BURKE ROAD MEDICAL CENTRE

Dr. G.C.M. Kemp *M.B.,B.S.(Melb).F.R.A.C.G.P., F.A.C.N.E.M.*
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19th August, 2003

To Whom It May Concern,

Cancer has become more common because of environmental changes in the domestic and commercial environment, such as the introduction of pesticides into the food chain and synthetic chemicals into food, drink and water.

However, cancer has been successfully controlled and even cured by the elimination of pesticides from the diet of cancer patients by the elimination of synthetic chemicals from their food, drink and water, and from their domestic environment, and by their replacement with a diet consisting of raw, unspoiled , organic fruit, vegetables, whole grains and nutritional supplements.

The current medical establishment does not provide enough information to patients about the real opportunities for the treatment of cancer other than conventional methods of chemotherapy, radiation, surgery etc.

This is largely because there has been minimal research in Australia into the adverse effects of modern technology on the environment and on human health.

In addition, International Business now pays for so much research in Science and Technology that the Scientific establishment is dominated by the agenda of International Business and is no longer in a position to provide Legislators with unbiased advice.

The agenda of the war against cancer is therefore seen to be under the direct control of International Business, with University Departments of Medicine, Surgery, Radiology and Oncology being funded by it and consequently under its control. The same may be said of Medical Journals.

International Business is active in suppressing research and dissemination of environmental and agricultural research and of medical knowledge which is in conflict with its own commercial agenda.

In subverting the role of Universities in their function of disseminating universal knowledge and consequently subverting the ability of the Science Establishment to provide Legislators with unbiased advice, International Business is retarding the research into the best means of preventing and curing cancer.

All of this is resulting in unnecessary death and suffering due to cancer on a massive scale throughout much of the industrially developed world, including Australia. Unbiased research, funded by Government and not by International Business, is urgently required in the areas of organic and long term sustainable agriculture and Nutritional and Ecological Medicine.

The result of such research could bring about a reduction in the incidence and mortality of cancer and of other degenerative diseases. This would save significant amounts of Government funds being used on drugs, surgery and radiotherapy, where diet and lifestyle based therapies could be more economical and effective.

The war against cancer can be won, however we are at the point where Government support is required to enhance knowledge in the areas of organic and long term sustainable agriculture and Nutritional and Ecological Medicine.

A Clinical Trial involving the use of Laetrile, as part of an integrated nutritional program, along the lines of the Gerson Therapy, which utilizes the body's own healing mechanisms, would be an example of such unbiased research in medicine.

Such a program has already been deployed by Dr. Phillip E. Binzel Jnr. with great success, as a result of support from members of his State Legislature in Ohio, U.S.A.

Extracts are included from Dr. Binzel's book, 'Alive and Well', in which his methods and the remarkable survival rates he achieved are described, along with extracts from the experience and work of other patients and practitioners in Australia and around the world.

I would urge you to consider supporting the funding of a clinical trial involving the use of Laetrile, as part of an integrated program, with the results being made available to the appropriate committee.

I would be pleased to write to you further outlining the anticipated cost and objectives of the trial, how it would be conducted and the trial period.

Yours faithfully,

Dr. Geoff Kemp.

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SUBMISSION TO THE VICTORIAN HEALTH DEPARTMENT ABOUT THE USE OF DIET, LAETRILE AND OTHER VITAMINS AND TRACE ELEMENTS IN THE TREATMENT OF CANCER.

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Wednesday, 13 August 2003

Dr Malcolm Dobbin,
PhD,MBBS,DipRACOG,MPH,FAPPHM ,
and
Dr Melanie Strang,
16th Floor,
120 Spencer Street, Melbourne
Victoria, 3000, Australia

Dear Doctors,

Thank you for coming to my surgery on 8th of July 2003 and for your courteous treatment of myself, and my wife, Rosemary. I am writing this submission to confirm in writing what was shared with you in conversation about the treatment of cancer by an integrated regime, based on diet and the use of nutritional supplementation, sometimes including Laetrile, or Vitamin B17.

As you know, medical teaching is disseminated to the profession through two main avenues, the University Teaching Departments, and the Peer reviewed medical journals. Both are dependent upon sponsorship, of which Drug Company financing is the principal source.

How and why is research undertaken ? Grants are awarded by Drug Companies to Institutions employing medical research workers. Both the Drug Company and the Institution have therefore reached common ground on an agenda to be pursued, usually in the form of a double blind controlled trial to assess the efficiency of a product produced by the company sponsoring the research.

As a result, there is little funding available to test the impact of diet on human health, and we do not even have a University Department of Ecological Medicine in this country, where the adverse impact of pesticides and other food additives and household products such as cleansing agents and cosmetics can be tested.

As a direct outcome of this narrow minded line of research, the War on Cancer has seen very little progress in the prevention and treatment of the most common cancers which remain the biggest killers, breast cancer, prostate cancer, and cancer of the colon.

The appropriate means of preventing and treating these and other cancers lies in optimising the level of functioning of the immune system, with diet as the foundation of treatment, combined with pure water, detoxification, the use of appropriate nutritional supplements, removal of obstacles to the

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recovery of normal immunity such as dental root fillings, mercury amalgam dental fillings, and foci of infection such as chronically infected tonsils. Surgery, chemotherapy and radiation may then be deployed with life saving effect, with smaller areas requiring excision, and/or smaller doses of chemotherapy or radiation being used with resulting reduction in unwanted toxic effects associated with these modalities of treatment. I make these assertions as a result of years of study of books written by such people as Dr Max Gerson and his daughter, Dr Charlotte Gerson, G. Edward Griffin, who outlined the story of Vitamin B17, Doctor Philip E. Binzel junior, who used Vitamin B17 or Laetrile in his General Medical Practice over a seventeen year period with great success, enabling 76 of the 108 patients with metastatic cancer whom he treated for a period of at least one year to survive their cancer, or die of unrelated causes, Professor Jane Plant, who survived breast cancer after changing her diet, videotapes produced by Dr Lorraine Day, who survived breast cancer by changing her diet and lifestyle, and books written by other people who have been afflicted with life threatening cancers, who have survived after using the Gerson therapy, or a series of treatment based upon Dr Gerson's concepts, and on the basis of my own experience. I will refer to this body of literature and videotapes as "The Survivor Literature".

It will be argued, "but these treatments were not scientifically administered". To which I would reply, "In clinical science, that which is scientific is that which works, and succeeds in saving the patient"

EXCERPTS FROM THE SURVIVOR LITERATURE

From "The Gerson Therapy" by Charlotte Gerson and Morton Walker, D.P.M. "In 1992, at the Fukushima Medical College on the island of Hokkaido in northern Japan, Professor of Medicine Yoshihiko Hoshino, M.D., Ph.D., learned that he had developed cancer of the colon. During the course of surgery to remove the malignancy, his oncological surgeon discovered that Dr Hoshino's cancer had already metastasised to his liver. While under postoperative care, the patient was advised by his personal friend and former classmate, the same surgical oncologist, to undergo multiple courses of chemotherapy.

As it happens, the Gerson Therapeutic Program for reversing acute and chronic degenerative diseases such as cancer, diabetes, stroke, arthritis, and other life-threatening illnesses is quite well known and highly respected in the industrialised countries of Europe and Asia. Professor Hoshino was among a growing number of health professionals aware of Dr Max Gerson's well-established book *A Cancer Therapy ; Results of Fifty Cases*, and the medical effectiveness of his treatment program.

Because of well recognized adverse side effects and an excessive rate of failure for colorectal cancer, 93% of patients die after receiving chemotherapy for such malignancy and an even worse prognosis for liver

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cancer metastases 97% of patients die after receiving chemotherapy, this professor of medicine refused to take cytotoxic agents. Instead, owning the broadly disseminated Japanese translation of Dr Gerson's book, Dr Hoshino followed its instructions and on his own proceeded to follow the Gerson Therapy.

Today, with a decent interval of almost nine years having elapsed since Dr Hoshino's diagnosis, he and his oncologist have pronounced the patient "cured" of both cancer and liver metastases. Here is the letter Charlotte Gerson recently received from Professor Hoshino.

As you know, I suffered from colon cancer and metastatic liver disease in 1992 and recovered from them by the use of the Gerson Therapy. I have written a book introducing the Gerson Therapy to medical consumers in Japan. My book was published in August 1998 and is the first about Gerson Therapy written by a medical doctor in Japan. It has caused a big sensation among Japanese people, because using the Gerson program twelve additional cancer patients also were cured. My book not only tells of my recovery, but also includes the stories of these twelve Japanese who no longer suffer from cancer."

Dr Gerson had succeeded in curing five patients of cancer by 1946, and members of the anticancer subcommittee of the Senate Committee on Foreign Relations of the United States Congress wanted to mount a testing program for his methods after hearing his testimony, and seeing the five patients whom he had cured.
Charlotte Gerson reports in her book that "massive numbers of lobbyists from the immensely wealthy Pharmaceutical Manufacturers' association, the American Medical Association, and the American Cancer Society" succeeded in preventing the information from becoming well known. The single journalist who pursued the matter at the time found himself without a job after his broadcast on the subject.

From "World without Cancer." Population studies directed at peoples who were living in a traditional manner with no incidence of cancer were carried out by Dr Ernst T. Krebs junior. He found a high level of Nitrilosides, from which he later extracted a substance which he named Laetrile, or Vitamin B17, in the diets of such people. He developed a hypothesis that the Laetrile disintegrated into Cyanide and Benzaldehyde when it came into contact with *beta-glucosidase,* an enzyme secreted only by cancer cells.

Research investigating this hypothesis was carried out by Dr Sugiura, of the Sloan Kettering Institute, over 5 years between 1972 and 1977, after which he concluded that Dr Krebs' hypothesis had been validated. Specifically, he found that Laetrile stopped the metastasis of cancer in mice, it improved their general health, it inhibited the growth of small tumours, it provided relief from pain, and acted to prevent cancer.

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The Sloan Kettering is privately owned by interests closely associated with the Rockefeller family and its business associates in the oil and pharmaceutical industries. Mr Griffin's book describes how this information was kept from the public in a process of deception which has had tragic consequences, which are still being felt up to the present day.

Dr Philip Binzel Junior, from 1974 to 1991 practised nutritional medicine and treated cancer patients with a regime which is quoted in full in the appended extract from his book. The cure rates he achieved far outstrip the contemporary cure rates for the many types of cancer which he treated.

"Your Life in Your Hands", by Professor Jane Plant, describes her personal struggle with breast cancer. She learned when six years into her disease, which had begun at 46 years of age, that growth hormones from beef, cows' milk and other dairy products, especially Insulin Like Growth Factor 1, were known to cause cancer in tissue cultures of breast and prostate origin. After strictly eliminating these components from her diet, a supraclavicular lymph node, which had been enlarged and was thought to presage widespread metastasis of her disease and death, spontaneously reverted to normal size. She had experienced no recurrence in nine years since this had occurred before writing her personal testimony. She advises women who have breast cancer or who want to avoid developing it, or men with prostatic cancer or who are keen to prevent it, to avoid foods which originate in milk or beef products.

"Living Proof", by John Cirrocco, describes the development of testicular cancer, which he treated by going to Mexico to undergo treatment with the Gerson Method, from his home in South Australia, which he sold in order to finance the venture. Only after learning and practising the Gerson method in Mexico at the Oasis of Hope Hospital in Tijuana, and for a few more weeks at home, did he undergo orchidectomy for the diseased testicle. The pulmonary metastasis which he had developed resolved with continued practice of the Gerson Therapy. A year after he commenced the Gerson Method, he and his wife conceived twins. They had been trying to have another child without success for six years prior to this.

"Living Proof", by Michael Gearin-Tosh, who is a Don who teaches drama at either Oxford or Cambridge University, describes his personal experiences and treatment after he developed multiple myeloma. He is treating his disease with a combination of the Gerson Method plus Chi Gong meditation, herbs picked fresh from the Scottish countryside, and additional vitamins and minerals. Nine years into his disease course, without bone marrow transplant, his para-protein levels were 24 grams. He had been warned that, without chemotherapy, his odds of surviving even two years were minimal.

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Dr Lorraine Day, an orthopaedic surgeon in San Francisco, developed breast cancer, which had invaded her chest wall by the time of diagnosis. She refused to accept chemotherapy or radiotherapy, and the only surgery she underwent was a de-bulking procedure to a painful portion of the tumour which was projecting from her chest wall. She became extremely sick and weak, having to be fed via enema infusions for a short period when apparently on the point of death. However, she recovered, and has made a series of videotapes about what she learned in the process, which she has encapsulated into ten healing steps: Diet, free of animal and dairy products, two quarts of pure water to drink every day, exercise, sunshine, temperance with avoidance of tea, coffee, alcohol and tobacco, fresh air, rest, with sleep being obtained for preference by 9.30pm every evening, Stress control, which she achieved through studying the Bible and, listening to inspiring music, and through prayer. She had been an agnostic for thirty years prior to her developing the breast cancer. Ninth was an Attitude of Gratitude, and the last of the ten steps was the Pursuit of goodness in our personal life, and in the manner in which we dealt with others.

"You can Conquer Cancer" by Dr Ian Gawler, in which he describes his illness with osteosarcoma and his recovery through diet, meditation, and positive visualisation.

"I went to my own wake", by Warren Gibbs, on page 88 of the Women's Day Magazine, March 23, 2003, describes the experience of Marilyn Blake, of Mount Beauty. She was extremely weak, with cancer affecting both breasts, and extensive metastases. Her oncologist had given up hope of saving her, and estimated that she had only five weeks to live. She consulted a naturopath, who recommended a nutritional program involving the use of apricot kernels, the richest source of Laetrile, Shark Cartilage Extract, and other ingredients used by Dr Hans Nieper at the Silbersee Hospital in Germany. Three years after undertaking this treatment, she appears to have made a full recovery. I understand through Mr Chris Collins, who is a friend of the Blakes and husband of Mrs Rosemary Collins, whose case is described later in this submission, that Marilyn's husband, Ron, found a farm where apricot seeds were being packed for export to Germany, to be used in the treatment of cancer.

"Fats that heal and Fats that Kill" by Udo Erasmus describes the work of Dr Johanna Budwig, who healed patients with advanced cancer through a diet rich in flaxseed oil, sixty millilitres daily, combined with skimmed milk cheese and organic vegetables. Flaxseed oil, or food grade linseed oil, is rich in Vitamin B17, or Laetrile.

The actress, Belinda Emmett, was given only months to live in an estimate by her oncologist three years ago. She sought alternate advice, and adopted a nutritional program including the use of Laetrile. Three years later, she is

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still battling her disease, but she is alive, against the expectations of her oncologist.

"How to fight Prostate Cancer and Win" by Ron Gellatley, N.D., describes his illness when aged 71 with Prostatic Cancer. He was found to have a PSA, or Prostate Specific Antigen, level of 120, where bony metastases are commonly associated with increases over 10. His book recounts his personal struggle with the disease, and how he succeeded in getting his PSA down to less than 1, with only minimal hormonal treatment being given in the first few months. He achieved a cure with meditation, diet, homeopathic remedies, Bovine Cartilage, and a long list of nutritional substances.

In "Beating the Age Barrier", published by the Margaret Gee Information group, author Russ Gleeson describes "The Diet of the Hunza Centenarians" in Chapter 6. He travelled to the Hunza Valley, in Northern Pakistan, and televised a documentary in which he interviewed three Hunza farmers who were all over one hundred years old. One was still running his farm with his 95 year old wife at 101 years of age All of these men had consumed large amounts of apricot kernels, which are the richest source of Laetrile, throughout their lives. Cancer was unknown in their society at the time the Documentary was made in the early nineteen eighties.

FEATURES IN COMMON DISPLAYED BY THE SURVIVOR LITERATURE.

Diet is the most important and prominent feature. Organic fresh fruit and vegetables, eaten as fresh and raw as possible. No pesticides, no added salt.

Pure water, free of Chlorine and fluoride.

Flaxseed, or food grade Linseed oil, at least 20 ml twice daily. This also contains Laetrile.

Supplementation with digestive enzymes, raw pineapple or both.

Vitamins and Minerals, especially Vitamin C, Zinc, Niacin or nicotinamide, Coenzyme Q10, Vitamin B12, Vitamin B17 or Laetrile, Liver extract. Vitamin E and Carotenoids, a range of nutrients, which belong to the Vitamin A category. Dr Gerson placed great stress on restoring low levels of Potassium commonly found in the cytoplasm of the cells of Cancer patients. He did this by using a Potassium mixture containing three salts of potassium, and by restricting the use of sodium chloride, and of foods rich in salt.

In patients with a low body temperature, Dr Gerson recommended the use of Lugol's Solution, which is a source of Iodine, and of Thyroid Extract
He titrated the dose of this against the patient's temperature.

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Detoxification Gerson program followers used coffee enemas every four hours when critically ill, which was generally during the first eighteen months after commencing treatment..

Transcendence of stress through meditation, positive visualisation, Chi Gong, prayer and bible study. Listening to inspiring music.

Open-mindedness.

Ecclecticism.

MY BACKGROUND.

I would ask the reader to refer to two papers I have written, one to Mr Peter Wills, Chairman of the National Health and Medical Research Strategic Review in 1998, and another entitled "The Scope of Ecological Medicine." These contain important information about how my understanding of the pathogenesis of chronic illness has been developed, and what we as a society can do about its prevention and treatment.

The only changes that have occurred since 1998 is that my service in Camberwell as a GP now spans 32 years, during which I have participated in excess of 250,000 consultations.

I have developed a particular interest in chronic diseases that are difficult to fix such as chronic fatigue syndrome, rheumatoid arthritis, endogenous depression, and cancer, all of which spring from problems caused by food, germ or chemical allergy or poisoning.

I explain my perception of the interaction of these factors under the CHAMPAGNE theory acronym, which is set out in my letter to Mr Wills.

Over the past three years, I have delivered two, two hour lecture at Avni Sali's Postgraduate School of Integrative Medicine on the relationship between Environmental Factors, chronic infection and Disease.

Dr Gerson's Theory of Totality has become an important concept informing my thinking about the pathogenesis of cancer. I quote from Appendix 1 to the 2000 Edition of *"A Cancer Therapy Results of Fifty Cases"*.
"In all textbooks, we find that single biological processes are studied and overestimated statements are made about them. The symptoms of the disease have become the main problem for research, clinical work, and therapy. Medical Science has eliminated the totality of the natural biological rules in the human body, mostly by dividing research and practice into many specialties.....It was forgotten that every part is still only a piece of the entire body.

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The specialisation of research and medical practice may be an outgrowth of the microbe theory of disease. It became fixed in the minds of researchers that there must be a specific cause for each disease. But, as Dr Gerson expresses it, cancer is not specific. It is a degenerative condition of the total metabolism, including damage to the liver and all essential organs, which then makes it possible for the cancer to develop. Similar damage also precedes other chronic diseases."

As a result, immune competence becomes depressed, and this permits the development of chronic disease of all types.

MY CASES.

Mr CV

This 37 year old gentleman presented with tiredness in 2001. Tests investigating this revealed a raised para-protein level on serum protein electrophoresis. I referred him to Prof Hatem Salem, who counselled an expectant attitude with no immediate intervention. But before the year's end, he had developed a pathological fracture, and he was diagnosed with multiple myeloma.

He underwent bone marrow transplant with follow up therapy by me consisting of the Gerson Method and the B17 administered according to Dr Binzel's protocol as outlined in his book "Alive and Well". I insert the chapter from his book entitled " The total Nutritional Program" He has continued to use the Gerson Diet, to chew apricot kernels, roughly twenty a day. As of December 2002, his para-protein level was 21 grams. As of April 2003, the para-protein level had fallen to 17 grams. In May 2003, Prof Salem wrote to say that he was very happy with his progress. His serum Thiocyanate level has been monitored by ARL Laboratories. The most recent level was 58 picomols per litre. The target level recommended by Dr Binzel in a telephone conversation with me is 200-250 picomols per litre.

Mrs RP

This lady was diagnosed with CIN3 carcinoma of the cervix in July 2002. She weighed 97.1 kilograms at the time and was told she must lose weight before her operation, which was to be a hysterectomy. She is a widow with an only son aged 17, and no relatives in Australia. I recommended that she use the Gerson Method, both to lose weight and to fight the cancer.

She was operated on, on 4/9/2002.

When she returned on 21/11/2002, she weighed 84.5 kilograms. On histopathological examination of her uterus and cervix, no residual cancer could be found.

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Mrs Maria K

Mrs K was diagnosed with pancreatic cancer in August 2002. At laparoscopy in September 2002 it was found that the tumour was inoperable. I understand that the family were told that she was unlikely to survive more than three months.

She first consulted me in November 2002. I commenced her on a combination of the Gerson Therapy and Vitamin B17 according to Dr Binzel's Protocol.

As of this month, she is in her twelfth month of survival post diagnosis, and has lost no more weight since January 2003. This is a significantly better result than could have been expected with orthodox therapy.

I enclose copies of correspondence from Box Hill Hospital.

Mr DW.

This 61 year old gentleman was diagnosed with primary cancers in the Lung and Larynx, in the same month of December, 2001.

He was treated with surgery to both lesions, with follow up radiotherapy and chemotherapy. When seen at the completion of his chemotherapy by his oncologist, three monthly review was recommended.

He first saw me in May 2002, when he sought advice about possible alternative medical care. I recommended the Gerson Therapy to him, which he agreed to undertake, with the exception that he refused to carry out any enemas. I also suggested the B17 therapy to him, which was carried out according to Dr Binzel's protocol as laid out in the Chapter from his "Alive and Well" book entitled "The Total Nutritional Therapy". He received intravenous injections and tablets over a period of six months.

He resumed drinking alcohol in moderation after the commencement of 2003. His findings on Lymphocyte Marker testing suggested declining immune competence when I saw him in early July 2003. I recommended that he consider a more strict diet, with less alcohol, and that he should consider the enemas recommended by Dr Gerson.

After reducing his alcohol intake, his Lymphocyte marker indices had improved on review a month later.

As yet, there has been no sign of recurrence of his cancers.

Mrs Rosemary C

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This lady was diagnosed with Lung Cancer in 2002. Spread had already occurred to her liver and bones at the time of diagnosis. She had undergone chemotherapy and had been treated with oral Laetrile and Vitamin C by another medical colleague when she first consulted me in January 2003, because of rib pain which she rightly suspected represented a bony metastasis. A bone scan at this time revealed wide spread bone metastases up and down her spine, and also in her ribs.

She continues to undergo chemotherapy, as well as B17 therapy and Vitamin C injections of Sodium Ascorbate through her PIC line. She is also receiving additional therapy through more than one naturopath.

Six months later, all recurrent disease had disappeared from her liver and lung, although her ALP remained elevated at 303. She has bony secondaries undergoing sclerosis in her cervical spine, and has recently undergone radiotherapy for lesions in her left shoulder. On 25/7/2003, she was found to have a malignant effusion in her left pleural cavity.

Mr H

This gentleman was diagnosed with Cancer of the Caecum with wide spread peritoneal and greater omentum seeding by metastases in February 2003. The letter written to his GP at the time of his discharge in early March 2003 stated that there were secondary lesions palpable in his liver as well. He was first seen in April 2003, when his ALT level was elevated at 159 compared to a normal range of 0 to 50, and his AST was 59 compared to a normal range of 13-33

He was offered palliative chemotherapy, with no prospect of cure of his advanced disease. After 9 weeks therapy with Laetrile as set out by Dr Binzel, and intravenous Sodium Ascorbate and 5 mgm of Zinc Chloride, now twice a week, he looks somewhat better, although he is distressed by recurrent episodes of abdominal pain. He also has an MRSA infection in his operation scar, which has not as yet required any more than local dressings.

One encouraging finding is that his liver function tests have returned to normal, with his ALT now 28 and his AST 25 as of early July 2003. All other LFTs were normal.

Mr RL

This gentleman developed a raised PSA in 1993. He was referred to a urologist, who counselled expectant treatment only in view of his age. At that time, he was 70 years old. When his PSA rose further in 1997, he was referred to the Peter MacCallum Hospital, where he was enrolled in a Clinical Trial with about 700 other patients with the same disease, in which they

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were all treated with radiotherapy to the prostate, and six months of Zoladex injections. Having learnt of Ron Gellatley's success in treating his prostate cancer, I suggested that he adopt a number of Ron's recommendations about diet and nutritional substances. In the middle of 2002, about five years into the trial, he was questioned by one of the research workers at Peter MacCallum Hospital. At that time his PSA was still only 1.4, and a significant number of the other participants in the Clinical Trial; had died, or had much higher PSA levels. In fact, he was told, his progress placed him in the top six of the seven hundred participants in the trial. He was asked if he had done anything in particular, to have achieved this extraordinarily good outcome.

When he informed the researcher that he had indeed been following a coherent program involving diet and nutritional substances, the researcher indicated that he was not interested in such strategies. At no time has he, or any of the other participants in the clinical trial, been given advice about diet by Hospital Staff at the Peter MacCallum.

Mr HH

This gentleman developed prostate cancer at age 54, in 1999. He was offered a radical prostatectomy after the diagnosis was confirmed by multiple punch biopsies, but he declined, preferring to try and work out his own salvation by alternative strategies. His PSA subsequent to diagnosis rose to a maximum of 11.5. He had succeeded in getting his PSA down to 5.5 at the time he consulted me in 2002. He was using a number of nutritional substances. After adding Linseed or Flaxseed oil to his diet, and after he started using coffee enemas as recommended by Dr Gerson, his PSA fell to 3.4, where it remained for months. It is currently 3.5.

CONCLUSION

Before I became interested in the therapeutic possibilities of Laetrile, I had already developed an interest in cyanide poisoning as a possible cause of chronic fatigue. The most common caused of cyanide poisoning are automobile fuel pollution and cigarette smoking. I had learnt that the most common metabolite of Cyanide in the body is Thiocyanate, the chemical formula of which is CNS, as distinct from that of cyanide, which is CN. In other words, the molecule is metabolised by having a Sulphur atom, usually from a sulph-hydryl group, or SH, added to it. I have diagnosed cyanide poisoning in a patient who lived in a depressed piece of terrain below Riversdale Road on the out of town side of the railway crossing in Camberwell. She was tired and unwell and was suffering from the results of automotive fume pollution. She had a very high level of Thiocyanate, the principal metabolite of Cyanide, in her urine. Another patient living on the corner of Toorak and Lansell Roads in Toorak also had raised levels of thiocyanate in his urine, and was tired and depressed. I have not

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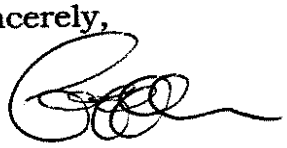
encountered this problem as a side effect in my cancer patients who are undergoing Laetrile therapy. I am not complacent, and continue to monitor all of my patients with periodic thiocyanate assays in their serum.

In view of the promising results outlined above, I formally request that I, and other doctors who have made an appropriate study of the subject, be allowed to continue to give my patients the freedom of choice of treatment by continuing the trial use of Laetrile in those patients who make a free, informed choice to undergo such a trial, which, for many of them, represents a last hope, as it did for Marilyn Blake and Belinda Emmett, both of whom appear to have derived life saving benefit from its use.

Yours sincerely,

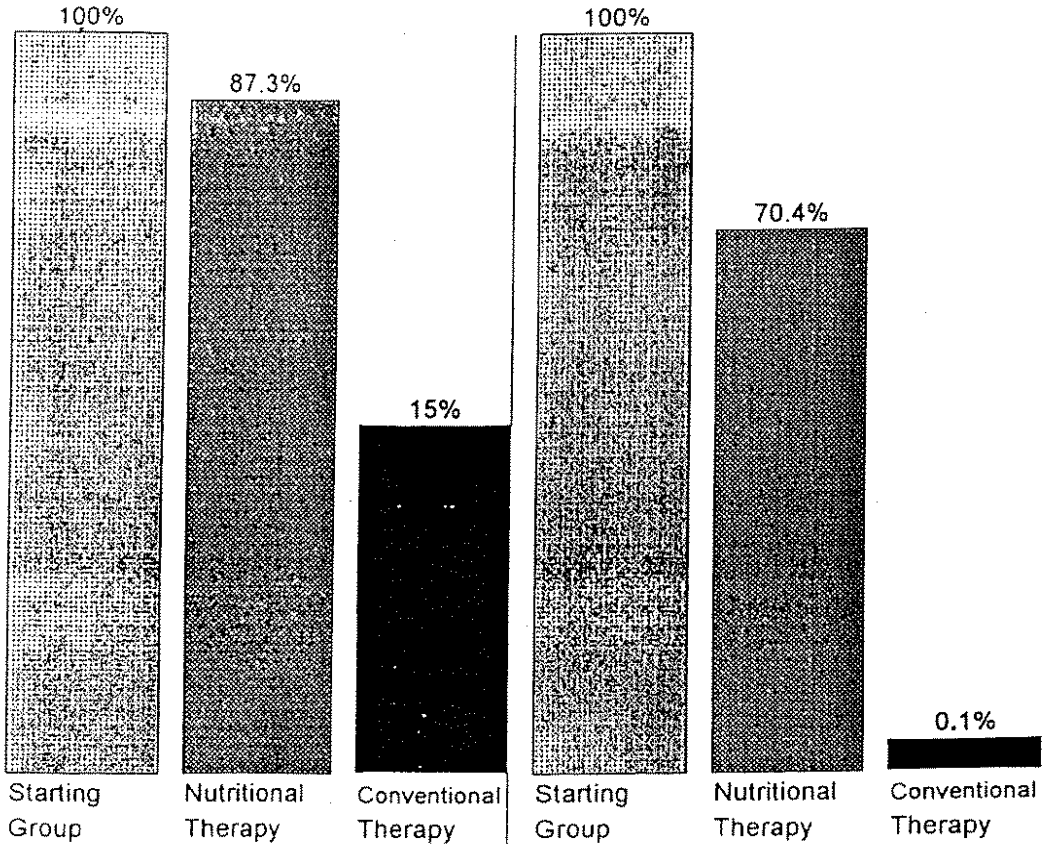


Dr. Geoffrey Kemp

Copies The Honourable John Thwaites
Deputy Premier
Care of Lucy O'Brien
357 Clarendon Street,
South Melbourne 3205

Dr David Kemp
Federal Environment Minister
Level 3, 4 Treasury Place,
East Melbourne 3002.

SURVIVAL RATES. Patient Survival (5 years or more) 1974 - 1991



Source: "Alive & Well" by Dr. Phillip Binzel.

The Total Nutritional Program

Chapter Eleven

In Chapter Two, I discussed the work done by Drs. Krebs, Burk, Nieper, Contreras, Navarro and Sakai. Their work showed that there are numerous nutritional deficiencies which may exist within the cancer patient. The most important thing they stressed was that, unless you correct *all* of these deficiencies, you are not going to help that patient. Thus, they were talking about a *total nutritional program.* It is that *total nutritional program* which I want to discuss in this chapter.

There is an old saying in the medical profession which goes something like this: "The doctor who treats himself has a fool for a doctor and an idiot for a patient." Or, as we would say in medical school of anyone who did something dumb, "He has bilateral stupidity with metastases."

I am going to outline, *in generalities*, the treatment that I use. For any individual reading this book who decides to treat *himself* with what follows, I say, "Please read the paragraph above again, and again and again!" If you think it is bad for a doctor to treat himself, how much worse is it for someone who knows little or nothing about medicine to try to treat himself? God did not make any two of us

exactly alike, thus the exact treatment must be fitted to the needs of each patient.

The whole objective of this nutritional program is to do two things:

1. To put into the body the nutritional ingredients that the body needs in order to allow its immunological defense mechanisms to function normally, and
2. To take away from the body those thing that are detrimental to the normal function of its immunological defense mechanisms.

There are three parts to this program:

1. Vitamins and enzymes
2. Nitrilosides
3. Diet

VITAMINS AND ENZYMES

1. Multiple vitamin – 1 twice daily
2. Vitamin C 1 gram – 1 twice daily
3. Vitamin E 400 units – 1 twice daily
4. Megazyme Forte (a combination of trypsin, chymotrypsin, bromalin and zinc) – 2 three times daily
5. Pangamic acid (B15) 100 mg. – 1 three times daily
6. Pro-A-Mulsion (25,000 I.U. Vitamin A per drop) – 5 drops daily.

Since vitamins are food, they should be taken with meals or immediately thereafter. It is never a good idea to take any vitamin on an empty stomach.

NITRILOSIDES

In order to supply the necessary nitrilosides I use Amygdalin (Laetrile). Laetrile is available in 500 mg. tablets and in vials (10cc-3 gms.) for intravenous use. I use both forms. The dosage that I use is as follows:

The intravenous Laetrile is given three times weekly for three weeks with at least one day between injections

(Mon., Wed., Fri.). The Laetrile is not diluted and is given by straight I.V. push over a period of one to two minutes depending on the amount given.

The dosage for the intravenous Laetrile is:

1st dose 1 vial (10cc-3 gms.)
2nd dose 2 vials (20cc-6 gms.)
3rd dose 2 vials (20cc-6 gms.)
4th through the 9th doses 3 vials (30cc-9 gms.)

Following this first three weeks of I.V. injections, the patient then has one injection of 1 vial (10cc-3 gms.) once weekly for three months. If the patient notices a considerable difference in the way he feels when the injections are reduced to once weekly, the injections are increased to two or three times a week for three weeks. The dose is then reduced again to once weekly. This is repeated as often as necessary until the patient notices no difference with the reduced dosage.

The oral Laetrile is given in a dosage of 1 gram (two 500 mg. tablets) daily on the days on which the patients do not receive the intravenous Laetrile. I have them take both tablets at the same time at bedtime on an empty stomach with water. The water is important because there are some enzymes in the fruits and vegetables and in their juices which will destroy part of the potency of the Laetrile tablets while they are in the stomach. Once the stomach has emptied, this is no problem.

It should be noted that I do not start my patients on their Laetrile, either I.V. or orally, until the patients have been on their vitamins, enzymes and diet for a period of ten days to two weeks. I find that the Laetrile seems to have little or no effect until a sufficient quantity of other vitamins and minerals are in the body. Zinc, for example, is the transportation mechanism for the Laetrile. In the absence of sufficient quantities of zinc, the Laetrile does

not get into the tissues. The body will not rebuild any tissue without sufficient quantities of Vitamin C, etc.

When I start the intravenous and oral dosages of Laetrile, I also begin to increase the amount of Vitamin C. I have my patients increase their Vitamin C by one gram every third day until they reach a level of at least six grams. In some patients I use more. I find that there are some patients who develop irritation of the stomach or diarrhea with the larger doses of Vitamin C. I find by increasing this by one gram every third day that, if these symptoms develop, I can reduce the Vitamin C to a level that causes no problem. I find that most of my patients tolerate the higher doses of Vitamin C very well.

On the days that my patients receive intravenous Laetrile I ask them not to take their Vitamin A. There have been some studies indicating that Vitamin A may interfere with the body's ability to metabolize intravenous Laetrile. This has not been fully proved, but I choose to have my patients not take their Vitamin A drops on the days on which they receive their intravenous Laetrile. Also, I tell my patients not to take the Laetrile tablets on the days that they receive their intravenous Laetrile. They have received intravenously as much Laetrile as the body can handle for that period of time. There are no ill effects from taking the tablets on those days, but the effect of the tablets is wasted.

The level of nitrilosides in the body can be monitored. When the body metabolizes nitrilosides, the by-product is thiocyanate. Thiocyanate levels in the blood can be measured. I find, in general, that the patients who do best are those in whom the thiocyanate level is between 1.2 and 2.5 Mg/DL. This level can be raised or lowered by increasing or decreasing the dosage of the Laetrile tablets.

THE TOTAL NUTRITIONAL PROGRAM

I do not want to leave the impression that Laetrile is the only source of nitrilosides. As stated in Chapter Two, there are some 1500 foods that contain nitrilosides. These include apricot kernels, peach kernels, grape seeds, blackberries, blueberries, strawberries, bean sprouts, lima beans, and macadamia nuts. The advantage of using Laetrile in the cancer patient is that Laetrile is a concentrated form of nitrilosides. It can raise the nitriloside level in the body (and, thus, re-establish the body's second line of defense against cancer) much more rapidly than can be done by diet alone.

DIET

The diet that I use on my patients can be summarized as follows: "If it is animal or if it comes from animal, you can not have it. (As one patient said, "If it moves, I can't eat it.") If it is not animal or does not come from animal, you can have it, but you can not cook it." I take away from my patients all meat, all poultry, all fish, all eggs, cheese, cottage cheese and milk.

The reason for such a diet goes back to Chapter Two. Remember, I said that Dr. Krebs *et al.* had found that the cancer cell had a protein lining (or covering), and that if the body dissolves that protein lining, it would kill the cancer cell. The dissolving of that protein lining, they said, is done by the enzymes trypsin and chymotrypsin, which are secreted by the pancreas. It is important to understand that it takes large quantities of trypsin and chymotrypsin to digest animal protein. Thus, the cancer patient who is eating animal protein may be using up all, or almost all, of his trypsin and chymotrypsin for digestive purposes. This leaves none of these enzymes available to the rest of the body.

The patient would be on this diet for a minimum of four months. In that period of time, I was attempting to free the trypsin and the chymotrypsin from being used up for digestive purposes and to put these enzymes back into the body in order to restore the body's first line of defense against cancer.

The reason for the fresh fruits and fresh vegetables is, again, because of enzymes. There are some enzymes in fresh fruits and vegetables which are tremendously important in good nutrition. Any temperature over 130 degrees will destroy the enzymes in the fruits and vegetables. For this reason, the fruits and vegetables may not be cooked, canned or bottled. Frozen foods from the grocery store are also prohibited because most of these frozen foods have been processed in some manner. They have either been blanched, pasteurized or sterilized so that the enzymes have been destroyed. Those who do their own home freezing are permitted to do so as long as they do not blanch the foods before they are frozen.

This means a diet that is high in salads. Salad dressings are permitted as long as the salad dressings do not contain anything which the patient may not have. Salad dressings which contain egg or sugar are not permitted. I find that many of my patients soon begin to make their own salad dressings. This is fine as long as they start with a pure vegetable oil and use no refined sugar. I do not attempt to severely limit the salt intake of my patients unless they have a medical problem which requires it. I tell them that salt may be used in moderation, but any salt that is used should be sea salt. The mineral content of sea salt is far superior to mineral content of the salt we normally use. Iodized sea salt is fine, if they need it. I encourage them to use a variety of other herbs and spices in order to vary the

salad dressings so they are not eating the same thing over and over again.

The patients are not permitted anything which contains white flour or white sugar. Whole wheat flour can be used instead of white flour. In the place of sugar they can use either honey or molasses. Foods containing preservatives are kept to an absolute minimum.

The patients are encouraged to have as wide a variety of vegetables as possible. I realize that all vegetables are somewhat similar, but each vegetable, in its own way, supplies something nutrition-wise that no other vegetable has. My patients are encouraged to have, within any two-week period of time, at least some of every vegetable available at that season.

My patients are encouraged to have as wide a variety of fruits as possible, except for the citrus fruits. Oranges, lemons, grapefruit and tomatoes (Yes, tomatoes are a citrus fruit.) are not to be more than ten percent of their fruit intake. Other fruits such as apples, peaches, and pears contain far more nutrition than do the citrus fruits. My patients are also told that, except for the citrus fruits, they should eat the seeds of their fruits. Apple seeds, grape seeds, apricot kernels, peach kernels, etc. have a high nitriloside content.

With the combined fruits and vegetables, I like for my patients to have about sixty percent vegetables and about forty percent fruits. I do not require that they weigh and measure their fruits and vegetables, but ask only that they keep the vegetable intake a little higher than the fruit intake.

Protein in the diet is, of course, very necessary. However, rather than using animal protein, I use vegetable protein. Vegetable protein requires nothing in the way of the enzymes trypsin and chymotrypsin for digestion. The

things that they use for their protein content can be cooked. You do not alter or harm a vegetable protein by cooking it. The things I recommended for protein are as follows:

Whole Grains

It is important that the patients read the ingredients on the labels of everything they buy. Everything labeled "Whole Wheat Bread" is not necessarily whole grain. Many of these breads contain only a small amount of whole grain and contain a large amount of white flour, white sugar and preservatives.

Whole grain cereals are permissible as long as they do not contain sugar. Most of these do contain some preservatives, but the amount is usually quite small. I do allow my patients to use some low fat milk or skim milk on their cereal. Whole wheat macaroni, noodles, spaghetti, etc. are also readily available and are good sources of protein.

Corn

This is an excellent source of protein. My patients are permitted to have corn-on-the-cob (which may be cooked), pop corn and corn meal in any form. Corn meal mush, grits and cornbread are permitted. It is necessary, in order to make cornbread, to use some egg and some milk. This is not a problem because the amounts of the egg and milk are quite small.

Buckwheat

This is high in protein. Buckwheat pancakes and pure maple syrup are excellent. Again, in order to make the buckwheat pancakes, you must use a little egg and milk. This is not a sufficient amount to cause a problem.

Butter

Butter in small amounts is permitted. Any butter that is used should be real butter rather than any margarine.

Vegetable oil hardened into a solid is detrimental to good nutrition.

Nuts

These are an excellent source of protein. This includes all nuts except the peanut. Roasted peanuts are not permitted because of an acid that is formed in the roasting. This is not true of any other nuts. Raw peanuts are permitted, but not roasted peanuts.

Dried Fruits

Dried fruits, such as dates, raisins, and figs, are excellent nutrition and provide protein.

Beans

Some vegetables, such as those in the bean family and in the *brown* rice family, cannot be eaten raw. Soup beans, lentils, split-pea, navy beans and kidney beans, are an excellent source of protein and should be an important part of this diet. Of course, they have to be cooked. Again, I repeat that anything used for its protein content may be cooked. Meals like bean soup and cornbread provide a complete protein, as would a meal of beans and brown rice.

Let me emphasize, again, the necessity of eating raw fruits and raw vegetables. Everything that can be eaten raw should be eaten raw. So many of the things we cook can be eaten raw. For example, broccoli, spinach, turnips, potatoes, and green beans can all be eaten raw.

Beverages

No milk, other than that used on cereal and in cooking, is permitted. No caffeine is permitted. This means no coffee, no Sanka, no Decaf, etc. Natural coffee substitutes are permitted along with any of the herb teas.

I keep my patients on this type of program for at least four months. It is my opinion, in twenty years of work in this field, that it takes that long to get this defense mechanism to function normally. If, at the end of the first four months, the patient is not doing as well as I would like, I continue the strict diet for as long as necessary. At the end of four months, if the patient is doing well, I then liberalize the diet. I will then allow the patient to add chicken, turkey and fish to his diet. Ninety percent of the diet at that time consists of the original strict diet plus the chicken, turkey and fish. The other ten percent of the diet may include red meats, cooked vegetables and dairy products. I caution my patients that, within any two-weeks period of time, the red meats, cooked vegetables and dairy products should never exceed more than ten percent of their total diet.

The patients are told that they also *must* stay on their vitamins, enzymes and Laetrile until the age of 130. They are instructed to call me on their 130th birthday (although I am not sure what my area code will be at that time), and we will discuss the possibility of reducing the dosage of some of these. This is simply my way of emphasizing to the patient the fact that you don't *cure* cancer. You can *control* it as long as the defense mechanisms continue to function normally. If a patient goes back to his old eating habits, he will soon be back in trouble again.

Boring Statistics and Exciting Cases

Chapter Twelve

Nothing that has been said so far in this book would be of any significance if there were not some statistics to show that the nutritional approach to the treatment of cancer offers the cancer patient a greater quality and quantity of life than does so-called "orthodox" treatment.

A speaker I recently heard said, "I am not going to bore you with statistics, I am going to do it another way." Well, I am going to bore you with a few statistics, because I feel that they are necessary to prove a point.

Let me repeat something that I said in Chapter Two. Cancer can be divided into two groups. The first group is known as *primary* cancer. This is cancer that is confined to a single area with perhaps a few adjacent lymph nodes involved. The second group is known as *metastatic* cancer. This is *primary* cancer which has spread into other distant areas of the body.

I consider *metastatic* cancer to be almost a different disease than *primary* cancer. I compare the two as I would a flood. The river rises, but the levee protects the low-lying town. Some small low areas may be damaged, but the town, as a whole, survives nicely. Those small areas can be

repaired. Suppose, however, that the levee begins to break. Water begins to come into the town. This not only causes more damage, but it also puts more strain on the rest of the levee. This may cause the entire levee to crumble, and now the whole town is destroyed. Thus, while the primary cause of both of the above situations was the flood, whether or not the levee held created two entirely different situations.

Primary cancer is similar to what happens when the levee holds. The damage is small and is restricted to a small area. With proper care, the body can repair it. *Metastatic* cancer is similar to what happens when the levee develops a major leak or breaks entirely. The cancer spreads into distant areas of the body. The damage to the body is infinitely greater, more serious and more difficult to repair. Success or failure in the treatment of *metastatic* cancer depends entirely on how big is the leak, how long it takes to repair, and whether the rest of the levee is strong enough to hold until the leak can be repaired. Thus, while both *primary* and *metastatic* cancer result from the same disease known as "cancer," whether it (the levee) can hold that disease in a small area or whether that defense mechanism (the levee) breaks down and allows the disease to spread widely can create two entirely different situations.

It is for this reason that I separate *primary* cancer and *metastatic* cancer into two different groups.

Statistics are meaningless unless you know how those statistics were derived. In my studies, I went back through my records from 1974 through the end of 1991. All of the patients that I included were diagnosed by physicians other than me and their diagnoses were confirmed by pathology reports. I then compared my results to those of the American Cancer Society. In this section, I want to give

the results of my study of patients who had *primary* cancer. I want to stress that in this section I looked at only those patients whose original diagnosis was *primary* cancer, with no metasteses at the time. The results of the patients whose original diagnoses showed metastic disease will be discussed later.

PRIMARY CANCER:

Patients excluded from this study:

It has been my opinion for some years that it may take as long as six months of nutritional therapy for the defense mechanisms of the body to begin to respond. Thus, I excluded from my study all patients with *primary* cancer who died within the first six months of treatment. These were patients whose defense mechanisms had been badly damaged or completely destroyed by their disease, the treatment they had received or a combination of both. Almost all of those in this group who were excluded were patients who had rapidly growing tumors in spite of (or perhaps because of) all of the radiation and/or chemotherapy they had received. They had been told by their radiologist and/or oncologist that their treatments had failed and there was nothing more that could be done. Usually the white blood cells and the body's ability to manufacture white blood cells had been destroyed. The white blood cells are the body's first line of defense against infection and, as mentioned in Chapter Two, are ultimately responsible for destroying cancer cells. Some of the patients had developed severe heart damage, kidney damage, etc. from their treatment. There were, at most, five patients who had a sudden, complete breakdown of their defense mechanisms and within a matter of a few weeks developed large, inoperable tumors. In these cases, no form of treatment was going to be of any value to these

patients. Too much damage had already been done to the body. It was possible in some of these patients to improve the quality of their lives, but not the quantity.

Patients included in this study:

I have included in this study of *primary* cancer patients only those patients with whom I have a follow-up of at least two years and who were alive at that time. There were a number of patients left out of this study who were doing well when I last had contact with them, but that contact was for less than two years. I have also included in this study those patients who lived at least six months, but subsequently died.

There are 180 such patients in this study. Thirty different types of cancer are represented. While none of these are the ordinary skin cancers, 10 of them are the deadly malignant melanoma type of skin cancer. From 1974 through 1991, a total of 42 patients have died. Twenty-three of those patients (12.7%) died from causes related to their cancer.

Three of the patients developed metastases while on the program and died. One of them lived 2 years and died at the age of 73. One of them lived 4 years and died at the age of 76. The third one lived 9 years and died at the age of 56. Five other patients developed metastatic disease while on the program but are still alive.

Thirty-nine of the patients on the program did not develop metastases but did die. As mentioned above, 23 died from cancer. Twelve died from causes unrelated to their cancer. Some died from heart attacks and strokes. One died from choking on food; one from a ruptured appendix; and one died in the MGM hotel fire in Las Vegas. Seven died of "cause unknown." These I put in because I had been in contact with these people less than

two months prior to their deaths. They were doing well at that time. I was unable to find out the exact cause of their deaths, but it is difficult for me to believe that these people died a cancer death in that short a period of time.

Results:

What all of this means is that out of 180 patients, over a period of 18 years, 87.3% *did not die* from their disease. Even if I concede that the 7 patients who died of "cause unknown" did, indeed, die from cancer, I am still looking at 16.7% of patients who died from their cancer and 83.3% who did not. One hundred and thirty-eight of these patients are still alive. Fifty-eight of these patients (42%) have a follow-up of between two years and four years. Eighty of these patients (58%) have a follow-up of between five and eighteen years. It is important to realize that this is ongoing. By the end of 1992, some new patients would come into the two-year category, and those in the four-year category would move into the five-year category.

I now ask you to compare my results with the statistics of the American Cancer Society for *primary* cancer. The American Cancer Society tells us that in *primary* cancer, with early diagnosis and early treatment with surgery, and/or radiation and/or chemotherapy, eighty-five percent (85%) of the patients *will die* from their disease within five years.

'Nuff said.

METASTATIC CANCER:

Yes, you are going to get more statistics. All of the patients in the study that follows had metastatic cancer when I first saw them. It was not I who made the diagnosis of *metastatic* cancer. These diagnoses were made by other physicians and confirmed by pathology reports.

Patients excluded from this study:

As I stated previously, it is my opinion that it takes as long as six months for the defense mechanisms of the body to respond to nutritional therapy in *primary* cancer patients. In *metastatic* cancer it may take may take as long as one year. Thus, I have excluded from my study all *metastatic* cancer patients who died within the first year of treatment.[1] The reason for this is the same as stated previously. Most of these patients had developed wide-spread metastases while on radiation and/or chemotherapy and had been told that nothing else could be done. The low white blood cell count and the inability to manufacture white blood cells was there. The heart damage, kidney damage, etc. was there. The total damage to the entire body was greater than in *primary* cancer, and the time needed to repair that damage was longer. Again, it was possible through nutritional therapy to increase the *quality* of life of some of these patients, but not the *quantity*.

Patients included in this study:

I have included in this study of *metastatic* cancer only those patients with whom I have a follow-up of at least two years and who were alive at that time. Again, there were a number of patients left out of this study who were doing well when I last contacted them, but that last contact was for less than two years. I have included in this study all patients who lived at least one year but subsequently died.

There were 108 patients in the study representing 23 different types of cancer. No ordinary skin cancers were included, but 4 of the patients had malignant melanoma with metastases.

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1. This is customary protocol. Cancer statistics based on orthodox therapies also eliminate those with incompleted therapy.

Results:

From the period 1974 through 1991 thirty-two of those patients (29.6%) died from their disease. Seven patients developed further metastases while on the program. Three of those seven died from their disease, 3 are still alive and 1 died of a cause unrelated to his disease. A total of 47 patients died. As stated above, 32 died from cancer. Six died of causes unrelated to their disease, and 9 died of cause unknown. Again, "cause unknown" is for the same reason that I used for my *primary* cancer study.

This means that out of 108 patients with *metastatic* cancer, over a period of 18 years, 76 of those patients (70.4%) did not die of their disease. Again, even if I concede that the 9 patients who died of "cause unknown" did, indeed, die from their cancer, I am looking at 37.9% who died from their disease and 62.1% who did not. Sixty-one of those patients are still alive. Thirty of those patients (49%) had a follow-up of between two and four years. Thirty-one of them (51%) had a follow-up of between five and eighteen years. Again, you must realize that this is an ongoing figure, just as I stated for my *primary* cancer patients.

The American Cancer Society tells us that in *metastatic* cancer, with early diagnosis and early treatment with surgery, and/or radiation and/or chemotherapy, only 0.1% (one out of one thousand) of those patients will survive 5 years.

If you consider only those patients who have survived five years or more, this means that my results were 287% better than those reported by the American Cancer Society for the treatment of *metastatic* cancer by "orthodox" methods alone.

CASE HISTORIES

Following are some case histories from my files. The full name is given where permission has been obtained; otherwise, the patient's initials are used.

Case No. 1: Polly Todd

This 59-year-old woman was seen by me for the first time on 1/10/75 with the history that she had her left breast removed one month previously because of carcinoma. Three positive nodes had been found. I will let the patient tell you the rest of her history in her own words:

"It was recommended by a prominent physician that I be a part of an experiment in a (then) new chemotherapy program. For a second opinion I went to another city where I had a personal contact with the head of a large hospital. There they told me that my odds of survival were slim, and that I should be treated with strong doses of chemotherapy and radiation. At this point, a friend told me about the Laetrile-nutritional program, which I chose."

The lady was placed on a nutritional program at that time and she has remained on it ever since. She is now 79 years old, in good health, and she has had no recurrence of her disease.

In a recent letter the patient said, "None of the above people on the chemotherapy program lived beyond 1 ½ years. Friends who scoffed at our choice then have much more respect now because others choosing the conventional treatment are gone, while I survive!"

Case No. 2: Sue Tarbutton

This 50 year-old woman was seen by me for the first time on 10/26/83 with a history that one week before she had a lump removed from her right breast which was found to be malignant. She did not want to have a mastectomy and wanted to go on a nutritional program.

She has now been on the program for ten years, has had no recurrence of her disease and is quite well.

Case No. 3: Elizabeth Winschel

This 51-year-old woman was first seen by me on 10/11/76. Four months before she had been found to have carcinoma of the colon with malignant cells in the abdominal fluid. She had four chemotherapy treatments but discontinued them because they made her so ill. She was started on a nutritional program. Now, seventeen years later, she continues to do well with no recurrence at the primary site of her disease and no metastases.

Case No. 4: Wasley Krogdahl

This 60-year-old man was first seen by me on 4/20/79. In November, 1977, he had been diagnosed with having carcinoma of the urinary bladder. The tumor was removed. In February, 1979, three more tumors were removed. He was started on a nutritional program. In April, 1981, and again in November, 1982, some small tumors were removed from his bladder.

He and his wife came to visit me just recently. He is now 75 years old. He has had no further recurrence of his disease. He looks well, says he is feeling well and his wife says, "He is just as hard-headed as ever."

Case No. 5: Beverly Batson

This 70-year-old woman was seen by me for the first time on 9/19/88. She had one-half of her stomach removed one month prior because of carcinoma. She received no radiation or chemotherapy. She has been on her nutritional program for five years. Now at the age of 75, she remains well with no recurrence at the primary site or with any metastases.

Case No. 6: Jean Henshall

This 48-year-old woman, that I saw for the first time on 9/8/87, had a history of being diagnosed ten months previously with malignant myeloma (a cancer which affects the bone). Her disease affected the bones in the pelvic area. She had received some radiation to that area which relieved the pain. She was started on a nutritional program which pretty much followed the protocol outlined in Chapter Eleven. However, after she had been off of her Laetrile injections for a few months, she was aware that she did not feel as well as she did while on them. She went back on some injections for a few months, and she felt much better. The injections were again stopped, and she remained on the Laetrile pills. This time she noticed no difference. She has now been on the program for six years and is doing well. "I'm doing everything. Even housework is a joy to me because I *can* do it."

Case No. 7: R.H.

This 43-year-old woman was seen by me for the first time on 10/26/79. Two months prior she had been found to have carcinoma of the ovary with metastases throughout the abdomen. She was, at that time, on chemotherapy. We discussed nutritional therapy—what it would do and what it would not do. I saw her next on 11/13/79. She had two chemotherapy treatments by this time, but she had decided to discontinue them and go on a nutritional program.

She stayed on the program until 1982, decided that she was "cured" at that time and went off of the program completely. I saw her on 6/19/84. At this time, she had a tumor running from her right pelvis up into the right upper quadrant of her abdomen. She went back on her nutritional program. I saw her again on 8/1/84. She was feeling very well. The edges of the tumor were much softer and much

more difficult to define. When I saw her on 9/2/84, the edges of the tumor were even softer than before.

I did not see her again until 8/20/85. She had been off of her program for 7 or 8 months. Why? It's a long story, and because of "privileged information" I am not free to discuss it. The tumor had enlarged and was now causing abdominal pain and some swelling in the right leg. I put her back on her program, which included some Laetrile injections, and recommended that she have the tumor surgically removed. On 10/1/85, the patient called me to say that she had undergone surgery. She said that the surgeon had found 5 well walled-off tumors that were easily removed. The pathology report, she said, showed mostly "dead" cancer cells.

In 1988 the patient went off her nutritional program. In 1991 she developed a bowel obstruction from her cancer and now has a colostomy. She did go back on her program again and has remained on it. In the three years that have passed since that time, there has been no recurrence of her disease.

Case No. 8: Joan Dewiel

This 45-year-old woman first was seen by me on 1/28/80 with a history of having been found to have carcinoma of the colon in September, 1979. Surgery was done, there were no metastases, and she received no radiation or chemotherapy. She was placed on a nutritional program. That was 14 years ago. She is now 59 years old and has had no recurrence of her disease.

Case No. 9: Rex Perry

This 42-year-old man that I first saw on 6/27/79 with a history of having malignant lymphoma, which was originally diagnosed in August, 1978. He had 8 months of chemotherapy, which he tolerated very well. His doctors

felt, however, that there was a significant amount of disease still present. They wanted to do several more months of chemotherapy and follow this with total body radiation. The patient did not want to do this because of his concern about what it would do to his immune system. He chose, instead, to use the nutritional approach.

It has now been almost 15 years since he started his nutritional therapy. The most satisfying part of such a case history is that this patient has had no further problem with his disease. He is well and very active.

Case No. 10: Pauline Wilcox

This 58-year-old woman was seen by me for the first time on 6/14/85 with a history of having had her left breast removed because of carcinoma in 1983. She received no radiation or chemotherapy.

She was placed on a nutritional program at that time. Since she had already gone for two years without any problem, I used only the Laetrile tablets as that part of her nutritional program. She did well on that program until 1988, when she went off of her diet and was taking her vitamins, enzymes and Laetrile only now and then. In November, 1988, she developed a small lesion on her chest wall. This was removed and found to be a spread of her cancer. She went back on her nutritional program again, except this time I added a series of intravenous Laetrile injections. Since then she has had two other small lesions removed from her chest wall which contained some cancer cells. Most importantly, chest x-rays and bone scans done on both occasions were normal. She remains in good health today. As this patient said to me recently, "My doctor is amazed."

Case No. 11: Connie Stork

This 24-year-old woman first was seen by me on 2/26/75. Her history was that in 1970 she had been found to have a malignant tumor of the brain. The tumor was partially removed. This was followed by 25 radiation treatments. In October, 1974, another large mass of tumor was removed, but much of the tumor remained. She was told that she had all of the radiation she could have. She was started on a nutritional program.

Now, some 19 years later, Connie has had no recurrence of her tumor. She did have greatly impaired vision as the result of her tumors in 1970 and 1974, and this has progressed to blindness. However, she is still very much alive and is blessed with a healthy mind and healthy body.

Case No. 12: Irene Dirks

This 59-year-old woman was seen for the first time on 8/19/80. Her history was that six weeks before I saw her she had been found to have a very low hemoglobin (anemia). She was given blood. Her workup showed that she had a gastric ulcer, but it was questionable whether she had any bleeding from that ulcer. I discussed with her at that time a nutritional program that included some changes in her diet, some vitamins and a small amount of Laetrile by mouth. These changes were obviously not sufficient, because in March, 1981, she began having occasional vaginal bleeding. Two months later this bleeding was found to come from endometrial carcinoma (cancer of the lining of the uterus). A hysterectomy was done, and she was put on the full nutritional program. Now, some 14 years later, she has had no recurrence of her disease and at the age of 73 is quite well and very active.

Case No. 13: Doris Dickson

This 50-year-old woman was first seen on 5/14/85 with a history of having had a node removed from the left side of her neck in 1979. From this a diagnosis of lymphatic leukemia was made. She had one chemotherapy treatment, but this made her so ill she discontinued it. She went on a nutritional program of her own, which she stayed on until six months prior to the time I first saw her. She stated that for the past two or three months she had not felt well and that a recent blood count showed a 21,000 white cell count. A white cell count done on the day I saw her was 24,000. (A normal count is about 5,000 to 10,500.)

Mrs. Dickson was started on my nutritional program. I did not feel in her case that the intravenous Laetrile was necessary, so I used just the Laetrile tablets as that part of her program. One month later Mrs. Dickson reported that she was feeling much better. Her white cell count was down to 17,300. Her white cell count continued to drop and by November, 1985, it was down to 9,700.

In June, 1991, Mrs. Dickson reported a gradual increase in fatigue. Her white-cell count was 13,700. I reviewed her nutritional program and found some slips here-and-there that needed to be corrected. By October of that year her cell count was down to 10,700. In a recent letter from her, Mrs. Dickson reports that she is doing well.

Case No. 14: T.P.

This 59-year-old man that was seen for the first time on 7/18/80. His history was that one month prior to this a routine x-ray showed a mass in his right lung. A biopsy showed this to be carcinoma. Five radiation treatments were given followed by one chemotherapy treatment that made him so ill he discontinued that whole program. He was started on my nutritional program.

An x-ray done in January, 1981, showed that the tumor in his right lung was completely gone. Let me quote from a letter I received from him on January 23, 1981:

"They were surprised here at [hospital name omitted] comparing the x-ray of last June and the one I just received.... Hope you understand what I am trying to say. I was really tickled when I learned the tumor was gone, and I thought of you right away. I know in my heart it was the Amygdalin and will never think differently.

"The doctor I had at the hospital in June said it was probably the 5 radiation treatments I had. They just don't want to admit [it was the Amygdalin], I guess."

My last contact with this patient was in April, 1993. At that time he was doing very well.

Case No. 15: Helyne Victor

This 54-year-old woman was first seen on 6/7/74. In 1967 she had her right breast removed because of cancer. In 1970 she had her left breast removed, also because of cancer. She had received no radiation or chemotherapy after either surgery. While yearly check-ups had failed to find any spread of her disease, this woman just didn't feel well and wanted to get on a good nutritional program.

Mrs. Victor tells her story best. This is from a letter she wrote to the Ohio State Medical Board on April 5, 1975:

"My health has not been good and it was approximately a year ago that I found myself going downhill as far as my health was concerned, not knowing what to do or to whom to go for help. My husband and I began to read and research various avenues for nutritional help or aid.

"I felt very strongly that my poor health may have been due partly to faulty nutrition. After reading materials on proper diets, etc., I heard of Dr. Binzel and had heard that

he did treat patients with a nutritional program. So, I called him and made an appointment....

"Following a good diet, as he suggested, and taking multiple vitamins for the past year, I can honestly say that I feel like a different person. My health has improved 100%, and I'm feeling like my old self and extremely happy with the results...."

Mrs. Victor continues to do well. She is now 74 years old and in a recent letter she said of herself and her husband, "We enjoy life and travel a lot."

Case No. 16: M.S.

This 62-year-old woman was first seen on 12/6/78. One month previously she had a mole removed from her back. This mole turned out to be a malignant melanoma. She had no radiation or chemotherapy.

She was placed on a nutritional program. She is now 77 years old, quite well and quite active. She has had small a skin cancer removed from her face, but this was not melanoma and was unrelated to her previous disease.

I bring this case to your attention because melanoma is a highly malignant disease which frequently metastasizes rapidly to the liver. This woman was one of 10 patients that I saw with primary malignant melanoma (it had not spread to any other area). To the best of my knowledge, none of those patients have developed metastatic disease.

Case No. 17: B.D.

This 62-year-old woman was seen by me for the first time on 5/22/84. In January, 1980, she had been found to have malignant lymphoma. She received chemotherapy from January, 1980, through November, 1980. In March, 1982, she developed a small nodule in the back portion of her left neck area and a few months later a larger nodule in the right mandibular angle (jaw). She placed herself on a

pretty good nutritional program at that time and the nodules had not progressed at all in size.

I up-graded the nutritional program of this patient by adding Vitamin A and Laetrile to what she was already doing. She was followed closely by her family doctor for the next two years. He could not detect any enlargements of these nodules. I saw her again on 4/30/86. I felt that the nodule in the right mandibular angle was the same size as before but was firmer and more movable. I thought the nodule on the left side of the neck was the same size but much firmer than before. The next time I saw this patient was on 2/18/91. I could not find any nodules at all.

It has now been 10 years since she started on her nutritional program. In a recent letter she said, "I am doing well and leading an active life...I continue to take all of the vitamins that you prescribed and I never miss a dose."

Case No. 18: B.W.

This 44-year-old woman was seen for the first time on 2/6/81. She had been found one month prior to have carcinoma of the descending colon with 7 positive lymph nodes. A colostomy was not required. She received no radiation or chemotherapy.

She was started on a nutritional program. Now, some 13 years later, she has had no recurrence of her disease and leads a normal, active life.

What is so unusual about this patient? She had cancer of the colon with metastases. The odds of her surviving 5 years were one in one-thousand. Yet, she lives a normal life with no recurrence of her disease after 13 years.

Case No. 19: Alice Silverthorn

This 46-year-old woman was seen by me for the first time on 1/5/76. Her left breast had been removed in 1971 because of carcinoma. This was followed by radiation and

chemotherapy. She had just been told that her disease had now spread to the cervical vertebrae (neck), her left rib cage and the vertebrae in her lower back. Her doctors wanted to give her more chemotherapy, but she did not want it. She wanted to go on a nutritional program.

When she started her nutritional program, she was having much pain. Within a month, the pain began to subside. In April, 1976, she began having more pain in her rib cage and in her lower back. She was put back on her intravenous Laetrile three times weekly for two weeks. The pain again subsided. In August of that year she began to have some pain once more in her rib cage. She was given intravenous Laetrile twice weekly for three weeks. Again the pain subsided. It has now been 18 years since she first started on her program. She is 64 years old and doing very well.

Let me share with you part of a letter I recently received from Mrs. Silverthorn:

"I remember only too well the fear and desperation, yes, and downright helplessness, I felt when the doctors at (hospital name deleted) told me the cancer had metastasized to my bones. It was a sentence of `death.' I was told I would need to start chemo-treatments immediately. There was even talk of taking the pituitary gland out at some later date. I had already had a radical left breast operation and was treated with mustard gas, cobalt and male hormones. I had enough of torture! ! !

"When a friend told me about your nutritional approach to treating diseases, I was ready to try it. Even though we both knew my chances of survival were slim, together, we were willing to take on the challenge of fighting for my life. Now, thank God, you can claim me as one of your survivors.

"I hope you include in your book how we feel, and just how difficult it is for those of us who were supposed to die, when the medical profession and well-meaning, intelligent people make the suggestion that the only reason we are alive is because it was a mis-diagnosis or the disease has gone into a `spontaneous' remission. Most people make us feel like psychiatric patients. It is difficult to explain miracles, yet, that is what happened."

Case No. 20: Grace Laman

This 59-year-old woman was seen for the first time on 10/5/76. She had been diagnosed as having carcinoma of the pancreas six months prior to this. The only thing that had been done surgically was to run a tube from her bile duct to the outside. She was on chemotherapy for two months but stopped it herself because it made her so ill. She was told at that time that she had only 6 months to live. She was placed on a nutritional program.

Let me quote part of a letter I received from her almost two years later (9/23/78):

"I was [recently] put through a new scanner which showed that my tumor had reduced to the size of a tennis ball. It had been the size of [the doctor's] hand, so he said."

Now, 18 years later, she is 77 years old. In the letter which accompanied her picture she said, "This is my activity picture of me *eating out*, which I do very well."

Note: With surgery and/or radiation and/or chemotherapy the chances of surviving more than one year with cancer of the pancreas are about 1 in 10,000.

Case No. 21: E.D.

This 57-year-old man was first seen on 4/28/92 (and for that reason is not included in my statistical study) with a history of a diagnosis of carcinoma of the left lung 10 months previously. Surgery had been done followed by

one chemotherapy treatment. This made him so ill that he discontinued it. He was then given 25 radiation treatments ending in December, 1991. In March, 1992, x-rays showed extensive growth of the tumors in that lung. He was placed on a nutritional program.

X-rays done in July, 1993, showed no further growth of the tumors in the left lung. X-rays done in November, 1993, showed that the tumors had all become scar tissue. In the most recent letter I received from him he stated that he was feeling so well that "I have no right to complain, so I have to cuss a lot about taxes, politicians, etc."

These statistics and case histories have focused primarily upon the extension of the patient's life span. That's certainly important, but the *quality* of life is also important. We will deal with that issue next.