Treating Cancer

Western Medicine has brought us a tremendous amount of progress in many fields. We are able to save premature infants that would have been doomed a few short years ago. It has brought us great strides in trauma and orthopedic surgery. It has given us a much better understanding of the human organism and its genetic make-up. Unfortunately, capitalism at times can be extremely harmful to progress in medicine.

An oncologist, as defined by the Loyola University health system, is a physician who specializes in treating cancer, including surgical oncologist, radiation oncologist, pediatric oncologist, gynecologic oncologist, and medical oncologist. The very definition of oncology explains its greatest shortcomings, and the reasons for its dramatic failures in progress in the United States of America. For example, in the USA, oncologists spend an inordinate amount of time attacking tumors and cancer cells, regardless of the detrimental effects on the patient. Unfortunately, their clinical training does not include complete and adequate diagnostic procedures or knowledge of the causes for immune system failure. This is the fault of their education, so the blame is really not theirs; it lies in the education system. They are ill trained in the recognition of secondary and tertiary health problems that contribute to immune system failure. They are ill trained in diet, and its relationship to cancer, and are totally untrained in any holistic approach to medicine.

In Western Medicine, oncologists are paid directly for using chemotherapy and radiation therapy on their patients. These therapies account for well over 1/3 of the total income for United States oncologists. They are one of the few physicians able to directly charge the patient and insurance company for selling and administering drugs. There is very little motivation for changing the status quo in the USA. As a matter of fact, it is often illegal for physicians other than oncologists to treat cancer in the USA. They do so often at the expense of their medical license. Once patients are labeled as having cancer, their private medical records are often given to the state for monitoring. This exposes any physician that treats them with "unconventional methods." This breeds a sense of fear in the USA for both patients and physicians. Florida is one of those states where patient confidentiality is forgotten.

Due to this state of affairs, progress in cancer in the United States remains in the hands of the pharmaceutical companies and their influence on education, laws and medical practice. There are few physicians willing to put their patients' welfare above their license to practice medicine. Many physicians that use proven alternative methods, considered outside the conventional norm, are censured or have their license to practice revoked. Patients without insurance are treated differently than those with good insurance. Some oncologists have become very adept at wringing as much income as possible with their position of authority.

My first serious thought on the subject of treating cancer will be extremely controversial in conventional circles. DO NOT LET FEAR RULE YOUR PATIENT'S DECISION MAKING. It has become painfully clear over the past two decades that physicians are using fear as a tool to induce their patients to undergo therapies that they would never allow to be used on themselves. When poled, over 70% of physicians stated they would not accept conventional therapies if they were diagnosed with cancer. Do not become a physician who utilizes fear to force decisions from your patients. Use your skills as a teacher to bring about understanding and needed changes in the

patient's lifestyle. Help the patient to understand that cancer is not just a disease, but a symptom of immune system deterioration as well. Let them know it is not a death sentence, explain tumor doubling time, and give them the knowledge to understand they have time to study their situation and make the correct decisions for the best outcome. Maintain yourself as an advocate for their health, not a dictator of your opinions. Knowledge is the most effective tool for both patients and their physicians.

My second thought is that in the vast majority of cancer cases, the cumulative results of multiple onslaughts to the immune system go unrecognized. Cancer treatment becomes the only priority in patient care. This is a devastating mistake and very often results in the death of the patient. Cancer must be treated not only as a disease in and of itself, but as a disease of opportunity that takes place in a compromised host. We must look at the patient as a whole multifunctional organism with immune responses that are as varied as the diseases they are required to fight.

1. **Cancer is a symptom of a serious underlying problem.**

When we hear the word cancer, we all think of a ravaging disease from which recovery is rare, and comes at the terrible cost of surgery, radiation and chemotherapy sessions. It means forever living under the dark cloud of its re-emergence and its ultimate victory in the taking of another life.

The fact is we develop cancer cells throughout our bodies throughout our lives. Our bodies are normally able to find them, identify them and destroy them before they are able to grow uncontrollably. It is a normal occurrence which is constantly taking place in a healthy body. It is only when the healthy body becomes unable to mount its normal defenses and the cancer cells are allowed to reproduce at an uncontrollable rate that cancer becomes life threatening. This is a failure or breakdown of our normal immune system.

The immune systems breakdown, and its cause, needs to be treated in conjunction with the cancer, in order to assure the best possible outcome for the patient. Any treatment that does not address underlying causes for the breakdown of the immune system will be palliative at best, and life threatening at their worst.

2. **Remember the basic physiology of all cancer cells.**

Look for commonalities in cancers, not differences. Whether it be breast, prostate, renal or lung, there are many facets of their physiology that will remain constant. Glucose is taken in as a primary food; lactic acid is excreted from the cancer cells into the blood. The blood carries the lactic acid to the liver, where it is converted back into glucose to feed the cancer cells. This occurs in all known cancer cells. It has been well documented in many studies, that, many years ago serum glucose levels were used to monitor the progress of the disease. It was well established that as the disease progressed, serum glucose levels would rise.

Knowing this, the wisdom of removing simple carbohydrates and sugars from the diet becomes obvious. The ignorant use of glucose I.V.'s in cancer patients also becomes painfully obvious.

The object is to make it difficult for cancer cells to reproduce. Why fuel them with a primary requirement? They are unable to efficiently use protein or complex carbohydrates for food. The healthy cells of our body and immune system are able to use these as fuel and for repair. Adapt the patient to a diet that includes protein and complex carbohydrates and eliminate the rest. This is a simple change that can make a huge difference in the final outcome of the disease process. To do this, you, as the physician, will need to know what constitutes complex carbohydrates, understand the glycemic index and know good sources of complete amino acid profiles in good protein sources. Included in this pamphlet is a dietary supplement guide. It also includes the use of some vitamins and minerals which many diets lack.

A large number of cancer cell types have receptor sites for opiates. In other words, opiates used to fight pain will actually increase the cancer cell's growth rate. Look for the cause of pain and treat that if possible. If that is not possible, look for pain medication that does not mimic or react to opiate like receptor sites.

Biochem Biophys Res Commun. 1988 Jun 16;153(2):722-7.

The effect of opiates upon prostatic carcinoma cell growth.

Moon TD.

Tulane University, New Orleans, LA.

The effect of opiate receptor agonists upon cell growth of the prostatic carcinoma cell line DU145 was studied. Dynorphin-A increased growth significantly with a peak response at 10(-13) M, of 21 +/- 4% (mean +/- SEM). The dose response curve had a typical inverted-U shape. Dynorphin fragments 1-13 and 1-7 also increased growth at 10(-13) M, while the 2-13 fragment failed to increase growth. Naloxone increased growth at high concentration (10(-7) M) suggesting a stimulatory effect, while at the same time blocking the effect of dynorphin-A. This data demonstrates that agents which stimulate opiate receptors, especially the kappa receptor agonist dynorphin, increase the growth of prostatic carcinoma, and that this effect is controlled by changes at the N-terminal end of the peptide. This effect is blocked by Naloxone.

PMID: 2898243 [PubMed - indexed for MEDLINE]

Brain Res Bull. 1986 Mar;16(3):363-7.

Morphine increases metastatic tumor growth.

Simon RH, **Arbo TE**.

Walker 256 carcinosarcoma cells produce subpleural pulmonary metastases when given intravenously to the Sprague-Dawley rat. The number of metastases increases when the rat is given morphine subsequent to the tumor load. The increase in the number of metastases

can be blocked be pretreatment with the opiate antagonist naloxone. Naloxone itself does not influence the number of metastases. Pentazocine is an opiate that is agonistic to the endorphin kappa-type opiate receptor and partially antagonistic to the mu-type receptor, where morphine acts primarily. While pentazocine alone has no influence on metastases and may decrease the number when given early, pentazocine partially blocks the metastatic inducing effect of morphine.

In treating pain, it is extremely important to isolate the cause and treat it as specifically and conservatively as possible. Removal of the cause is always preferred over masking the pain with drugs.

3. **Finding the cause of immune system failure must become a primary factor in the treatment of all cancers.**

Normally immune system failure is gradual and takes place over a prolonged period of time. We may notice more frequent colds, chronic coughs, fatigue, malaise, depression, enlarged prostate, obesity, loss of libido, or a host of other symptoms. These may be direct symptoms of immune system breakdown, or of other problems that will directly affect immune system function.

The most common problems that are found accompanying the diagnosis of cancer that directly affect immune system function are:

a. Hormone abnormalities such as high levels of estradiol, low levels of testosterone, or low levels of DHEA or improper ratios of these hormones.

The only acceptable test for both men and women is a complete **"Free"** hormone profile. "**Total**" hormone values have no clinical significance. If the hormone is bound, it no longer can exert its effects, so "**Free"** hormone values are required for an accurate picture. This profile should include free testosterone, estrone, estradiol and total DHEA, progesterone for all patients and DHT should be included for males. It may be done with saliva testing or with Radioimmunoassays.

Be sure to question the patient about continued exposure to xeno-estrogens, pseudo-estrogens and phyto-estrogen exposure. If they are constantly or heavily exposed to pesticides, fertilizers, petrochemicals, contaminated water or other environmental toxins, instruct them of the importance of avoiding these during treatment and after treatment as well.

In medical school we learned that high testosterone levels could cause prostate cancer. DHT increased prostate cancers growth rate as well. As a treatment, Lupron (an anti androgen) was and still is widely used. The report issued from a very large research sample at John's Hopkins University proved that not a single case of prostate cancer had been cured with this treatment. We still see the treatment in use in Western medicine today. After reading the first several hundred complete hormone profiles on prostate cancer patients, I learned why. They were all hypogonadal with low testosterone to estrone ratios. Most also had lower than normal DHT

levels. How could treating them with chemicals that further lowered their testosterone levels and made the estrone to testosterone ratios worsen, possibly help the patient? It did not.

Never allow yourself the luxury of assuming that what you learned in Medical School was complete or accurate. Consider Medical School a "kindergarten" of the learning that will take place in the clinic if you continue to explore and increase your knowledge.

b. Adrenal insufficiency which results in poor immune system function and prolonged recovery time.

To test for adrenal insufficiency, a complete IG series, and complete "free" hormone profile which includes: testosterone, estrone, estradiol, DHEA and progesterone, as well as a complete thyroid profile, including "free" T3, T4 and TSH should be done. It is very common for adrenally insufficient patients to be both hypogonadal, hypothyroid and have abnormal IG series.

The safest and most common treatment for adrenal insufficiency is the use of small physiological doses of cortisol at times that will closely mimic the body's natural biorhythms. If the adrenal insufficiency is severe enough, the use of aldosterone may also be required. This is usually required only in rather severe cases.

NOTE: Unless the patient is extremely hypothyroid I suggest that the thyroid condition not be treated until the cancer is in complete regression. Always recommend Armour thyroid for supplementation when needed and avoid Synthroid. Thyroid hormone should only be used in cases where the patient's hypothyroidism is severe enough to hinder immune function, and keep it on the low side of normal until remission has occurred. High levels of thyroid hormone may increase cancer cell growth rates and metastasis.

c. Hyperinsulinemia and type two diabetes: Not only do these conditions result in high serum glucose levels, but they inhibit normal pituitary and hormonal function as well as the immune system function.

Do not rely on a hemoglobin A1C to determine if a patient is hyperinsulinemic. They are ineffective due to the fact that they give an average value of serum glucose levels over a three month period. We know that hyperinsulinemic patients glucose levels will range from well over 200 to below 50 in most cases. These variations make it useless in evaluating Hyperinsulinemia.

A much better test, if you are unable to determine this by observation and deduction, is a glucose tolerance test with coinciding insulin levels taken with each glucose level. This will give you an honest set of values with which to make your determination. For treatment, diet once again becomes of paramount importance.

d. Chronic or systemic fungal infections. These infections, such as systemic candidiasis or other human mycoses can be life threatening. They are extremely prevalent and are very often overlooked, and often give symptoms, such as tumors, that are similar in nature to cancer tumors.

Clinical evaluation of the patient's tongue, finger and toe nails, vaginal or urethral discharges and digestive problems may all indicate human mycoses. It is also very helpful to include a stool analysis with culture and sensitivity for both beneficial and pathological growth. This should be treated aggressively to enable the body's defenses to concentrate on the cancer. Fungal infections are very common among cancer patients and go hand in hand with hyperinsulinemia and type two diabetes due to the higher serum glucose levels.

e. Low grade or chronic bacterial infections. These infections interfere with the body's ability to fight both viral and cancer invasions. The immune system will choose to apply its limited resources to the infection it believes to be more immediately threatening. In these cases, culture and sensitivities become very important. This will insure the quickest response time to the proper antibiotic and will lessen the time on the antibiotic. This becomes important when trying to keep the natural gut flora healthy and the body's ability to fight mycoses at a high level. When the immune system is fighting bacterial infections, it will not effectively be able to fight the cancer.

One of the most prevalent problems in treating cancer patients is attributing many symptoms, that would normally otherwise be caught clinically and treated, to the symptoms of cancer. This often delays proper treatment for other conditions that can contribute to further deterioration of health. This is often a life threatening mistake. While the body is attempting to produce cells specifically designed to fight cancer and viral infections, it is unable to mount a coinciding attack against a bacterial invasion, fungal infection or other chronic conditions. Due to the body's natural protection of itself, it will immediately switch its defenses to fighting what it perceives as a more direct threat. For example, the bacterial infection takes dominance over the uncontrolled cancer growth. While this occurs, the body is relatively defenseless against the cancer invasion.

Culture and sensitivity tests should be done whenever possible prior to prescribing antibiotics or anti-fungal medication. This will allow for the most productive course of treatment possible, as well as reduce the possibility of further complications. It must be remembered that the use of antibiotics will often bring about more severe mycoses and further hinder the patient's progress. Antibiotics may also interfere with the normal functioning of the immune system. For these reasons it is imperative that the correct antibiotic or antifungal be used for the shortest duration possible.

All of these conditions should be expected, tested for, and treated at the same time the cancer is being treated. The repair of the immune system must be the primary goal. Delaying these treatments will only hinder the immune system's normal function and enable the uncontrollable spread of cancer cells to continue.

Initial Visit Protocol:

The first visit is used to get a thorough and detailed case history, counsel the patient on the importance of diet and nutrition, explain the purpose of the lab tests to be done and instruct them in

the use of the suggested supplements and medications. Thorough examination of the skin should also be done at this time. Biopsies should be taken of suspicious lesions whenever possible.

Cancer Lab Protocol:

The following tests should be done on the first visit:

1. CBC with manual differential; manual/visual counts are more accurate. The best method will include a reading by a pathologist.

2. Comprehensive Metabolic Panel which should include; Glucose, Calcium, Albumin, Total Protein, Sodium, Potassium, CO2 (carbon dioxide, bicarbonate) Chloride, Magnesium, BUN (blood urea nitrogen) Creatinine ALP (alkaline phosphatase) ALT (alanine amino transferase, also called SGPT) AST (aspartate amino transferase, also called SGOT) and Bilirubin.

3. Complete Lymphocyte Immunophenotype Enumeration (lymphocyte subset panel) which should include; Absolute lymphocyte count, CD3, CD4, CD8, CD19, CD56 as a minimum.

4. AMAS (Anti-Malignin Antibody in Serum) should be performed whenever possible. This test offers excellent reference numbers for both the initial identification of cancer and remission. Note: Test parameters require a functioning immune system for it to be accurate. The CBC and total lymphocyte count are needed to verify the body's ability to normally produce antibodies.

5. All appropriate cancer antigen testing should also be done at this time, but they are far less reliable than an AMAS test. Regardless of their accuracy, they may offer additional reference markers for measuring progress.

6. Biopsies when applicable may be beneficial, however, seeding is often an under-reported result and the risks should be discussed with the patient. Whenever biopsies are performed, culture and sensitivities should always be mandated. When an AMAS is possible and other tests confirm a malignant tumor, my personal preference is to leave the tumor wall intact, and forego a needle aspirate biopsy. This leaves the malignant cell encapsulated with less likelihood of metastasis.

7. CT scans and MRI scans with contrast should also be done at this time when indicated. They will give valuable comparative information and should be repeated within 60 days for comparison.

8. Urine cytology is often very helpful in renal cancers and can show signs of remission very early in the treatment. It will also show accompanying problems such as yeast or bacterial infections. If there are accompanying infections, they will need to be addressed and treated at this time.

9. Scraping of open lesions on cervical cancer need to be done upon the first visit. They tend to heal very early and may be completely gone within a few weeks of treatment.

10. AMID test (Arthur Morphological Immunostatus Differential).

11. AFP (alpha-fetoprotein) for certain types of liver cancers.

12. CA (carcinoma) 27-29 for certain types of breast cancers.

13. CA 125 to test for ovarian cancer.

14. CEA (carcinoembrionic antigen) for colon cancer.

15. PSA (prostate specific antigen) in conjunction with FREE PSA for prostate cancer. **Measuring your percent free PSA will help improve the accuracy of prostate cancer detection.** PSA exists in multiple forms in the blood. Most is bound to proteins, but some is free-floating. In the early 1990s, it was discovered that measuring the ratio of "free" to "total" PSA could further help in distinguishing prostate cancer from benign prostate disease.

16. Complete "**free"** hormone profile as outlined above. Only hormones unbound to proteins such as SHBG (sex hormone binding globulin) are free hormones. It is only free hormones that are able to exert effect and these levels must be monitored.

17. Complete IG series as outlined above.

18. Complete thyroid series as outlined above.

Over the years I have come to have less and less confidence in cancer antigen tests. The developer of the PSA actually told me that after many years of study, he had come to the conclusion that the PSA was actually only an indicator of swelling of the prostate gland. This can have a myriad of causes. I have observed PSA elevations in certain female breast cancer patients as well. I have also seen a large number of elevated CA 27-29 tests that ended up being caused by inflammatory responses unrelated to cancer. However, these tests may still be used as indicators and may be valuable in monitoring progress in some cases.

After baseline labs, all lab tests should be repeated every 30 days in order to accurately monitor remission or progression of the disease, as well as clinical changes that may go unnoticed.

Normal clinical notes concerning general health status, compliance with diet, weight, etc., must also be taken at least every two weeks for the first 30 days, and every 30 days thereafter.

When patients are put on restricted simple carbohydrate and low sugar diets, they will normally lose weight. Patients must be told to expect this weight loss so it is not attributed to the cancer. Many patients equate weight loss with cancer progression. This is in large part due to the fact that over 2/3 of cancer patients in the USA die from cachexia (general physical wasting and malnutrition usually associated with chronic disease).

Diet:

The diet must eliminate all simple sugars and simple carbohydrates or essentially, anything white.

The diet should consist of large amounts of fresh vegetables, fish (not farm raised fish) estrogen and antibiotic free poultry, fresh fruits, whole grains and some nuts, etc. However, breads (which includes bagels, pretzels, crackers, muffins, waffles, etc.) white flour, corn, white potatoes, white rice etc. must be eliminated from the diet to aid in the control of glucose levels.

Protein intake for adults should be a minimum of 60 grams/day. This should be supplemented with whey isolate protein drinks when possible, and the total protein intake should be taken in three divided doses. Whey isolate proteins are low carbohydrate/high protein and easily assimilated through the intestinal wall with little digestion or gastric function required. Colon cancer patients may easily assimilate this type of protein and amino acids.

Drink large amounts of distilled water. One fluid ounce of water per 3 lbs. of body weight per day is adequate. It is extremely important to keep the body flushed with pure water. An average man weighing 180 lb. should drink approximately 60 ounces of water daily. The reason I have suggested distilled water is that we know it is pure and contains no chemicals that will contribute to cancer growth. Much of today's water supply is contaminated, and patients with compromised immune systems are less able to deal with this additional contamination.

Many believe the myth that distilled water will leach minerals from the body to be true and factual. This is a complete lack of knowledge on the subject and has been scientifically proven false, as explained by an exceptional practicing biochemist, Robert Crandall. He has done extensive research on this subject.

"The gut is a reactor and will separate any solution with any minerals/contaminates then move water to the intestine where it is absorbed. As a comparison of normal water and distilled water I will offer the following fact as a comparative example: 12 oz glass H2O with 5 percent minerals will empty 1 oz into the intestine. The same 12 oz glass of distilled water will empty 10 oz water into the intestine. Can you say Hydration?"

To explore this further I would suggest the statements and writing of the following;

"Tap water invariably contains a variety of poisons such as: chlorine, chloramine, asbestos, pesticides, fluoride, copper, mercury, and lead. The best way to remove all these contaminants is by distilling."

How to Save Your Teeth: Toxic-Free Preventive Dentistry,
Dr. David Kennedy, D.D.S.

"Distilled water is the only water which is pure - the only water free from all impurities."
The Choice Is Clear,
Dr. Allen E. Banik.

"The home distiller is the best method to get distilled water. It is the only reliable home water purification system for taking fluoride out of the water".
Fluoride: The Aging Factor,
Dr John Yiamoyuiannis, PhD.

"We believe that only steam-distilled water should be consumed."
Prescription for Nutritional Healing,
James F. Balch, MD. & Phyllis A. Balch, C.N.C.

"If you decide on bottled water, make sure it's distilled, (however), in the long run you'll save money if you clean your water at home**.**"
Maximum Health,
Dr. Robert D. Willix, Jr ., M.D.

"The only type of water that seems to be fit for consumption is distilled water. Distillation is the single most effective method of water purification."
A Diabetic Doctor Looks at Diabetes, Peter A. Lodewick, M.D.

"Distilled water is the world's best and purest water!"
Water - The Shocking Truth,
Dr. Paul C. Bragg & Dr. Patricia Bragg.

"Far and away the cleanest water is produced by the new home distillers."
Dr. Michael Colgan, Ph.D., CCN,
Optimum Sports Nutrition.

"Since we started using distilled water, our athletes have been drinking more. We can only attribute that to the fresh, clean taste."
Dave Ellis, Director of Performance Nutrition at the University of Nebraska Athletic Department.

Dietary Supplements

Other supplements may be helpful, but these should be discussed on a case-by-case basis with the attending physician. These would include high quality multi vitamins and minerals as well as other specific nutritional supplementation when appropriate. Vitamin D is often very beneficial in stimulating the immune system and is often deficient in winter months in some northern climates. Supplements should also include antioxidants, essential fats and high quality protein as well.

Special notes:

Blood pressures are showing a strong tendency to drop in hypertensive patients taking LifeOne. This must be monitored carefully. This is especially important with patients currently on beta-blockers, calcium channel blockers, etc. In the vast majority of cases, these medications were no longer needed within 8 weeks after starting treatment.

Above all, realize that LifeOne is not a panacea. Even with the best medication in the world, the quality of medical care received is what will ultimately make the biggest difference in patient outcome. Cancer is relatively easy to control. It is the secondary and tertiary problems that continue to inhibit immune function and ultimately cost the most lives.

AMAS test abstracts:

Cancer Lett. 2000 Jan 1;148(1):39-48.

Anti-malignin antibody in serum and other tumor marker determinations in breast cancer.

Thornthwaite JT.

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In this study, 154 healthy volunteers and 76 patients were tested using the anti-malignin antibody in serum (AMAS) test. Of the 154 volunteers, three were AMAS positive. After further examination, two were positive for cancer and one had a history of ulcerative colitis. Tumor biopsies of 43 suspicious mammography patients revealed that 32 were cancerous and 11 were benign by pathology. For the cancer patients, 31/32 were positive for the AMAS test, while 4/11 of the pathological benign cases were AMAS positive. In comparison to cancer antigen tests, AMAS was more sensitive (97%) in detecting breast cancer than CEA (0%), CA 15-3 (10%), CA 19-5 (5%) or CA 125 (16%) in the same patients.

Int J Biol Markers. 1997 Oct-Dec;12(4):141-7.

Anti-malignin antibody evaluation: a possible challenge for cancer management.

Botti C, Martinetti A, Nerini-Molteni S, Ferrari L.

Nuclear Medicine Division, National Cancer Institute, Milano, Italy.

The major problem in the management of cancer is the difficulty of an early diagnosis. Clinical signs and symptoms generally appear late in the course of the disease. The availability of a non-invasive test which detects a blood molecule closely associated with the malignant transformation of the cells could be of help in the early detection of cancer. Malignin is a 10 kDa polypeptide located in the cytoplasmic and outer membranes of all malignant cells. Anti-malignin antibodies (AMAs) are IgM immunoglobulins spontaneously produced by the host against the oncoprotein malignin when neoplastic transformation occurs; since AMAs are IgM, they can represent an "early" transformation indicator useful for the early detection of cancer. Elevated AMA serum concentrations, measured by means of TARGET@ reagent, (Target preparation for CodeLink Bioarrays using the new CodeLink Expression Assay Reagent Kit)
has been demonstrated in patients with a wide spectrum of non-terminal active cancers, regardless of the anatomical site and histotype of the tumor. The AMA test showed a sensitivity and specificity of 95% on first determination and > 99% on repeated determinations, and has been reported to be a promising diagnostic tool for the early detection of cancer, as well as for monitoring of the response to treatment and possibly for screening of an asymptomatic population.

Cancer Detect Prev. 1994;18(1):65-78.

Early detection and monitoring of cancer with the anti-malignin antibody test.

Abrams MB, Bednarek KT, Bogoch S, Bogoch ES, Dardik HJ, Dowden R, Fox SC, Goins EE, Goodfried G, Herrman RA, et al.

Beth Israel Hospital, New York, NY.

The serum anti-malignin antibody (AMA) test determines the antibody to malignin, a 10,000-Da peptide present in patients with a wide variety of cancers. A total of 3315 double-blind tests demonstrated that AMA is a general transformation antibody, elevated in active nonterminal cancer, regardless of the site or tissue type, with sensitivity and specificity of 95% on the first determination and > 99% on repeat determinations. Data have not however been published yet that indicate whether, in daily clinical practice, the AMA test provides accurate prospective and predictive information. Forty-two physicians from 11 states, who ordered the AMA test, performed blind, report here on their results on 208 determinations in the first consecutive 181 patients and controls. Used in monitoring treatment in 56 patients, the test predicted or agreed 94.1% overall with the clinical status. Used in early detection in 125 patients and controls, of which 118 now have confirmed diagnoses, AMA was elevated in 21, all of whom were proven to have cancer; AMA was normal in 97, none of whom had cancer. Transient elevated AMA occurred in 3%, followed by normal values. Seven patients with still uncertain diagnosis who have had elevated AMA on repeated tests for 1 year or longer include six who are symptomatic, and three whose families have a high frequency of cancer. The conditions of these 7 may include undetected cancer because of the 118 with now certain diagnosis the AMA test predicted all correctly. From our experience, the AMA test should be used together with other routine procedures whenever signs and symptoms suggest cancer to facilitate early detection.

AMID test (Arthur Morphological Immunostatus Differential).

Invented in America by Dr. Thelma Arthur, tested by the Stanford Research Institute, and used clinically for decades in America and internationally, this test is reported to be 85% accurate in general use. When used according to more stringent guidelines (including no infections for the preceding 2 weeks, no meat for 24 hours, and 12 hours fasting before the test) one trial found it to be over 95% accurate, and able to detect cancer 1-2 years before conventional tests.

Government authorities were disturbed by the ability of the test to detect cancer before it was large enough to treat with conventional therapy. Also it requires a highly skilled microscopist and a pathologist to analyze the test. So it was declared to be too difficult to be cost-effective in America.

The AMID has the additional convenience of measuring the relative strength of the main components of the immune system, so it is useful in immunotherapy. It is often accompanied with a CBC test to measure the immune system in absolute cell counts.

If either AMAS or AMID results are positive, additional testing is often performed to determine the specific type and location of the cancer. Technically this is not necessary when using alternative therapy that heals the whole body systemically, but all tests should be confirmed in some way.

Common specific cancer blood tests include AFP (alpha-fetoprotein) for certain liver cancers, CA (carcinoma) 27-29 for breast cancers, CA 125 for ovarian cancer, CEA (carcinoembrionic antigen) for colon cancer, and PSA (prostate specific antigen) in conjunction with FREE PSA for prostate cancer.

Note that some of these other tests may produce as many as 80% false positives when used alone, so it can be very important to combine them with the accuracy of AMAS or AMID.

During therapy, some doctors alternate between the AMID and the AMAS every 2 - 4 weeks to evaluate the effectiveness of various treatments from the two different perspectives of the tissue test and the serum test.

Relevant Clinical Observations

Both squamous cell carcinoma and basal cell carcinoma lesions on the skin will respond much faster if gauze soaked in LifeOne is kept moist and taped over the lesion while the patient continues with the normal recommended oral dose. All open lesions will respond much more quickly if the LifeOne is kept in constant contact with the lesion. This includes advanced open lesions in breast cancer patients. The covering must be kept moist with fresh LifeOne several times over a 24 hour period. I would suggest changing the dressing at least every 6 hours. Sometimes scraping the site to expose the underlying tissue layer will allow easier penetration of LifeOne to the actual neoplastic cells.

Renal cell cancer is usually picked up with abnormal hormone levels in practices that that do them regularly. This is long before most clinical signs appear. Simple cytological examination of urine samples will yield cancer cells in almost all cases. Renal cell cancers resolve very quickly, from 45-60 days. It has been found that the tumor often does not disappear completely, and actually may remain almost the same size, but upon biopsy will be completely benign. Those physicians working with LifeOne have found no living cancer cells in any biopsies of renal cell tumors after a full year following treatment. All of these renal cell malignancies were verified with CT scans, AMAS test, urine cytology and hormone profiles. All hormone profiles returned to within normal limits within 60 days of treatment in spite of the tumor remaining.

In colon cancer cases, they have been very successful in using 1 ounce of LifeOne with 4 ounces of water including using LifeOne in colon irrigations twice daily. The patient can easily be taught how to give themselves an enema. The patient is asked to hold the liquid in as long as possible. This is in addition to the oral doses. It can effectively cut the required treatment time by half. After the colon has recovered, a maintenance dose of ½ ounce of LifeOne twice daily (BID) should be maintained for a minimum of 6 months. At the beginning of treatment, 400 I.U. of vitamin D should be orally administered B.I.D. This should continue for a least a few

years. Make sure the vitamin D source is not mercury contaminated. When I teach physicians, the first rule is: to do no harm. The second rule is: never compound a problem.

All cancer patients recover more quickly if their activity level is increased. Even small increases in movement will be helpful in severely ill patients. In patients that are able, both walking and resistance training have been found to be most effective. Those patients in resistance training seem to have lymphocyte subset panels return to normal in the shortest amount of time. Resistance training stimulates the bone, which seems to in turn, to stimulate marrow production of the humeral immune cells. As an example, walking is far more beneficial than bike riding due to the fact that the skeletal system is weight bearing while resisting gravity. If walking is no problem for the patient, moving them into a supervised progressive weight lifting program is ideal. It should emphasize full range movements as well as increasing resistance and should be done on a regular basis.

Liver cancer responds quickly to LifeOne, however, as in renal cancer the tumor may remain relatively unchanged in size. AMAS results return to normal, usually within 90 days, and liver function tests return to normal as well, but the tumor may remain. If there is more than one tumor in the liver, they seem to react in the same manner. They either shrink very little or remain the same size, but they no longer grow and show no further signs of malignancy. Ablation seems to make matters worse, and should not be attempted if it can possibly be avoided. All blood work and AMAS tests have remained normal, and in many cases, patients 6, 7, and 8 years post treatment remain healthy with normal liver function.

The Beginning

Autopsies performed on cancer victims taught me an invaluable lesson. No autopsy I performed, nor any autopsy I witnessed, showed evidence that the patients had died from cancer. On the contrary, patients had died from organ failure, starvation, or a myriad of other conditions caused by the complete shutdown of the immune system or organ system brought on by chemotherapy and/or radiation treatments. In the simplest of terms, the patients had died from the results of chemotherapy, radiation, and lack of education in determining secondary problems such as the patient's immune system function and overall health. According to the American Cancer Institute statistics, approximately 2/3 of cancer patients in the United States die from cachexia. That excludes patients that die from heart, liver, or kidney failure induced by chemotherapy or radiation therapy. It also excludes those that die from a complete breakdown in immune system function from the most common cancer treatment protocols, resulting in pneumonia or other infections. These statistics concur with my own direct observations.

More distrust of the current treatments used came upon close examination of the most currently available cancer research data. Upon closer examination of the research that had taken place in order to attain FDA approval for drugs, I noticed gross manipulation of statistical data. The most obvious methods of manipulation of the statistics, and efficacy evidence, are described below:

1. As an example of how statistics are easily manipulated I offer the following hypothetical case: 100 patients participate in a new cancer drug research project. Fifty of these patients

die during the course of treatment. These 50 patients are removed from the research group due to the fact that they failed to complete the course of drug therapy. It is never mentioned whether the patient died from the therapy. They are simply removed from the testing statistical data base. Of the remaining 50 patients, 20 have a positive reaction to the drug as measured by reduction in tumor size. The statistical reports will be evaluated as a positive response of 20 out of 50 patients or a 40% positive response to the medication in order to achieve FDA approval. In actuality it shows that of the 100 patients that began the medication, 50% survived the entire research protocol on the researched drug, and 20 out of 100 patients experienced a reduction in tumor size. This is not science; it is the influence of capitalism in medicine. When the quest for profits supersedes the patient's welfare, neither the attending physician, his patients, nor his profession is served.

Below is an actual published study in which I have highlighted in red the point I am making.

J Clin Oncol. 1994 Jan;12(1):176-83.

- **Phase I clinical and pharmacokinetic study of high-dose mitoxantrone combined with carboplatin, cyclophosphamide, and autologous bone marrow rescue: high response rate for refractory ovarian carcinoma.**

Stiff PJ, **McKenzie RS**, **Alberts DS**, **Sosman JA**, **Dolan JR**, **Rad N**, **McCloskey T**.

Department of Medicine, Loyola University Medical Center, Maywood, IL 60153.

PURPOSE: To develop an active high-dose chemotherapy regimen for the treatment of ovarian carcinoma. Due to the rapid development a drug resistance, conventional chemotherapy cures only 20% of patients with advanced disease. However, in vitro data demonstrate a steep dose-response curve to a variety of agents, most notably mitoxantrone. PATIENTS AND METHODS: A phase I study of escalated bolus mitoxantrone (10 to 25 mg/m2 x 3) and cyclophosphamide (30 to 50 mg/kg x 3) with a 5-day infusion of carboplatin (1,500 mg/m2) and an autologous bone marrow transplant (ABMT) was performed. Mitoxantrone pharmacokinetics was performed to document levels required to kill platinum-resistant ovarian carcinoma in vitro. RESULTS: We treated 25 patients; the maximum-tolerated total doses (MTD) were 75 mg/m2 for mitoxantrone, 120 mg/kg for cyclophosphamide, and 1,500 mg/m2 for carboplatin. The dose-limiting toxicity was gastrointestinal, with severe diarrhea, ileus, and resulting sepsis. Transient partial deafness was seen in four patients, and acute renal failure (ARF) occurred in one patient at the first dose level, but was eliminated in subsequent patients with aggressive hydration. There were four early deaths due to ARF (n = 1), Legionella pneumonia (n = 1), and sepsis (n = 2). Peak mitoxantrone levels at the MTD were 623 to 2,810 ng/mL, and the area under the curve (AUC) values of the concentration versus time measurements were 560 to 1,700 ng/mL/h. Of 20 assessable patients, 65% responded, with a 45% complete remission (CR) rate. All six of the assessable patients with ovarian cancer responded:

CR in five (83%) and partial remission (PR) in one (17%); the CRs have lasted 7 to 30+ months. Responses were also seen in testicular and breast carcinoma. CONCLUSION: This regimen was well tolerated at the MTD and appears promising for relapsed/refractory ovarian carcinoma, with mitoxantrone levels achieved that are active in vitro against platinum-resistant ovarian carcinoma cells.

PMID: 8270975 [PubMed - indexed for MEDLINE]

2. What defines a successful therapy? What in actuality is the only measure of success that is truly relevant? The answer is painfully simple and logical. A therapy may only be defined as successful if it enables the patients to have a better quality of life and a longer productive life when compared to those patients receiving no cancer therapy at all. The argument used to justify this lack of legitimate data is that it would be cruel to deny a cancer patient therapy. This is of course nonsense. It is far crueler to subject a patient to a therapy that will reduce both quality of life and life expectancy. There are thousands of patients every day, unable to afford therapy or who refuse therapy to treat their cancer. This is an extremely simple data base to form, and much early work in the 40's and 50's did just this type of comparison. Some early research from those decades actually showed that patients that had no treatment whatsoever for their cancer lived up to three times longer than those patients that were treated. If these statistics have changed, I have not seen them proven in a legitimate way. There are of course a few exceptions to this. There are approximately nine cancer types that respond favorably to a very select few cancer therapies, but they are the exceptions, certainly not the rule. Without this simple comparison it is never possible to say a therapy is effective. To be effective it has to be compared to some baseline that is relevant. All that is relevant is the patient's length of and quality of life.
3. "Tumor size reduction shows a successful treatment outcome." This is the mantra of the vast majority of cancer research. We have found that tumor size, unless its size actually inhibits normal organ or nervous system function, is not relevant to either longevity or quality of life. Radiation induced tumor size reduction does not in and of itself increase a patients survival rate. It may in fact, through its actions on the immune system, decrease both longevity and quality of life. The same may be said of chemotherapeutic agents that receive FDA approval based on tumor size reduction. We have seen numerous malignant tumors, including glioblastoma multiforma, renal, hepatic, prostate and breast to name a few, remain relatively the same in size, but upon dissection and microscopic examination reveal no malignant or neoplastic cells after treatment. With a healthy functioning immune system, the tumors function is intended to separate the healthy body from the malignant cells. They wall off the malignant cells from the blood stream to prevent metastasis, and allow time for the appropriate immune cells to identify and destroy them. They are then often replaced by benign cells that offer no harm to the body.

Since LifeOne was developed to act on a myriad of levels in a synergistic fashion, many parameters had to be measured. First in importance was direct observation of any improvement in the immune systems function.

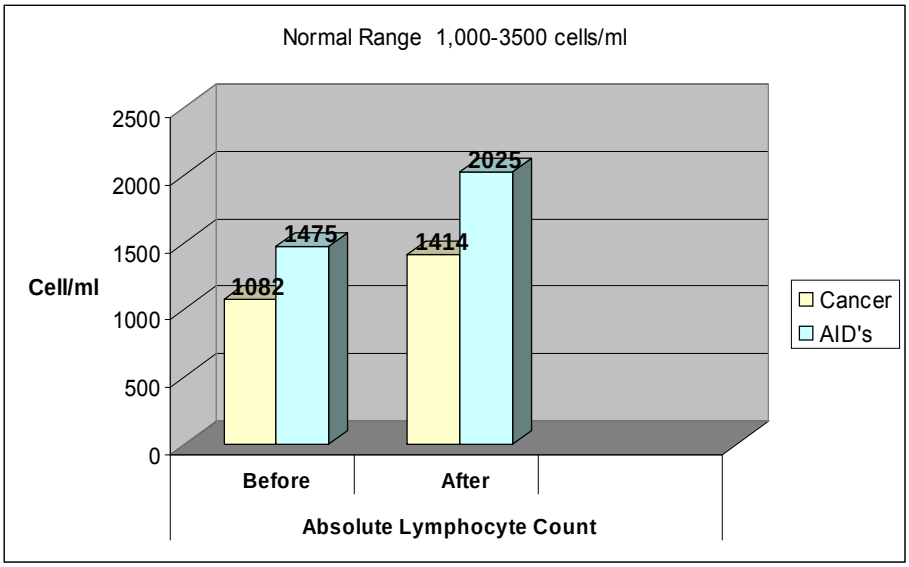
To determine LifeOne's effects on the immune system, patients were given a complete lymphocyte subset panel before treatment started. This gave a baseline from which any improvement in CD cell counts could be directly measured, and determine exactly what cells were being affected. We could also insure LifeOne was doing no harm to the immune system by repeating these subset panels 30 days after treatment commenced and every 60 days thereafter. The clinical results showed dramatic increases in immune system function as measured by increases in all CD cell types that were tested.

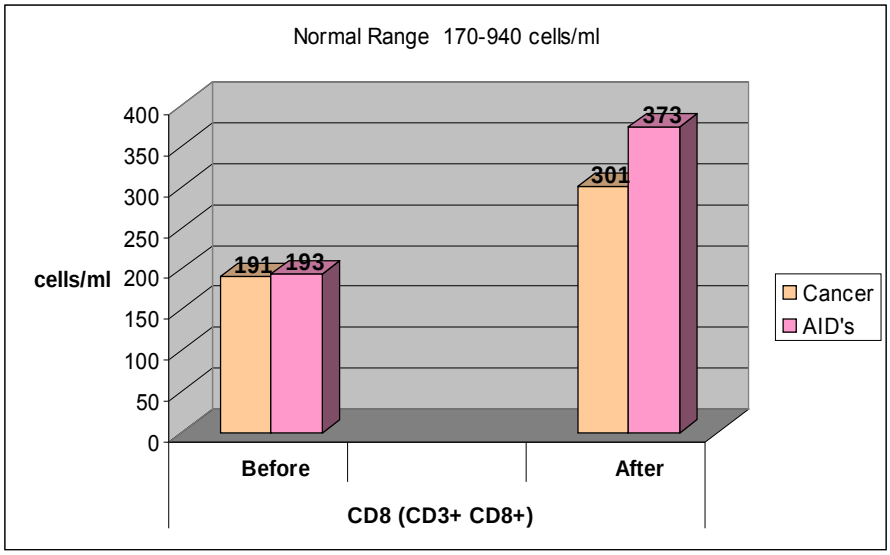
The following are averages of the first 13 cancer patients and 4 AIDS patients tested over a period of **38 days**:

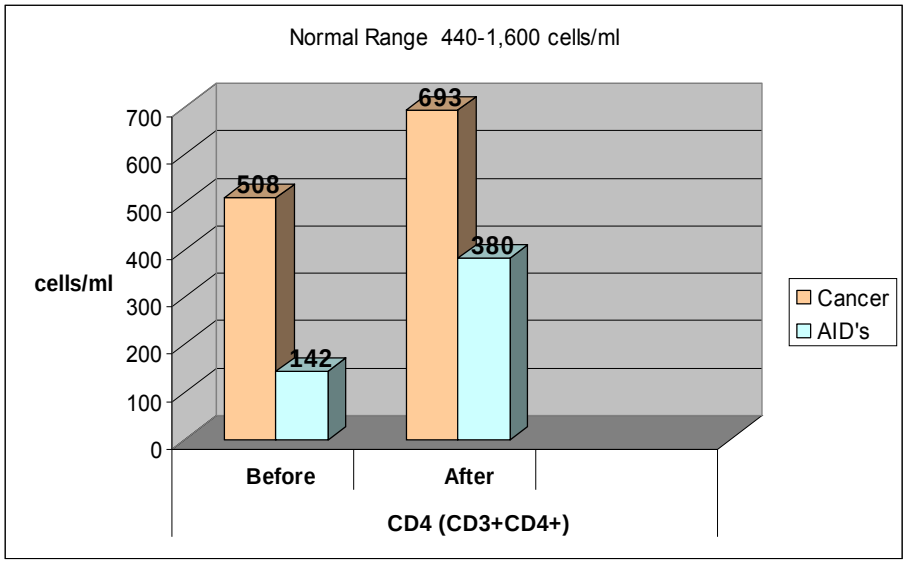
Specific Lymphocyte Subset Data for Both Cancer and AID's Patient's

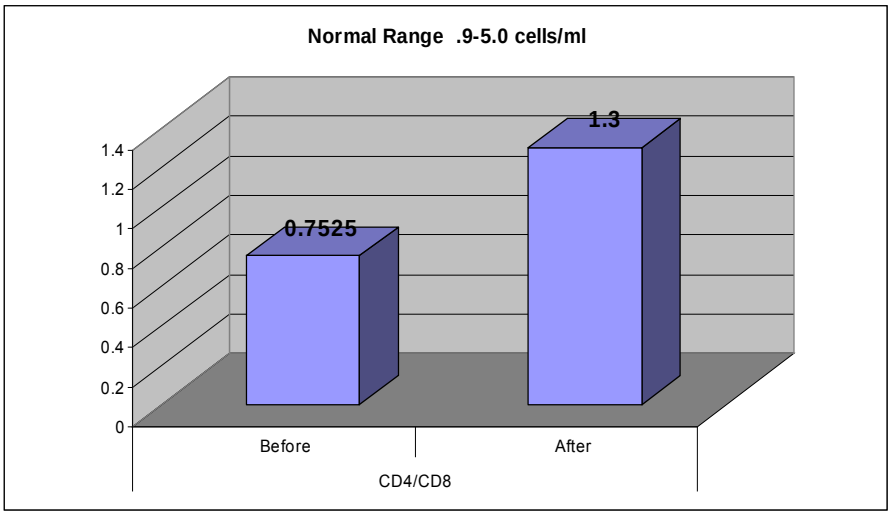
These graphs give a direct comparison of immune response for both cancer patients and AID's patients. The cancer patients were all severely ill, and many of their immune systems had been compromised by both chemotherapy and radiation therapy. The average age for the cancer patients is 65 years, and the average age for the AID's patients is 33 years.

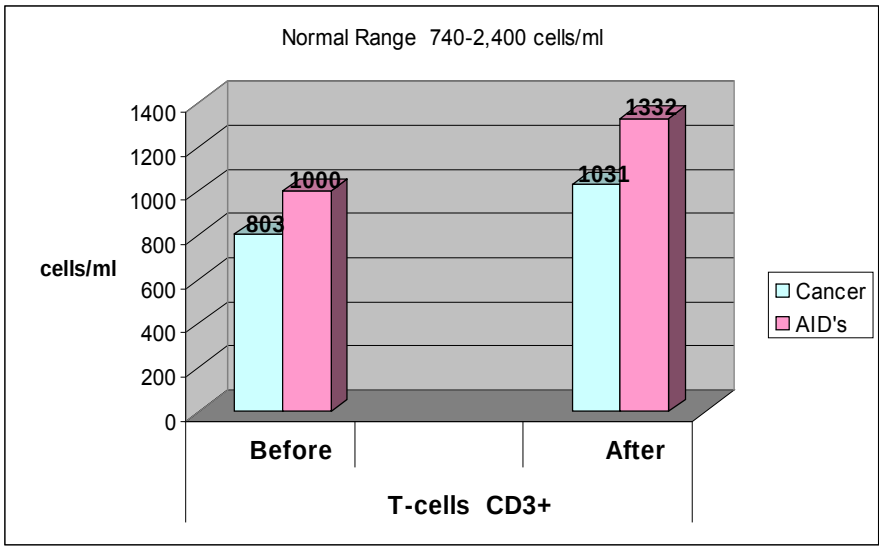
A more complete description of cancer response follows.

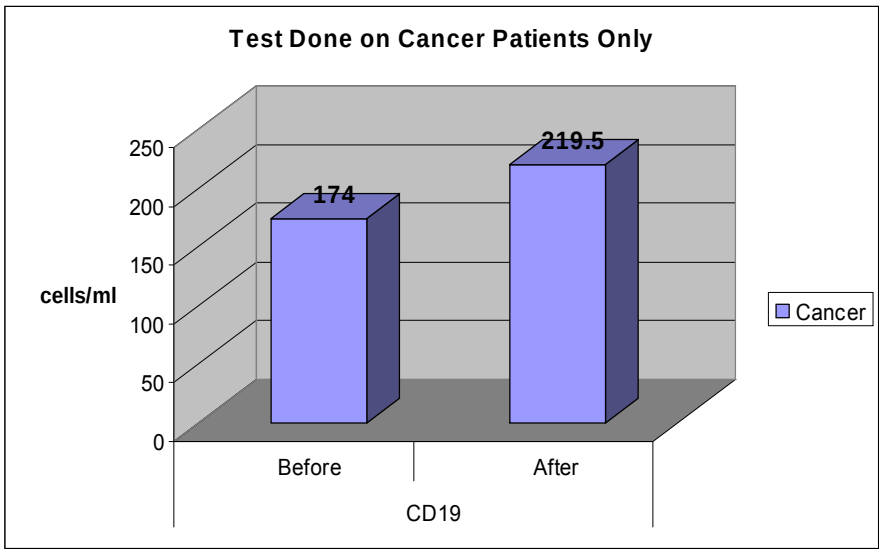

Normal Range 1,000-3500 cells/ml
2500
2000
1500
1000
500
0
Cell/ml
1082
1475
1414
2025
Before
After
Absolute Lymphocyte Count
Cancer
AID's

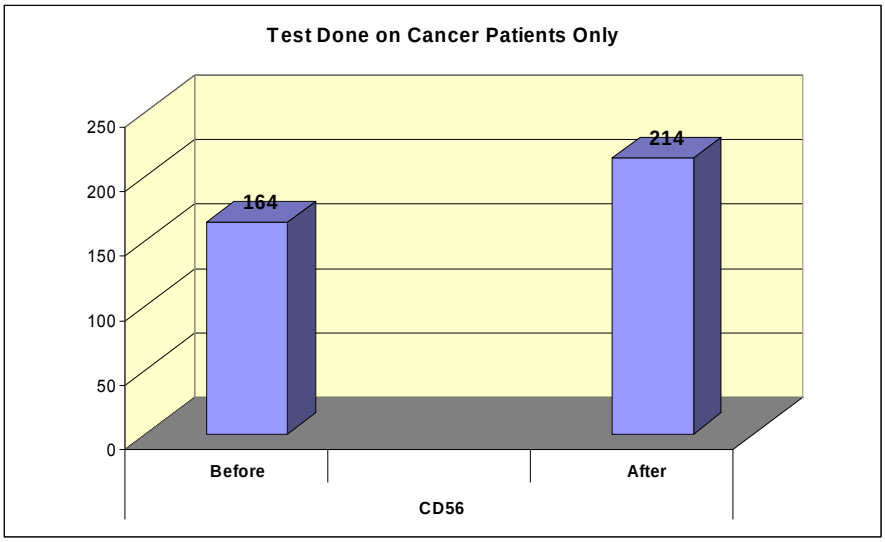

Normal Range 170-940 cells/ml
400
350
300
250
200
150
100
50
0
cells/ml
191
193
301
373
Before
After
CD8 (CD3+ CD8+)
Cancer
AID's


Normal Range 440-1,600 cells/ml
700
600
500
400
300
200
100
0
cells/ml
508
142
693
380
Before
After
CD4 (CD3+CD4+)
Cancer
AID's


Normal Range .9-5.0 cells/ml
1.4
1.2
1
0.8
0.6
0.4
0.2
0
0.7525
1.3
Before
After
CD4/CD8


Normal Range 740-2,400 cells/ml
1400
1200
1000
800
600
400
200
0
cells/ml
803
1000
1031
1332
Before
After
T-cells CD3+
Cancer
AID's


Test Done on Cancer Patients Only
250
200
150
100
50
0
cells/ml
174
219.5
Before
After
CD19
Cancer



Below is the first set of 8 diverse cancer patients taking LifeOne under the care of Dr. Glenn Wagner of Indialantic, Florida many years ago. It demonstrates what you and your physician are looking for and will give you an average for both time and improvement.

LifeOne Formula and Cancer Patients Immune Function With AMAS Results

Name	Age	Sex	Cancer	Time on LifeOne	Absolute Lymphocyte Count			T-cells CD3+			CD4 (CD3+CD4+)		
				Weeks	Start	Finish	Change	Start	Finish	Change	Start	Finish	Change
St., J	69	M	Liver	20	966	1352	386	736 L	1061	325	419 L	612	193
K., G	64	M	Lung	27	360	1062	702	562 L	627 L	65	450 L	456 L	6
Mu., P	81	M	Prostate	44	663 L	1300	637	463	936	473	364 L	700	336
L., M.L.	66	F	NH Lymphoma	18	2426	2582	156	1701	1736	35	1090	1144	54
G., E	75	M	colon met. to lung	11	1409	1581	172	744	1034	290	553	759	206
Sm., A	71	M	Bladder	113	1079	1071	-8	609 L	789 L	180	459	591	132
Fr., M	57	F	Breast	6	713 L	956	243	353			259 L	illeg	
Sa., B.	40	F	Breast	36	1035	1068	33				469 L	587	118
Average					1081.71	1414.43	? 332.72	802.5	1030.5	? 228	507.88	692.71	? 184.83
Normal					1,000-3500 cells/ml			740-2,400 cells/ml			440-1,600 cells/ml		

	CD8 (CD3+ CD8+)			CD19			CD56			CD16+56			AMAS	
	Start	Finish	Change	Start	Finish	Change	Start	Finish	Change	Start	Finish	Change	Start	Finish
St., J	320	460	140	67 L	126	59	139	157	18				222	68
K., G	94 L	116 L	22								298			57
Mu., P	96 L	175	79	34 L	50	16	159	267	108				251	196
L., M.L.	573	657	84	503	512	9				193	278	85	91	38
G., E	198	236	38	192	288	96							119	125
Sm., A	126 L	191	65	40	40	N/C	193	219	26	22	21	-1	218	22
Fr., M	117 L	illeg		209	301	92	pending	pending	pending	148	154	6	243	68
Sa., B.	260	272	12											
Average	190.5	301	? 110.5	174.17	219.5	? 45.33	163.67	214.33	? 50.66	170.5	216	? 45.5	185.2	82.5
Normal	170-940 cells/ml													Below 135

The average increases for these 8 diverse cancer patients were as follows;

Absolute lymphocyte count increased from 1081.71 to 1414.43 which is an average increase of 332.72 cells/ml
CD3 T-cells count increased from 802.5 to 1030.5 which is an average increase of 228 cells/ml
CD4 T cells count increased from 507.88 to 692.71 which is an average increase of 184.83 cells/ml
CD8 T-cell count increased from 190.5 to 301 which is an average increase of 110.5 cells/ml
CD19 T-cell count increased from 174.17 to 219.5 which is an average increase of 219.5 cells/ml
CD56 T-cell count increased from 163.67 to 214.33 which is an average increase of 50.66 cells/ml
CD16+CD56 T-cell count increased from 170.5 to 216 which is an average increase of 45.5 cells/ml
AMAS test result decreased on average from 185.2 to a normal of 82.5. AMAS results above 135 are considered positive for cancer.
The above research was completed and submitted by Dr. Glen Wagner, MD

Physicians are asked to use complete free hormone profiles to determine LifeOne's effects on hormone balances. These have proven very beneficial in determining improvement in hormone profiles of estrogen reactive cancers such as breast, ovarian, prostate, renal, adrenal and uterine cancer. Again, they used a baseline that was taken before treatment began, and then repeated in 30 days and every 60 days thereafter.

The same baseline and follow up methods were used for CBC's, comprehensive metabolic panels, etc. This method of following the patients overall immune system function and other health parameters allowed us to determine quickly that we were doing no harm, and indeed were creating a very positive effect with the therapy. In other words, in my mind, baseline comparisons are the only legitimate method of determining a treatments efficacy on a given patient. Improvements were expected in glucose metabolism, blood pressure, and general overall health. It was only after several hundred patients showed very consistent results in all of these parameters that we expanded our research to include viral infections.

Viral Infections

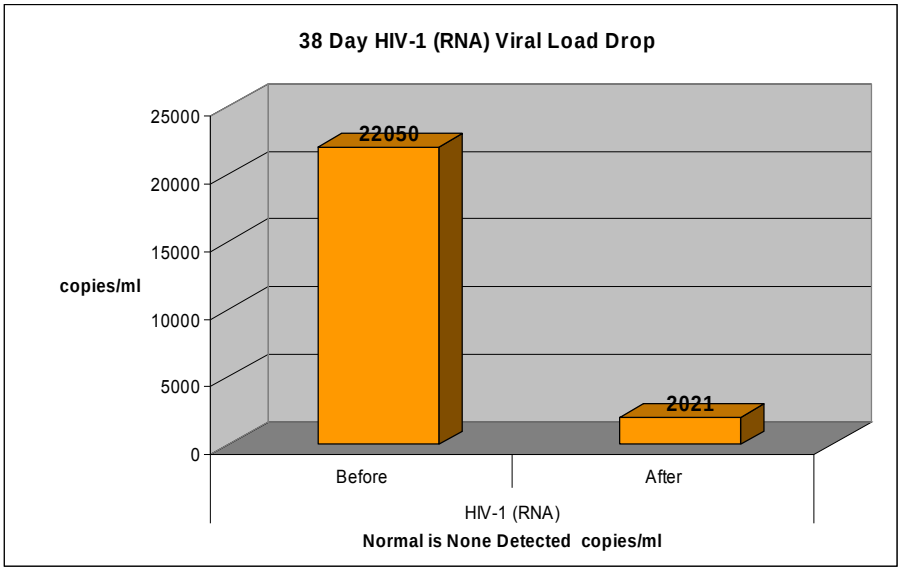
In the development of LifeOne it was discovered that the immune system breakdown that occurred in cancer patients was identical to the immune system challenged by viral infections. It became important to understand this relationship more deeply in order to enable stimulation of the entire CD

cell mediated immune system. As this research progressed serious flaws in the current reporting on the effects of anti-retroviral drugs became evident. Complete lymphocyte subset panels were not being done on HIV patients using the most currently used "cocktail" of drugs. CD 4 cells were always measured, but CD8's were seldom measured. Only after closer examination of the research was it discovered that these new drugs were increasing a few subsets of the CD cells, but on the other hand, were actually inhibiting other CD cell subsets production. While these drugs seemed to prolong the life of the patient, they also came at the cost of other serious side effects such as diabetes, cancer and eventual complete immune system breakdown.

Synergy is a word often used to describe the multiple actions of LifeOne. It seemed a natural progression of this research to include stimulation of the entire series of CD cell subsets as well as inhibition of viral replication. This would enable the LifeOne formula to be used for the more simple viral infections such as colds and flu as well as more serious viral infection such as SARS and AID's.

The first flu season proved it to be extremely beneficial for numerous people that used it as an aid in recovery. Very often, relief was within a few hours for many corona viral infections, and most flu cases responded within 12-24 hours. The first SARS case responded within 12 hours and her lungs were clear within 48 hours.

After initial testing on the corona virus, the formula was sent to Mexico to explore its effects on the AID's virus. The early results of these tests is available for viewing. They were most impressive, even with the addition of a non-responder as far as viral load changes, the results showed immediate clinical improvement in all of the patients and an average reduction in the AID's viral load of 92% in 75% of the patients in only 38 days with an overall average of 78% viral load reduction. This was most impressive by any standard, even considering the small patient sample size.



AID's Lymphocyte Subset and Viral Load Data

			Time on LifeOne		Absolute Lymphocyte Cou			T-cells CD3+			CD4 (CD3+CD4+)		
Name	Age	Sex	Start	Finish	Start	Finish	Change	Start	Finish	Change	Start	Finish	Change
A, F	24	M	9/28/2002	11/9/2002	1500	2600	↑ 1100	975	1850	↑ 875	148	335	↑ 187
B, M	26	M	10/3/2002	8-Nov	1900	1500	↓ 400	1300	1100	↓200	150	225	↑75
C, D	48	M	10/14/2002	12/2/2002	1200	1500	↑ 300	840	626	↓ 214	117	575	↑ 458
J, R	35	M	10/15/2002	W.B.11/22	1300	2500	↑1200	885	1750	↑ 865	151	385	↑ 234
Average	33.25				1475	2025	▲ 550	1000	1331.5	▲564	141.5	380	▲238.5
Reference Range					1,000-3500 cells/ml			740-2,400 cells/ml			440-1,600 cells/ml		

	CD8 (CD3+ CD8+)			CD4/CD8			HIV-1 (RNA) "VIRAL LOAD"				
Name	Start	Finish	Change	Start	Finish	Change	Start	Finish	Change	% Change	
A, F	235	450	↑ 215	0.63	0.75	0.12	1900	1900	N/C	N/C	43 Days
B, M	150	326	↑ 176	1	0.7	0.3	67,400	4,010	↓ 63390	↓ 94%	37 Days
C, D	168	189	↑ 21	0.7	3.04	2.34	2900	75	↓ 2825	↓ 97%	49 Days
J, R	222	525	↑ 303	0.68	0.76	0.08	16,000	2,100	↓ 13900	↓ 87%	23 Days
Average	193.75	372.5	▲ 178.75	0.7525	1.3	▲ .55	22050	2021	▼20029	▼ 70%	38 Days
Reference Range	170-940 cells/ml			.9-5.0 cells/ml			None Detected	copies/ml			

75% of the patients showed an average 92.66 percent drop in viral load in an average of 38 days.

Side Effects

			Glucose			Cholesterol			Triglicerides			
Name	Age	Sex	Start	Finish	Change	Start	Finish	Change	Start	Finish	Change	
A, F	24	M	86	82	↓4	174	176	↑2	282	150	↓132	43 Days
B, M	26	M	95	85	↓10	219	195	↓24	199	138	↓61	37 Days
C, D	48	M	149	107	↓42	264	268	↑4	327	540	↑213	49 Days
J, R	35	M	107	88	↓19	268	164	↓104	540	339	↓104	23 Days
Average	All mg/dl		109.25	90.5	▼18.75	231.25	200.75	▼30.5	337	291.75	▼45.25	38 Days

Patient C,D. stopped taking the formula after 23 days due to a misunderstanding of the protocol. His follow up lab work was done on day 38. This was 15 days after stopping the formula.

The above research was completed and submitted by Dr. Carlos Alessandrini, MD and Dr. Paul J. La Rochelle, MD

Further evidence linking viral infections and cancer are currently being explored. In my opinion, there will come a time when the effects of both viral infections and many types of cancer will be traced to various environmental factors that directly interfere with the immune systems ability to react in a normal manner.

An excellent example of the currently ongoing research into the viral-cancer connection is the following:

Study links infections to childhood cancer

Mother's common illnesses could be trigger for disease, study finds

REUTERS

Updated: 10:52 a.m. ET Dec. 12, 2005

LONDON - Common infections that affect mothers and babies may trigger certain types of childhood cancers, researchers said on Monday.

They found that leukemia and brain tumors, leading cancers in children, occurred in clusters which suggest that outbreaks of infections are a contributing cause of the disease.

"We found that place of birth was particularly significant, which suggests that an infection in the mother while she is carrying her baby, or in a child's early years, could be a trigger factor for the cancer," said Dr Richard McNally, of the University of Newcastle upon Tyne in northern England.

"These could be minor, common illnesses ... such as a cold, mild flu or a respiratory infection," he added in a statement.

McNally and a team of researchers from England and Scotland, who reported the findings in the European Journal of Cancer, said the results could improve understanding about how cancer develops and may lead to better prevention and treatment.

Although cancer in children is rare, rates of the disease in youngsters in Europe have increased over the past three decades. Survival rates however have improved. Five-year survival rates are about 75 percent in Western Europe and 63 percent in Eastern Europe.

Leukemia is the most common childhood cancer, accounting for nearly one-third of all cases. Most of the rise has been in children aged 1 to 4.

The researchers believe an infection in the womb or early in life could lead to cancer in young people who already carry mutant cells that would make them more vulnerable to the disease.

"The virus would hit this mutant cell and cause a second mutation, prompting the onset of cancers like Leukemia or brain tumors," said McNally.

It was this intimate connection in immune system response that allowed me to create in LifeOne the ability to have a direct affect on both viral infections and cancer. Viral infections of a serious or chronic nature require the same series of tests that cancer patients require. Once again, it becomes necessary to address the cause of immune system failure.

Fungal Infections

To further complicate the issue, the research into fungal infections and their direct link to cancer should also be more thoroughly considered. There has been recorded direct linking between viral infections and cancer, but irrefutable connections to fungal infections must be considered as well. The following studies and excerpts explain this connection clearly.

In the Book "Breast Cancer - Hope At Last" by A.V. Costantini, M.D. Head (Retired), H.Wieland, M.D. Head, Lars Qvick, M.D. Director WHO Collaborating Centre For Mycotoxins In Food and Albert Ludwigs School of Medicine, Freiburg, Germany, the following are excerpts from chapter 29.

FUNGI/MYCOTOXINS CAUSE BREAST CANCER IN HUMANS

CALCIFICATIONS IN BREAST CANCER LESIONS ARE FUNGAL

FUNGI/MYCOTOXINS CAUSE BREAST CANCER IN ANIMALS

THE REPORTED CLINICAL FACTS AND THE CORRELATIVE FUNGAL/MYCOTOXIN FACTS

Aflatoxin Found In Human Breast Cancer Tissue

Harrison *et al.* (1993) examined human breast cancer tissue for evidence of the presence of aflatoxin, a recognized potent carcinogenic mycotoxin. The researchers examined human DNA from a variety of tissues and organs to identify and quantify aflatoxin DNA-adducts. Such adducts are considered to be proof of the mycotoxin's presence in a particular tissue. (These researchers had already proved the value of this method in the detection of aflatoxin-DNA adducts in tissue from a case of acute aflatoxin poisoning in Southeast Asia.)

DNA from normal and tumorous tissue obtained from patients with cancer of the breast was examined. Tumor tissues had higher aflatoxin-adduct levels than did normal tissue from the same individual.

The result of this study is that it verifies the presence of carcinogenic aflatoxin within the cancer tissue and thus implicates aflatoxin as a cause of breast cancer.

Cyclosporin (A Mycotoxin) Causes Breast Cancer In Humans (3 Studies)

Cyclosporin is a fungal derived drug. It is classified as a mycotoxin in the mycology literature (Betina [1989]).

1. Vogt *et al.* (1990) reported the occurrence of *de novo* malignant tumors occurring in 598 renal transplant recipients who were immunosupressed with cyclosporin.

Eighteen of 598 patients receiving their first renal graft along with cyclosporin treatment between 1981 and 1986 developed a malignancy at a mean interval of 33 months. The cyclosporin-induced cancers included breast cancer.

2. Escribano-Patino *et al.* (1995) reported the occurrence of breast cancer as a complication of cyclosporin use in their series of kidney transplant recipients.

3. Penn and First (1986) reported 88 tumors in eighty-seven organ transplant recipients after the use of cyclosporin. Malignancies appeared an average of 14 months after the cyclosporin treatment. There was a surprising frequency of endocrine-related malignancies (ovarian, testicular and breast) among these malignancies.

Aflatoxin Induces Malignant
Changes In Human Breast Cells

Eldridge *et al.* (1992) noted that some environmental chemicals are stored in human breast fat which are documented to be rodent mammary carcinogens. These researchers stressed the importance of determining the cancer potential of environmental agents in this key target tissue.

An assay was developed for detecting cancer potential using cultures of normal human breast epithelial cells derived from 5 different women. A positive response was observed with aflatoxin.

The conclusion of this study was that aflatoxin causes normal human breast cells to become cancerous.

Moldy Cheese Causes
Breast Cancer In French Women

Le *et al.* (1986), in a French case-control study of 1,010 breast cancer cases and 1,950 controls with nonmalignant diseases, found that breast cancer was found to be associated with increased frequency of mold-fermented cheese consumption (see Chapter 41, entitled *Cheese Causes Breast Cancer,* for other reported studies).

Oxalic Acid (A Mycotoxin)
Found In Breast Cancer Lesions

Going *et al.* (1990) found that weddellite (calcium oxalate) crystals are present in calcifications found in the breast tissue of patients with breast cancer. Calcium oxalate crystals are formed when calcium binds with oxalic acid. In human and animal systems, this is a protective process which considerably reduces the severe toxicity of oxalic acid. Oxalic acid is a powerful corrosive agent and oxalate salts are widely used for their cleaning and bleaching properties!

Oxalic acid happens to be a mycotoxin which can be produced by a number of different fungal species. Some fungi produce such large amounts of oxalic acid that they are used for commercial production of the chemical.

Aspergillus niger fungal infection in human lungs produces large amounts of oxalic acid which is extremely toxic to the blood vessels and which may cause fatal pulmonary hemorrhages. Consequently, oxalic acid (calcium oxalate crystals) in the sputum or lung specimens of patients is

also an indication of an *Aspergillus* infection of the lung. These calcium oxalate crystals are the same as the calcium oxalate found in breast cancers.

The presence of oxalates in the breast is indicative of the presence of fungi interwoven within the stages of breast cancer development. Since humans do not make oxalic acid themselves, this is an appropriate conclusion.

Breast Oxalate Calcifications
In Mammographic Examinations

Thomas *et al.* (1993) examined calcifications found in breast mammograms and evaluated their relationship to the risk of subsequent breast cancer. The presence, morphology, and distribution of calcifications visualized on baseline mammograms of 686 women who developed breast cancer over a 7- to 10-year follow-up period were compared with those of 1,357 controls who remained cancer free. It was found that there was a significant correlation between such calcifications and subsequent development of breast cancer.

Breast Cancer Calcifications Decrease
With Tamoxifen (Antifungal) Treatment

Taylor and Georgian-Smith (1994) reported the regression of breast cancer in four patients who had been treated with tamoxifen. The patients were closely monitored with physical examination and mammography for a minimum of 2 years.

In all cases, the features of malignancy which were seen on mammograms regressed. These results were documented by a decrease in the number of calcifications and in the size of spiculated masses. These results suggest that these breast calcifications are dynamic in nature, being able to regress as effective treatment reduces the cancer.

CLINICAL PERSPECTIVE

The presence of oxalate calcifications in the breasts of virtually every patient with breast cancer, and their subsequent regression as a result of treatment with the antifungal agent tamoxifen, points to the strong possibility that there is a fungal role in this cancer. There have even been reports of fungal cells growing out of cancer cells. The existence of a viable fungal sub-forms—with its DNA co-mixed with a human's own DNA—could well explain the bizarre appearance of the DNA in cancer cells. Support for such a "science fiction" type scenario is found in the observation that a lectin staining procedure, used to find "invisible" fungi in tissue specimens, happens to identify breast cancer cells. Normal cells do not stain with these same lectin staining procedures.

The lectin stain is also taken up by strange multinucleated giant cells which suggests that these cells may, in fact, be fungal cells. This could explain the presence of oxalates in breast cancer tissue, a metabolite produced by fungi and not by humans. It might also help explain how breast cancer is caused by a number of fungal-fermented foods, particularly those made with Baker's or Brewer's

Yeast (both being *Saccharomyces cerevisiae*), known producers of uric acid which degrades to oxalic acid (Costantini [1989]).

Baker's yeast is used to make bread, a documented cause of breast cancer in Japanese women. Brewer's yeast is used to make many alcoholic beverages, all of which are known to cause breast cancer in every country where the connection has been investigated, a fact which is well documented (See Chapters 27, 30-32, relative to alcohol, beer and wine causing breast cancer.)

Aflatoxin Causes Breast Cancer in Rats

Leszczyszyn (1986) reported the results of experiments in which aflatoxin induced mammary cancer in rats.

Breast Tumors In Rats Caused By
The Fungus *Penicillium camemberti*

Gibel *et al.* (1971) conducted experimental studies of the cancer-causing fungus *Penicillium camemberti var. candidum* in which mammary neoplasms were induced in rats. (*Penicillium camemberti* is the fungus which is used to make Camembert cheese, frequently consumed in the Western diet.)

T-2 Toxin (*Fusarium*)
Causes Breast Tumors In Rats

Schoental *et al.* (1979) reported that breast cancers were induced in rats which were dosed with T-2 Toxin.

T-2 Toxin is a *Fusarium* toxin frequently found in the human food chain. The fact that T-2 Toxin induced breast cancer in an animal model is most significant, for this cancer occurs so often in humans.

Furthermore, antibodies against *Fusarium* fungi are frequently found in human blood. These fungi and their toxins are the most frequently encountered contaminants found in animal feed and human foods. See also Saito (1971) and Corrado (1971), both of whom induced breast cancer in mice using moldy rice and its extracts.

Ochratoxin Causes Breast Tumors In Mice

Fibroadenomas in the mammary gland were found in over half of a group of female mice which were dosed with ochratoxin (Boorman [1988]). In humans, fibroadenoma is a documented risk factor for breast cancer (Dupont *et al.* [1994]).

Ochratoxin Causes Breast Fibroadenomas In Animals

Huff (1991) investigated the carcinogenicity of ochratoxin, a naturally occurring mycotoxin of the fungal genera *Aspergillus* and *Penicillium,* which was studied in three strains of mice and in one strain of rats.

It was found that fibroadenomas of the mammary glands were induced by ochratoxin administration. In humans, fibroadenoma is a documented long-term risk factor for breast cancer (Dupont *et al.* [1994]).

Penicillic Acid/Patulin Cause Breast Adenomas And Breast Sarcomas In Mice And Rats

Penicillic acid was found to induce mammary adenomas, as well as local sarcomas and fibrosarcomas in mice and rats. Patulin was also reported to cause mammary adenomas in mice and rats (Dickens and Jones [1965], Dickens [1967]). See also Ciegler *et al.* (1971).

Verrucarin E-Induced Breast Tumors In Mice

Jodczyk (1984) was able to induce breast tumors in mice by exposing them to a derivative of the mycotoxin verrucarin E.

Moldy Rice Extract Causes Breast Cancer In Animals

Mammary cancers (breast cancers) were induced by feeding an alcohol extract of moldy rice to animals (Corrado [1971]). See also Saito (1971).

Summary to Date

It seems that cancer has been associated definitively with viral infections and fungal infections. It is also obvious that our immune system is vulnerable when it is under attack from any type of infection. It therefore becomes imperative that the treating physician look for and discover any and all causes for compromise of the immune system and treat them concurrently with any other diseases or infections present.

When selecting a physician to treat the uncontrolled growth of cancer cells, it is imperative for the prospective patient to question and interview potential physicians and therapies. In countries that offer physicians financial incentives to use expensive drugs with little or no efficacy and often reduce the immune systems ability to fight disease, they must be approached with the same skepticism as a used car salesman. In all honesty, it would be best to find a competent internist that will follow the aforementioned protocols with your oncologist if you decide to use conventional

chemotherapy. This will at least allow you to know what is happening to your body and will aid you in making other health decisions as they present themselves.

If the patient will not take this responsibility for themselves, little can be done to help them. Feel free to discuss and request proof of efficacy of any treatment used. Look for information, and use your mind.