PRACTICAL SECTION

CHAPTER XIII

CASE MANAGEMENT

REPETITION OF THE DOSE

This is a subject that requires detailed study and cannot be treated fully in an introductory treatise. We will present a few principles that determine the repetition, and the details will be demonstrated in case studies in the complete text.

The purpose of repeating the dose is to restore a recovery process that has been wiped out fully, that is, the reaction chain that was started by the curative reagent and was broken. The conversion of toxin to antitoxic peroxide free radicals was stopped. Thus the recovery process was halted at its very basis. One should find out how such a situation has arisen, since if the recovery reactions were started so as to have progressed far enough to be observed, they should continue unless a definite inhibitory agent entered the system. There are several means of stopping the process, and we will return to them in a minute. However, after the dose was given, it could be that no recovery reaction ever started, and for that reason the dose must be repeated. Interfering factors that could prevent the recovery from getting started could also prevent the recovery from progressing if they came along after recovery had started. They may be considered together therefore. In either event at least one of several interferences should be sought, though all may exist in the same person. The most common are the following.

Highly polar double bonds, as exist in some **terpenes, perfumes, fruit flavors, lemons and orange skin oils, mangoes** and **even tomatoes,** may be at fault. One of the most powerful "innocent" substances that is supposed to be "good medicine" are the **carotenes.** These in cancer cases may prove serious since the cancer patient is not always able to oxidize carotene to vitamin A, and as carotene it is useless. Its rich content

of double bonds even though recipient of electrons from their methyl substituents still show a polarity that can attract the free radicals of oxidation chains in process of formation Clinically we have found that too much carotene in the vitamin mixtures have interfered with the recovery mechanism. The **terpenes of paints, floor waxes,** and **similar affairs are even more serious hindrances to the recovery process. Perfumes** have in certain cases been tagged as the obstacle and therefore **soaps that are highly scented** should be avoided as well as scented powders and the like. **Many medicines and Kerosene oil** as well as **gasoline** are carriers of unsaturated oils that **interfere seriously with the conduct of the free radicals of the** recovery oxidation chains. The physician must force the patient to analyse the situation to avoid interference from the ordinary household affairs. Triple bonds as of **acetylene and garlic are** to be avoided.

Free radicals as of the common anaesthetics are serious obstacles which may reverse the recovery process even after it is under way with splendid progress. **Chloroform** offers a free radical on the same basis as **carbon tetrachloride,** and of all anaesthetics **nitrous oxide is the worst.** All oxides of nitrogen carry permanent free radicals that are ever ready to add to those that carry the oxidation chains, They thus are wide open to swallow up the mediators of recovery. **If an anaesthetic** is to be used **it should not be nitrous oxide,** but rather a local use of cocaine or one of its derivatives should be tried. It is best to look forward before treatment is instituted and have all dental or surgical work attended to first. On the same basis after an anesthetic has been used the treatment should be postponed a week or so to allow the evil products to be eliminated, when it is possible. But in emergency cases the treatment may be given and repeated in three and a half days once or twice to make sure the recovery process has really started. In greater emergency one may repeat every twenty-four hours or thirty-six hours until the recovery process shows it has started by either a positive or negative phase of a reaction.

Steric hindrance resulting from effects of amine medication must also be considered. Clinical experience has convinced

us that when the host cell's energy producing mechanism is integrated with a virus or toxin pathogen, its molecular configuration is so altered that it will accept one or other type of the carbonyl reagents as a free radical or double bond addition. However to be therapeutically efficient, the integration with the remedy must allow the *steric advantage* necessary to the dehydrogenation of the pathogen's carbon atom located alpha to the double bond formed by the condensation of the pathogen's amine group with the host cell carbonyl group that initiates the functional oxidation chains. The remedy must attack in a plane perpendicular to the coplanar arrangement of the system just mentioned.

However when this host cell pathogen integrate is exposed to an antibiotic carrying activated amine groups as in streptomycin, condensation with the latter may also take place and hold rather permanently to change the molecular configuration of the functional mechanism in a way that offers steric hindrance so that the remedy carbonyl group is not able to attack in the preferential plane.

Therefore before giving the carbonyl catalysts one must allow some time for the elimination of the interfering agent and a recovery from the distortion they cause. If an emergency exists, the dose may have to be repeated every 72 or 84 hours until an effect is had.

Remedies of similar structure to the carbonyl catalysts can also interpose steric hindrance and hence mixtures of the remedies are not desired for clinical use.

The treatment itself may be the most effective inhibitant, when used in too heavy a dose or when repeated too often. Both the double bonds of benzoquinone or of diphenoquinone, and the free radicals of the polymerizing chains of carbonyl groups with free radical terminals interfere as described above. Dose repetition is therefore as serious as the excessive amount of reagent in the first dose. The best dosage is that which presents the carbonyl groups in such dilution that in the tissues each is surrounded by a blanket of toxin molecules, and the conversion can go from one to another until all are converted to their antitoxic structure and serve as centers for new oxidation chain initiation.

The process will then go to completion. The highly electrophylic nature of the double bonds of the two quinones and of orthoquinone too, but especially of diphenoquinone make the dosage a matter for expert decision, and this is especially true of the repetition. **When a recovery process is once started and going well,** the dose should **never** be repeated, no matter how good the patient wants to feel. One goes by the fact that the recovery is in progress and by the evidence given by the **crenation test** of the red blood cells. This will be discussed later. When the patient has been properly prepared for treatment, and the avoidance of gas engine exhausts, and other interferences has been followed, the dose does not need repetition as a rule. So the diligence should not be toward finding a time to repeat the dose, but to eliminate factors that call for it.

Direct and indirect interference with oxygen supply and usage is a fairly complicated matter, and comes under two heads.

Interference with oxygen transport, is caused by the usual pain-killers of our day with salicylate origin, as aspirin, sodium salicylate etc. The barbituric acid preparations may even be worse. They cause, like other coal tar products, a change in the hemoglobin so it does not carry oxygen any more and a state of more or less asphyxia is set up. The free radicals of toxins and virus that have been opened up by the treatment have no oxygen to add to so they add to whatever else they can find, host cell, the reagent, or even to themselves and in a sense polymerize to form spores possibly. The fate of an aspirin addict is the worst and requires the greater care. The methemoglobins formed by these poisons may allow the blood to look rich, but they are of no use to the patient and block the production of serviceable hemoglobin besides. All other materials of similar action are to be avoided too, hemolytic materials included. The advanced case of cancer after prolonged use of coal tar products probably has a fairly complete exhaustion of the blood forming organs, and transfusions do no good either as experience has shown us, but may make the situation worse by overwhelming the reticulo-endothelial system, so that the effete and worthless blood cells are not removed from the circu-

lation and converted into blood forming materials any more. In cancer the reticulo-endothelial system is already exhausted before the neoplastic process is very far advanced, and throwing a load of foreign red cells at it to break down, is adding more work than it can carry and making the situation worse. At times one transfusion may get by with benefit, but as a rule not.

Interference with use of oxygen is offered by the toxic amines of intestinal origin or in some medicines. A meal of animal protein taken by a patient with an intestinal flora rich in amino-acid decarboxylases, or even the taking of avocadoes raw when the digestive juices are weak, may set up the production of enough toxic amines to inactivate the tissue functional carbonyl groups and also the carbonyl groups of the treatment reagent, and thus block recovery. One therefore inquires into the diet when a recovery process is blocked. Such amines also tend to gellate the tissue colloids so oxygen transport to and within the cell is blocked. Then the oxidases that take care of the hydrogen atom the reagent carbonyl group removed have no oxygen to work with, and the recovery process is broken. MacDonagh of London has identified several substances that cause this colloidal gellation in the blood and the same action holds for the intracellular proteins, as well. His work requires study and gratitude. We hold that the fungi that infect cancer tissue accomplish the same gellation changes. Amidines are the worst of all.

Metals like arsenic act like the toxic amines and block the phosphorylations we described previously. All such "uncouplers" are to be watched for and avoided. Many a fine recovery process has been cut short by the use of arsenic to speed the blood production. In our cases it never works, but has always interfered, even in highest homeopathic potencies. The action is not a simple uncoupling affair therefore. Gold and Lead used in the past caused hemorrhagic degeneration of the liver and kidneys, and did no good. Still one must be on the lookout for their use even today, and to avoid them.

The diet is discussed soon, and articles that carry the violations mentioned above can be identified and eliminated.

The identification of an interfering agent may be just provocation for the repetition of the dose, yet one must distinguish

between a true block to recovery with cessation of its advance or even its reversal, and a negative phase of the recovery reactions. This is not always easy. Besides even the latter situation may call for a repetition of the dose.

Prolonged negative phases with aggravations of the symtoms, when the crenation test of the blood shows no progress may call for the repetition of the dose, and so the crenation test is important.

The Crenation test should rule the decision. If it shows improvement the dose should not be repeated, no matter what the patient desires, or what the symptoms may indicate, provided the test is made correctly. It is performed like making a blood count; a properly exposed drop of blood is taken into the pipette and quickly **a one percent solution of sodium chloride** is drawn up with it into the mixing chamber and mixed. It is placed on the slide and the number of crenating cells and the non-crenating cells are approximated. I say approximated, since one must not spend too much time recounting as the task should be accomplished in from one half to one minute, to get a true picture. Therefore everything should be in order for performing the test. Alcohol used to clean the finger must be fully removed before making the puncture. Clean glass and pipette are essential and the sodium chloride solution must be accurately made up. In order to make up this one percent salt solution properly, the salt should be dried first before weighing. The test should be made before the treatment is given and then every week or two in order to obtain a true picture of the changes. It is important to remember that the patient's bowels should be well washed out with a mild sodium bicarbonate enema and the diet be followed carefully for a few days before making the initial test.

The change that constitutes crenation is a shriveling due to the withdrawal of water from the inside of the red cell to the slightly hypertonic salt solution on the outside. It should take place immediately. Some cells will not crenate but appear the same while others swell up. The latter are effete, and should have been removed. Those that stay the same are intermediate in their status. All should be approximated or

counted and recorded quickly. The water is drawn into the cells that swell as the number of molecules within has increased as the cell undergoes protein lysis and death. All should crenate in healthy blood and so the salt solution should be tested on a few healthy persons first. As the patient improves the number of cells that crenate will increase and the number that swell will diminish, until normal is reached. Under such circumstances the dose is not repeated. But when the symptoms call for repetition and the crenation test confirms it, it should be done.

The choice of the repeated dose. As a rule it should not be a quinone type compound after a serial system of carbonyl groups is used, unless the quinone has a higher oxidation reduction potential than the dose that was given. This holds for the repetition of the serial systems of carbonyl groups, the repeated dose when given must show higher oxidation reduction potential value. These matters are explained in the completed text in detail so the correct molecule can be chosen for progress instead of reversal of the recovery procedure.

The time of the repeated dose is also important. It should never be given during a period of improvement, but during an aggravation phase of a reaction when the adverse symptoms are on the increase, or when the disease is advancing. The cycles should have been watched and the time for an aggravation to show could then be predicted. This is the time for the repetition, when the progress is more or less stationary but the crenation test shows a failure to advance, or a reversal. Ordinarily, the 24th day after the first dose is a good time to repeat, if it has not been done three and a half days after the first dose. Otherwise the last days of the ninth or twelfth week or beginning of the tenth or thirteenth week, the end of the twenty-fourth or thirty-sixth week or even of the sixtieth or seventy-second week or at some other multiple of twelve. When reactions run on over 100 weeks a repetition may be in order and be followed by most satisfactory results. The patient may have been cured so far as one can tell from a very virulent lymphosarcoma, but may exhibit slight febrile reactions at three week intervals. These promptly have ceased after the dose was repeated, even as late as 108 weeks following

the original treatment. The health quickly boomed also thereafter. However, it should be remembered that the recovery process is a chain affair, that is theoretically at least, and in many practical instances, has featured health improvements for decades after the dose was given. These improvements include better circulation of the blood, better liver and bowel function, and even brain and eye function. Many such patients who have been getting stronger glasses each year now reverse the change and require weaker glasses instead. Some have gone back into business and made a fine success at it, where formerly they had failed, and were rated as having a nervous breakdown. Other functions have improved in the same manner.

MEDICATION AND FOOD POISONS

Our reagents do not contain the phenolic group, and indeed may be hindered in their action by that group. Therefore all medication containing it is eliminated from the regime. This includes the common analgesics and narcotics. They produce effects contrary to those for which we labor. As a rule however the severe pain of the cancer patient as he comes in from the ordinary hospital care, can be controlled by good intestinal lavage, and the use of proper diet, and certain homeopathic remedies, until the treatment has been given, and then the pain soon ceases as a rule. This applies to cases taking heavy doses of morphia and other narcotics where irradiation was not applied. In the latter cases a special situation arises that needs careful discussion. The salicylates and barbiturates are forbidden, and morphine if actually needed is used in decreasing amounts until it can be given up entirely.

Medication is used as a physiological complement, such as the gastric or pancreatic juices and a small amount of dilute hydrochloric acid when required. Soda or chalk may be required to keep the intestinal tract alkaline and is given one or several hours after the meal. For catharsis as may be required at times Rochelle salts, magnesia, appear least harmful, but the daily use of plenty of molasses of the cruder varieties, is the best procedure. It can be taken in warm water to substitute for coffee. One soon develops a taste for it and

its benefits should be sought. The enema with dilute soda solution, a teaspoonful to a quart of water may be the daily need. Cod liver oil may be the best regulator of all.

The vitamins, except too much carotene and vitamin E, are required, and of these Thiamine, Riboflavine, and vitamin A from fish liver oil must not be neglected. Likewise the trace elements and some potassium are required. Copper and cobalt should be emphasized.

Pure water and fresh air are essential—free from all contaminants.

The diet is vegetarian entirely, with fruit and freshly ground cereals. Rye is most important and can be cooked into a porridge or baked into bread, pies or cakes, avoiding the use of eggs or milk. Fresh pure butter and honey and pure rich cream are the only animal foods allowed.

Greases are not used and foods are not fried or baked in them. Thus the acrylic aldehydes are avoided. Nothing is over heated or burned and the tars are thus avoided too. Fats are used if unexposed to air, and olive oil should be used exclusively if possible, as its unsaturated fatty acids are protective somewhat against cancer. Corn oil is not used as it tends to stimulate cancer, possibly due to its selenium contaminant, taken from the soil.

Corn, peas and lentiles seem to pick selenium out of the soil and the risk in using them must not be taken, unless one has a garden of known soil purity. This applies to arsenic also for many an old orchard is so badly saturated with arsenic that the fruit is actually toxic.

The sugars should be as natural as possible, honey, brown sugar, and molasses are preferred. White sugar may not be harmful in itself, but it displaces the use of the natural sugars that are very valuable in nutrition. No other details will be given here, except to recommend the raw, well washed fruit or vegetable.

SELENIUM POISONING

Selenium poisoning of cattle was first encountered in the western plains, and was thought to be due to the high alkalinity of the water that was encountered in these regions. Later

it was found that the vegetation carried toxic quantities of selenium, **that is more than four parts per million.** Some plants as the Astragalus of several varieties appears to thrive on it while others die under the same supply from the soil. These plants serve to mark the area as selenium rich as they run as high as several thousand parts to a million. The selenium is distributed in patches and is found in shallow wells and ponds, but not in deep wells as a rule. Farmers find that wheat or other grains grown on the patches are toxic to their cattle or chickens and sell it to buy better food for them.

The toxic effects are had when the food contains four parts per million of this element. An acute condition, which may be quickly fatal, can occur when food containing twenty parts per million is taken in sufficient amounts. The chronic condition which develops, produces such effects as loss of hair, hoofs or finger nails, a general malnutrition, impotency and infertility. In chickens, the eggs do not hatch and in some cases the chickens may not even lay eggs.

Tissue studies in the Warburg chamber show that after being exposed to toxic amounts of selenium the oxidation of glucose succinate, lactate or citrate is blocked, but the oxidation of para-phenylenediamine is not hindered. This holds for all tissues examined as muscle, brain, kidney, liver or tumor slices. Thus from our standpoint it is a serious inhibitant of recovery.

It is possible that selenium may upset favorable steric advantages . Its action as a dehydrogenating agent can be concluded from the unusual oxidative behaviors of its oxide. Instead of oxidizing the aldehyde group of acetaldehyde to the carboxyl, as other oxidation agents do, it leaves the aldehyde group untouched and acts on the beta carbon atom oxidizing it to the aldehyde, thus producing glyoxal. The influence of selenium on the steric advantage offered by the host cell-pathogen combination is thought likewise to be irregular, so that distortion suffered does not permit the addition of the carbonyl catalyst in a position favorable to attack the pathogen for optimum dehydrogenation. Patients who have started splendid recoveries after a well selected dose of the treatment reagent, on returning to selenium rich districts, have suffered reverses, and

have finally landed in some hospital where the staff is entirely uninstructed in the situation at hand and know no better than to follow the routine of care that yields their usual high percent of failures in the treatment of real cancer. The patients, themselves, seem addicted to the toxic situation and long to return from a place where they are making splendid recoveries, to the unfavorable selenium laden district. Once they land there, they can not be persuaded to leave. Selenium requires competent psychiatric investigation, as well as its carcinogenic influences. For this reason, patients from selenium laden districts should not be placed under treatment unless complete arrangements are first made for their continuance in a correct environment until their recoveries are completed and well seasoned. The United States is spotted with such selenium areas, as for example, those located in the state of Ohio and Michigan.

Selenium exists in two forms, the inorganic and the organic. It is a widely distributed substance, so that we are always exposed to small nontoxic amounts. These may even be necessary to good nutrition, such as one or two parts per billion. The organic form is most toxic as it clings to the tissues longer after ingestion while the inorganic form finds its way into the urine more quickly. Our patients, because of the part played by the tissue oxidations in the recovery process, must be protected from any amount more than the normal trace amounts, and the urines should be regularly examined, as should the food on sufficient occasions. Sanitarium care properly conducted will prevent many mysterious failures we have encountered in the past. It is the duty of the Food and Drug administration to protect the public from the interstate commerce in foods poisoned by selenium. But although they know full well the havoc it causes, the public lacks adequate protection.

Selenium interferes with recovery much like the sulphides do. It is not found in sandy soil. Hence rye is free from it while wheat which is grown on heavy soil often carries appreciable quantities.

CHAPTER XIV

FURTHER APPLICATIONS OF THE FOREGOING PRINCIPLES

THE PREVENTION OF CANCER

We have considered the elements that enter into the initiation and propagation of the carcinogenic process and of virus parasitism, and also the means of terminating both in line with the same hypothesis. The practical application of the principles discussed is now in order. Two sources of toxin that play parts in the initiation and conduction of the pathogenesis need review.

Toxic amines produced by decarboxylation of amino acids in the acid reacting colon, or in tissue foci by bacteria, block the action of the tissue cell functional carbonyl groups, and thus wipe out the oxidative protection. They cause block in oxygen transport inter, and intracellularly besides, by gelling the tissue colloids. They cause weakness and clinical fever, as do other amidines. Their elimination is dealt with later.

Toxins brewed in old foci of infection where hypoxia is maintained through scar formation and vascular obliteration. Under hypoxic conditions, the free radicals formed by dehydrogenations are not peroxidized, and react with each other to polymerize with increase of molecular weight over long periods. Such old foci of infection flare up with acute inflammation, and then disappear with absorption of the old scar at the end of the recovery process from cancer. The acute inflammatory phase of the beginning of the whole pathogenesis is thus reproduced, but this time with the cure of the lesion, and the elimination of the disease from the system. Such toxins reaching the blood stream can copolymerize with tissue metabolic products and the collagenous material that forms the interstitial fibrosis, where hypoxia is more or less a factor. They play a part in the aging and insufficiencies that follow sclerotic degenerations of the heart, kidneys and brain, as well as other organs. This fibrogenic status of the cancer patient even before a