CHAPTER 8

ATROPHY, ANAPLASIA, AND NEOPLASIA

One may compare the correction of nerve atrophy and neoplasia very nicely in retinal cases where cell reconstruction can go on, but not cell reproduction; we may also compare the corrective responses of anaplastic and neoplastic tissues in reproductive cells. In all four situations, the correction is achieved by restoring normal FCG function, and thus a Least Common Denominator is established in these supposedly widely varying conditions. So the basic pathology is the same. There is a suggestion that the requirement for neoplasia is the loss of the functional mechanism.

In Glioma, there is no development of functional mechanism, because the cells are too embryonic and immature or undifferentiated. In the Sympathicogonioma case, one sees how the nucleus is separated from the functional mechanism, the fibrillar structure. The latter lays separated as a fibrillar syncitium supported by cytoplasm, while the reproductive portion is separated off as individual entities, — cells. Thus the functional mechanism is discarded. The return to normal which, we are not able to see must be like the maintenance of the normal; a correct balance and interaction of the reproductive and functional mechanisms. Thus the energy production in nerve cells must serve their work of repair and Nissle substance synthesis only to keep them normal. But when these systems are blocked, the energy has only one place to go and that is mitosis. When the working part is shed as in Sympathicogonioma, of course, there is the visible separation. The very high-grade malignancy of such neoplasms may therefore be understood.

In this case of Neuroblastoma, which will be detailed a few pages further on, visible separation of reproductive and functional elements of the cell is demonstrated, even though the child is born with the neoplasm, latent in his system. In the Retinoblastoma case, the functional mechanism did not exist in the cells that went malignant, so the mitotic mechanism had no other course than to use the energy produced in the nucleus for reproduction. There was no other path for it to follow. It appears from these two cases alone, that energy production is primarily evolved in the nucleus, even though the nucleoprotein grana are found throughout the cytoplasm. In the Glioma case, these granules did not exist, while in the Neuroblastoma case their connections with the nucleus were severed.

In the Optic atrophy case to follow, complete atrophy was not possible as yet, as a result of the Retino-choroiditis, for regeneration of the affected cells took place with restoration of function. A bacterial origin, of the toxic injury, is of concern here.

There is another situation due to toxic injury, that of chronic alcoholism, where this weakness

can be transmitted from parent to child for several generations. A case of Delirium tremens presented on this topic, should interest the geneticist, in view of the foregoing remarks, for indeed hereditary transmission is concerned in all of these conditions. Even in this case of Delirium tremens, the effect of a toxin on the cerebral cells, the connection between the genes and the functioning elements is concerned, — the nucleus and the mitochondria. Evidently, this is the toxin that caused the cancer in this case, for the Delirium tremens returned during the 12th week reaction in his recovery from cancer of the face. The patient himself had never used alcoholic drinks but his father, and other predecessors, did drink themselves to death. Still, the patient gave the D.T. symptoms during the correction of the neoplastic defect. Both defects were corrected by the Reagent, which corrected the hereditary Neuroblastoma defect, in the case to follow very shortly.

This case, with its high malignancy characteristics, teaches another very important fact; namely, that trauma, with its circulatory injury and consequent anoxia alone, is not sufficient to cause cancer. Also it teaches that the recovery from this disease removed the carcinogenic factor that requires anoxia to become effective as our Postulate outlines. For as will be seen this boy, after being cured by restoration of his FCG Survival Factor, did not again get cancer after being severely injured by the automobile accident that bruised him at the site of the former rumor. This case repeats the lesson learned from case **No. 11** to follow.

Recovery Reactions

Cyclic reactions: 1) often characterized by the symptoms of the pathogenesis showing up in the reverse sequence to their coming, 2) accompanied by a local congestion at the lesion, 3) as well as constitutional symptoms of grippiness, as occurs in so many virus infections, are to be expected periodically, while recovery is in progress. The cycles run in a definite periodicity, in which a three-hour unit, or more often, a twelve, twenty-four, thirty-six, seventy-two, or eighty-four hour interval, is usually observed. Thus a reaction of chills, fever and achiness can show up twenty-four, seventy-two or eighty-four hours after the Treatment. Or, it may come the third week, the sixth week, the ninth week, or the twelfth, twenty-fourth, thirty-sixth, sixtieth, seventy-second, eighty-fourth, ninety-sixth, hundred and eighth, or even later multiples of twelve weeks.

The local features in the lesion are: congestion, swelling, hyperasthenia, hyperreflexia, more or less pain, local heat, and maybe some bleeding. But this passes off in three hours or a multiple thereof, and improvement is then noted. When biopsies are taken of the lesion undergoing recovery in this way, it will be found to undergo: 1) a coagulation necrosis, 2) then a calcification, much like accompanies or mediates the digestion of a blood clot or of milk, 3) vascular in-growth is observed, first angioblastic and fibroblastic tissue, and 4) mast cells or other white blood cells to help carry off the debris. (Koch, New York, Medical Record, October 30, 1920) 4) Angioblastic tissue finally replaces the growth, and then 5) functionating

parenchyma grows in to reform the organ on physiological lines. The cure is therefore complete, as it could not start without preliminary elimination of the pathogen, and its functional status is returned. The sequence of events during reconstruction is exceedingly interesting and will be discussed.

PRIMARY ATROPHY OF THE OPTIC NERVE AND RETINA SEQUEL TO SCARLET FEVER

CASE No. 6

R. J., 14 years old, gave a family history negative to tuberculosis and cancer. The pretreatment control period and diagnosis are well described in the correspondence between the Henry Ford Hospital and Jennings Hospital experts as follows:

HENRY FORD HOSPITAL
DETROIT, MICHIGAN

Henry A. Du----, M.D. September 10, 1946
7815 E. Jefferson Ave., Detroit, Michigan

Case No. 453242 Re: R. J.
Dear Dr. Du----:

Our first contact with the above named child, according to our records, was a precamp examination done by Dr. J. A. Jo---, of the Division of Pediatrics, in July, 1945. At this time his vision was recorded as being 20/20 bilaterally. He was seen by us April 15, 1946, at which time he had developed a scotoma in the right eye. Vision without correction on the right was 8/200, left 20/20. External examination of both eyes revealed them to be normal. Funduscopic examination of the right eye revealed a normal lens. In the macular area there was a chorioretinitis which fits the description given by you in your letter. The left eye was normal to Fundascopic. Tangent screen examination was done which showed an absolute scotoma in the supracentral region. The periphery was normal; red field was reduced.

He returned to Pediatrics for a general physical examination by Dr. Jo----April 17. Dr. Jo---- noted that the child had been seen by Dr. Ca--- who had applied .1 mgm. of 1/10,000 O.T. He had been negative to 0.01 mgm. when seen by Dr. Jo---- the previous year.

Sinus and chest X-Rays were made. Dr. Do--- reported them as showing chronic pathology of both antra and probably the ethmoids and frontals as well, and were suggestive of a pan sinusitis.

There was only a moderate increase in the broncho-vascular markings in the bases.

Blood count showed on 4-16-46 a hemoglobin of 13.5, white blood cells 10,100, red blood cells 4.66, polymorphonuclears 46, small lymphocytes 52, monocytes 2.

He was last seen April 20 by Dr. Di---- for ear, nose, and throat consultation. No foci of infection were found in the ears, nose or throat to account for his eye condition. Dr. Di---- reviewed the sinus X-Rays and washed out the left antrum. The return flow was clear.

He did not return for follow-up eye appointment, and we have not seen him since. Trusting this information will aid you in your studies, we are,

Sincerely yours,

Henry Ford Hospital

Per; /s/ E. L. W.----, M.D.
M. W. S---, M.D. Surgeon-in-Charge
rms. Division of Ophthalmology.

Our History

Our examination made April 26, 1946, gave a history of headaches and chronic sinus drainage with acute exacerbations, sore throats often, and a history of exposure to scarlet fever that did not take on him. He was slightly sick, but had no rash and did not peel. He noticed the eye condition when at a shooting gallery he aimed a gun using the right eye and found he could not see with it. Thus in one year exactly, a 20/20 vision went to zero so far as practical use was concerned. He could not make out objects with it nor read any size print. The area of "absolute scotoma" noted by the experts was an area of retinal and optic nerve "atrophy" that involved the upper half of the retina and the central field. There was some peripheral vision but it did not help much.

We gave him a 2 cc. injection of the 10-(12) solution of the serial system of Carbonyl groups (SSR), the Synthetic Survival Reagent, on April 26th. The sinus drainage and headaches soon ceased. The sore throats returned only twice during two reaction periods. But the other symptoms were aggravated during the 12th, 24th, 36th, and 60th weeks. During this last reaction the throat was most sore, and he had a fever of 103° F. as well as a typical scarlet fever rash that lasted only 12 hours. His health was perfect after that.

Examinations of the eye by the same experts found that the vision in the right eye was 20/400 in

August 1946, that is four months after Treatment. Thus a definite improvement had taken place. In June, 1948, it was 20/100, and in October 27th, 1948, it was 20/40. Thus the improvement was continuing. Further reports, but without examination, claim his eye is perfect so far as reading fine print is concerned or for any other use. Here we see the polymerized scarlet fever toxin causing a degenerative change, and after it was broken down to the monomeric phase, it gave rise to the symptoms of the acute infection transiently. This was burned away in only twelve hours, and the recovery was complete. Other similar occurrences could be reported.

ACUTE CHORIORETINITIS SEQUEL TO PELVIC AND TONSIL INFECTION

CASE No. 6A

Dr. Jayme Treiger

Mrs. L. P. S., age 35 years. April 9, 1957 when first examined. Her Pretreatment Control Period of observation extended until December 5th, 1958, during which time she received all of the homeopathic remedies, and a course of Cortisone and its derivatives with the most recent and efficient antibiotics. There was a steady downward course in her general health and her two chief areas of infection, the pelvis and the tonsils, and steady deterioration of the function and pathology of the retina of the left eye, that developed during the last six months of this period.

Physical Examination on entrance showed, fever of 38.6° C. with a bilateral tonsillitis that had persisted for the past three years, worse at the end of the menses. She was very exhausted because of excessive use of antibiotics and antipyretics. Also there was an inflammatory process in upper and lower abdomen, sequel to violent gynecological infection sustained shortly after marriage. The tonsils—red, hypertrophied; tonsils full of pus, Heart—O.K., Gall Bladder sensitive XXXX, Chaufford Zone XXX, and Ovaries inflammation. The menses were prolonged. There was no benefit from medication followed during the first six months. Indeed, headaches, fetid leucorrhea, and varicose veins were aggravated. Three months later oedemas of feet and hands on waking, and of the upper eyelid with severe sacro-ovarian pains were added to the symptoms, with severe chest pains, and blurred vision, also cracking of the skin on the palms of her hands. Fundascopic examination by the ophthalmologist showed no retinal pathology at this time, 7/18/58. The examination on 10/28/58 showed the left eyelid congested, vision blurred, photophobia. Fundascopic examination on 11/5/58 showed left eye vision 0.67 fundas turbid with exudate, and a focus of Chorioretinitis in evolution, juxta-papillary. Right eye normal. V--I, Signed Dr. A. H.

Prognosis—Healing with scar causing corresponding scotoma. This Ophthalmologist placed her on Cortisone and its derivatives, antibiotics and topical applications. One month later the eye was strongly congested, much worse than a month previously, and she could see nothing at all with

the left eye, much worse than at the beginning when she still had some vision, Her weight was 80 Kilograms. Two millimicrograms of the SSR were given intramuscularly, 12/5/5 8, by Dr. J. Treiger.

Post Treatment Period-12/6/58, swelling of peritonsilar lymph nodes, dizziness, uneasiness, and violent pain in the pelvis recalling the time of her acute initial pelvic infection, with exquisite tenderness. Vision more blurred for 2 days. Copious flow of pus from genitals for the past three weeks, 12/31/58. On January 12, 1959, she had severe tonsillitis that lasted for 3 days at the end of her menses, fever 39.5° C., great hypertrophy of the tonsils, weight down to 74 kilos. with terrible vaginal itching, that soon improved. By the middle of 6th week, 1/14/59, much better, temp. 36.7° C. On 2/17/59 her weight was 72 kilos, feels better, and shows cracking in the skin of the palms of hands as of ten years earlier, and skin desquamation. Temporary improvement of left eye vision. On 3/18/59 she reported she spent a wonderful week, including her eye. On 5/5/59 she reported she had two weeks of normal vision and was in good health generally. On 4/9/60 she had three days of reaction with slight swelling of the left tonsil, pain in the left eye, slight blur in vision, and then quickly normalized and has stayed well ever since. The pelvic and throat pathology completely disappeared. This was the 69th week reaction,

Fundascopic examination by Dr. B., reads as follows:

Dr. A. De S. B.

Petropolis
Estado de Rio de Janeiro
December 21, 1959

Dear Dr. Treiger:

The “Fundus Oculi” examination which was done on your recommended patient, Mrs. L. P.S. accused on the left eye an inferior nasal focus, entirely healed of chorioretinitis all the way well into the periphery. There is no abnormality concerning the vascular supply. The visual field through comparison, showed no abnormality. Therefore, I did not try the instrumental perimetry.

Yours truly,
Dr. B.

Discussion-- No scar was produced as always happens with corresponding blindness. The retina was restored. If or not a scarlet fever infection played a part in the etiology no one can say. However, the cracking of the skin of the palms of the hands and the desquamation that showed up as she finished her recovery may have some indicative value. Even though it may not be

scarlet fever, it is a toxic effect of infection antecedent to the retinal lesion. In contrast to the former case, which showed no inflammatory change reportable, but only the atrophic changes, here the inflammatory changes predominated, and the degenerative effects were also in evidence. This woman was also too heavy at first. She lost weight down to 70 kilos and then got thinner without losing more weight, showing a building of solid tissue with functional efficiency that went with her return of happy good health. Both foci of pus infection cleared up, and the non-pusy inflammatory and degenerative changes likewise disappeared. Thus, an integration of the toxins of bacterial infection that excite no leukocytosis, as they are bound to and become part of a different tissue, are separated from their host cells by the SSR as we will show viruses are separated and carcinogens are separated, leaving the host cell in good functional status while the pathogen is destroyed. This accompanies destruction of unbound toxins that excite leukocytosis in other parts of the body.

Her reactions occurred typically, twenty-four hours after the Treatment was given and at multiples of three week intervals thereafter for a few times only, the sixth and the 69th weeks. The last reaction occurred after the retina function had returned to normal and examination showed it was structurally normal. Thus the reactions are not to the lesion, but to the cause of the particular lesion, a matter much deeper than the toxic factor of the etiology. One case alone demonstrating this phenomenon, would be good to remember, but many such cases showing reactions for example coming five years after a large cancer of the stomach has been absorbed and health follows a normal course, indicate that a phenomenon is observed that clears up the predilection to the pathological response to the etiological factor rather than an attack on the pathogenic factor which is long out of the system. The correction is more basic than getting rid of the etiological agent and healing the lesions.

Confirming this, one recalls the case of cancer of the face of Dr. M, of a small town in Texas in 1927. He was 81 years old and blind with bilateral retino-choroiditis of several years standing. He was treated with the SSR for the cancer and while that lesion was healing up, the vision returned, so that before the growth had entirely healed, his vision had so perfectly improved that he could see the string that was used to tie up packages in the country store that hung from the ceiling. This was visible to him as he entered the store. He had reactions which he reported long after he considered himself cured. There was high fever, 106.5° F. three years after full recovery. During this fever, which was different from any he had seen in his long practice of medicine, he was surprised by a good appetite and the desire to work and expend effort. Here is food for thought. He reported the best health for years afterward.

Here are three different etiological factors, scarlet fever, a mixed infection of the gonococcus with strep and staph resistant to all latest antibiotics, and the etiological factors in cancer. In the latter case, an infiltrating type of basal cell, solar rays were one big factor, and high winds, frostbite, etc., that caused a circulatory injury, anoxia, etc. This circulatory injury was present in

the mixed infection case too as scar formation was in progress with the vascular injury that goes with the inflammation, and neuron injury. In **Case 6**, the inflammatory changes were a minimum but the degenerative changes were neuron loss and scars were most prominent. This is rather strange as there was no inflammatory history, but a very rapid development of the degenerative change. The other cases of this disease, we may review, add nothing to the present meager information. This is unfortunate, since the presence of degenerative change away from the pus-forming areas that supported the infection and toxin production gives one a chance to investigate the cause of degenerative disease. If we had sufficient data, we could demonstrate its different steps. This much is brought to mind anyway, it is the job of an Ophthalmologist.

The old doctor had plenty of contact with scarlet fever, and he no doubt had an attack that gave lasting immunity of high degree, but maybe not enough to prevent or clear out a suppressed infection he had carried for some years. Did his immunity lay the foundation for the degenerative change in the retina? If so does vaccination which, brings about comparable condition not play a big role in the great dominance of degenerative diseases of today? We say the virus or the germ toxin must integrate with the cell's functional structure to bring about the loss of function and its sequel of tissue degeneration and visa versa. Does not vaccination do the same? If vaccination altered the steric set-up of the cell so fresh entrance of the pathogen could not take hold, then the vaccine must persist and do its damage to function. This would lead to degenerative changes with gene effects.

Let us compare this type of immunity with the oxidative protection used in Dr. Treiger's **Case 6A** and in the others. The scars did not form or they went away, as they were replaced by functional parenchyma and the distant site of the infection that brewed the toxin, be it scarlet fever, ordinary pus infection, or some other factor that enters the etiology of cancer, was also wiped out.

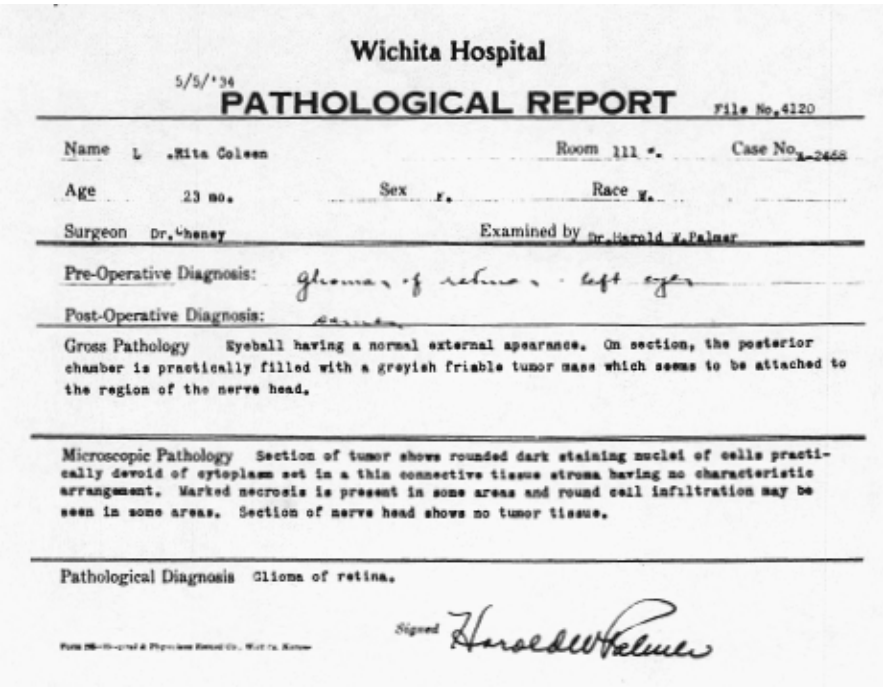
The cow experiments, a few of which are reported here, show that the most vicious Staphylococci, etc., lose their pathogenicity and maybe become faithful members of the great Biological Economy after they are "cured" by oxidation restoration facilities. Inferior oxidations, it will appear as we go along, are the basis of disease.

RETINOBLASTOMA OF BOTH EYES (GLIOMA)

CASE No. 7

Rita Long was one year of age when the disease first made its appearance. In less than a year the left eye was filled with a tumor mass, irritated, swollen, and blind. The diagnosis was made clinically by Dr. C., a noted Ophthalmologist, of Wichita, Kansas, He removed the eye. The pathological report confirmed his diagnosis of Retinoblastoma. The accompanying document

from the court records gives the gross and microscopic pathology. This was in May 1934.



Wichita Hospital

5/5/'34

PATHOLOGICAL REPORT File No. 4120

Name L .Rita Coleen Room 111 *. Case No. [illegible]

Age 23 mo. Sex F. Race W.

Surgeon Dr. Cheney Examined by Dr. Harold W. Palmer

Pre-Operative Diagnosis: glioma of retina - left eye

Post-Operative Diagnosis: [illegible]

Gross Pathology Eyeball having a normal external appearance. On section, the posterior chamber is practically filled with a greyish friable tumor mass which seems to be attached to the region of the nerve head.

Microscopic Pathology Section of tumor shows rounded dark staining nuclei of cells practically devoid of cytoplasm set in a thin connective tissue stroma having no characteristic arrangement. Marked necrosis is present in some areas and round cell infiltration may be seen in some areas. Section of nerve head shows no tumor tissue.

Pathological Diagnosis Glioma of retina.

Signed Harold W Palmer

Within a year, the right eye showed the same changes. The same surgeon observed the same disease here and so stated that it was the same disease that had attacked the left eye. This is a well-known characteristic of this disease. Prof Frohlich, of the University of Michigan, testifying as an expert, stated that there is nothing known to scientific medicine that can combat this disease. Even when operated early, it returns and kills. She was taken to a renowned Ophthalmologist in Niles, Michigan, who made the same diagnosis and referred her to us.

We examined her with Dr. H., a good specialist, and made the same diagnosis. He found that one-third of the retina was replaced by the neoplasm, including the optic disc. The eyeball was bulging and distorted, the iris dilated and fixed. There was no ability of the iris to move from its infiltrated attachments. Behind the pupil was a yellowish, pinkish reflection to light, showing that a tumor was present within. The area where the left eye was removed was not healthy, but showed neoplastic degeneration, though only in a minor degree. Both foci disturbed her. At this time, November 25, 1935, she was over two years old, and we gave her one cubic centimeter of the 10-(12) solution of the SSR serially arranged Carbonyl groups with free radical terminals by intramuscular injection. The irritation of both foci soon left. Every third week, she exhibited a reaction with general achiness, slight fever, and an aggravation of the irritation of both foci. Each reaction lasted a few days and was followed by improvement.

Examination on August 18, 1936, showed that all visible pathology had been removed. Dr. H---- and Dr. W. made Fundascopic examinations and found the retina normal, fully restored. Since she lived so far away, we gave her another dose for assurance, and no reaction thereto ever developed. She has remained well to date with perfect vision in the right eye. She went through her school courses and college at the head of her classes, is now married and a healthy, happy woman. Reports made in June 1950, June 1953, and September 1960 confirm her full recovery.

This case along with the cases treated in Canada, all used the same Treatment and are the only cases of Retinoblastoma ever cured. And as Prof. Frohlich, of the University of Michigan Department of Ophthalmology stated, "there is nothing known to scientific medicine that can cope with this disease," there is no information available as to the changes in the retinoblastoma cells during the recovery process. This is unfortunate for here we have a tumor of a nerve tissue that is supposed not to be able to reproduce in its normal state, even for a reconstructive or compensatory purpose that does reproduce wildly with great stubbornness, as a malignant tissue. In this case and the others, the retina was restored with good vision performance. In this case, the reconstruction was back to 20/20. The question is, where did the new neurons come from, or were they some of the tumor cells that were able to reconstruct functional mechanisms, as soon as the FCG's were liberated by the SSR? Thus an undifferentiated tissue, probably because of FCG inactivation, went malignant and then underwent normal differentiation so as to be able to again function and take its place in the organism's economy, after its FCG's was liberated. This sequence of events calls for deep thought. It shows full reversal of the malignant state.

EUNUCHOIDISM

CASE No. 8

J. S., at age 14, was subject to infections of the respiratory tract and skin, presented marked obesity, female type shape, was very dull mentally, was found to have an infantile penis and undescended testicles. In fact, they had not even descended to the canals. He had been under thyroid and pituitary hormone therapy from the age of 10 in 1931, to age 14, in 1935, without any improvement mentally, physically, or in his resistance to infections. He was closely watched by Dr. S., a relative, who reported that in this time the testicles had not even entered the canals. Thus the disease was classified as the type that is not helped by modern therapy and is permanent.

He received his dose of the SSR serial system of Carbonyl groups in November 1935, and within three months, he lost weight, his infections were gone, and the left testicle had traversed the canal and was entering the scrotum. After the sixth month, both testicles were in the scrotum, the penis was developing, and the pubic hair distribution became masculine. He grew taller, his hips reduced and his shoulders and jaw developed to good proportions. He became very bright in his

schoolwork, soon making up for his backward position. He became a good athlete. He entered the army and was soon promoted to a corporal. He is married, and is raising a nice family of children of his own. At the time this Testimony was given, he was in the Army Law School where he was making splendid progress. His boy and girl are physically normal and mentally excellent. Thus his genes were re-established in normal line. One may contrast 14 years of FCG insufficiency with a few months of rescued FCG efficiency, placing him in the normal progression of full health. *

* Photographs and a more complete case history of this patient are included in *The Birth of a Science*.

CANCER OF THE TESTIS

CASE No. 9

Mr. T., age 38 in June 1925, when treated with SSR serial system of Carbonyl groups with free radical terminals, his testis had become malignant six months previous to its removal. At this operation, no metastases were noted. The biopsy report was "Medullary Carcinoma of the Testis." Recurrence showed in the groin and scrotum within six months, and another operation revealed that the neoplasm had invaded the abdomen. Removal was attempted and the microscopic report on the material removed read again "Medullary Carcinoma of the Testis." Recurrence was not long in coming with more rapid spread of the disease. The abdomen was again opened, but was found so inoperably involved and a biopsy is all that was done. This biopsy was reported: "Carcinoma, probably secondary to previous carcinoma of the testis, as the cells are histologically similar."

At this time, he was rather emaciated, exhausted, and a general cachexia called for an early termination — a hopeless prognosis. Through the intervention of Dr. Alpheus Hoyt, this patient was given the SSR Reagent in June 1925. He regained his health, and all tumorous tissues disappeared. He remained well thereafter, and in 1946 he offered his report stating he was perfectly well. This was 21 years after he received his Treatment in the terminal phase of the disease. The preceding case of anaplasia and this case of neoplasia were corrected by the same Reagent, which restored good FCG function in both. Here is food for thought.

MALIGNANT SYMPATHICOGONIOMA

CASE No. 10
Dr. Julian Baldor

John L., age 13 months, developed a tumor in the abdomen that required an exploration on

September 25th, 1951. A retroperitoneal growth had infiltrated the region too thoroughly to permit removal of any more than a biopsy. On October 6th, examination revealed a visible bulging of the abdomen in the umbilical region which we found on palpation to be the size of an ordinary Florida grapefruit, about 10 to 15 cms. in its diameters, firmly fixed to the surrounding structures. The stools were bloody showing the intestine was invaded, and the blood count agreed with his pallor, — 2,300,000 red cells with a hemoglobin of 52%. The next day, he received from Dr. Julian Baldor an injection of the SSR Reagent, the serially arranged system of Carbonyl groups with free radical ends, 2 cc's 10-(12) solution. Recovery began promptly and at the end of a year no more tumor could be palpated on careful examination.

On May 5th, while in good health he was run over by an automobile and sustained a broken leg and abdominal injuries. While in the hospital for repairs, he was carefully examined by the same surgeons who had removed the biopsy. They found him free of any trace of palpable growth. He made a nice recovery and is in excellent health still. His blood count on April 5, 1953, was 4,750,000 red cells, hemoglobin 87.5%. All the documentation and facts of this case were put in the Florida State Court Records by his surgeons in May 1953. His last report was good health in 1958.

Discussion-

The case of Sympathicogonioma is of interest not only because it is so very highly malignant, but also that the mitotic mechanisms, which are now the malignant cells, are separated from the nerve fibrilla, the functional mechanism, as entities. The functional mechanism is entirely shed or discarded and, of course, as an immature and unorganized fibrillar syncitium. The malignant cells are practically only made of nuclear material. It is unfortunate that periodic sections could not have been taken of the tumor as it normalized, to see if the neoplastic cells made any efforts to form cytoplasm and fibrilla, as a recovery response. In the Retinoblastoma case, the new neurons that restored the retina to normal structure, probably had their origins in the neoplastic cells, as new neurons are supposed never to be formed. In the case of Optic atrophy, this assumption would also have to be made with the conclusion that the new functional retinal neurons were developed from remnants of atrophied cells that probably were integrated with toxin as in symbiotic viral infections, and the atrophy was never complete enough to prevent reconstruction after the FCG was relieved of impediment.

SAINT ANTHONY'S HOSPITAL, INC.
Saint Petersburg 6, Florida

PATHOLOGY REPORT

Name L Baby John
Tissue No. O-1558-51
Age **Sex** Male S.M.W.D.

Date September 25, 1951
Physician F. H. Langley, M. D.
Clinical Resume: ABDOMINAL MASS OF RECENT DURATION, PROVED NOT TO BE THE BLADDER. TESTICLES PRESENT IN SCROTUM AND APPARENTLY NORMAL.

SPECIMEN: BIOPSY OF RETROPERITONEAL TUMOR

GROSS: The specimen measures 5 x 3 x 4 mm. in size. It appears to be partially encapsulated by a relatively thick, fibrous membrane immediately beneath which is a brownish discolored thin area 1 mm. in width that separate the underlying, somewhat lobulated, gray, friable tumor from the capsule.

FROZEN SECTION DIAGNOSIS: UNDIFFERENTIATED CARCINOMA.

MICROSCOPIC: Sections reveal a trabeculated, fibrous, thick capsule which merges with the underlying tumor. Immediately beneath the capsule tumor cells are arranged in small clusters surrounded by thin strands of fibrous tissue. Large dilated vascular spaces are seen in this area. In the deeper portions, the tumor consists of strands of small lymphoid like nucleated cells which are separated by intervening masses of a fine eosinophilic sieve-like network of tissue. The nuclei vary from a round to an irregular shape and the chromatin from a fine granular to a heavy dark staining clumped variety. Cytoplasm is scant. Near the capsular surface, the nuclei assume in some instances a spindle shape. Scattered throughout the tumor are large relatively giant sized nuclei having a hyperchromatic appearance. There are areas of hemorrhage. Tumor cells are found in the vascular channels. Some sections show a tendency toward the formation of rosettes although these are very poorly defined.

DIAGNOSIS: IMMATURE TYPE TUMOR OF NEUROGENIC ORIGIN, SYMPATHOGONIOMA.

LHD/fa

L. H. DOMEIN, M.D.
Pathologist

That the FCG is the position that is stopped from functioning to cause the pathology in each condition is quite evident.

Often a biopsy may reveal a tumor to be of grade one or two malignancy, and after the tumor is removed the sections show it is definitely a grade four, thus being changed by the manipulations of the biopsy, the effect of the anesthetic, etc. The case to be reviewed now is one that was

exceedingly anaplastic and a grade IV malignancy at biopsy, as the examinations of the specimen by several leading pathologists and many well-trained practitioners of medicine found. Some microphotographs are submitted besides.

This case shows that the Survival chemistry, as established by the high efficiency synthetic Carbonyl activity, may fade out in ten years when the environmental conditions are adverse as they were in this case, and the data should be compared with that of the case that follows it, where a similar neoplasm of malignancy was cured after the Synthetic Reagent was given, and still remains cured 36 years afterward. Here, the environmental conditions were satisfactory, even though she was submitted to the trauma of four natural perfect childbirths, and no return of the neoplasm ever threatened. As in the neuroblastoma case just reviewed, trauma alone is not sufficient to cause cancer or its return. The anoxia may thus be established for a sufficient time for the co-factor and the pathogen to make the integration. However, with the improved Carbonyl function established by oxidizing the pathogen away from the FCG system so that the FCG is activated by a Carbonyl group, a sufficiently high O/R potential is established to burn the pathogen, instead of condensing with it. Still the Survival chemistry is a comparative matter, as any other phase of life, and as this case demonstrates.

It will be seen as we go along, as in the above case, that anoxia alone is not sufficient to cause cancer, A CO-FACTOR, be it a virus or another carcinogen, is required. Where trauma is not concerned in causing the anoxia, toxic amines of colonic origin may prepare the soil, and the response may not be neoplastic, but a necrosis instead.

GRADE 4 SQUAMOUS CELL CANCER OF THE CERVIX UTERI

CASE No. 11

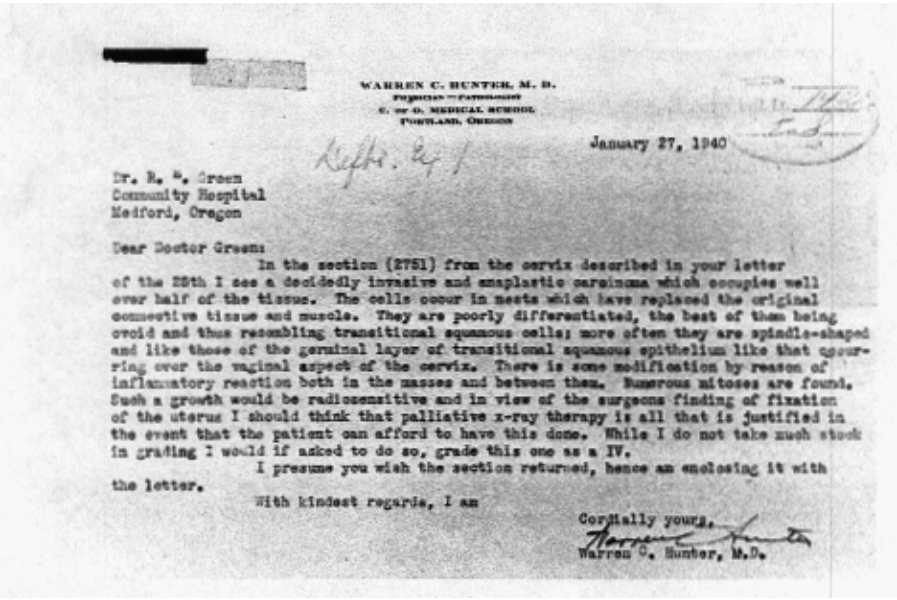
Mrs. M. W. came under the care of Dr. L----, Dr. H----, and Dr. D- -, of Medford, Oregon, in January, 1940. Dr. L---- examined her and found that she had an enlarged and fixed uterus. She had a cervix that protruded into the vagina and could be seen by a vaginal examination with a speculum; a cervix which was indurated and showed islands of apparent new growth. A diagnosis of far-advanced cancer of the uterus was made clinically. Dr. L---- reported that her cancerous condition would probably, if untreated, end her life within a year. That because of the fixation of the uterus and the involvement of the adnexia, it was his opinion, that it was not a surgical case, as surgery would have had to be too extensive. It was too late for that sort of thing. The case had already entered the cachexia stage as Doctor L----'s Testimony reveals:

"She had lost 30 pounds in six weeks, was complaining of general weakness and had a rather poor color at the time." As Ewing states: "Characteristic cachexia in uterine cancer develops in the terminal stage of the generalized disease, but when the lesion is localized in the pelvis,

cachexia is missing."

Dr. L---- gave the SSR Treatment, 2 cc.'s of the 10-(12) solution on March 20, 1940, December 30, 1940, and October, 1941. His examination made a year and a half later, in the summer of 1942, found that: "She had gained weight, she had gained color, and improved in general appearance. The mass in the abdomen had subsided to the extent that he could no longer palpate it. The appearance of the cervix by examination with the speculum appeared normal."

Before giving the SSR injection, she was placed in the Medford Hospital, and there Dr. L---- removed a specimen from the cervix for microscopic study. The slide was very carefully prepared by Dr. Green, the hospital's Pathologist, and diagnosed by him as squamous cell cancer of the cervix uteri. But the case was so interesting that he sent the slide to Professor Hunter, the Pathologist at the University, who established the grade of malignancy. Dr. Hunter, in his letter to Dr. Green on January 27, 1940, wrote: "I see a decidedly invasive and anaplastic carcinoma which occupied well over half of the tissue . . . I would if asked to do so, grade this one as a IV."



[redacted]

WARREN C. HUNTER, M. D.
PATHOLOGIST
U. OF O. MEDICAL SCHOOL
PORTLAND, OREGON

January 27, 1940

Dr. R. [illegible] Green
Community Hospital
Medford, Oregon

Dear Doctor Green:

In the section (2751) from the cervix described in your letter of the 25th I see a decidedly invasive and anaplastic carcinoma which occupies well over half of the tissue. The cells occur in nests which have replaced the original connective tissue and muscle. They are poorly differentiated, the best of them being ovoid and thus resembling transitional squamous cells; more often they are spindle-shaped and like those of the germinal layer of transitional squamous epithelium like that occurring over the vaginal aspect of the cervix. There is some modification by reason of inflammatory reaction both in the masses and between them. Numerous mitoses are found. Such a growth would be radiosensitive and in view of the surgeons finding of fixation of the uterus I should think that palliative x-ray therapy is all that is justified in the event that the patient can afford to have this done. While I do not take much stock in grading I would if asked to do so, grade this one as a IV.

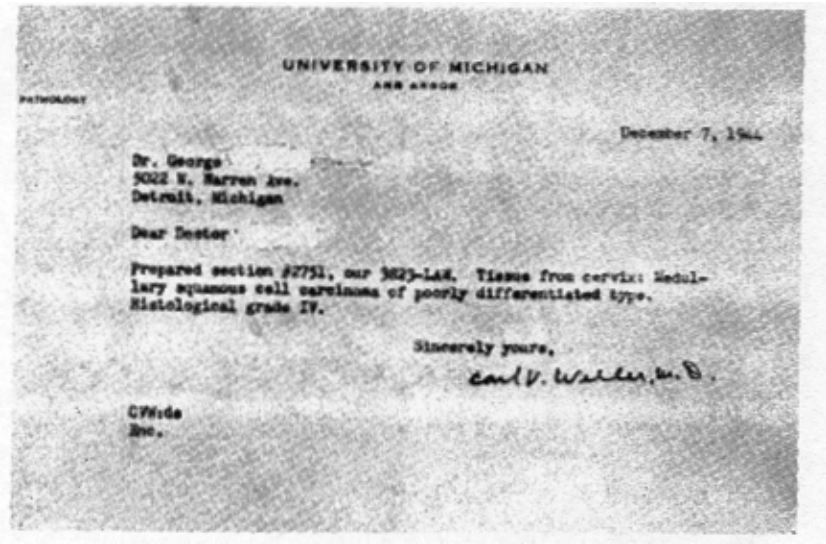
I presume you wish the section returned, hence am enclosing it with the letter.

With kindest regards, I am

Cordially yours,

Warren C. Hunter, M.D.

The confirmatory diagnosis made by Dr. Weller, professor of Pathology at the University of Michigan, was secured to complete our records. He found the specimen well prepared, and diagnosed it instantly as follows:



UNIVERSITY OF MICHIGAN
ANN ARBOR

PATHOLOGY

December 7, 1944

Dr. George
5022 W. Warren Ave.
Detroit, Michigan

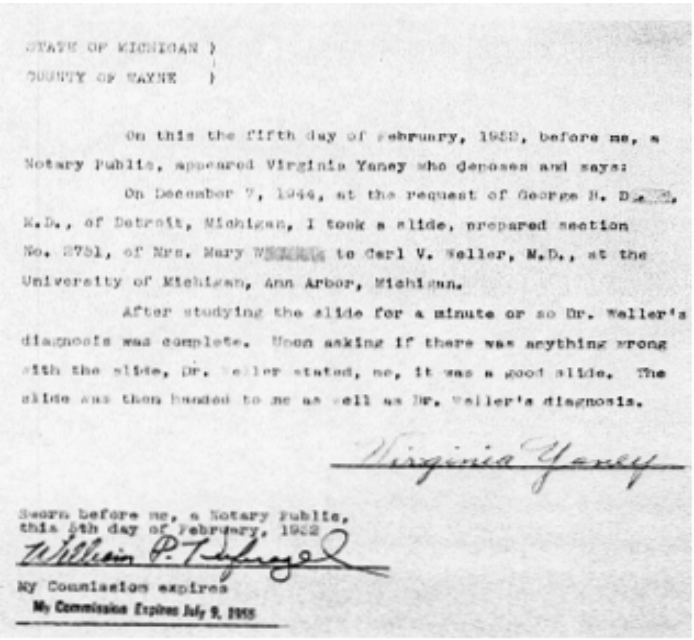
Dear Doctor:

Prepared section #2751, our 3823-L44. Tissue from cervix: Medullary squamous cell carcinoma of poorly differentiated type. Histological grade IV.

Sincerely yours,
Carl V. Weller, M.D.

CVWide
Enc.

Dr. Weller's statement that the slide was well prepared is incorporated in an Affidavit which reads:



STATE OF MICHIGAN)
COUNTY OF WAYNE)

On this the fifth day of February, 1952, before me, a Notary Public, appeared Virginia Yaney who deposes and says:

On December 7, 1944, at the request of George H. D[illegible], M.D., of Detroit, Michigan, I took a slide, prepared section No. 2751, of Mrs. Mary W[illegible] to Carl V. Weller, M.D., at the University of Michigan, Ann Arbor, Michigan.

After studying the slide for a minute or so Dr. Weller's diagnosis was complete. Upon asking if there was anything wrong with the slide, Dr. Weller stated, no, it was a good slide. The slide was then handed to me as well as Dr. Weller's diagnosis.

Virginia Yaney

Sworn before me, a Notary Public,
this 5th day of February, 1952
William P. Tolfree

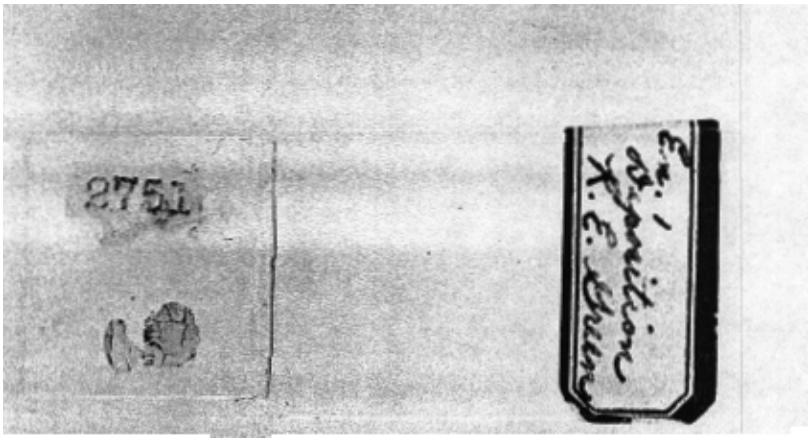
My Commission expires
My Commission Expires July 9, 1955

During her fifth year after Treatment, it was desired to ascertain her exact status so an exploratory laparotomy was done by Dr. Haines in June 1944. He found a normal cervix and uterus to which a small fibroid was attached. He removed the body of the uterus and the fibroid,

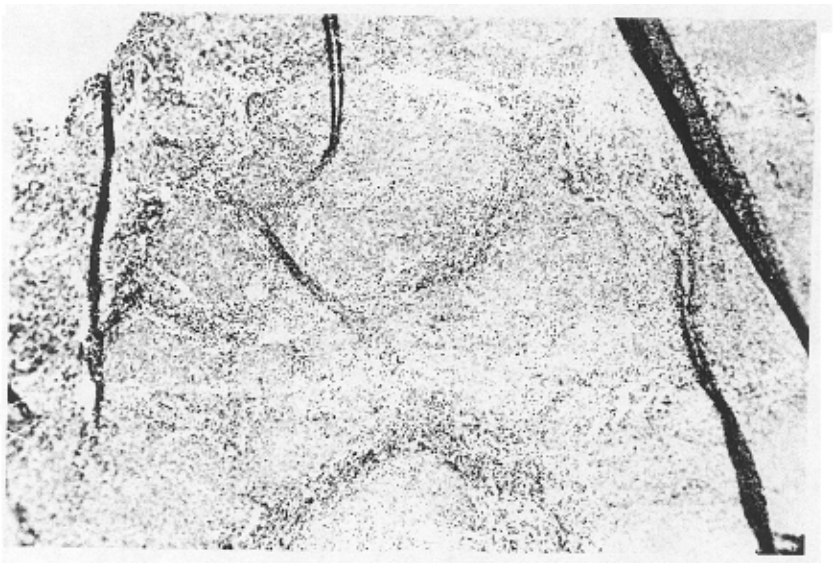
but left the cervix in place as he found it perfectly normal. On gross examination the uterus and fibroid were normal, that is no signs of malignancy were observed but they were both submitted to careful serial section for a thorough microscope search for malignant cells. None were found. Dr. Inskeep, the Pathologist, found no malignant cells and testified that the fibroid was benign.

Here we see, that at the time Dr. Haines operated on Mrs. M. W., there was no evidence of this Grade IV carcinoma present. Dr. Inskeep's report shows that no cancer cells were found. This indicates that, except for the benign fibroid tumor like so many healthy women carry ordinarily, the uterus was perfectly normal. Thus, we believe, she was found cured several years after being treated in the terminal stage of Grade IV cancer of the cervix when her life expectancy was less than a year.

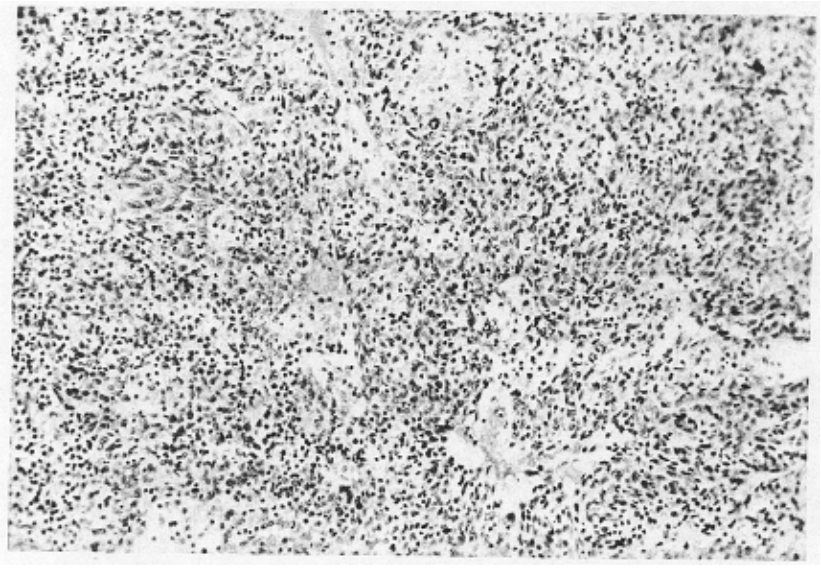
A photograph of the slide carrying the biopsy specimen well placed under the cover slip is given, and three microphotographs made by the Harper Hospital expert are also submitted for your study.



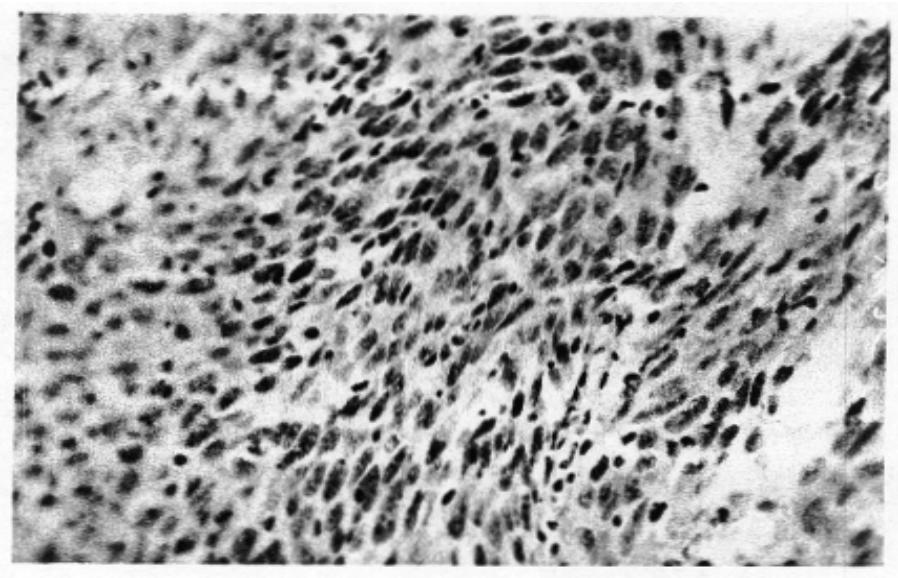
Photograph of the Biopsy slide showing its perfect condition.



Low Power Magnification of part of specimen Microphotograph by Mr. Rinelander of Harper Hospital. (150X)



Medium Magnification Microphotograph by Mr. Rinelander, of Harper Hospital (200X)



High Power Microphotograph by Mr. Rinelander (675X)

Mrs. M. W. was seen by Dr. L----. again just a few months before her death in December, 1950. At the time of her death he was not aware of the subtotal hysterectomy. Dr. L---- found a very foul smelling friable mass with the gross appearance of a disintegrating carcinoma in the left side of the pelvis and involving the lower end of the large bowel. A complete autopsy was not performed and no biopsy was taken post mortem. He reported that the condition leading to her death was cancer of the uterus.

In light of the whole case history, it is questionable that the original Grade IV squamous cell carcinoma of the cervix uteri in 1940 was the cause of her death in 1950. Her death should have occurred within the year period, had there been a connection between this pathological condition, and her death.

Even though the exact cause of death is not established, this case serves our purpose here, namely to show that the Survival chemistry can be restored to curative efficiency and that it persists for a period of years without further Treatment. That when ill health threatens again, its repetition must be required to restore the desired Survival chemistry again as in the first instance.

This case also illustrates the importance of continued medical observation of a patient even after the accepted five-year period. That the Survival factor, after being restored synthetically, can be subsequently destroyed by inhibiting factors.

This case should be compared with the case of Mrs. T., who also had advanced squamous cell

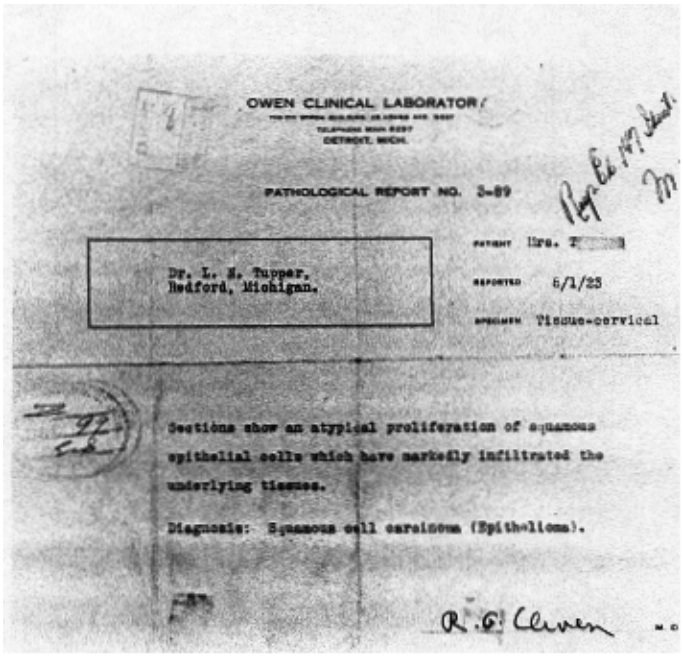
carcinoma of the cervix uteri. Mrs. T. is enjoying best health over thirty years after Treatment. One sees that the Survival chemistry is subjected to environmental influences. In Mrs. W.'s case, they were the worst possible. She was on Welfare for many years prior to her death and the type of care she could receive was limited. In the case of Mrs. T., they were ideal even with the traumata of four childbirths. Thus the physician must carefully measure all influences that may determine health in each case and see that the ideal is maintained, both while the Treatment is followed and after recovery occurs.

SQUAMOUS CELL CANCER OF THE CERVIX UTERI

CASE No. 12

* This case is included in the book, *The Birth of a Science*.

In August 1923, Mrs. T. was 31 years old. She could never carry a baby to term and spontaneous abortion took place. For over a year before seeing a physician she had irregular bleeding, mucopurulent discharge and increasing pain with progressive reduction in the capacity of the urinary bladder. She consulted Dr. T. who took a biopsy. A very responsible laboratory in Detroit made the diagnosis of squamous cell cancer of the cervix as follows. Several visiting Pathologists also confirmed this diagnosis as a high grade of malignancy was observed.



OWEN CLINICAL LABORATORY

DETROIT, MICH.

PATHOLOGICAL REPORT NO. 3-89

Dr. L. H. Tupper,
Bedford, Michigan.

PATIENT Mrs. T

REPORTED 6/1/23

SPECIMEN Tissue-cervical

Sections show an atypical proliferation of squamous epithelial cells which have markedly infiltrated the underlying tissues.

Diagnosis: Squamous cell carcinoma (Epithelioma).

R. G. Owen M.D.

My examination was made two weeks later and the findings were those typical of a far advanced

widely invading squamous cell type of cancer. It had invaded all the structures of the pelvis, but was more extensive on the right side. All the normal contours were obliterated and the structures hardened by the firm infiltrations. The bladder wall was extremely involved and the mass could be easily palpated above the pubes half way to the umbilicus. Her surgeon did not offer an operation, or recommend any treatment, but watched her progress with interest and took care of her four pregnancies later on.

This case was not so far advanced as the case previously outlined. She bled profusely, especially since the biopsy was made, and she gave a yellow color that one would attribute to the prolonged excessive bleeding aside from the natural cachectic effects of a neoplasm that had broken through into the abdomen.

She received two injections of 2 micro micrograms of the Synthetic Survival Reagent (SSR) on August 7th and 21st, 1923. She had the typical reactions of general achiness as

one observes in most viral infections. The bleeding soon stopped, the pussy drainage soon stopped, and her color took a change for the better. The pain steadily let up and the growth on examination became softer, more elastic and movable, and the normal contours of the pelvic structures returned. After the 36th week, no more evidence of the disease was observable, but the right side of the cervix was a little deficient. This did not fill in fully to make a symmetrical cervix until a few more months had passed.

Her reactions came most vigorously on the twelfth and twenty-fourth weeks. They exhibited chills, fever, achiness, pains in the back, and increased urinary frequency. But after each reaction, her health gained very rapidly and the bladder capacity normalized. She became pregnant and after a normal term of gestation gave birth to a fine healthy boy, with a normal easy delivery, managed by her surgeon, a man of exceeding expertness. Three more children were subsequently born at two-year intervals. All are fine physical specimens, and the births were easy and normal in every way. There was never any return of a neoplastic condition or any other trouble, nor even any serious sickness. She has been remarkably resistant to colds besides, and is still alive in perfect health 36 years after being treated for a terminal stage squamous cell cancer of the cervix that was widespread into the abdomen.

The important lesson from this case is the fact that she had plenty of exercise, taking care of a big strong husband, and four vigorous children. She did the family washing with tub and rubbing board and had plenty of exercise of the abdominal muscles that massaged the intestinal wall, aiding its movements and its circulation. Her diet was well chosen and well prepared, and her life was happy and inspiring. In contrast to the previous case, one sees that the environment was very favorable for the maintenance of a good Survival chemistry.

This case is also interesting in that her husband developed a cancer of the prostate gland 33 years after his wife was cured. The hospital put him through surgical and radiological procedures without offering a diagnosis. Radioactive Cobalt was new then and used vigorously. He quickly suffered widespread bone metastases and died in great agony. The infectious nature of the provocation of neoplasia may be inferred from this history, as well as its conjugal nature. It would have been a helpful observation to remove the cause of the husband's cancer with the same reagent that cured his wife. But the hospital doctors had no guiding information.

Trauma of four parturitions did not re-excite cancer in her and neither did her exposure to the viral agent that infected her husband. Here is food for thought.