

# The war on cancer

## 33 years (and still counting)

### Key points

- *Cancer deaths have doubled in 30 years*
- *Conventional treatments just don't work*
- *The best treatments combine dietary and spiritual changes*

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In 1971, Richard Nixon famously declared war on cancer and predicted that medical technology would find a cure for it "within six years"—a boast to rival Kennedy's goal to put man on the moon. But while the might of US technology conquered space within a decade, conquering cancer has proved rather more difficult.

Since then, the total amount spent on cancer research and treatment is estimated to have passed the two trillion dollar (\$2,000,000,000,000) mark (*Wall Street Journal*, 16 Oct 2002). Most of that money has come from us taxpayers, patients, consumers and donors to cancer charities.

What have we got to show for it? If you listen to doctors, the drugs industry and cancer charities, the constant refrain is that the war against cancer is being won—or at least that there's a cure just around the corner.

But are they right? Let's start with the crude cancer-mortality rates in our so-called developed world.

### Cancer statistics

Despite the might of medicine, in every year from 1971 to 1991, more Americans died of cancer than the year before—this in a country with the most advanced medical care in the world and the best cancer records. Although there's been a slight fall in the last 10 years, the plain truth is that cancer deaths have doubled over the last 30 years.

This embarrassing statistic is often explained away by the fact that we're living longer (supposedly thanks to medicine), and so more of us are alive to contract degenerative diseases like cancer.

But if you ask an expert like Dr John Bailor, this excuse won't wash. Bailor was a senior cancer statistician for the US National Cancer Institute for 20 years and editor of its journal. "Cancer death rates continue to go up year after year," he said in 1985. "These are real increases . . . This has been going on quite steadily for a number of years now" (Address to the Annual Meeting of the American Association for the Advancement of Science, May 1985).

Ten years later, Bailor again looked at the figures and concluded: ". . . years of intense effort focused largely on improving treatment must be judged a qualified failure" (*N Engl J Med*, 1997; 336: 1569-74).

Similarly, in Britain, death rates increased up to the end of the 1980s, but have since slightly declined. But, at the same time, some cancers have risen alarmingly. For example, there were only 3300 prostate-cancer deaths in 1964, but 8600 in 1998. Teenage cancers, too, are on the rise—by more than 1 per cent a year for the last 20 years (*Br J Cancer*, 2002; 87: 1267-74).

### Biopsies cause cancer

Once a cancer has been isolated by screening (see box, p 2), doctors need to confirm the diagnosis, using diagnostic tests such as a positive prostate-specific antigen (PSA) reading or a biopsy, which involves taking tissue cores (from as many as 12 different sites in the case of the prostate) to check for cancer cells.

But the procedure is not without risk: most patients become infected because of the procedure, 20 per cent suffer severe pain, and 15 per cent are rendered impotent (*J Urol*, 2001; 165: 445-54). To add insult to injury, biopsies themselves may be inaccurate, often failing to detect cancerous tissue (*Prostate Cancer Prostatic Dis*, 2000; 3: 13-20).

But the crowning absurdity is that biopsies can actually spread cancer, thus precipitating the very disease they are trying to diagnose. This alarming discovery was first made about 50 years ago, when a case of



## SCREENING DOESN'T WORK

● *harms more than helps* ● *leads to unnecessary treatment*

One of the reasons given for the so-called advances in the war against cancer is that doctors are now screening for cancer, and so are able to detect and treat it earlier. This belief has become so entrenched in the medical mind that no amount of contrary evidence appears able to shift it – not even the fact that for every single type of cancer, screening doesn't work.

Take the story of the conversion of Professor Michael Baum, a leading British breast-cancer expert and one of the major forces behind the establishment of NHS breast screening in 1987. At first, he was pleased with his creation but, over the years, he has become increasingly concerned. A hard look at the evidence over the last 15 years has convinced him that the supposed benefits of screening are largely a myth. "It's a common misconception that early detection is of benefit and implies reduced mortality," he says (*BMJ*, 2003; 327: 101–3). Indeed, Baum now believes that screening may actually cost lives by leading to unnecessary biopsies or surgery (*Int J Epidemiol*, 2004; 33: 66–7).

It's the same with prostate cancer. Here, the prostate-specific antigen (PSA) test has been touted as an infallible marker of the disease. But experience has shown it to be worse than no test at all. Not only is there "a lack of credible evidence" that PSA screening saves lives, but some experts say that screening has harmed and even killed people as a result of the unnecessary treatment it leads to. A Yale University report spells it out in cold clinical terms: "... population-based screening (with subsequent diagnosis and treatment in many men) can be associated with considerable morbidity and mortality in the context of a disease that is often not fatal" (*J Sci Am*, 2000; 6 Suppl 2: S188–92).

prostate cancer was found to have been spread by biopsy (*J Urol*, 1953; 70: 937).

However, far from raising a red flag, doctors continue to recommend biopsy for prostate-cancer detection. To what effect? One large US military hospital reported that biopsy kills as many as one in every 100 patients (*J Urol*, 1989; 142: 86–8).

The news is even worse with breast biopsy, found to 'displace' malignant cancer cells in about a third of cases (*Am J Roentgenol*, 1999; 173: 1303–13). As a result, one in 15 women develops breast cancer from biopsy itself (*Acta Radiol Suppl*, 2001; 42: 1–22).

Pancreas, lung and kidney biopsies can all cause cancer 'seeding' (spread), too, with liver biopsy being the most hazardous, causing a "significant risk" of cancer dissemination in one in every six cases (*Dis Colon Rectum*, 2003; 46: 454–8).

Nevertheless, doctors persist in recommending screening and biopsies, seemingly mindless to the medical principle to "first do no harm".

### Cutting out cancer causes cancer

Cancer treatment still relies on the three-pronged approach of surgery, radiation and chemotherapy—dubbed 'cut, burn and poison' by its critics.

Critics tend to be least hostile to surgery because removing cancer is believed to reduce the 'tumour burden' on the body. But is it always good news?

Breast-cancer surgeon Michael Baum says surgery isn't always benign, pointing to statistics showing that surgery actually tends to increase the risk of cancer relapse or death. In an article entitled "Does surgery disseminate or accelerate cancer?" that shocked his colleagues, he argued that surgery could stimulate the formation of metastases (secondary cancers) elsewhere in the body (*Lancet*, 1996; 347: 260).

Baum is influenced by the theories of Harvard researcher Dr Judah Folkman, who showed that cancers spread by forming new blood vessels (angiogenesis). This occurs whenever flesh is injured, and may be a trigger for cancer growth and spread. "The newly formed blood vessels [after an incision into cancerous tissue] bring the blood and oxygen that encourage tumour growth," says Baum. "They also provide the means for cancer cells to travel to distant organs and form new tumours."

A similar process occurs with biopsy, says Baum, which would explain why cancer seeding is so common. "Biopsy could be considered as an angiogenic switch," he says. "You take a latent cancer that might never harm a patient, biopsy it, turn on the angiogenic switch, and it ceases to be latent—it becomes an aggressive disease."

### Burning cancer causes more of it

The second line of treatment is radiation and here, again, experience over the last 30 years is showing that it can be self-defeating. The treatment involves bombarding the body with rays that, in high doses, are lethal to all living cells—and known to

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## ● helplessness ● hopelessness ● unremitting stress

cause cancer at any dose. Its rationale is to target only cancer cells, but that's an often forlorn hope. It's now known that if breast-cancer patients are treated with radiation, over 60 per cent of them will eventually contract lung cancer (*Med Oncol*, 1994; 11: 121-5).

In some women, radiotherapy may actually cause more immediate cancers, in particular, rare aggressive 'angiosarcomas', which are almost always fatal (*J Am Acad Dermatol*, 2003; 49: 532-8). Others have even fallen victim to radiation-induced breast cancer (*Int J Radiat Oncol Biol Phys*, 1995; 31: 405-10).

Small wonder that a recent review involving over 20,000 breast-cancer patients found that, after just two years, radiotherapy had killed 21 per cent more women than it cured (*Lancet*, 2000; 355: 1757-70).

Radiotherapy for lung cancer may also be totally counterproductive. In a major survey of such patients, at two years, their risk of death was 21 per cent higher than those not receiving radiation (*Cochrane Database Syst Rev*, 2003; 1: CD002142).

Then there are the side-effects. The most common of these are fatigue, nausea and vomiting. But there's also physical damage, for example, to bone marrow, causing osteoporosis and joint problems. Breast radiotherapy is particularly hazardous. The UK Radiotherapy Action Group Exposure (RAGE) was set up by women who had suffered catastrophic arm injuries, excruciating pain and repeated corrective surgery as a direct result of radiotherapy.

### Poisoning cancer doesn't work

The third major anti-cancer weapon is chemotherapy—the use of toxic chemicals that kill all dividing cells, normal as well as cancerous—which hopes to destroy the cancer before it kills the patient. Many chemo drugs used today are chemical cousins of mustard gas and so toxic that hospital staff use protection while administering these agents to patients.

Most people are aware of the vicious side-effects of chemo, but what doctors often don't tell patients is that there is little evidence that such a blunderbuss delivery prolongs life. When American Tom Nesi, who worked for drugs giant Bristol-Myers Squibb, persuaded his wife to use his company's latest chemo drug for her cancer, after just two weeks of it, she pleaded, "No more, please" (*The New York Times*, 5 June 2003).

Indeed, many patients look upon chemo as a trial by ordeal—a penance of such suffering that it will miraculously absolve them of their sinful cancer.

Doctors themselves won't undergo it. A Canadian survey of doctors revealed that the vast majority would refuse chemotherapy as it was believed to be unacceptably toxic and largely ineffective (*Br J Cancer*, 1986; 54: 661-7).

Sir Peter Medawar, the great British scientist and Nobel prizewinner in immunology, was once asked what the best prescription for success against cancer might be. "A sanguine personality," he replied.

The relationship between cancer and personality has been commented on for centuries, but has come to the fore only in the last 20 years with our new understanding of the link between mental attitude and the immune system.

One of the gurus of this field of psychoneuroimmunology (PNI) is US psychologist Lydia Temoshok, who has identified a set of personality traits that, she claims, predisposes people to cancer. The two main ones are difficulty in expressing emotions, and a tendency towards helplessness/hopelessness. These add up to what she calls a 'type C' personality (*Cancer Surv*, 1987; 6: 545-67). Temoshok argues that these personality traits prevent people from "resolving stressors", thus forcing the body into chronic stress-reaction mode which, in turn, overloads the immune system with stress chemicals, leaving an individual vulnerable to cancer (*Ann NY Acad Sci*, 2000; 917: 446-55).

Someone who has taken this concept even further is German cancer surgeon Dr Ryke-Geerd Hamer. He has studied over 20,000 cancer patients, and found that the vast majority of them had experienced some kind of unresolved emotional conflict just before getting the cancer. Hamer has now largely abandoned surgery in favour of psychotherapy, and claims to have successfully brought about dramatic turn-arounds in his cancer patients.

Indeed, the plain truth of the matter is, on looking at the evidence, in many cases, chemotherapy doesn't work at all (see box, p 4). A huge breast-cancer survey concluded that 'adjuvant therapy' (chemo and radiation) did not increase overall cancer survival (*JAMA*, 1991; 265: 391-5).

The knee-jerk response of cancer doctors to the fact that chemo doesn't work appears to be not to abandon it, but to up the dosage. One celebrity example was Linda McCartney, who bravely underwent high-dose chemotherapy, but ultimately succumbed—to either the cancer or the chemo. A report published around the time of her death showed that high-dose chemo kills 8 per cent of patients while bringing little benefit (*Lancet*, 1999; 353: 1633).

But this has been known for years. In 1992, German cancer expert Dr Ulrich Abel did a comprehensive analysis of all clinical data on chemotherapy in cases of advanced cancer. "There is no direct evidence that chemotherapy prolongs survival in patients with advanced carcinoma," he concluded, attacking the prevailing beliefs of his colleagues. "Many oncologists take it for granted that response to therapy prolongs survival, an opinion which is based on a fallacy and which is not supported by clinical studies" (*Biomed Pharmacother*, 1992; 46: 439-52).

As Abel implies, the term 'response' has been used by cancer specialists to persuade patients of the benefits of chemotherapy, omitting to mention that a response rarely translates into a significant improvement in survival time or quality of life for the patient. A peculiarly candid admission of this came in 1978 from a leading US specialist in colon cancer, Dr Charles Moertel, at the prestigious Mayo Clinic. "Even when



administered in most ideal regimens," he wrote, summarising the value of 5-FU (5-fluorouracil), the major chemotherapy drug for colon cancer, "5-FU will produce objective response in only about 15 to 20 per cent of treated patients. These responses are usually only partial and very transient. This minor gain for a small minority of patients is probably more than counterbalanced by the deleterious influence of toxicity for other patients and by the cost and inconvenience experienced by all patients."

Nevertheless, echoing the view of most physicians, Moertel concluded that chemo should not be abandoned, but be used essentially as 'snake oil'—to convince the patient that some treatments might still work. "Patients with advanced gastrointestinal cancer and their families have a compelling need for a basis of hope. If such hope is not offered, they will quickly seek it from the hands of quacks and charlatans" (*N Engl J Med*, 1978; 299: 1049–52).

Despite evidence that 5-FU itself is nothing more than licensed quackery, 25 years later, this drug is still the standard treatment for colon cancer. Indeed, Xeloda, one of the latest in chemo drugs, was approved last year for use in the UK—and all it does is metabolise into 5-FU.

Even within the cancer community, a few doctors are now questioning the whole approach to treatment, openly expressing their horror at the crudeness of the un-Holy Trinity of cut, burn and poison. As US cancer expert Dr Robert Wittes put it: "One may hope that in another 10 to 15 years, medical progress will make this edition of the Manual read like an archaic document for the Middle Ages" (*Manual of Oncologic Therapeutics*, National Cancer Institute, 1991).

## CHEMO: BASICALLY, IT DOESN'T WORK

- causes new cancers
- doesn't work on solid tumours

Chemotherapy results in substantial remission for only 3 per cent of cancers – mainly blood-based ones like Hodgkin's disease, leukaemia and Burkitt's lymphoma. Also successfully treated are testicular and ovarian cancers.

However, even for these, there may be serious short- and long-term side-effects. Many chemo drugs cause cancer later in life. Up to 8 per cent of children treated for leukaemia go on to develop cancers of the bone, thyroid and breast (*J Natl Cancer Inst*, 2001; 93: 618–29). Chemo for ovarian cancer is linked with a high incidence of later leukaemia (*Prog Clin Biol Res*, 1992; 374: 167–74).

But most of today's common cancers are solid tumours, against which chemotherapy is inherently less suitable. These include cancers of the breast, colon, lung, stomach, liver, pancreas and prostate, against which chemo has essentially no benefit.

As New York cancer expert Dr Albert Braverman observed, "Trainee doctors should be taught that chemotherapy is not part of the management of every cancer patient. Many cancer physicians recommend chemotherapy for virtually any tumour, with a hopefulness undiscouraged by almost invariable failure" (*Lancet*, 1991; 337: 901–2).

## Wrongheaded research

Where will progress in cancer come from? The vested interests involved in surgery, chemotherapy and radiotherapy are hardly likely to welcome changes that might threaten the status quo—after all, as one wag put it, "There are more people living off cancer than dying of it".

An obvious place to look for advances is the cancer charities, supposedly altruistic bodies devoid of commercial interests. These huge institutions are the wealthiest charities in the world. Britain's Cancer Research UK (CRUK), for example, raises nearly £300 million a year. In the UK, most of that money goes to research, mainly clinical trials. And what breakthrough cancer therapies are they researching? Answer: none. Of the 188 clinical trials currently funded by CRUK, virtually all involve existing chemo or radiotherapy. Only one trial is looking (very narrowly) at diet, and another is investigating "guided imagery and relaxation", an already well-studied technique.

So, again, where will the breakthroughs, promised so earnestly by the cancer charities when rattling their collection tins, actually come from?

The current 'just-around-the-corner' hope being hyped is genetics. The prevailing theory says that cancer is caused by genetic mutations in a few oncogenes (cancer genes). All that's required is to find drugs that will turn those genes off and hey, presto! cancer will be cured.

But, if it's that simple, where are the cures? A growing number of geneticists believe that the reason there are no gene-based cures for cancer is that the basic theory is wrongheaded. Says biologist Professor Brian Goodwin, "We now know that every cancer is different, so it will be very difficult to target cancer cells specifically with new gene-based drugs" ('Rethinking cancer, from cure to prevention', *Institute of Science in Society*, 8 Feb 2001; [www.i-sis.org.uk](http://www.i-sis.org.uk)).

Research from the University of California at Berkeley confirms that cancer is not primarily a genetic disease, but one in which normal cell division is disturbed by external factors, such as environmental chemicals, radiation or stress (*Biochem J*, 2000 348: 497–506).

"This new/old approach to cancer shifts the emphasis from cure to prevention," says Goodwin. "The multiple chemicals that pollute our environment need to be screened for their cancer-causing capacity. And the phenomenon of cancer remission in which the individual gets rid of the cancer spontaneously, needs to be much more thoroughly explored. Remissions can occur after various types of stimulus to the whole body, such as change of diet, change of life style, and many other non-specific influences."

*continued on page 7*



## THE BEST ALTERNATIVE THERAPIES

- Find the cause ● Detox is a must ● Find your metabolic type

If conventional treatments fail so badly, where do you turn? According to Lothar Hirneise of Menschen Geben Krebs and Frank Wiewel of People Against Cancer, cancer survivors:

- ◆ **Find and change the psychological/emotional cause.** Germanic New Medicine (Ryke-Geerd Hamer), and Synergetik (Bernd Joschko), nexus (Lothar Hirneise) and adrenaline (Waltraut Fryda) theories fight the cause of cancer, not the symptoms. All four work to eliminate stress and to resolve the trauma or unresolved conflicts leading to cancer.
- ◆ **Change their diet.** The most success has been achieved with:
  - ❖ *The metabolic typing diet*, developed by William Wollcott, who discovered that each of us is individual in the percentage of carbohydrate or protein we need in our diets
  - ❖ *The Stockholm protocol*, an anti-cancer regimen based on coenzyme Q10, very high levels of which (400–600 mg) can result in tumour regression (*Biochem Biophys Res Commun*, 1994; 199: 1504–8). The protocol includes a good multivitamin/mineral plus 1.2 g of gamma-linolenic acid, 3.5 g of omega-3, 58 mg (32,248 IU) of beta-carotene, 2.8 g of vitamin C, 2500 IU of vitamin E, 385 mcg of selenium and 390 mg of CoQ10 taken with a tablespoon of olive oil.
  - ❖ *The Gerson diet and other raw-food therapies.* These work largely by transmitting food – and the photons, or subatomic light molecules that comprise them – at their strongest.
  - ❖ *Dr Johanna Budwig* was a proponent of an oil-and-protein diet (including cottage cheese and flaxseed oil) that raises the voltage of cells, drastically too low in cancer patients.
- ◆ **Detox their bodies.** Most cancer patients have highly polluted bodies. A detox programme is central to the success of any therapeutic programme, and should include:
  - ❖ *colonic detox* using coffee enemas and colonic hydrotherapy
  - ❖ *removal of amalgam fillings and root canals* (see *The WDDTY Dental Handbook* for the correct protocol)
  - ❖ *baths in baking soda*, to remove excess acid from cells, too high in cancer patients
  - ❖ *infrared sauna*, in cases of high levels of chemical pollution.
- ◆ **Kill cancer gently.** The safer cancer-killers include:
  - ❖ *PAPIMI*, invented by Professor Panos Pappas in Athens, using electromagnetic rays to increase the voltage in cells of the body
  - ❖ *Electro-Galvano*, using low-voltage electricity to kill tumour cells (but not healthy cells)
  - ❖ *High-dose hormone blockers*, such as busarelin, at 20–40 times the usual dosage for up to 12 weeks
  - ❖ *Heat therapy* (hyperthermia), using highly focused radiowaves to raise the temperature of the tumour to about 44 degrees C (only kills cancer cells)
  - ❖ *Cancer vaccines*
  - ❖ *Specialised immune cells* that are programmed to attack only cancer cells
  - ❖ *Fever therapy*, using bacterial toxins to induce a fever, which kills cancer cells.

For more information, contact: **People Against Cancer** [tel: +(515) 972 4444; fax: +(515) 972 4415; e-mail: info@PeopleAgainstCancer.net; website: www.PeopleAgainstCancer.net]; **Menschen Geben Krebs (Germany)** [tel: +49 (715) 191 0217; fax: +49 (715) 191 0218; e-mail: nexus@GMBH-Online.de; website: www.krebstherapien.de].

### Why does cancer just go away?

Cancer research clearly needs to change direction. Perhaps, as Professor Goodwin suggests, one avenue might be to explore the mechanisms of spontaneous remission.

Indeed, peppered throughout the medical literature are accounts of seemingly advanced, even 'terminal', cancers that inexplicably and suddenly disappeared. Just before his untimely death in his 40s, medical researcher Brendan O'Regan collated over 1000 case histories of apparently 'miracle'

cancer cures—without any obvious medical, or indeed divine, interventions (*Spontaneous Remission: An Annotated Bibliography*, Sausalito, CA: Institute of Noetic Sciences, 1993).

What this shows is that spontaneous regression of cancer is not a miracle, a fantasy or fluke. It is a biological reality suggesting that there may well be a switch to turn cancer off. However, if cancer research fails to change its course, medicine will continue to fumble for that switch in the dark.

Tony Edwards

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