice

Warning. This document recounts four episodes in which the subject came close to death. It has no diagnostic or therapeutic aim, and gives no medical advice. It honestly documents a pattern — the duration of the crises decreases over time — and discusses its possible causes, without deciding. Anyone living with an inflammatory disease has their own path; this account prescribes nothing.

Summary

A part of the longitudinal self-tracking series, and the most serious: four severe ulcerative-colitis flares, from 2020 to 2026, and a striking pattern — recovery duration collapses: about two months, then five weeks, then nine days, then a few days (the last managed alone, without hospital). The pattern is real. The honest question is not "is it true?" but "why?" Several explanations account for it without any recourse to the device: experience (the subject acts earlier), the variable severity of the trigger, the medical history (diagnosis, biologic therapies, access to care), hydration management, and survivor bias. Only one is measurable: muscle reserve — a high lean mass acting as a metabolic buffer against a catabolic shock — and it comes from training, not the device. Crucial point: no data links the device to the course of the illness (firewall). The subject is convinced the technology makes him more resilient; he holds this as a personal conviction, not demonstrable and not excluded — distinct from anything substantiated here. Conflict of interest declared; no medical claim or advice.

1. Transparency — conflict of interest, scope and firewall

Conflict of interest declared, and framing. The author is the subject, the inventor and the manufacturer of the technology. Personal account, health data published voluntarily by the subject. No medical claim, no medical advice; this document is not medical advice.

The device is held outside any attribution (firewall). Absolute rule of the whole series: no data links the device to the course of the ulcerative colitis. The crises existed before continuous wear (the 2022 nadir attests to this). The device is neither blamed for the crises nor credited for the

remissions. What is described here is a behavioral and physiological resilience, not a therapeutic effect.

2. The four crises

The four severe flares, in chronological order:

Crisis	Loss	Care	Recovery
Crisis 1 — Canada, 2020	114 → 80 kg	2 months in hospital	~60 d
Crisis 2 — Switzerland (~2022)	~−34 kg	care in Eastern Europe then 5 wk hospital (intensive care)	~35 d
Crisis 3 — Switzerland	severe dehydration	9 days; erroneous diagnosis ruled out	9 d
Crisis 4 — Egypt, 2026	−10 kg	managed alone, staying active, no hospital	a few d

The care trajectory goes from a long initial hospitalization to a brief episode managed without hospital. Recovery duration decreases with each crisis.

3. The pattern

The slope is clear: recovery duration decreases, crisis after crisis. The subject has, in fact, become more able to get through these flares — it is a trajectory, not an impression. The real question remains: why?

4. Why — the explanations that do not need the device

Several explanations account for the pattern without any recourse to the device:

- Experience and early action. At the first crisis, the subject was discovering it; at the later ones, he recognizes the signals and intervenes early. Acting faster mechanically shortens a crisis.
- Variable trigger severity. The last crisis starts from a travel digestive infection — an irritation, not necessarily the same autoimmune cataclysm as a −34 kg crash. Shorter may mean less severe at the outset.
- Medical history. Between the first and the last: a diagnosis made, biologic therapies, years of knowing the illness, better access to care. A major factor.
- Hydration management. One of the crises was linked by the subject to dehydration; managing water better changes the outcome.
- Survivor bias. Only the crises survived are analyzed; the “I cope better” reading is partly retrospective.

5. The only substantiated mechanism: muscle reserve

The only explanation the series actually documents is muscle reserve. The subject now enters a crisis with a high lean mass, non-sarcopenic — where a patient may enter already wasted. This reserve (lean mass, metabolic capital) is a real buffer against a catabolic shock: it gives the body something to draw on while intake is at zero. It is documented in the other parts of the series (mass, strength, post-crash rebuilding). But it comes from training, not the device.

6. The balance point — conviction vs proof

Two sentences not to confuse. “The subject is more resilient”: true, and the best measurable explanation is muscle reserve + experience. “Thanks to the device”: a personal conviction, sincere,

but not demonstrable — and not excluded. The subject holds the two together without merging them: one can be convinced and remain honest about the limits of the evidence. That is, in fact, the only way to stay credible where it matters most.

7. Limitations

- Retrospective account, 4 episodes, N = 1; hospitalization duration is a coarse proxy for “severity.”
- Heterogeneous triggers (autoimmune vs travel infection) → crises not strictly comparable.
- Major, irreducible confounding: experience, diagnosis, treatments, hydration and reserve all evolve together over time.
- Survivor bias; N = 1; full conflict of interest (subject = inventor).

8. Conclusion

Four severe flares, and an ever-faster recovery: the pattern is real and it makes sense. Its most solid reading is muscle reserve and experience — one measured, the other evident. That the technology contributes is a personal conviction held as such, neither demonstrated nor excluded, and kept strictly apart from any data on the illness. Being both convinced and honest about the limits of the evidence is not a contradiction: it is the condition of credibility. Framing: an exploratory N = 1 clinical narrative, with no medical claim or advice; no effect of the device on the illness is tested or claimed.

Nicolas Desjardins · DBA(c) · PhD(c) IMD · MSc in Neuroscience (in progress) — Q-Technology OÜ, Narva mnt 5, 10117 Tallinn, Estonia

Source: the subject’s retrospective clinical account (four severe ulcerative-colitis flares, 2020 → 2026); recovery / hospitalization duration as a proxy for severity. N = 1; conflict of interest declared; health data published by the subject. No data links the device to the course of the illness; no medical claim or advice. Unaudited internal data. Not medical advice.