# No Fear Cancer Treatment

**Note to all readers:**
**Some of the medical terms in this presentation, as well as the abstracts, may be foreign to you. Don't be intimidated by these words. There are numerous medical dictionaries, both on line by computer, at libraries and book stores. Since we are dealing with a potentially devastating disease, please take the time to learn their meaning, to better increase your chances of survival.**

You may believe that this is a crazy title for a cancer lecture; however a look at a few facts may change your mind.

Fear is the one emotion you cannot afford when making life and death decisions about your cancer treatment. It will cloud your judgment and you will be far more likely to react positively to any hope that is offered rather than take the time to look at facts.

Unfortunately, fear is the primary tool used in the sale of cancer treatments. What do you mentally picture when you are told you have, or may have cancer? In most cases, someone in our family or a friend has been stricken with cancer. We have seen the devastating effects of chemotherapy and radiation therapy and surgery. We have seen the slow lingering deaths with extended periods of severe and debilitating illness, hair loss, weight loss, depression, nausea, etc. What else can we envision for our own fate?

Let's look at a few facts about cancer.

According to the American Cancer Institute over 60% of cancer patients die from starvation.

No chemotherapy patient groups are compared to a similar group of patients that receive no therapy. What this means is that there is no study that shows the vast majority of chemotherapy is more effective than no therapy at all.

Almost all chemotherapy is listed as experimental. This implies that they are new and may offer hope after initial failed therapy. The common sales line is, "We have one more drug to try, it's experimental but I feel it's worth a try. The truth is that they are listed as experimental so that as a patient, you cannot sue the pharmaceutical company when it makes you more ill or kill you.

Many of the most commonly used chemotherapies have been proven to be useless in the treatment of cancer, yet are still routinely used. An excellent example is Lupron's use in prostate cancer. The following study, done at Johns Hopkins University demonstrates the dilemma:

**1**: J Urol 2001 Aug;166(2):508-16

**A structured debate: immediate versus deferred androgen suppression in prostate cancer-evidence for deferred treatment.**

**Walsh PC, Deweese TL, Eisenberger MA.**

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PURPOSE: We present a structured debate supporting the premise that immediate hormonal intervention has not been conclusively shown to provide a survival advantage in the management of advanced prostate cancer. MATERIALS AND METHODS: The literature emphasizing randomized trials was reviewed. Recommendations are based solely on a demonstrated advantage in survival. RESULTS: In patients with stage Tx Nx Mo or MI disease who did not receive other primary therapy there is no demonstrated survival advantage to immediate hormonal therapy. In men with positive lymph nodes who underwent radical prostatectomy a relatively small study showed a survival advantage in favor of immediate hormonal treatment compared to deferred treatment. This study did not reach the projected accrual of 240 patients and results have not been supported by other trials. In men with stages T2-4 Nx Mx disease who underwent primary treatment with radiotherapy a survival advantage for early hormonal therapy is primarily limited to high risk subgroups. In patients with biochemical relapse following primary treatment there are no trials. CONCLUSIONS: Because hormonal therapy is associated with the development of irreversible resistance in virtually all patients, it does not cure, there is usually a long interval from first prostate specific antigen elevation to the development of metastatic disease, and hormonal therapy has profound side effects and is expensive, delayed treatment is recommended in men with biochemical relapse following surgery or radiotherapy. Patients should be strongly encouraged to enter clinical trials to answer this question.

Now a normal intelligent person would ask how this is possible. How can we be told by an oncologist that this is an effective therapy, and be made to co-pay for this expensive therapy, when it has been proven to be ineffective? Good question. It is a very good question for your oncologist. Make sure you ask it if Lupron or any other anti androgen therapy is suggested for you.

This brings us back to the point of acting without fear. Act out of knowledge and the odds of your survival will rise dramatically, and the chance of serious side effects to cancer treatment may be minimized. We started with one suggested question; now let's go on to a few other important questions you will need to have answered before you begin any treatment.

Here are the first few questions you need to ask your oncologist:

1. Will you show me a few studies that verify the treatment you are recommending will increase my lifespan, when directly compared to no treatment?
2. Will you show me a few studies that will verify the treatment you are recommending will enhance my quality of life?
3. Please do not give me studies showing that the chemo or radiation shrinks the tumor. Please be specific and be sure the studies directly relate to longevity and quality of life compared to no treatment at all.
4. Will you get permission from a few of the patients you have treated with this method so that I can speak to them? Don't accept refusal from the physician due to a patient privacy issue. Any physician can ask a patient if they would be willing to speak with another patient. It is done by legitimate physicians all the time.
5. Should I change my diet or take any vitamins, minerals or other supplements? This simple question will tell you immediately if this physician is keeping up with hundreds of study findings from all over the world that have shown dietary changes and supplements that have a direct effect on many types of cancer.

Do not accept any excuses for their not complying with your requests. They are not only reasonable questions, the answers are critical for you to make informed decisions which may determine whether you or your loved ones live or die.

If the physician seems insulted or becomes angry, he is definitely not putting your interests first and another physician may be in order. If they say they are too busy to fulfill your request, they are already telling you they have not got the time to treat you in the best manner possible. Any therapy that is used consistently will have many case histories and studies that compare it to other therapies. If the therapy they are offering is really effective, providing these studies should be extremely easy and would take no more time than a few minutes to produce. Please remember not to be afraid at this time.

Especially, do not be frightened or intimidated by the physician you are INTERVIEWING for employment by you. Remember, "no fear", is most important when you are gathering FACTS in order to make decisions on what is the best course of treatment for you.

Common physician statements that instill fear, and the truth behind them:

1. "We caught this tumor just in time. If we move quickly, we have a much better chance of curing this cancer".

   Truth: The vast majority of tumors grow fairly slowly, with some growing exceedingly slow over a period of years. The only way to determine a tumors growth rate is to measure its doubling time. This is the medical term meaning the time it takes a tumor to actually double in size. It rarely is less than several months and even if it doubles in size every 3 months, you still have time to learn and explore all options of treatment. Most tumors have been there for a fairly long period of time. Don't be rushed by this type of physician statement. If yours is a rare type of cancer with a very aggressive tumor growth, still take the time to measure all options before deciding on a treatment. If you are unfortunate enough to have a lethal form of very aggressive cancer such as glioblastoma multiforma, de-bulking, or removal of as much of the tumor as possible may be necessary. If it is, you will still have time to discuss and decide on what therapy is best after the surgery.

2. "It's either too late to treat effectively, or it is very advanced. There is little I can do, but chemo or radiation may slow the progression and is worth a try".

   Truth: Remember the previous questions discussed. Regardless of what the physician tells you, or how hopeless it sounds, always ask those initial questions. If the therapy has no proof of being useful, why take it. It will provide additional income for your oncologist; they make about 1/3 of their total income through the sale of chemotherapy to patients. But it is not your oncologist's income we are concerned with. It is your health and well being. If it won't help and cannot be proven to help, it will almost certainly make your situation worse.

3. "This cancer is very easy to treat and has a very high cure rate".

   Truth: Cancer cells are created each and every day of our lives. We may produce anywhere from thousands to hundreds of thousand of these neoplastic cells daily. For those with a healthy immune system, these cells present very little challenge. The humoral immune system is responsible for producing cells that recognize the aberrant cells, mark them and destroy them. This is done constantly and is a normal part of life. It is only when the immune system has become compromised that the cancer cells can grow in an uncontrolled manner, thereby causing the onset on cancer as a severe life threatening disease. To say you can cure a naturally occurring process is nonsense and dishonest. The discovery of what caused the failure of the immune system is paramount in the successful treatment of cancer as is the repair of the immune system itself. Therapies that further compromise the immune system will invariably have an unhappy ending. This occurs due to metastasis of the cancer because the body no longer has the ability to protect itself.

The truth of this statement is easily verified by the results of a simple blood test called an AMAS. The following is a simple explanation of this test by Dr. Stephen B. Edelson, MD. It is the most accurate method of determining if a patient has active cancer known. It received its FDA approval in 1978. The abstracts following the AMAS explanation verify its extreme accuracy. The point being made and which will be understood after reading the following, is that after many years of using an AMAS test, both to diagnose and evaluate patient progress, I have never seen an AMAS reading of 0. This is very effective proof that all of us at all times have an immune system, that when functioning properly, will keep cancer cells under control. There is no cure for a naturally occurring process.

**By Stephen B. Edelson, M.D., F.A.A.F.P., F.A.A.E.M.**

**The AMAS Test (Anti-Malignin Antibody in Serum)**

In 1974, Dr. Samuel Bogoch (MD, Ph.D.) discovered a new antigen located on all cancer cells. He and his researcher / wife, Eleanor Bogoch, MD, founded Oncolab to do this test for research and later clinical purposes.

Dr. Bogoch is a Harvard-trained research neurochemist. He discovered that the outer coating on cancer cells contain sugar molecules over an inner layer of protein (glycoproteins). Cancer cells bump into each other and the outer layer is ground off—exposing the inner protein layer and the malignin antigen.

It took Drs. Bogash seven years to determine that the antigen was on all cancer cells, not just brain cancer which they were originally studying.

Due to cell recognition, our immune system spots Malignin. When it sees this foreign protein it produces antibodies to destroy it—Anti-malignin antibodies. This is what is measured in the study; it is our body's defense against cancer. By 1988, Dr. Bogash showed that the anti-malignin antibody killed cancer cells in the test tube.

Greater than 95% of patients with cancer have AMAS levels above 135. AMAS levels below 135 are seen in normal individuals who do not have cancer. Sometimes there is doubt about the test (borderline numbers) and at these times the test needs to be repeated and followed up at certain intervals.

Normal levels of AMAS are seen in successfully treated cancer patients and in patients who never had cancer. Cases of advanced or terminal cancer may also have normal levels or even very low normal. *The clinical status of the patient must be correlated with the AMAS test result*.

The test is patented and the FDA has approved it. The test is available for use in several areas related to cancer:

1. **Cancer Screening Test** - Today a check-up in your physician's office includes a history, a physical examination and selected laboratory tests aimed at detecting potential problems including cancer. It will now include an AMAS test, and thus might defer using a chest X-ray, proctoscope, CT scan, pap smear, and even mammography. These cancer screens will not be needed unless the AMAS test is abnormal.
2. **A Cancer Monitoring Test** - After cancer has been treated both the patient and the doctor want to know if the cancer has been cured or if some malignant cells are still in the body. The AMAS test can answer this dilemma. If there is cancer present, the AMAS test remains elevated.
3. **In Differential Diagnosis** - At times a shadow on a chest X-ray or a spot in the liver or kidney on a CT scan are suspicious for cancer and only a biopsy can tell. That is an invasive procedure. The AMAS test can tell you if the tissue is malignant. If the AMAS is normal, the lesion in question is not a cancer.

To date, over 1000 patients with breast cancer have been studied using the AMAS test. It has been used to tell if the cancer has been cured. New data suggests that the breast cancer cannot be said to be in remission unless the AMAS test returns to normal. AMAS has found breast cancer as small as a pencil dot long before a mammogram can show it.

The AMAS detects all common cancers and the uncommon ones too. Studies on more than 6000 patients show the sensitivity of AMAS to be greater than 95%. The false positive rate and false negative rates are about 1% of the total, making the specificity about 99%.

Dr. Bogoch will probably receive the Nobel Prize for this unique discovery that will save hundreds of thousands of lives.

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

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

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

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

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

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

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

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

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

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

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

Beth Israel Hospital, New York, NY.

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

Remember, anything that compromises your immune system dramatically reduces your chances for long term survival. It is not the size of a tumor that is normally the cause of death. It is almost always metastasis that is the cause of death. Remember this when you are evaluating offered treatments. **It is of the utmost importance.**

Never be intimidated by your physician. Always remember that they are your employee and they are being paid by both your insurance company and you. They work for you and if they seem unaware of that fact, take the time to find another physician. You must take control of your treatment options from the beginning. You will only get one chance to choose your first therapy.

**TAKE CONTROL OF MONITORING YOUR PROGRESS**

Do not count on your physician to be adequately trained in monitoring your progress, many will not even know what an AMAS test is. Their education has been very limited and they have never been taught how to evaluate research data. This is the data they rely on to determine what treatment to use on you, the patient. They read abstracts of studies paid for by the pharmaceutical companies. These studies are hardly useful. The data is skewed and the reported results are never compared to “no treatment”. What this means in simple terms, is that the patient may live better and longer with no treatment. They do not compare any current treatment with those receiving no treatment for a reason. An exceedingly large number of patients actually die from the effects of chemotherapy and radiation. Unfortunately for the general public, the real cause of death is hardly ever listed as cause of death. The death certificate invariably states that the cancer is the cause of death. This keeps both the medical community and the public from ever learning the truth of treatment options and their long term outcome.

It is vital to be able to determine if the treatment you have chosen is being effective. The following tests should be run every 30-45 days:

1. AMAS test.

If your immune system is still functioning enough to produce antibodies, this test is an extremely accurate method of monitoring the progress or regression of the cancer. If the numbers are going down, the number of cancer cells is decreasing, thus the therapy is being effective. If, on the other hand, they are rising, the current therapy is not being effective. Knowing if the therapy is ineffective early gives you the chance to change therapies without wasting time. This dramatically increases your chances of long term survival.

2. CBC-complete blood count

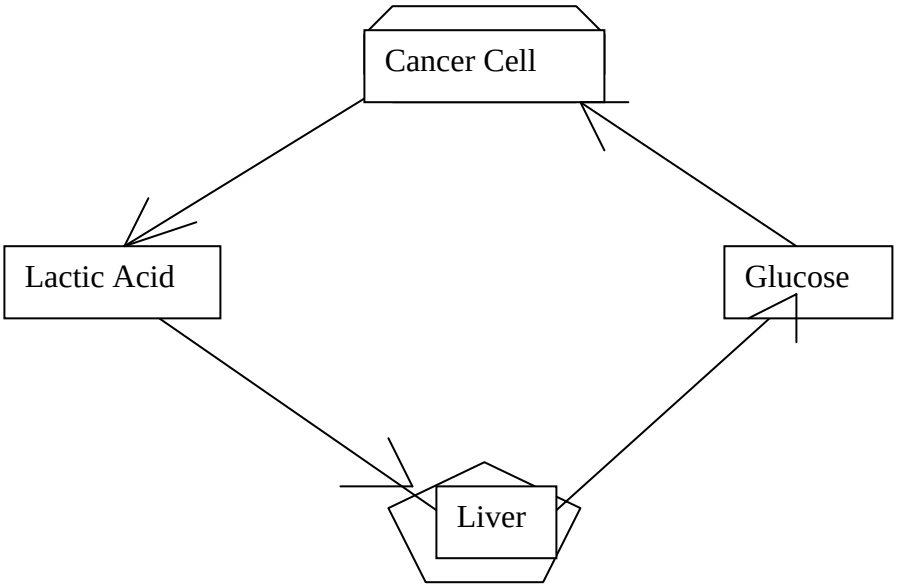
A complete blood count will tell you if your immune system is functioning and will enable you to verify the AMAS results, knowing they are accurate. It will also give warning of other potential problems, such as bacterial infections or decreasing numbers of cancer fighting cells.

3. A complete lymphocyte subset panel.

A complete lymphocyte subset panel gives a very accurate picture of your humoral immune system. Remember that it is the humoral immune system that enables the bodies own defenses to control cancer growth. It should include all the major lymphocyte subsets that are relevant, such as CD3, CD4, CD8, CD57, CD19, etc. By seeing if these numbers go up or down you can determine if the effect of the therapy you have chosen is beneficial to your long term survival. If your immune system is being destroyed, your chances for long term survival are dramatically decreased. IF the treatment is successful, the lymphocyte subset panel should continually improve.

4. CMP-comprehensive metabolic panel

The comprehensive metabolic panel gives a picture of several organ functions. Therapies that shrink tumors are useless if they destroy the heart, liver or kidneys. The cause of death on the death certificate will read cancer, but the real cause is most probably the treatment. Monitor these organ functions carefully. This panel will also give you glucose levels. As the cancer progresses, glucose levels and lactic acid levels will rise. As the number of active cancer cells drop, the glucose and lactic acid levels will drop. The mechanism is simple:




This mechanism also directly relates to dietary changes that should take place. This will be discussed in greater detail later.

5. CT scans

CT scan with contrast can be used to help determine if tumor size is changing and if metastasis is occurring. Always have these checked by at least one other radiologist for a second opinion. You will often find differences of opinion, and you need to be aware of all the facts.

6. Cancer antigen tests

These tests are not nearly as accurate as the AMAS, but when applicable, they should be used as an additional indicator of the success of a therapy. If they are going down, the cancer is responding to the therapy. If they are not going down, seriously consider changing therapies.

7. Never use tumor size as an indicator of cancer therapy success. Even if the tumor is shrinking due to a current therapy, if your immune system is being destroyed, more tumors will return. Unless you are dealing with an aggressive brain tumor, or a tumor that is directly impeding a normal organ function, you now have time to learn the doubling time of your tumor. If, for example, you have a 2cm tumor, with a doubling time of 12 months, you have a great deal of time to evaluate your current therapy and change it if the monitoring tests indicate it is not being beneficial.