Defeating cancer requires more than one treatment method: A 7-year retrospective case series using multiple nutritional and herbal agents, 2013 update

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Abstract

INTRODUCTION: Research has shown that for cancer to occur in the body multiple normal functions must break down. Therefore multiple-agent treatments may be the only successful way to treat cancer. We used well-tolerated natural substances to assess their usefulness in combination anti-neoplastic therapy. The following has been the goal of our clinic in treating cancer patients: It is not enough to repair genetic damage or to stop angiogenesis and neglect to reverse all other cancer-causing problems. It is also not enough to attack metastases and leave the primary tumor in a comfortable environment. In order to defeat cancer, it must be attacked at every level and with every method necessary to reverse cancer's multiple-layered assault on the body, even if that means that some of the various treatments have redundant effects. And this all must be accomplished while maintaining the maximum possible wellbeing of the patient, and without sickening or weakening the patient.

METHODS: We treated a total of 317 patients with cancer from October 2006, when we opened our practice, until July 1, 2013, when we stopped collecting data for this year's update of this paper, originally written in 2009. Data from all 317 patients who came to us with a definitive diagnosis of cancer are included in this paper, excluding only those cancer patients who decided against further treatment after less than two weeks in our care. We treated with natural methods alone, choosing among methods with research-established anti-neoplastic effect, both oral and intravenous, dietary and supplemented, nutritional and herbal, having a preference for those with high patient tolerance and compatibility, and varying with individual needs and tolerance, according to the standard naturopathic principle of "Treat the whole person."

FINDINGS: 94 patients voluntarily left our practice, against our advice, primarily for financial reasons, while still having cancer. Of the remaining 223 patients, 151 either went into confirmed, complete remission, which we define by no evidence of cancer remaining in the body on imaging, or have remained in good to excellent wellbeing, as determined retrospectively by prolonged stable health of at least 6 months after leaving our care and needing no other physician supervised cancer care, and as confirmed by annual telephone conversation with either the patient or a family member. Those patients in remission stayed in our care an average of 3.7 months; those who left, 2.7 months, (this data last measured in 2010). Of those in remission, 6 patients left our clinic, then went within a month to either another naturopathic clinic (one), or had chemotherapy (4) or had radiation (one), and remained in remission. Two of these had been in remission from our clinic, left to have chemotherapy, and during chemotherapy their cancers recurred. The other 145 went into remission while still being treated by us. We were still treating 18 patients at July 1, 2013 plus giving ongoing maintenance treatments to some of those who are still in remission. 32 died while still our patients. Of those 32, 12 died after a significant dietary dispute with us. That is 20 patients died although they received our treatments and complied with our requested diet. 20 more were killed by hospital procedures and/or chemotherapy and/or radiation side effects while still our patients. 29 total patients chose to have chemotherapy while having our treatments. Yet, of the 151 who went into remission, only 7 had chosen to have chemotherapy while having our treatments. 16 of those in remission have come out of remission as of this writing, and of those, five are back in remission again. Stages 1, 2, 3 and early Stage 4 patients at start of treatment had much better outcomes than late Stage 4 patients in general.

INTERPRETATION: The 20 patients who complied with our dietary and treatment protocol, and still did not survive their cancers must be seen as a 6% failure rate if considered of all 317 patients, or a 9% failure rate if taken of the 223 patients who stayed to complete our treatments. Therefore, these treatment strategies are still not adequate to eliminate all patients' cancers and must be further developed. On the other hand, 100% - 9% = 91% survival exceeds that of other known clinics and treatment protocols.

Introduction

Cancer treatment, more so than other areas of medicine, has been constrained by the prevailing view that a single agent must be isolated and tested for its either successful or failing role as the therapeutic agent to eliminate cancer. This viewpoint is disastrous for most patients, for the following reasons. Many agents are needed to fight cancer, primarily because it arises after several normal mechanisms break down, and because cancer preys on the body in numerous ways simultaneously, and because no single agent, whether chemotherapeutic or natural, has yet been found that has enough anti-neoplastic strategic effects to reverse all of those abnormalities in all patients, in effect, to be "the cure" for cancer. At our clinic in Tempe, AZ, USA we therefore employ multiple naturally derived unpatented, and therefore inexpensive, substances for use in cancer patients.

Background

As John Boik has described, cancer becomes possible, and has its only opportunity to arise in the body, when seven different events, such as genetic damage, angiogenesis, immune system evasion, etc. all occur,[1] as listed below. Then, once established, cancer is adaptable enough to be able to thrive and grow with the continuation of just one or a few of those deviant events.

Boik describes the seven pro-cancer events as follows:

1) genetic instability or vulnerability to mutation, necessarily the first of the variety of events that lead to a tumor;
2) abnormal gene expression, in this case that produce proteins that facilitate cancer, or at least do not prevent it;
3) abnormal and autonomous cell signal transduction, which allows cancer cells to grow through self-stimulation rather than depending on growth factors from other cells;
4) Abnormal cell-to-cell communication, which sets a tumor apart from its neighboring cells metabolically, leaving the tumor in a position to ignore homeostatic mechanisms and, unlike cells throughout the rest of the body, to act in the best interests of the tumor rather than in the best interests of the organism.
5) Angiogenesis, the creation of blood vessels and resultant hoarding by the tumor of disproportionately large amounts of blood-borne molecules;
6) Invasion and metastasis, which not only results from the aggressive nature of the tumor, but also the low integrity and too friable nature of the surrounding normal tissue and basement membranes;
7) Evasion of the immune system, which involves both camouflage functions and immune-disabling functions of cancer cells.

Once established in the body, cancer seems to have the ability to thrive and reproduce despite most of the efforts against it by oncologists, and without necessarily requiring all seven of the above pro-cancer events to still be in place. Therefore, without certain knowledge of the precise mechanisms governing any one patient's cancer, any therapy that targets fewer than those seven major disturbances leaves the body of the cancer patient potentially vulnerable to the disastrous result of allowing continued growth of existing tumors. Shortchanging the patient of a diverse range of available, effective, well-tolerated, well-targeted, compatible, complementary and feasible treatment options also would allow too many of the conditions to persist that gave rise to tumors previously and may do so again, leaving the fertile ground and pro-neoplastic conditions that produced the cancer in the first place. For this reason, successful cancer therapy should be multi-purposed and with multiple agents, many more than are now used with each patient by oncologists.

We have used natural therapies for cancer treatment, because they are well adapted for multi-agent use. Unrefined plant materials have tens of thousands or more phytochemical components, originally useful for protecting a plant from extreme or adverse conditions in its environment, and ultimately employed as described below by naturopathic physicians in adaptation to the needs of the human patient. Licensed naturopathic physicians, because of thorough medical training, having more classroom hours and more than twice the number of courses in medical school as Medical Doctors[2], as well as extensive training in the use of natural agents, are well suited to choose appropriate combinations of natural therapies for the individual cancer patient. We also take advantage of the greater compatibility among natural substances than among numerous pharmaceuticals. It seems obvious that a meal may contain many different foods without the need for conscious consideration of potential interactions among nutrients and plant molecules. In the same way, we have combined many different nutrients and plant materials in each cancer patient's treatment protocol, with regard for the specific cancer burden in the body, the origin of the cancer, the nature of that particular patient's cancer and any co-morbid conditions.

Materials and Methods

Dietary interventions are of the utmost importance in cancer therapy, especially keeping blood sugar low. The significant majority of research on the subject establishes a correlation between blood glucose and tumor growth. Using PET imaging preferentially for tumor evaluation, clinicians make use of the fact that tumors take up blood glucose disproportionately over benign tissue, which implies an especially glucose-dependent metabolism in cancer cells.
Research has shown a correlation between blood sugar or glycemic load and cancer growth for pancreatic cancer,[3] breast cancer, [4 5] gastric cancer, [6 7] colon cancer,[8 9] ovarian cancer[10] and prostate cancer.[11] Given all of this evidence, it would be reckless for a physician to allow a cancer patient to assume that sugar intake is harmless. We therefore ask all of our cancer patients to avoid sweeteners, such as sugar, honey, maple syrup, corn syrup, as well as fruit juices, because such foods tend to have the highest glycemic indices. Use of stevia is encouraged if and when a sweetener is desired. For the same reason, we asked patients to also limit other refined carbohydrates, specifically flour products. Whole natural foods: vegetables, fruits, whole grains, eggs, dairy and other animal proteins are encouraged as the entire diet, with the widest available variety in those groups. Many patients arrive to our clinic already

consuming all of those types of foods. Some patients have chosen a vegan diet. Others have chosen an ovo-lacto-vegetarian diet. Many others are omnivores. We have not actively pushed our patients to one or the other of these diets, because we tried to maintain the primary dietary focus on the avoidance of sweeteners. Use of soy is discouraged because of its mineral-depleting and phytoestrogenic components, which in some studies has been linked to a possible association with cancer.

Of equal emphasis with diet are the intravenous nutrients that we administer three times per week to each cancer patient. These consist of high-dose intravenous vitamin C (ascorbic acid), as well as other nutrients chosen for specific anti-neoplastic effect with regard to the patient's type of cancer. For solid malignant tumors, we address the problem of pH, by infusing both sodium bicarbonate to alkalinize systemically, as well as other specifically anti-cancer nutrients, tailored to the individual patient's tumor load, type of cancer and other health circumstances. B vitamins and minerals and other nutrients are often added for synergistic effect with Vitamin C, or because of their history of reducing and eliminating tumors, or their usefulness in converting malignant tumors into benign tissue.

Naturopathic training emphasizes the treatment of the individual with regard to the entire symptom picture. Therefore, there is no specific formula to be repeated in cookbook fashion from one patient to the next, or even for the same patient from one day to the next. Quantities of the different components of this combination vary among individual patients depending on symptoms, signs and type of cancer. Quantities also vary as the patient's needs change. All components are kept far below the LD50 for each component, and are only administered if they have not produced any side effects in our patients.

Research has established that ascorbic acid taken orally cannot attain sufficiently high concentrations in the bloodstream to kill cancer cells.[12] [13] However, intravenous use of ascorbic acid has been shown to rise to concentrations that have killed cancer cells in vivo [14] [15] [16] and in vitro.[17] [18] [19] The ascorbic acid that we use is in much higher dose than would be tolerated orally, yet at a level where there is sufficient concentration of vitamin C in the bloodstream to create a substantial concentration of the products of vitamin C in the extracellular fluid.[20] Intravenous doses of ascorbic acid have been found to produce from 25 to 70 times as much plasma concentration as may be attained by oral dosing.[21] Research has confirmed that Vitamin C in such high concentration kills cancer cells while leaving normal tissue unharmed.[22] [23] Indeed the cancer patients whom we treat do not have side effects from these treatments, with few exceptions. Three of the exceptions were allergies to specific B vitamins in four individuals. Two of the three went into remission after we had removed the offending agent early on. One is still being treated.

In addition to this directly and selectively cytotoxic effect on cancer cells, vitamin C has been shown to form collagen[24] and to inhibit hyaluronidase[25] leading to stronger membrane integrity and tensile strength[26] of normal tissue, which inhibits invasion[27] and thus metastases.

Empirical data shows an inverse correlation between vitamin D intake and cancer incidence.[28] [29] [30] Research over the last several years has confirmed the essential role that Vitamin D plays in cancer prevention and treatment.[31] [32] [33] [34] Vitamin D has been shown to induce differentiation,[35]

and apoptosis,[36] to reduce proliferation by effect on signal transduction,[37] to improve intercellular communication by means of gap junction communication preservation,[38] to inhibit angiogenesis,[39] [40] and to inhibit metastasis.[41] At our clinic, most cancer patients are prescribed a regular dose of Vitamin D that is compatible with customary sunlight exposure, current pharmaceuticals if any, as well as the assessed condition of the liver and gallbladder and calcium metabolizing mechanisms.

Vitamin A is a less-widely appreciated but quite crucial part of the treatment protocol for its immune-stimulating property[42] and inhibition of cancer cell migration[43]. Another very important quality of Vitamin A with regard to neoplastic cells is its ability to introduce differentiation.[44] [45] It has also been shown to induce apoptosis in cancer cells,[46] as well as growth inhibition.[47] Although there have been some objections made to Vitamin A for an allegedly competitive and detrimental effect to vitamin D,[48] vitamin A seems to be vindicated by a preponderance of older research that supports the use of vitamin A and vitamin D dosed together.[49] [50] [51]

We frequently add the recommendation to take Essiac tea (Resperin Canada Limited, Waterloo, Ontario, Canada), because of its long history in North America, over most of the last century of folk use (outside of conventional medicine) against a wide variety of cancers. Essiac was developed by a Canadian nurse, René Caisse, together with the Ojibwe people of Canada. It is a combination of four herbs, Arctium lappa, Rheum palmatum, Rumex acetosella, and Ulmus fulva. Later versions of Essiac, using additional herbs with some pro-estrogenic effect, have been linked to breast tissue proliferation,[52] and we do not recommend those altered formulas. Essiac has been found to have in vitro cytotoxic effects specifically against neoplastic cells, without damage to normal cells.[53] Its main effect seems to be protective against DNA damage.[54] It also seems to have anti-proliferative effect.[55]

For some of our patients, we have also used digestive enzymes apart from meals, for a presumed proteolytic effect against tumors. This use is still speculative and does not appear to be well-supported at this time in the medical literature. However, various digestive enzymes, and bromelain in particular, have been found to heighten immune system response to cancer [56] [57] and to inhibit metastasis.[58] [59]

For different cancers there are additional appropriate treatments. For example, Kenneth Proefrock NMD has done extensive original work with nebulizers, as well as in many other areas of medicine, which he taught us to use with lung cancer patients, as well as others with metastases the lungs, to good effect.[60] Whereas all of the rest of our treatments arrive to the lungs by way of the bloodstream, Dr. Proefrock has introduced such nebulized botanicals and nutrients as required by the individual patient by way of the airways, thus carrying anti-neoplastic treatments to lung tissue via its other major port of entry.

Findings

Of the 317 cancer patients whom we have treated long-term, all came to us with a diagnosis of cancer from another physician, none originally diagnosed by us. Of those 317 patients, 32 have died of cancer while still our patients under our care, and of those 32, 12 did not comply with our

main dietary advice to avoid sweeteners. Therefore, 32 – 12 = 20 patients died while under our care and complying with all of our protocols. 151 have gone into complete remission, substantiated by PET/CT or other imaging, and/or biopsy, and/or stable good health for at least 6 months after stopping our treatments.

Specific results are shown in Table 1. A summary is shown in Table 2.

Table 1: Outcomes of naturopathic management of 317 cancer cases

Patient #s assigned for reporting purpose only (referred to by name only in clinic)	**Stage** at start of treatment If a medical onco-logist said 'no hope of recovery regard-less of treat-ment' (NHR)	**Type** of cancer	**Conventional therapies** also used during our treatments: Chemotherapy (C) Radiation(R) Surgery (Su) Prior chemotherapy but still had tumor load after chemotherapy (PC) Prior radiation (PR); Prior surgery (PS) **C** **R** **Su**			**Final result**: Proven total remission (R), Assumed remission after long time well (AR) Proven reduced tumor load but not remission (Red), Proven increased tumor load (Inc), New metastases (Met) Tumor softened (Sof) Death (D), Death after dietary dispute (DDD) Left (L) Left against medical advice (L ama) Our treatments had no apparent effect (NOFX) Could not afford to continue treatments long enough (No$) No further information (NFI) Still treating (Current)	**Quality of Life at end of treatment** Improved (Imp) Worsened (Wor) High-functioning (HF) High- functioning with Exercise (HfwE) Same from beginning to end of treatment (Sa) Patient is employed (Job)
1	4	neuro-endocrine tumor	No	No	No	AR	HfwE/Sa
2	1	prostate	No	No	No	R	Imp/Job
3	3	breast	No	No	No	R No recent info	HF/Job
4	2	liver	No	No	No	Red, L ama, NFI	HFwE/Sa
5	1	breast	No	No	Yes	Red, Sof, L ama –No$ D, 1 year after leaving	HF/Wor
6	2	breast	No	No	Yes	R	HFwE/Job
7	4	testicular teratoma	No	No	Yes	R	HfwE/Job
8	1	breast	No	No	Yes	Uncertain; conflicting results on imaging, L ama	Now having different alternative tx abroad

9	4	breast	No PC	No	Yes	R	Sa
10	1	prostate	No	No	No	R	HFwE/Sa/Job
11	1	breast	No	No	No	AR. Red, Sof, L No recent info	HFwE/Sa
12	4 NHR	pancreatic	PC	PR	PS	NOFX, D	Arrived very sick, very late, severe pain
13	1	prostate	No	No	No	R	HFwE/Sa
14	4	colon	No	No	No	L after 3 txs → NFI	Unsure of how to proceed
15	Un-known	prostate	No	No	No	We referred to another clinic for staging	NFI
16	4 NHR	breast	No	No	Yes	Sof; rare allergy to txs. →L → now radiation tx	Sa
17	4 NHR	breast	PC	PR	PS	Gave up on txs, D	Too sick to come in; house calls only 3x
18	4 NHR	prostate	No	No	No	R	HFwE/Job
19	2	breast	No	No	Yes	R	HFwE/Job
20	4 NHR	breast	No	No	PS	NOFX, D	Arrived very sick, late
21	4 NHR	breast	No	Yes	No	NOFX L → radiation → R, back at work	Arrived very late; imp.
22	1	mesothe-lioma	Yes	No	No	Inc., L, then 1 mo, then DDD	Wor
23	2	lung	No	No	No	R x years. Now battling Valley Fever.	HfwE/Job
24	2	Hodgkins lymphoma	No	No	No	AR. L, then one year,, then 6 mos chemo, then R	Hf, Imp, then Wor after dietary difference
25	3	breast	No	No	Yes	Red, Sof, dispute over txs and diet, Lama, DDD	No tx for 1 yr after large mass found
26	2	breast	No	No	Yes	AR	HfwE/ Sa
27	1	breast	No	No	Yes	R	HFwE/Sa/Job
28	4	breast	No	No	No	2 weeks of treatment → L AMA → NFI	Very ill on arrival; unsure of how to proceed
29	1	breast	No	No	Yes	R	HfwE/Sa
30	4 NHR	SCC	No	No	No	L before remission→ several months→ D	HfwE/Sa
31	1	parotid adenoma	No	Yes	Yes	AR No recent info.	HfwE/Sa
32	3	lung	No	No	No	L after strong dietary dispute, then 1 mo, then, DDD, L ama	Sa
33	3	colon	No	No	Yes	L ama, NFI	Sa
34	4	lymphoma	No	No	No PS	Red, then left to do chemo→ 5 rds→D	Imp till chemo, then worsened quickly
35	4	breast	No	No PR	No PS	R	HF/Sa
36	1	breast	No	No	Yes	Tumor free; finishing txs. Current	HFwE/Job
37	2	breast	No	No	Yes	Red prior to surgery, R	HFwE/S/Job Diet dispute → tumor returned → more treatments → in Remission again

38	4	lung	No	No	No	R x 2 yrs, then recurred, then no treatment at all, then D	Imp/Job
39	4	bladder	No	No	No	R	HFwE/Sa, age>90 yo
40	1	prostate	No	No	No	AR No recent info.	Imp
41	1	prostate	No	No	No	AR	HF/same
42	2	lung	No	Yes	No	R, then radiation, then radiation poisoning, then fall, then broken hip, then D.	Wor from radiation treatments; D of fall and broken hip after Remission
43	2	colon	No PC	No	No PS	R	HF
44	1	breast	No	No	Yes	R	HfwE/Sa/Job
45	4 NHR	lung	No	No	No	L ama-No$, then 2 mos. Then D	HF/same
46	1	SCC	Yes	No	No	L AMA Decided chemo instead	Sa
47	4 NHR	rectal	No	Yes	Yes	L ama after a few txs; D	Arrived very sick, very late; left early
48	4	lung; mets to brain	No	No	No	Of 8 brain tumors, 5 eliminated in treatment. Then L AMA. Then some months. Then D	Imp; Hf/Job
49	2	brain	No	No	No	R No recent info.	HfwE/Job
50	4	prostate	No	No	No	Improved, then L AMA	Impr.
51	4	SCC of the throat	No PC	No PR	No PS	L AMA due to no $	Imp/ HFwE
52	2	breast	No	No	No	Current	Imp; HfwE
53	4	CLL and SCC	PC	No	No	R from CLL; then dispute over tx, then Lama, then D	Imp, then dispute, then Wor
54	3	lymphoma	No PC	No	No	R	Imp; HfwE
55	4	prostate	No PC	No PR	No PS	NOFX, D	Arrive very sick, very late; Sa
56	4	stomach	No PC	No	No	AR	Imp, but improved more after surgery
57	4	breast, inflammatory	No PC	No	No PS	NOFX, D	Pt did most but not all of our recommended treatments
58	2	lymphoma	No	No	No	AR	Imp
59	4 NHR	breast	PC	PR	PS	Had 4 txs, then L ama, then D	Arrived very sick, late
60	1	rectal	No	Yes	No	Dispute about how to treat. L ama. Tumor shrunk and grew with irritation; average same size; then chemo →D	HFwE/same
61	4 NHR	lung	No	No	No	Stable cancer D of pneumonia	Weak; Same, but died of pneumonia
62	4 NHR	small cell lung	No PC	No	No	L, NFI	HF/Job

63	4	esophageal	Yes	No	No	Only 1 treatment per month; only having treatment in order to endure chemotx	Same; Red
64	4	breast, 4th recur.	No, PC	No PR	No PS	R, then alleged recurrence and several years of chemo→ D	HFwE/Job/same
65	1	squamous cell	No	No	Yes	R	Hf/Job/Same
66	1	breast	No	No	No	L ama, NFI	HFwE/same
67	1	breast	No	No	Yes	R No recent info	HFwE/same
68	1	thyroid	No	No	No	R	Concurrent Lyme Disease
69	1	breast	No	No	Yes	R	HFwE/Sa/Job
70	4	SCC	No	No	No PS	L AMA	HF/Sa
71	1 recurred	breast	No, PC	No PR	No PS	R	HF/Sa/Job
72	1	breast	No PC	No PR	No PS	AR; currrent	HFwE
73	1	breast	No	No	Yes	L ama→ chemo → ca has recurred 3x since.	Imp, then wor since chemo
74	1	testicular	No	No	Yes	R; L AMA → had chemotherapy → R	HF
75	4 NHR	kidney	No	No	No	L ama-No$, NFI, then 1.5 years, no other treatment, then D	HF/Sa
76	4	colon	Yes	No	No	L ama, NFI	Sa
77	4	colon	No PC	No PR	No PS	Had a few txs; L AMA due to no $ → a few months → D	HFwE during treatments
78	4 NHR	ovarian	No	No	No	L ama, then 2 mo, gave up, then D	Entered very ill, same
79	4	uterine	No	No	Yes	R	Zumba, yoga, very active
80	4	prostate	No	No	No	L AMA due to no $	Imp
81	3	squamous cell tongue	No	No	No PS	L ama, DDD; very strong dietary dispute	Imp, then Wor
82	1	lymphoma	Yes	No	No	AR, then was forced by family into chemotherapy against patient's wishes	Imp, responded immediately to natural treatments; all lymph nodes down to normal prior to L
83	3	uterine	No	No	Yes	AR	HFwE
84	4	ovarian	No, PC	No	Yes	R, then recurrence, then resumed tx → L AMA → a few months → D	Imp,Wor, Imp L AMA
85	1	breast	No	No	No PS	AR	HFwE/Job/Sa
86	4	Lynch Syndrome: colon, ovarian, uterine cancers; all primary	No, PC	No	No, PS	R. No recent info.	Imp
87	1	glioblastoma	No	No	No	L AMA. Planned surgery and NFI	Imp

88	4 NHR	esophageal	No	No	No	L after 3 weeks; NFI	Wor
89	2	uterine	No	No	Yes	R	HFwE/Imp/Job
90	4 re-curred NHR	ovarian	No PC	No	Yes	Stopped treatment at worst possible time, much too early L ama → D	Imp significantly to HFwE/Job; then stopped treatment against clinic advice; then Wor significantly
91	4 NHR; several dozen mets from neck to feet	colon	Yes	No	Yes	D from chemotherapy side effect.	Only 3 of our treatments. Improved; went back for more chemo → D
92	1	CLL	No	No	No	AR, L with no lymphadenopathy, borderline leukocytosis	HFwE/Sa/Job 71yo, bikes miles, hand built cabin, x 2 yrs since treatment
93	4	prostate	No	No	No	R	HFwE/Imp/Job
94	2 NHR	breast	No	No	Yes	R	HFwE/Sa
95	1 NHR	lung	No	Yes	No	R, then D of Pulm fibr, not lu ca	Wor from pulm fibrosis not ca
96	2 NHR	vulvar	No PC	No	No	Strong dietary dispute. L ama, then 2 mo, then no treatment, then DDD	Wor from chronic antibiotic resistant infection
97	4 NHR	neuro-endocrine	No PC	No PR	No	NOFX, A few weeks, then D	Very sick; widely metastasized on arrival.
98	4	lymphoma	Yes	No	No	R	HFwE/Sa/Job; hiked Grand Canyon after R
99	4	lung	No	No	No	L AMA	Imp
100	1	breast	No	No	Yes	Patient suspects she never really had cancer	Sa
101	4 NHR	GIST	Yes	No	No	D	Came in with huge tumor load; metabolic activity of cancer decreased. Wor from complications, ascites and chemotherapy.
102	3 NHR	cervical	No	No	No	R now 5 years	HFwE/Sa/Job
103	2	breast	No	No	Yes	R, after short treatment	HFwE/Sa/Job
104	1	breast	No	No	Yes	R	HFwE/Sa/Job
105	4	pancreatic	No	No	No	L AMA, due to no $ for treatment	Imp
106	4	ovarian and breast	No	No	Yes	L suddenly. NFI	Imp., HF/Sa
107	2 NHR	lung	No	No	No	Red, Met, then L ama, then 6 months, then D	HF/Sa
108	4	prostate	Yes	Yes	No	R, then family bullied into conventional tx.. L ama. No recent info.	Imp then L ama, then Wor
109	2	squamous cell tongue	No	No	No	L ama to have radiation, then NFI	Wor/HFwE/Job

110	4 NHR	breast	Yes	Yes	Yes	L ama to have chemotherapy, then 1 mo, then D	Same; severe lymphedema
111	2	breast	No	No	No	R	HFwE/Sa/Job
112	4	ovarian and peritoneal	No	No	Yes	R	HFwE/Imp
113	4	breast	No, PC	No, PR	Yes	L ama-No$, NFI, then chemo, then 3mos then D	HF/Sa. Until L ama, then chemo, then Wor, then D
114	4 NHR	breast	No	No	Yes	R	HFwE in her 70's/Sa/horseback riding
115	1	colorectal	No	Yes	No	L ama for other alternative therapy. NFI	HfwE/Sa
116	4	lymphoma	No PC	No PR	No PS	Stable through months of treatment	Sa
117	4 NHR	liver	No	No	No	L AMA after a few weeks → D	Arrived very late, very sick. Had refused dialysis, despite urgent need
118	4 NHR	melanoma	No	No	No	Decided against tx. L for hospice, then 1 month, then D	Arrived very late, very sick, huge tumor burden
119	4	multiple myeloma	Yes	No	No	R after adipose stem cell therapy	HFwE and travel, Sa
120	4	breast	No	No	No	Pt was treated briefly, then decided against all recommended txs. "Hanging in there."	Sa
121	4 NHR	bladder	No, PC	No	No, PS	R Critical electrolyte levels after K+ regulation destroyed and much kidney tissue destroyed from no fluids given in hospice → D	Entered very ill from hospice; greatly improved, regained consciousness, w/E. No cancer found on MRI one day before death
122	4	lymphoma	No	No	No	R; no recent info	Sa/job/travel
123	1	cervical	No	No	Yes	R	HFwE/job, Imp
124	4	breast	No PC	No	Yes	Current	Imp. HF
125	4	breast	No	No	No	R	Imp; HFwE/Job
126	4	lymphoma	Yes	No	No	AR. Then chemo→ recurrence. Now we are treating again. Current.	Imp during treatments. Then Wor during chemo. Now Imp again
127	1	lung	No	No	No	R. Then stopped treatment, then MI, then D	Imp
128	1	prostate	No	No	No	R. No recent info	Imp; HFwE/Job
129	2	breast	No	No	Yes	R	HF/Sa/Job
130	1	prostate	No	No	No	R	Imp
131	1	breast	No	Yes	Yes	R, then recur, then R	HFwE/Sa/Job

132	4 NHR	lymphoma	No	No	No	NOFX, D from concurrent liver disease	Pt arrived very sick, very late; liver was mostly non-functioning from late-stage cirrhosis
133	4	melanoma	No	No	Yes	L AMA; long distance patient returned home	Sa
134	3	non small cell lung	No	No	No	D unexpectedly; no cause reported	HfwE/Job
135	4 NHR	brain	No	No	No	No $, no insurance. L after a few treatments, then D	Arrive very sick, very late
136	2	esophageal	No PC	No PR	No PS	L ama. NFI	Hf with controlled pain
137	4 NHR	pancreatic	No PC	No PR	No PS	NOFX, L, then 2 months, then D	Pt arrived very sick, very late
138	4	breast	No	No	No	Interrupted tx repeatedly, when consistency was advised; L ama, No recent info	Wor
139	4 NHR	esophagus	No PC	No	No	Strong dispute over diet, then L, then hospital, then DDD	Imp, then Wor
140	1	prostate	No	No	No	R, no recent info	HF/Sa/Job
141	4	breast	No, PC	No, PR	No PS	A few weeks of treatments. Then collapsed veins, could not receive treatments, then L, then D	Imp, then Wor
142	4 NHR	pancreatic	No	No	No	L ama, went to another clinic, then D	Sa
143	4 NHR	prostate	No	No	No	Imp, from hospice to outpatient, then L ama, then 1 mo. Then D	Imp. Then Wor
144	2	lung	No	No	No	AR → still smoked → recurred →D	HFwE/travel/Sa
145	4 NHR	colon	No	No	Yes	L ama, then barbiturate overdose, then D	Imp, then left, then Wor, then Hospital
146	1	breast	No	No	Yes	R	HFwE, Job
147	2	ovarian	No PC	No	Yes	R, then dietary dispute, then recurrence → DDD	Imp, HF w/E, Job, then Wor
148	4	prostate	No	No PR	No PS	L ama after a few weeks	On chemotherapy; now hospitalized
149	4 NHR	glioblastoma	No	No	No PS	D	Imp, then Wor
150	1	prostate	No	No	No	R	HFwE/Sa/Job
151	4	breast	No	No	No	Lama after 2 weeks; No recent info.	Sa
152	4 NHR	ovarian	No	No	Yes	R	HFwE in 80's

153	4	breast	No, PC	Yes	Yes	Inc (while improving stamina), Met, radiation →D	Imp/HFwE (intense exercise), 69yo then radiation then rapidly Wor, then died
154	1	prostate	No	No	No	AR	HFwE/Sa/Job strenuous. 70 hrs wk in his 70's.
155	1	prostate	No	No	No	R	HF/Sa
156	4	colon	No	No	No PS	R	HF/Sa/retired
157	4	colon	No PC	No	No PS	R	Imp HFwE/Job
158	2	breast	Yes	No	Yes	Red, then disa-greement about diet, then Inc, Met, L ama, then 12 mos, then D	Wor
159	4	prostate	No	No	No	R, PSA from >100 to <6. No recent info.	Imp; well
160	4	breast	No PC	No PR	No PS	L AMA → went to chemotherapy → D	Arrived very sick
161	4	breast, inflam	No	No PR	Yes	Skin metastases were resistant to treatment, then recently improved	Active/Job
162	4	lung	No	No	No	L ama → on chemotherapy	NFI
163	4	tongue	PC	PR	PS	Blood glucose went 170 to 400's from hospital treatment between consults with us => D suddenly of DM2	Died of diabetes mellitus
164	1	multiple myeloma	No	No	No	R	Imp blood labs, but not much improvement in fatigue
165	3	prolymphocytic leukemia	No	No	No	R Pt left to have chemotherapy → Now in remission.	Pt stayed miserable with extreme relentless muscle pain; our treatments had no effect. Now working again
166	4	breast	No	No	No PS	L ama, NFI	Sa
167	1	breast	No	No	Yes	AR	HFwE/Sa/Job
168	4	colon	No	No	Yes	R	HF/Imp
169	1	thyroid	No	No	No	R. NFI	Imp, Job, HFwE
170	1	colon	No	No	No PS	R	Hf/Job
171	4; 36 bone mets. at start of treat-ment	lung	Yes	Yes	No	NOFX, D	Wor. Neither chemotherapy nor our treatments worked for this patient.

172	2	breast	Yes	No	Yes	No insurance → L AMA → on chemotherapy; feeling sick	Sa during treatment
173	4 NHR	liver and colon	No	No, PR	No PS	L ama, NFI	Imp
174	4 NHR	squamous cell tongue	No	No	No	Red, L ama, then 3 months, then D	Imp, and speaking again, then Wor, then left, then died
175	4 NHR	prostate	Yes	Yes	Yes	L ama, NFI	Close to death at time of 1st visit, then 2 treatments, then improved, then left.
176	4	breast	No	No	Yes	R, then assumed recurrence, but little evidence. Current while uncertain	Imp HFwE
177	4 NHR	liver	No PC	No PR	No PS	Red, Wor, L ama, then D	Wor from rapid tumor breakdown, without adequate elimination, left
178	2	breast	No	No	PS	R	HFwE, Job
179	4	liver	No	No	No	L AMA due to family pressure → no tx →D	Imp
180	4	breast	Yes	No	No PS	R Then more chemo→ D	Sa
181	1	breast	No	No	Yes	R	Mostly feeling good
182	1	prostate	No	No	No	Imp, R	Sa, HFwE, bench presses 200 lbs in his 70's.
183	1	colon	No	No	No	"working with a different clinic"	"Doing okay."
184	4 NHR	squamous cell in throat	No	No	No	R Then dietary dispute, then recurrence → L for different treatment; now worse, but less pain	HFwE/Sa
185	2	lymphoma	No	No	No	Dramatic improvement from 1st treatment, then family dispute, then left	Imp
186	4 NHR	lymphoma	No PC	No	No	Strong dispute over course of treatment; L AMA →2 months, then D	L. Then 2 months, then infection, then D of infection
187	4 NHR	ovarian	PC	PR	PS	Red, then L AMA, then Inc. Then chemo → D	Worse after L AMA
188	4NHR	pancreatic	No	No	No	Not a candidate for Whipple; well for months; AR. Then L AMA then recurred widespread → D	Imp. Red. HFwE/Sa/Job; "Feeling great" before L AMA
189	4 NHR	breast	No	Yes	No	Rx 2 yrs, then recurrence to bones; Then radiation AMA→ radiation poisoning →D quickly after radiation	Imp HF/Job, then Wor from radiation

190	4	sarcoma	No PC	No	Yes	Inc, but improved vitality, stamina, Current	HFwE, strenuous
191	4 NHR	ovarian	No PC	No PR	Yes	R, L ama-No$, then same for 6 months, then weaker, then surgical complications from double colostomy, then D	Low functioning; ill and weak. Arrived after several years of low dose chemo.
192	3	liver	No	No	No	R, then D from complications from liver burden	HFwE, then Wor
193	4 NHR	lung	No	No	No	L ama after 2 weeks; NFI	Very weak; arrived late; Sa
194	1	breast	No	No	No	R	HF/Sa/Job
195	1	breast	No PC	No	No PS	R for years. Then recurred. Now radiation.	HFwE Sa/Job; then hiked Grand Canyon
196	4	ALL leukemia	No PC	No	No	R	Imp, HFwE
197	4	lung	No	No	No	L AMA → uncertain outcome	Arrived sick; Sa
198	4	breast	No	No	No	AR "I think you're the one who has kept me alive and well."	Sa
199	4	breast	No	No	Yes	Current	Imp
200	2	colorectal	No	No	No	Treated for 3 weeks → L AMA → taking hemp → uncertain outcome	Sa
201	4	breast	No PC	No	No PS	Didn't start treatments → went to a different clinic	Feeling well
202	1	squamous cell	No	No	No PS	R	HFwE, Sa
203	4	Hodgkins lymphoma	No PC	No	No	Current	HFwE, Imp
204	1	breast	No	No	yes	Current	HF
205	1	brain	No	No	No	R, even though L ama	HFwE/Sa/Job
206	3	breast	No	Yes	Yes PS	R, then 2 years, then recurrence, then lumpectomy. Current.	Imp, HfwE/Sa
207	3	colon	Yes	No	Yes	Red by 80%, L then 2 mos D from surgical complications	Imp
208	1	thymus	No	No	Yes	R Then years. Then recurred→ no tx→ D	HFwJob, travel
209	3	thyroid	No	No	Yes	AR	Sa
210	1	squamous cell	No	No	No	L AMA due to no $ after only 2 weeks. Then went to do chemotx and radiation. Now R	Sa

211	4 NHR	cervical, recurred to colon before starting our treatments	No	No	No PS	NOFX, D	Wor. Cancer did not respond to our treatments
212	2	colon	No	No	Yes	R. NFI	HF, Job
213	4 NHR	Unknown origin	No PC	No PR	No	D	Arrived very sick, very late
214	2	multiple myeloma	No	No	No	L ama, then 2 years then D	Same
215	4	pancreatic	No PC	No PR	No PS	AR, but with damage to lung from cancer and repeated thoracentesis. Then 1 year, then D in sleep.	HF w daily walks till end.
216	1	pancreatic	No PC	No	No PS	R, then 2 months, then DDD	HFwE
217	4	breast	No PC	No	No PS	Imp, then Wor, L ama to have chemotx. AR. NFI	HFwE; ran or walked 2 mi/day while on our txs.
218	4 NHR	mediastinum	No	No	No	Imp, then went hiking, had MI → D	HFwE
219	1	prostate	No	No	No	Had MI; L AMA	HFw E/Job until MI
220	4 NHR	gastric	No PC	No	No	NOFX, L then 1 mo, then D	Came from hospice, Sa, then Wor, then hospital, then D Cancer did not respond to our treatments.
221	1	breast	No	No	No PS	AR, then 2 months, then bone mets, then D	HFwE during treatment. 2 mos later, bone mets, Wor.
222	4 NHR	pancreatic	No, PC	No	No	Red, then disa-greement about diet, then Inc, DDD	Imp then Wor
223	4	lymphoma	No	No	No	L AMA; chose chemotherapy instead → D	Imp under our care
224	4NHR	breast	No	No PR	No PS	AR	HFwE
225	1	prostate	No	No	No	R; no recent info	HFwE/Sa/Job; active performing musician in his 70s while under our care
226	4	prostate	Yes	No	Yes	L AMA. NFI	Imp
227	3	breast	No	No	No	L ama; chose to go have chemotherapy, no recent info	HF/Sa/Job under our care
228	3 NHR	breast	No	No	No	L ama, NFI	HFwE/Sa while under our care

229	2	multiple myeloma	No PC	No	No	AR Imp quickly; could not afford to continue treatment. Then recurrence; now recovering from stem cell tx	HFwE/Sa
230	4	lymphoma	No	No	No	R	Active in community in her 70's
231	4	colon	No	No	Yes	Long drive → L AMA	HF except for long drive
232	4	multiple myeloma	No	No	No	AR, then doubts raised by blood test. Current	Imp, HF/Job
233	4 NHR	lung	No	No	No	L AMA. Then DDD	HFwE during tx. Brain mets shrunk.
234	1	SCC	No	No	Yes	L AMA after a few treatments	Sa
235	4 NHR	thyroid	No PC	No	Yes	Came in after being assigned to hospice; L ama, D	Sa; Left against medical advice, then some months, then D
236	2	breast	No	No	Yes PS	R, then recurrence, then lumpectomy. Current.	HFwE, Sa
237	4	lung	No PC one time	No	No	Imp dramatically, then L ama, then Wor, then D	Hf/Sa
238	4	hairy cell leukemia	No	No	No	Surgeons refused sugery→ splenic rupture → D	HF till splenic rupture
239	4	breast	No	No	No	L AMA	Imp
240	4 NHR	breast, inflammatory	No PC	No	No PS	NOFX, D	Pt arrived very sick, very late.
241	4 NHR	breast	No, PC	No	No, PS	Killed by overdose of morphine in hospital, D	Came in 27 yrs after 1st diagnosis and after recent worsening of symptoms
242	2	macroglobuline mia	No	No	No	AR	Imp
243	4	breast, cervical	No	No	No	Long distance → L AMA	HFwE/Job; Imp
244	2	squamous cell of neck	No	No	No	R x 5 y	Dramatic Imp; stayed well all this time
245	1	thyroid	No	No	No	R	HF/Job/Sa
246	4	esophageal	No	No	No	2 weeks treatment. Then L AMA	Sa
247	1	ovarian	No PC	No	No PS	L ama. Then chemotx. Then R	HFwE/Job/Sa
248	4 NHR	breast	No	No	No	D	Arrived very late, very sick, in severe pain. Our treatments had no effect
249	1	prostate	No	No	No PS	AR	HFwE/Job/Sa
250	1	breast/ Paget's	No	No	Yes	R. No recent info	HF/Sa
251	4	colorectal	No	No	Yes	Long distance; L AMA	HFwE

252	2	CLL	No	No	No	Up and down leukocytes. Current	HFwE/Sa
253	2	breast	No	No	Yes	AR. NFI	HFwE/Sa/Job
254	4	colon	No	No	Yes	Inconsistent with tx, L AMA → some months → DDD	HF/Sa
255	2	prostate	No	No	No	R	HFwE/Strenuous outdoor Job
256	4 NHR	colon	No	No	No	D	Worse from rapid tumor breakdown without adequate elimination. Arrived very sick, very late with huge tumor burden
257	4 NHR	prostate	No	No	Yes	L AMA. NFI	Intense back pain. Sa
258	2	breast	No	No	Yes	R	HFwE/Imp
259	4 NHR	breast	Yes	No	Yes	Very briefly treated by us, on a brief break from chemo	Weak; Sa
260	2	breast	No	No	Yes	R	HFwE
261	3 NHR	giant cell endometrial	No, PC	No, PR	Yes PS	R	Imp/HFwE/Job
262	4	melanoma	No	Yes	Yes	R, then 2 years off diet, then DDD	Imp/HFwE during treatment
263	2	liver	Yes	Yes	Yes	L for surgery, then D from Valley Fever	Well until chemo and radiation and surgery, then Wor
264	1	prostate	No	No	No	R	Sa/Job
265	2	kidney	No	No	No	Red tumor size, L ama due to no $ for tx. NFI	Red, Imp. HfwE/Job during tx
267	1	prostate	No	No	No PS	Out of state → L AMA	HFwE/Job/Sa
268	4	colon	No	No	No	R, NFI	Imp
269	4	breast	No	No PR	No PS	Current	HFwE
270	1	prostate	No	No	No	AR for years, but now uncertain imaging	HFwE
271	2	CLL	No	No	No	AR	HFwE
272	1	prostate	No	Yes	No	AR, but first pessimism about prospects→ experimental txs→ same outcome→ AR	HFwE, Job
273	1	prostate	No	No PR	No PS	R	HFwE
274	4	breast	Yes	No	Yes	Chemo-resistant mets; no $ for tx. 5 years of chemo → then no more offered → D	Sa, Job during our regular treatments
275	3	squamous cell	No	No	No	R. No recent info	HF/Job
276		glioblastoma	No	No	No	NOFX → D	Wor

277	4	gastric	No	No	No	R, but no surgery available for damage created by tumor, D from complications	Imp/ HF, then Wor from complications, after cancer was gone on imaging.
278	3	lymphoma	No, PC	No	No	R, then recurrence; then AR, then recurred→ no chemo	HF/Sa/Strenuous outdoor Job for years after R. Then recurred, then chemo → now Wor
279	4	lung	No, PC	No	No	L ama-No$, NFI, then D 2 yrs later	Sa
280	4 NHR	colon	No PC	No PR	No PS	Cancer had metastasized from neck to feet, and to most major organs before patient started our treatments. NOFX, NFI	Our treatments did not work for this patient
281	4	breast	No	No	No	Only a few treatments → L AMA due to no $ → D	Arrived very late; one breast totally consumed with cancer
282	2	breast	No	No	No	L ama, NFI	HFwE/Sa
283	4	breast	No	No	No	L ama, NFI	Sa
284	4	pancreatic	Yes	Yes	No	D from chemo reactions	HF till 2nd chemo treatment, then hospital
285	1	rectal	No	No	Yes	R. Then chemo → D	Sa; strenuous outdoor job during tx
286	3	lung	No	No	No	AR, L ama, then had chemo, then quickly sickened and D	Pneumonia during treatment, complications, hospital. But tumors gone.
287	1	breast	No PC	No	No PS	R "so far so good"	HFwE
288	1	gallbladder	No	No	No	AR; stable, then chemo. "Chemo made my cancer worse."	HF/Sa, then Wor during chemo
289	2	breast	No	No	No	AR	HfwE/Job
290	1	CLL	No	No	No	R Then had hip replacement→well now	HF/Sa
291	4	NHL	No PC	No	No PS	R "Naturopathic medicine rescued me."	Imp
292	3	squamous cell	No	No	No PS	NOFX, D	Our treatments had no effect for this patient.
293	1	prostate	No	No	No	AR x years, then a stroke, now recuperating	HFwE/ Job
294	3	colon	No PC	No	No PS	AR	HF/Sa
295	3	testicular	No, PC	No	No	R, "doing fine"	HFwE/Strenuous outdoor job
296	1	CLL	Yes	No	No	R "doing good"	HF/Sa
297	4	adenoid palate	No	No, PR	No	L ama, then 1 year, then D	Same
298	1	prostate	No	No	No	L ama, NFI	HF/Sa

299	4	liver	No	No	No PS	L following stroke; now recuperating	HFwJob; then severe drug rxn→stroke
300	1	breast	No	No	Yes	R	HF wE/Sa
301	1	colon	No	No	No	Imp; AR. Then recurrence, then D	HFwE/Sa; bicycled miles per day during tx
302	4	liposarcoma	No	No	Yes	R	Imp
303	4	colon	No PC	No	No	L ama, then two months, then D	Arrived very sick, very late
304	4	breast	No PC	No PR	No	NOFX, D of complications from liver mets	Arrived very sick, very late
305	4	esophagus	Yes	No, PR	No	Severely sickened with each chemo treatment, then D	Wor after chemo treatments.
306	4	cervical	Yes	Yes	Yes	Current. After diagnosis, but before chemo, "I have never felt better in my adult life."	HF/Imp/Job
307	4	ovarian	Yes	No	Yes	Current	Imp
308	3	squamous cell, throat	No	No	No	Stable for several months; L, Wor. D	HF/Sa during tx
309	3	breast	No PC	No PR	No PS	R then recent recurrence; "I'm convinced you kept me alive as long as I am."	HF/Sa/Job, then left then Wor
310	1	breast	No	No	No	R, NFI	HF/Sa
311	4	cervical	Yes	No, PR	No	L, then 1 month, D of chemotherapy side effects	Arrived very sick, very late. Sa
312	2 NHR	breast	No	No	No	Spontaneous remission (Patient only had one of our treatments then no$, then L ama.) AR with no other tx → we probably deserve no credit for outcome. Then recurrence, then seldom txs due to no$ Then D	HF/Sa then L then Wor
313	2	breast	No PC	No	Yes	Recurrence after chemo; inconsistent tx	Up and down
314	4 NHR	colon	No, PC	No, PR	No, PS	Came in late stage, after hospice, NOFX, L, then 1 week, D of hepatic coma	Arrived very sick; very late.
315	4	lung	No	No	No	Pt discouraged from effect of brain mets → L, then one month, then D	Wor from brain mets, but Imp lungs
316	1	lymphoma	No	No	Yes	R prior to surgery (clear pathology report). NFI	HFwE/Job
317	2	liver	Yes	No, PR	No	L, NFI	Sa

The results in Table 1 are summarized as follows:

Table 2: Summarized outcomes of naturopathic management of 317 cancer cases

Outcome	Number of patients	Average number of months this group of patients stayed for treatments *	Number in each group also receiving chemotherapy	Number in each group also receiving surgery
Remission or assumed remission	151	3.7	7	47
Died while still only in our care, following all of our protocols	20	2.2	0	1
Iatrogenic death in hospitals or by MDs	20	2.7	14	7
Of those who left before finishing treatment, number who died after leaving (except for DDD)**	46	2.7	1	10
Death after dietary dispute	12	No data	1	2
Still being treated, not yet in remission	18	4.0	3	10
No current information but never known to be in remission	33	1.4	3	9
Waiting to know status, or conflicting information	17	No data	0	2
Total	**317**		**29**	**88**

***This column has not been updated since 2010, due to the labor-intensive nature of this research, and not much expected change or significance of any change.**
**** Please see legend of abbreviations at the head of Table 1. For example, DDD: death after dietary dispute.**

I call all the cancer survivors every summer to annually update the data for this paper, based on patients' subjective reporting of their wellbeing. Although it would be more scientifically and statistically valuable to insist on, with all former patients, and to receive updated, comprehensive, whole body imaging to confirm continued remission, expecting compliance with such a demand is not feasible. We therefore have to rely only on subjective reporting of health status by telephone. Speaking by telephone year after year with former patients who consider

themselves well, whose last imaging was clear, with no further cancer treatment since leaving our clinic, have been grouped together in the category of "remission" in this study. "Assumed remission" (AR) satisfied fewer of these criteria, but involved at least stable good health of at least 6 months following cessation of our treatments. Beginning in July 2009 and continuing through the summer of 2013, I found all the patients who were in remission stayed in remission by self-reporting, with the exception of 16 people. 10 of those 16 now have a recurrent cancer, one died after recurrence, and five are back in remission for more than one year. I could not reach 38 patients.

94 patients left our practice before completing our treatments. 20 patients were killed in hospitals by medical procedures, non-cancer iatrogenic causes or simultaneous chemotherapy. The above numbers do not include any of the currently treated patients, because their complete data is not yet available. Of the 223 patients who were steadfast in treatment, 151 went into remission, and 32 died while still our patients in our care alone. Of those 32, 12 died after a significant dietary dispute with us. The remainder is 20 patients who died while still our patients, under our care alone, following all of our protocols. This reflects a failure rate of 20 / 317 = 6% of the total patients we treated, or a failure rate of 20 / 223 = 9% of the patients who were steadfast in their treatments and followed all of our recommendations. Of the 223 patients who were steadfast in treatment, if we simply look at survivors, without confirmation of remission, then our success rate = 100% - 9% = 91%.

223 steadfast patients minus 20 killed by iatrogenic causes, minus 12 who died after a dietary dispute leaves 191 patients who were steadfast and made good decisions. If we consider that we had 151 in remission of 191 who were steadfast and made prudent decisions in the treatments, then the remission rate is 79%.) Late Stage IV patients tend to not do well with our treatments, although even early stage IV patients seem to have a good likelihood of going into remission.

It cannot be emphasized enough that cancer treatment has been far more effective at our clinic when patients began treatment as early as possible after diagnosis. For all stages of cancer between Stage I and early Stage IV, the success rate is between 76% and 100% (Table 5). However, for late Stage IV, the success rate has been only 32%. After a certain critical juncture of loss of vitality and overwhelming tumor burden, our treatments are as unlikely to work for the patient as any other available treatment. We therefore strongly advise against a strategy of postponing natural treatments until after chemotherapy stops working.

27 of 32 patients who died while only being treated by us were Stage IV at start of treatment. This paragraph describes the ordeals of some of those individuals. One Stage IV patient had over 36 bone metastases, over 50 total metastases, and chose to have chemotherapy during our treatment (Patient #171). Three others began treatment with a tumor load that was almost a cubic foot in the abdomen (Patients #101, 117 and 256). Another chose not to follow our main dietary recommendation during the last month of his treatment, i.e. not to eat sweetened foods (Patient #222). The latter patient's tumors had reduced considerably during our treatments. Of the 2 pancreatic tumors, one disappeared completely, and the other shrank to approximately half the volume. This was after they had not been reduced at all by previous chemotherapy, and his oncologists had given no hope of recovery (NHR in Table 1). During this time, the patient stayed very physically active, doing construction work in his own house at age 67. Several

weeks went by, and then new pain arose. The patient then admitted to starting to eat cookies every night after dinner for the past month, which was contrary to our main dietary treatment focus, to be described below. Within 2 weeks he was dead of pancreatic cancer with new, extensive metastases. Numerous others in this group had also declined our main dietary recommendation. Another had an extensive, fast-growing inoperable glioblastoma at start of treatment, had improved briefly, then worsened and died (Patient #149). Others had cancer that our treatments simply had no effect on. Another decided to enter hospice before finishing our treatments, and we could not obtain information about how much morphine he had been given (Patient #143). And yet another had an unfortunate combination of severe constipation with fast tumor breakdown (Patient #177). This combination allows toxins to build very quickly in the body, and we could not clear them out fast enough to save her life.

Most of the late stage cancer patients who died while still only in our care arrived to our clinic very late in their disease process, years after first diagnosis, and after one of two things: 1) they had been told by an oncologist that there was no remaining hope, or 2) they had never seen an oncologist and had a growing tumor burden that had been untreated for years.

Table 3: Patients who died while only in our care, and stage at diagnosis

Stage	**Number of patients**
I	1
II	1
III	3
Early Stage IV, still functioning, activities of daily living	12
Late Stage IV, very sick, very late arrival to our clinic	15
Total	**32**

Table 4: Patients in remission or assumed remission during our care, and stage at diagnosis

Stage	**Number of patients**	**Previous chemotherapy with active cancer at start of our treatments**	**Number in each group also receiving chemotherapy concurrently**	**Number in each group receiving radiation concurrently**	**Number in each group receiving surgery concurrently**
I	64	6	2	4	19
II	29	4	0	1	14
III	14	6	0	1	3
Early IV	37 (a)	9	5	2	12
Late IV	7 (b)	3	0	0	1
Total	**151**	**28**	**7**	**8**	**49**

Table 5: Success rate by stage of cancer

Stage	Total patients treated until remission or death	Remission	Died	Remission / Total = Success rate
I	65	64	1	**98%**
II	30	29	1	**97%**
III	17	14	3	**82%**
Early IV	49	37	12	**76%**
Late IV	22	7	15	**32%**
Total	**183**	**151**	**32***	**83%**
Stage I through early Stage IV	**161**	**144**	**17 (including DDD)**	**89%**

***This number includes those who did not follow our dietary recommendations.**

Only 7 of the 151 patients we treated who went into remission also had concurrent chemotherapy (Table 4). Of all our other patients who went into remission, most had refused current chemotherapy prior to starting our treatments, although some had chosen to have it in the past. It is common for a patient who finds their way to our clinic to comment that cancer is difficult enough to endure, without the additional burden of the ill health attributable to chemotherapy alone. Our clinic's policy is never to insist that a patient either have chemotherapy or avoid it, because of the profound and severe effects on the health of such drugs and our respect for the individual's right to make his/her own healthcare decisions.

Of the patients who had chemotherapy along with our treatments, all commented on feeling stronger and better able to tolerate their chemotherapy with our treatments. One patient whose tumor volume had reduced by 80% subjectively attributed this good result to both our treatments as well as chemotherapy, an evaluation that seems to defy proof or disproof (Patient #207).

49 of our 151 patients to go into remission also had either surgical resection or debulking of their tumors while getting our treatments. This would suggest that surgery is often a reasonable choice, perhaps even a life-saving choice, when available, and that the combination of surgical tumor resection and natural treatments was a feasible strategy for a successful outcome, although not always required for a successful outcome.

Table 6: Results for patients completing our program with all dietary recommendations and choosing not to have chemotherapy

Outcome	Number of patients
Remission without chemotherapy	144
Now out of remission after stopping our treatments, but maintaining diet	10

Table 6 shows that our treatments are likely to ensure continued remission. 140 / 151 = 93% of those who went into remission with our treatments and maintained our dietary recommendations afterward were found to be in remission as of July – August, 2013. We are not aware of such a high rate of sustained remission achieved at other clinics or with other cancer treatments, conventional or natural.

One of our patients in remission is and has been for years the only known survivor of Stage 3 giant cell endometrial carcinoma (Patient #261), at least according to published medical literature.[61] This remission occurred with only natural treatments after all three conventional cancer treatments, chemotherapy, radiation and surgery, were each tried multiple times and failed for this patient.

Table 7: Results for patients who left to have chemotherapy

Went into remission following chemotherapy	**Died following chemotherapy**	**Not now in remission, but surviving both chemotherapy and cancer at this time**	**Evidence of remission from our treatments alone prior to starting chemotherapy**	**Total who left our clinic to have chemotherapy (total of all outcomes)**
4	9	5	6	**24**

Table 7 shows that leaving our treatments to pursue chemotherapy only possibly benefited 4 of the 24 patients who left. However, it is possible that those 4 would have gone into remission if they had continued with our treatments alone.

Table 8: Results for patients for whom the treatments had no apparent effect

Stage at start of treatments	**Number of patients**	**Of these, how many had prior or current chemotherapy**	**Of those never having chemotx, waited years with growing mass before seeing a doctor**
Stage I	1	0	0
Stage II	0	0	0
Stage III	1	0	0
Early Stage IV	4	3	1
Late Stage IV	12	6	5
Total	**18**	**9**	**6**

Table 8 shows that 15 of the 18 people for whom our treatments had no apparent effect either had prior chemotherapy or waited years with a growing mass before seeking treatment. This is

likely because the patient's tumor burden became more resilient either due to the chemotherapy-imparted resistance to treatment or due to an unopposed sizeable cancer burden having the opportunity to establish a stronghold in the body.

We have data for change in tumor size for relatively few patients. It must be considered that by the time a person seeks the help of a naturopathic physician for any ailment, they have often rejected, for one reason or another, the conventional medical system, leading to a distrust and disdain for conventional imaging. Imaging such as PET/CT fusion is a "hard sell" to such people. ("You want me to have radioactive glucose after telling me not to eat sugar?") Biopsy was even less likely to be acceptable to our patients. Many of those patients left our practice for one reason or another, as discussed below, before we had any information about changing tumor size. A strong will must be present in a person to ignore the exhortations of oncologists and worried loved ones, and to pursue treatment by a naturopathic physician. This strong will easily enables rebellion against naturopathic physicians and our recommendations as well. Because we have so little information on which patients actually had increased or decreased tumor load, we have not yet had the advantage of the best way to determine the success or failure of our treatments. At present, we primarily rely on MRI imaging of the part of the torso or head or neck with the known tumor burden prior to finishing the treatments. For the blood dyscrasias, we rely on blood tests. After finishing the treatments, our contact is one time per year with each patient, every summer, by telephone, to inquire about the current state of health. However, many of the patients in remission choose to maintain an ongoing intravenous nutrient treatment one time per month. Of those patients in remission coming in for one time per month ongoing intravenous nutrient treatments, not even one of those patients has come out of remission. Therefore, we recommend this strategy for all of the cancer patients who have been treated by us.

There is another factor that we kept track of from July 2010 to June 2011: that year we also called people who came in to our clinic for an initial consult, but did not start our treatments. Of the 4 who visited that year, but never started our treatments, and whose family we were able to contact by phone, all four have died, according to their family members. We are no longer calling people in this category, because we are focusing our attention on the people who chose to undergo our treatments.

It cannot be assumed that those for whom our treatments failed to reduce cancer are entirely worse off. Most have described a better quality of life since starting the treatments. For example, one of the patients with stage IV breast cancer, and an increased tumor load since starting our treatments, described herself as more fit than ever since beginning our treatments, far more healthy than when she had previous chemotherapy, at 68 years old, walking 2 miles up and down hills in 22 minutes, gradually improving her time right up to the time she chose to have concurrent radiation, at which point her wellbeing, her energy, her tumor burden and her disease state began to worsen dramatically (Patient #153). Although we have not yet found the necessary combination of therapies to reduce and eliminate such a resilient cancer as hers, this patient expressed to us that the quality of life that she gained from our treatments was tangible and valuable to her.

It also cannot be assumed that conventional treatments would succeed when ours did not. For example, an ovarian cancer patient (Patient #90) was persuaded by family members to stop our

treatments and resume chemotherapy, even though chemotherapy had not eliminated her cancer in the past, and our subsequent treatments did in fact reduce the tumors to a fraction of their original size, in only a fraction of the usual treatment time. When this patient complied with her family members and resumed chemotherapy, the remaining tumor mass grew again, steadily through two months of chemotherapy. The oncologist then gave up and offered her no more chemotherapy and directed her to hospice care. A number of other patients also did very well in measures of tumor size and wellbeing with our treatments. Then in some cases, oncologists or family members persuaded or pressured or coerced the patient to have chemotherapy instead. Usually, that patient then quickly declined and died.

For the 94 patients who decided to leave before finishing our treatments, it is difficult to assess the degree of success or failure. Reasons for leaving were often not given. There was sometimes a phone message requesting to cancel the future appointments without explanation. However, when we were told reasons for leaving, the following were common:

1) Financial reasons: no insurance reimbursement made it hard to continue paying for our treatments out of pocket. This was by far the most common reason given. This is expected to change in 2014 when the Affordable Care Act mandates insurance reimbursement of naturopathic medicine, to the best of our understanding, under new private insurance plans.
2) The patient did not feel that anything important was happening with the treatment. There was a strange viewpoint expressed by some patients that cancer is not very frightening, once they saw that they, as well as all of the other non-chemotherapy cancer patients in our IV rooms maintained their vitality, their hair and their bodily functions, and almost always with improved fitness. This led some to the dangerously wrong conclusion that cancer was easy to conquer, could probably have happened at home with store-bought nutrients, and that our treatments had not accomplished much, and perhaps had not even contributed to their continued wellbeing.
3) A related viewpoint was that improvement in the patient's condition should have been faster and more dramatic. If the condition seemingly stayed the same, some patients viewed this as evidence of failure, of not defeating cancer fast enough, and concluded that the treatment was not working, and that they should not waste any more time or money pursuing it, and that it was time to leave and explore other avenues.
4) Family members or oncologists disapproved of natural cancer treatment and persuasively urged chemotherapy exclusively.
5) The patient had traveled from another state to receive our treatments, but wanted to return home to be with family, regardless of expected outcome.

***Table 9: Summary of quality of life changes, as of July 2011, by assessment of naturopathic physician along with patient self-evaluation during naturopathic care of the patients whose wellbeing stayed the same or improved prior to July 2011**

Quality of life changes	Number of patients	Number in each group who went into remission	Number in each group also receiving chemotherapy
Came in with high wellbeing / Still the same way	92	70	3
Came in occupationally functional but not physically fit /Ultimately improved vitality	34	25	3
Came in occupationally functional but not physically fit / Still the same way	17	3	4
Total	**143**	**98**	**10**

***Note: This table has not been updated since the 2011 edition of this paper, due to the labor-intensive nature of this research, and not much expected change in proportion of the different groups.**

If one considers quality of life as a criterion for success, then of the patients who stayed well or got better during our treatments, 143 patients out of 165 who had come to us prior to July 2011, make a success rate of 87%. For most of the remaining 13% of total patients, they mostly came to us after exhausting all conventional cancer treatments and were mostly late stage 4, or had other co-morbidities. These co-morbidities included: pulmonary fibrosis, asbestosis, uranium poisoning, radiation poisoning, more than 15 CT scans done on one individual, chronic antibiotic-resistant infections, Clostridium difficile, scleroderma, cirrhosis, pneumonia, asthma, diabetes, rapid tumor breakdown with poor elimination, radiation illness, chemotherapy intolerance, complications from previous surgery, blood clots where the tumor had compressed multiple veins before the tumor was eliminated, hepatic coma.

It is important to note that not all of the patients did all that was recommended by us. For example, although we recommend beginning our treatments immediately after diagnosis, almost all patients delayed naturopathic treatment for months to years after initial diagnosis of cancer, mostly due to lack of information to the public about the effectiveness of natural treatments for cancer. The enormous disadvantage of such delay to the naturopathic physician's work and effectiveness cannot be overstated. Chemotherapy is known to impart a resilience to tumors that makes it hard for any subsequent treatment to have an effect. It is surprising that our success has been as high as it is, given the severe disadvantage of beginning natural treatments months to years after cancer has had a head start in its growth and takeover of the body, as well as the debilitation of the general health of the patient.

Other patients chose to disregard the dietary recommendations that we made or to only observe the recommendations partially. Others chose to have fewer in-office treatments than were recommended. Others decided to choose only some of the recommended treatments due to financial constraints or inconvenience. However, as our clinic has demonstrated longer, sustained success with an ever-increasing number of patients, and a majority obviously well patients are present and visible in our clinic on our busiest workdays, and the value of our treatment protocols become obvious to more and more visitors to our clinic, both patients and their family members, compliance with our recommendations has generally been much better during the last few years than previously.

16 of our cancer patients have come out of remission. 5 of those are now back in remission. 4 of the 16 discontinued our main dietary recommendation. This was especially disappointing to us because after being out of contact for almost two years after they went into remission, one called to inform us that she was now physically active and had at last stopped smoking. (She had smoked all through our treatments.) Months later, she went off of the diet, and then developed recurrence of cancer and died. Another patient went quickly back into remission. Another opted to be treated by chemotherapy for her recurrence. Twelve of the 16 who came out of remission are living productive lives, as confirmed by recent contact with them. One is currently back in our treatments.

Discussion

151 patients went into remission during our treatments of a total of 171 who complied with all of our treatment protocols until either remission or death. This is 151/171 = 88% success over all stages and all types of cancer. If one considers those who were steadfast in their treatments and died, divided by all who were steadfast in their treatments, then the failure rate is 20 / 223 = 9% of the patients who were steadfast in their treatments and followed all of our recommendations. Of the 223 patients who were steadfast in treatment, if we simply look at survivors, without confirmation of remission, then our success rate = 100% - 9% = 91%.

Numerous natural agents were simultaneously employed to reduce or inactivate or necrose or eliminate human neoplasms in vivo. We chose to use these agents together because cancer is a multifactorial disease and has not yet been fought effectively in a majority of patients with a single agent. Specific combinations of natural substances were chosen with regard to the type of cancer and circumstances of each individual cancer patient. Licensed naturopathic physicians are well-qualified to design such treatment programs because of our broad and extensive training with natural and conventional substances and how to combine them.

Successful outcomes were more likely with steadfast patient compliance during the entire duration of the treatment process. Although our results are a strong improvement over any other cancer treatment protocols that we have found, both conventional and natural, if measured by either patient remission or survival, these treatment strategies are still not adequate to eliminate all patients' cancers and must be further developed.

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