CHAPTER VI

ANAPLASIA, HYPERPLASIA, NEOPLASIA, DYSFUNCTION

Their Common Basis and Correction

PRIMARY ATROPHY OF THE OPTIC NERVE AND RETINA* **

Sequel to Scarlet Fever

Treated in collaboration with
Dr. Frank Richards

Anaplasia As In Diagram V, (b)

R. J., age 14, family history negative to cancer and tuberculosis. The pretreatment control period and diagnosis are well described in the correspondence between the Henry Ford Hospital and Jennings Hospital of Detroit, as follows:

HENRY FORD HOSPITAL
DETROIT, MICHIGAN

Henry A. Du . . ., M. D.
7815 E. Jefferson Avenue
Detroit, Michigan

September 10, 1946

Re: R. J.
Case No. 453242

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 of the right eye. Vision without correction of both eyes revealed a normal lense. In the macular area there was a chorioretinitis which fits the description given by you in your letter. The left eye was normal to fundoscopic examination. Tangent screen examination was done which showed an absolute scotoma

in the supra-central region. The periphery normal red field 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 of OT; 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 in both antra and probably the ethmoids and frontals as well, and were suggestive of a pansinusitis. There was only a moderate increase in the bronchovascular markings in the base.

Blood count showed on 4-16-46 a hemoglobin of 13.5, white blood cells 10,000, 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 appointment, and we have not seen him since. Trusting this information will aid you in your studies, we are,

Sincerely yours,
Henry Ford Hospital
/s/ E. L. W . . . , M. D.
Surgeon-in Charge
Division of Ophthalmology

per;
M. W. S . . . . M. D.
rms.

Our History

At my examination, the absolute scotoma reported in this case was an area of retina and optic nerve atrophy confirmed by the blindness to include the central visual field and much of the upper part of the retina, leaving a ring of periferal tissue

that showed some function. However, the eye was blind for practical purposes, since he could not read or make out objects with it, nor could he get much help from the periferal vision. This condition had been progressing rapidly.

The injection of two cc. of the 12X dilution of carbonyl catalyst, the serially arranged carbonyl groups, was made on April 26, 1946. The headaches attributed to sinus infection, and the drainage from the sinuses soon stopped. The usually frequent sore throats returned only twice. This was during two different reaction periods. The recovery was characterized by the usual reactons for the infection foci in the tonsils and sinuses at the twelfth, twenty-fourth, thirty-sixth, and sixtieth weeks. During the sixtieth week reaction, the fever rose to 103 degrees and there was the usual sore throat of the past, but a rash developed similar to that of scarlet fever. It lasted twelve hours and disappeared. His health seemed to be perfect thereafter. This return of a scarlet fever rash in a person who had the infection only slightly in spite of exposure is not unique. We have observed such occurrences after treatment in similar cases where they had never developed scarlet fever, in spite of exposure, and where the optic nerve atrophy also recovered under a dose of this treatment. We may attribute the nerve atrophy to chronic scarlet fever whose toxins attacked the optic nerve and did not leave the patient's tissues until they were burned down from the polymeric sequelae-producing form, through the erythema-producing monomeric phase, and then to complete harmlessness.

Examinations of the eye made by Dr. Du . . . found that the vision in the right eye was 20/400 in August 1946, 20/100 in June 1948 and 20/40 on October 27, 1948. This shows that improvement was continuing. This, we believe, demonstrates the progressive chain reaction type of recovery. Diagram V, (G), possibly pictures the pathology here.

RETINOBLASTOMA (GLIOMA OF THE EYES)* **

Treated in collaboration with
Dr. Garret Warnshuis

Neoplasia As In Diagram IV

Rita L. 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 . . . of Wichita, Kansas. He removed the eye. The pathological report is given below.

Within a year the right eye showed the same changes, and the same surgeon observed the same disease here that he had found in the left eye. Operation was not advised. The patient was taken to a renowned ophthalmologist who made the diagnosis of retinoblastoma and referred her to me. The result of my examination and of Dr. H . . . was likewise retinoblastoma and we found that about one-third of the retina was involved as well as some of the optic disc. The eyeball was bulging and somewhat 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 of light showing that a tumor was present within. The area where the left eye was removed was not healthy, but showed neoplastic degeneration in a minor degree. Both foci disturbed her. At this time, November 25, 1935, Rita was over two years old and we gave her one cubic centimeter of the 12X dilution of the serially arranged carbonyl groups by intramuscular injection. The irritation of the affected eye and of the area where the left eye was removed from the socket quickly disappeared after the injection. Every third week she suffered a reaction with general aching of her muscles, some slight fever and considerably more irritation of the affected eye and the operation area. Each lasted a few days only and was followed by improvement. On Aug. 18, 1936, we could not see any bad effects. The iris contracted to light as it normally should do. There was no reflex behind the pupil, no gray curtain, as it were, behind the eye to shut off vision, as far as we could see. Evidently she was able to see at that time all right. She appeared to have recovered, but to reinforce the recovery process she was given a second treatment. We con-

Wichita Hospital

5/5/'34

PATHOLOGICAL REPORT File No. 4120

Name L , Rita Coleen Room 111 . Case No. A-2468

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: same

Gross Pathology Eyeball having a normal external apearance. 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

Form 38—Hospital & Physicians Record Co., Wichita, Kansas

sidered her cured after recognized five year period. Her vision has been fully restored in that eye. She went through school at the head of her classes regularly and is a beautiful normal young lady now. Follow-up report of June, 1950, records perfect health and vision and graduation at the head of her class in Junior College. She was married in 1953, and remains in good health. The same type of carbonyl reagent that cured the optic atrophy case cured the retinoblastoma case. Our thesis is confirmed. Scarlet fever or an associated virus cannot be proved here, but virus integrating with embryonic retinal cells cannot be denied.

MALIGNANT SYMPATHOGONIOMA
In A Baby Boy

Treated in collaboration with
Dr. Baldor

Neoplasia As In Diagram IV

John L., age 13 months, developed a tumor in the abdomen

that required an exploratory operation on September 25, 1951. It was found to be retroperitoneal and had infiltrated the surrounding tissues too widely to permit its removal. A biopsy was taken. The report is reproduced below.

On October 6 examination revealed a visible bulging of the abdomen at the umbilical region which palpation revealed to be the size of an ordinary Florida grapefruit, about 15 to 18 cms.

SAINT ANTHONY'S HOSPITAL, INC.
SAINT PETERSBURG 6, FLORIDA

PATHOLOGY REPORT

Name L , Baby John
Tissue No. 0-1598-51
Date September 25, 1951 Age Sex Male S. M. W. D.
Physician F. E. Langley, M. D.
TO
Clinical Resume: ABDOMINAL MASS OF RECENT DUARTION, PROVED NOT BE THE BLADDER. TESTICLES PRESENT IN THE SCROTUM AND APPARENTLY NORMAL.

SPECIMEN: BIOPSY OF RETROPERITONEAL TUMOR

GROSS: The specimen measures 5 x 3 x 4 cm. 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 separates 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 seperated by intervening masses of a fine eosinophilic sieve-like network of tissue. The nuclei vary from a round to anirregular 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

J. N. Carmichael M.D.
Pathologist

Physicians' Record Co., Chicago 5 - M12-1249 10M

in diameter, firmly fixed to the surrounding structures. The stools were bloody, and the blood count agreed with his pallor, showing a red cell count of 2,300,000, and a hemoglobin of 52 per cent. The next day, October 7, he received from Dr. Julian Baldor an injection of the linear arrangement of carbonyl groups, 12X dilution, with free radical terminals. Recovery began promptly and by the end of the first year no more growth could be palpated.

On May 5, while in good health, he was run over by an automobile and sustained a broken leg and abdominal injuries. While in the hospital for repair of the injuries, he was thoroughly examined by the surgeons who made the exploratory laparatomy and found free from any trace of palpable growth. He made a nice recovery and is in excellent health. On April 5, 1953, the red blood count was 4,750,000, and the hemoglobin 87.5 per cent.

The facts of this case were given by the surgeons under oath in court testimony at Tampa, Florida, with the operative findings of a malignant neoplasm that could not be removed. They removed a biopsy to identify the cellular type of neoplasm and origin. They also testified to the cured state as found in May, 1953. It shows that other factors than trauma are required to cause cancer. He continues to enjoy good health. (1956).

EUNUCHOIDISM**

Treated in collaboration with
Dr. Catherine S.

Anaplasia As In Diagram II

J. S., at age 14, subject to infections of the respiratory tract and skin, presented marked obesity, female shape, very dull mentality and infantile penis with undescended testicles. He had been under thyroid and pituitary hormone therapy from the age of 10, in 1931, to 1935, without improving his development physically or mentally or increasing his resistance to disease. Examination at the age of 14, by the writer, and testified to by Dr. S . . ., showed that the testicles had not even entered

the canals and so, from all standpoints and authorities, the disease was of a type that is not helped by modern therapy. He was given an injection of the carbonyl catalyst, and in three months definite improvement had already been established. Dr. S . . . 's testimony shows that within three months he lost weight and the left testicle was observed to be entering the scrotum. Within six months after treatment both had successfully passed through the canals into the scrotum and were normalizing in size, while at the same time the penis began to develop. He grew taller, his hips reduced and his shoulders broadened out and his jaw developed a normal prominence. The pubic hair appeared in normal distribution with a stream toward the umbilicus. His mentality changed entirely so that he became alert and did very well in his school work, soon making up for his backward position. By the age of 21 he was a good athlete and student, entered the army and was quickly promoted to a corporal. At the time the testimony was given he was in the Army Law School, making fine progress, married, living a normal, happy sex life and raising children of his own. He has two, a boy and a girl. Both normally developed physically. The inhibiting factor was therefore removed completely.

Here we have the inhibition of development probably based upon an infection focus in the respiratory tract. The history provides no unquestioned relation to scarlet fever infection, although a suspicious rash showed up after the twelfth week reaction and was discounted as a food affair. However, the continued colds from infancy point to respiratory infection and may be a suppressed scarlet fever. At any rate, the toxin that inhibted the development of this section of the urogenital ridge at a late date did clear up, as did other signs of infection, and the inhibition ceased as soon as an effective carbonyl catalysis was established.

The following case of cancer of the testis, in contrast, shows the neoplastic expression of carbonyl deficiency.

CANCER OF THE TESTIS

Neoplasia as In Diagram IV

Treated in collaboration with
Dr. Alpheus Hoyt

Mr. T. was 38 in June, 1925, when treated with carbonyl catalysts. The testis had become neoplastic six months previous to 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 biopsy report read again "medullary carcinoma of the testis." Recurrence was not long in becoming evident and with much more rapid spread of the disease. The abdomen was again opened, but was found so inoperably involved that the opening was closed after only removing a biopsy. This biopsy report read, "Carcinoma, probably secondary to previous carcinoma of testis, as the cells are histologically similar." At this time he was rather emaciated and exhausted and a general cachexia called for a hopeless prognosis. Through the intervention of Dr. Alpheus Hoyt of New York City this patient was referred to us as a test case by the late Dr. James Ewing, the well-known cancerologist. Mr. T. was still well in 1946 when he offered to testify for us in the Federal Court. This was twenty-one years after he received the treatment during the terminal stage of the diseases.

ECLAMPSIA**

Treated in collaboration with
Dr. Baldor

Function Suppression As In Diagram V (b)

Mrs. D. was married seven years and had never been able to go through a pregnancy. Three previous pregnancies had to be terminated because of eclampsia before the end of the second month. In each instance she vomited profusely, formed less and less urine until only blood came from the kidneys.

There was much salivation. The vomiting increased until nothing but blood was thrown out and she developed convulsions and coma. She did everything to keep the baby, as it was her object in life to have one. Of course, abortion was necessary in each instance. It is well known too, that each such experience makes the case more severe. The kidney function is greatly reduced each time and the next pregnancy is more certain to call for earlier abortion. This is what happened in the fourth pregnancy, now under discussion. The symptoms reached the coma stage after going through the others as described. It was then that the attempt was made to overcome the toxemia with the serially arranged carbonyl group reagent. In twenty-four hours the vomiting decreased from twenty times a day to two times. After seventy-two hours she began passing a half liter of urine a day. This urine still carried blood and albumen. In four days she passed a full quart of urine a day. The vomiting had ceased entirely within two weeks, but she still salivated a large quantity a day. During the third week vomiting again started, so another dose was given. She cleared up completely thereafter and carried her baby without adverse symptoms into the seventh month, when she had an accident and miscarriage threatened. Eclampsia symptoms, however did not return. She was delivered of a perfectly healthy premature baby of five and one-half pounds. She retained good health and was able to make a trip to Georgia to visit her relatives soon after the delivery care was over.

This case represents our usual experience in this deficiency. It shows not only the return of function that could be considered normal for the patient, but an added increase able to take care of the products of metabolism excreted by the fetus into the patient's blood stream.

TOXIC AND STRUCTURAL TISSUE INJURIES AND THEIR CORRECTION

Postpneumonia Glomerular Nephritis**

Treated in collaboration with
Dr. Evans, the father.

Functional Aggravation As In Diagram II

The case of T. E., age 4 years, the son of Dr. Evans.

He had enjoyed good health until he had a severe bilateral confluent broncho-pneumonia in 1938 and with good care made a fair recovery. Immediately following the major pneumonia state, an acute glomerular nephritis set in rather suddenly and progressed rapidly to its terminal stage. His father, a physician of very good judgment and wide experience, had left the boy Sunday night in good condition. Early Monday morning the nurse called him to the hospital for his young son Tom, was in convulsions. They lasted several hours and were followed by visual symptoms, delirium, oedema that rapidly increased so that in two days the contours of the chin and neck were obscured and other malformations appeared generally. At the time of the first convulsion the blood non-protein nitrogen was found to be 74.6, and the blood pressure 146/68. In the afternoon of the same day the blood pressure was found to have increased to 160/100, and two days later, when the second convulsion occurred, it was 180/130. The leucocyte count was 23,000. The second convulsion occurred Wednesday morning and was more severe than the first; delirium had preceded it, the oedema had increased, and doubtless had also affected the brain. Coma followed this convulsion and at this time the carbonyl oxidation initiators were administered, one cc. of one part to a trillion of water. Since no medical treatment was known at the time to be of help, he was not bothered much by any other measure before or after the treatment was given. The urinary output was lessening as compared to the intake, less than half being excreted, the other accounted for the oedema which was rather serious.

The injection was followed by the subsidence of the pathological findings. The mental symptoms quickly normalized, the oedema left, the blood pressure dropped to normal and the non-protein nitrogen came to 25 mgms. per cent, so that in a few days he was normal and so he remained. It took a few weeks to regain his strength and be on the go again; but the pressor substance that was rapidly developing without hindrance was quickly oxidized away with other oxidation inhibitors that the boy could not defend himself against, and so his life was saved. The toxins were converted into their own anti-toxins and kidney functions restored by the same oxidation process.

PSEUDO-NEOPLASTIC TISSUE INTOXICATION

Toxic Nodular Goitre**

Treated in collaboration with
Dr. Baldor

Function Aggravation As In Diagram II

This disease reveals the tissue hyperplasia and the perverted secretion of an essential endocrine gland which is incurable surgically, and which does not respond to iodine therapy. The defect is here demonstrated to be a defective oxidation catalysis. This patient was in extremus when given the treatment and the recovery is just what one should expect, if, in fact, an insufficiency in the tissue oxidations resulted from the action of a toxic inhibitor.

Mrs. M. J. was 35 in July, 1943, when examined by Dr. Julian Baldor. She had lost considerable weight recently, suffered from excessive nervousness and tremor, pains in the legs, terrific heart palpitation, shortness of breath and such extreme weakness that she had to be carried into the car to be brought to the doctor. The blood pressure had risen to 190/110, indicating toxically dangerous hypertension. There was throat constriction and muscle twitching.

Examination revealed a woman with well-developed tremor and muscle twitching, exophthalmus, tachycardia, loss of weight

and strength and nodular thyroid enlargement. The basal metabolism rate was plus 104, July 8, 1943.

The heart was failing. The systolic pressure in the next few weeks dropped to 170, while the heart beat became weaker and the diastolic pressure stayed up to 110, showing that the fundamental toxic state was not abating, and the myocardial injury was increasing. She rapidly became very thin and weak, so that her muscles were too atrophied and incompetent to carry her and her husband had to carry her to the automobile and into the doctor's office.

From July 8 to November 10, 1943, iodine was tried with absolute rest and ice packs to the thyroid gland, but the condition steadily grew worse. The iodine was not succeeding in preparing her for operation and the heart had to be protected from further toxic injury. The nodules on the thyroid kept increasing.

Therefore two cc. of the 12X dilution serial system of carbonyl groups were given intramuscularly, and in a few days one could see that the trend of the disease was reversed.

The tremor improved, the heart beat was stronger, she could soon get around on her own strength; the whole picture steadily changed so that by the end of the eighteenth week she was back to work, a normal woman. The tremor was gone, the exophthalmus was gone, the nervousness was gone, the blood pressure was normal, 145/97 and later 140/80. The heart rate was 80 to 90. The thyroid was normal in size and the nodules had been absorbed. Instead of being carried and helped, she was out working carrying a heavy suitcase of goods. Her basal metabolism, March 16, 1944, four months after treatment was plus 6, a very fine normal.

TOXIC GOITRE WITH CANCER OF THE STOMACH

Impeded Function, Hyperplasia and Neoplasia Based on One Factor, Yielding to Same Atomic Arrangement in the Same Patient

Exemplifying Diagram II, IV, and V (b).

Mrs. W. comes from the goitre belt of Ohio. Cancer is

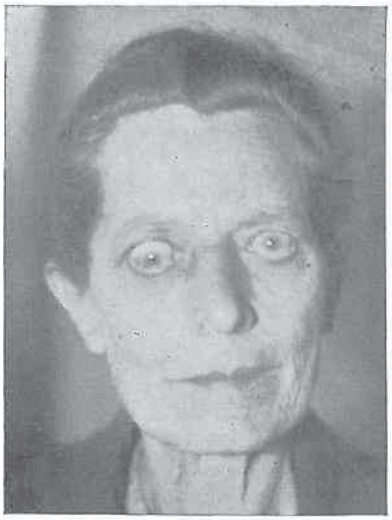
very frequently met in this locality. Although she was only 58 years old at the time of examination and treatment in September, 1929, she appeared to be at least seventy. It is worth notice that after her recovery she became "younger" in every way as the years passed. The photographs show the condition of the face, neck and eyes before and after the treatment.

Cancer was not recognized in the ancestry, but her husband died of cancer eight years previously, and her daughter, age 28, had a brain tumor that progressed as a malignant neoplasm subject to reversal by the same treatment that corrected the mother's defect.

The disease started two and one-half years previously as a steadily-increasing nervousness, progressive cardiac weakness, tachycardia, increasing ease of perspiration, loose bowels, and tremor of characteristic hyperthyroid type. Radiographs showed considerable enlargement of the heart and mediastinal shadows early in 1927. There was dyspnoea on slight exertion or lying down. Exophthalmus developed rapidly, the skin bronzed, and gastric distress and inefficiency set in. The feet and ankles swelled considerably, yet she lost weight, falling from 150 pounds to 108 pounds in less than nine months. The physical examination revealed the exopthhalmus as shown in the photographs (reproduced below); there was also a greatly enlarged lymph gland (walnut size) in the left supraclavicular, space; the veins of the head and neck engorged with blood when she laid down, and percussion showed a marked increase in the mediastinal dullness. Examination showed the epigastrium and the whole area below the costal border down to two centimeters below the umbilicus on the right side to be occupied by a huge, bulging, solid, fixed, irregular tumor. The stools showed decomposed and occult blood; there was vomiting and great weakness and considerable pain throughout the abdomen. Thus the stomach, the liver, and probably the suprarenal glands were involved by the neoplasm. At the time of this examination she was very weak.

One dose of two cc. of the 12x dilution of the serial carbonyl system was used on September 28, 1929. The recovery process exhibited the usual cyclic three week reactions, with

chills, fever, and general aching; and with improvement following each reaction until the recovery became complete. At last report ten years later she was in good health. We lost track of her thereafter.



Mrs. W. before treatment showing the exophthalmus from toxic goitre excited by the carcinogenic toxin.

Mrs. W. after treatment and recovery from cancer of the stomach, and toxic goitre as secured from one chemical reagent. The exophthalmus is gone for good.

GRADE 4 SQUAMOUS CELL CANCER OF THE CERVIX UTERI* **

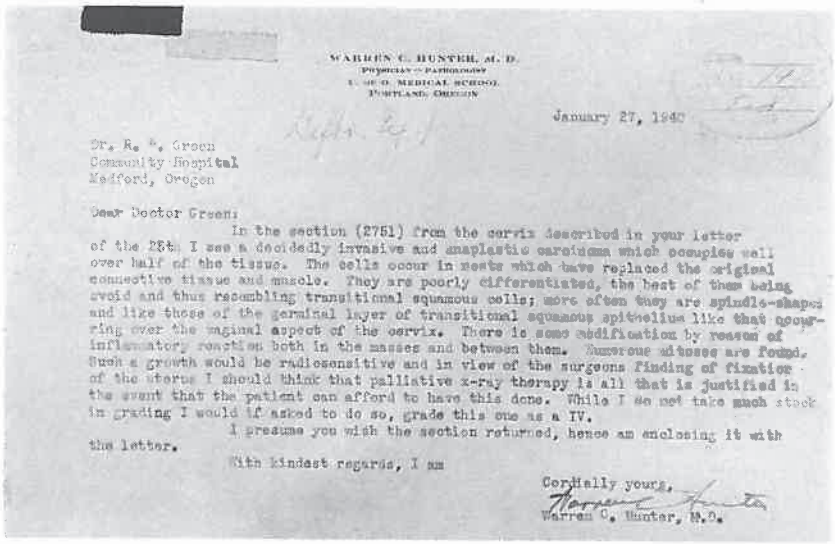
Treated in collaboration with
Dr. L . . . .

Neoplaia As In Diagram IV

Mrs. M. W. came under the care of Dr. L . . . . of Medford, Oregon, on January 12, 1940. Dr. L . . . . stated: "I examined her at that time 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. On January 19, I took her to the hospital and removed a section of tissue from the cervix, which was examined by Dr.

R. E. Green, following which the tissue was sent to Dr. W. C. Hunter, University of Oregon Medical School."

This slide was very carefully prepared by Dr. Green, the hospital pathologist and diagnosed by him as squamous cell cancer of the cervix uteri. Dr. Hunter testified that grading of tissue is done for the purpose of telling someone else how malignant the tumor is, that is, how rapidly growing. The degree of malignancy is indicated by the highest number given, which is IV. It runs from I to IV. So grade IV would be the highest degree of malignancy that we recognize. In his letter to Dr. Green he 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."



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

January 27, 1940

Dr. R. E. Green
Community Hospital
Medford, Oregon

Dear Doctor Green:

In the section (2751) from the cervix described in your letter of the 23rd 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 avoid 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 acidification 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.

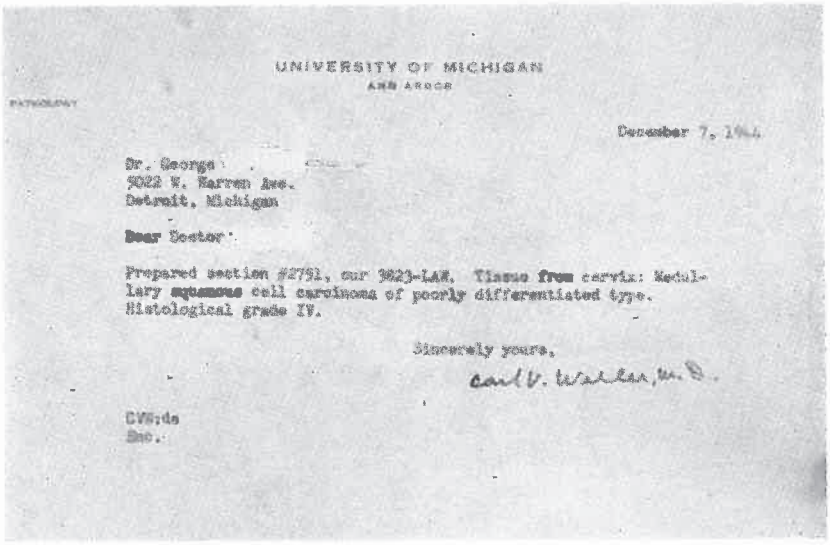
With kindest regards, I am

Cordially yours,
Warren C. Hunter, M.D.

Dr. L.... testified that her cancerous condition would, if untreated, end her life within a year. 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 to be too extensive. It was too late for that sort of thing.

The case had already entered the cachexia stage as his

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



UNIVERSITY OF MICHIGAN
ANN ARBOR

PATHOLOGY

December 7, 1944

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

Dear Doctor:

Prepared section #2791, our 3823-LAK. Tissue from cervix: Medullary squamous cell carcinoma of poorly differentiated type. Histological grade IV.

Sincerely yours,

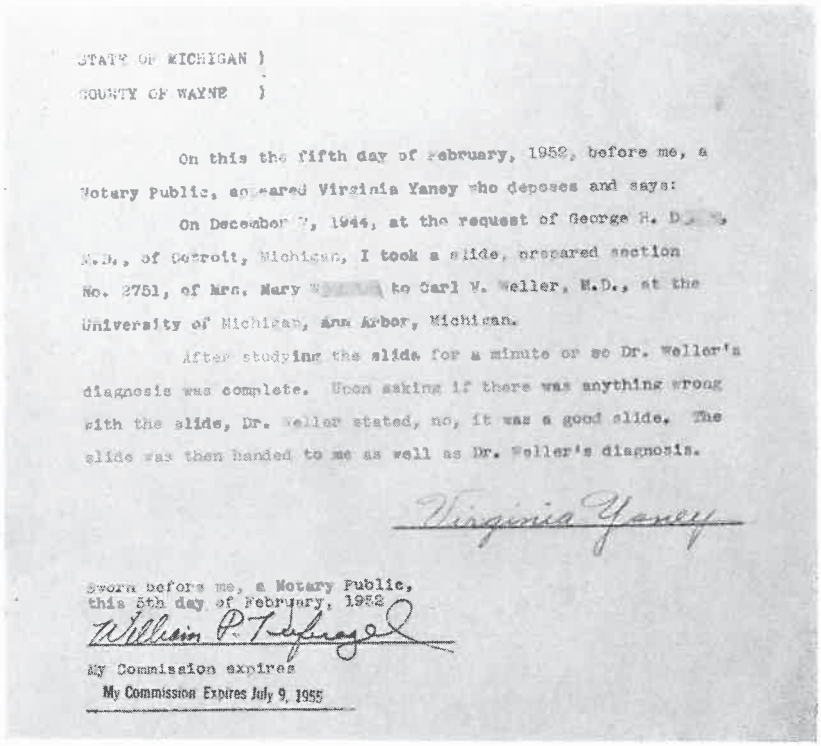
Carl V. Weller, M. D.

CVW:ds
Enc.

but when the lesion is localized in the pelvis, cachexia is missing."

While under Dr. L . . . .'s care Mrs. W. M. received 3 injections of the serial system of carbonyl groups. These were given on March 20, 1940, December 30, 1940 and in October 1941. (It should be noted that this patient was on the Welfare. She

had pernicious anaemia and her diet was modified to permit her to eat liver. She also was given liver extract.)



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. Talmage

My Commission expires
My Commission Expires July 9, 1955

Mrs. M. W. remained under the medical care of Dr. L.... for approximately two and one-half years. At the time of the last vaginal examination by Dr. L.... which was made in the

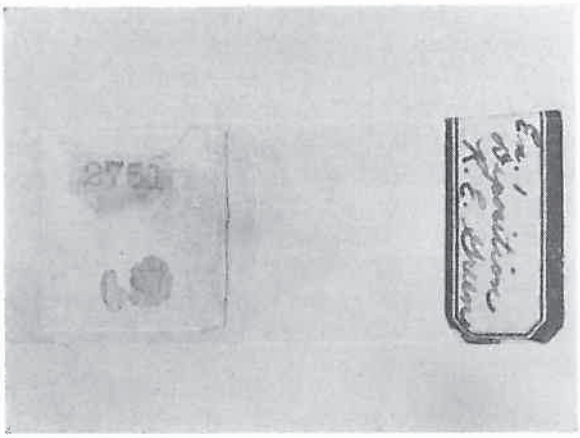
late summer of 1942, sometime before entering the military service, he noted that the appearance of the cervix by an examination with a speculum appeared normal. The mass in her abdomen had subsided to the extent that he could no longer palpate it. She had gained weight, gained in color and improved in her appearance. Though there was marked improvement, she was not classified as cured.

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

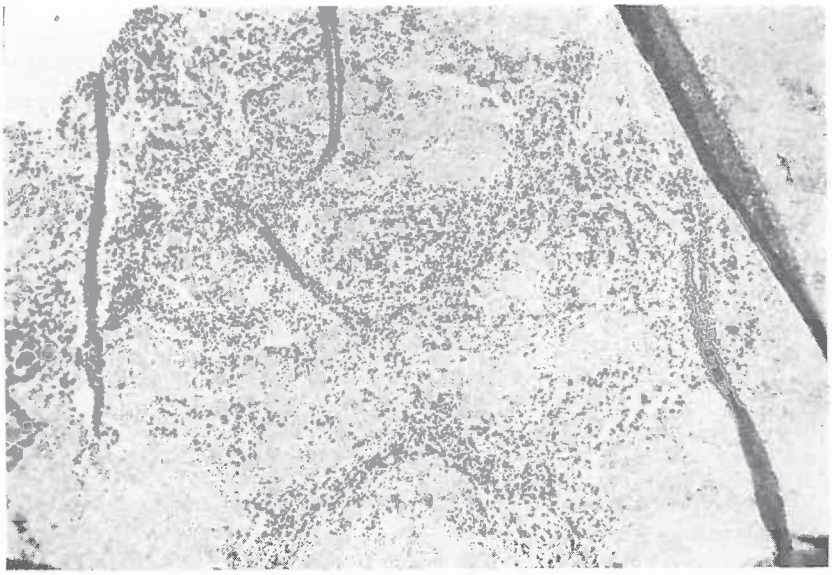
At the second Federal Court Trial in Detroit, Michigan, on May 29, 1946, Dr. Haines testified that he had seen Mrs. W. in June of 1944. That on physical examination he found only a fibroid tumor. He removed the tumor from the left side of the uterus and at the same time did a sub-total hysterectomy. The post operative diagnosis was a "simple fibroid." He stated: "I observed no malignancy, no—nothing except a fibroid tumor." The cervix was not removed, even though this had given rise to the malignant neoplasm. Hence we see that they left it in place in the body since it was normal. Dr. Inskeep, the pathologist, testified that he examined the tissue from this tumor and that his pathological finding was "Fibromata of the Uterus" and that this is a benign tumor.

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 health 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.

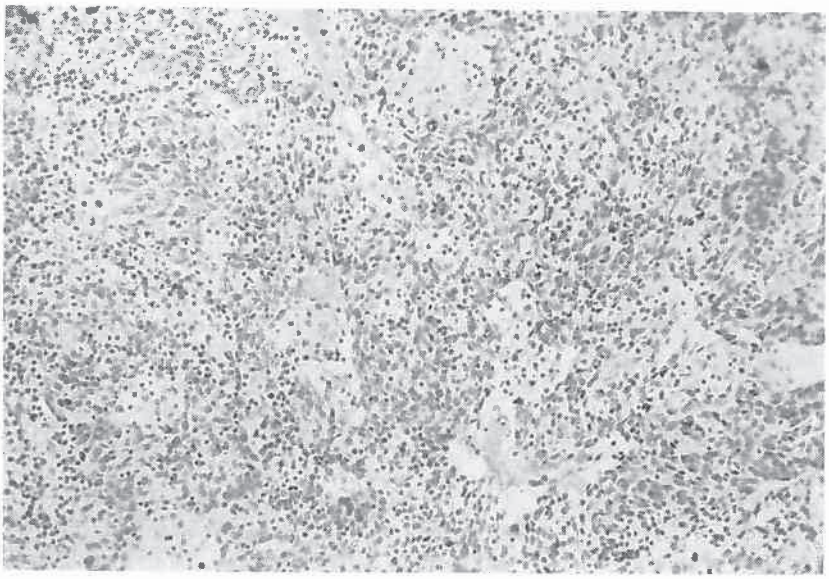
A photograph of the slide carrying the biopsy specimen well placed under the cover slip is given, and three microphotographs made by the Harper Hospital expert are also submitted for your study.



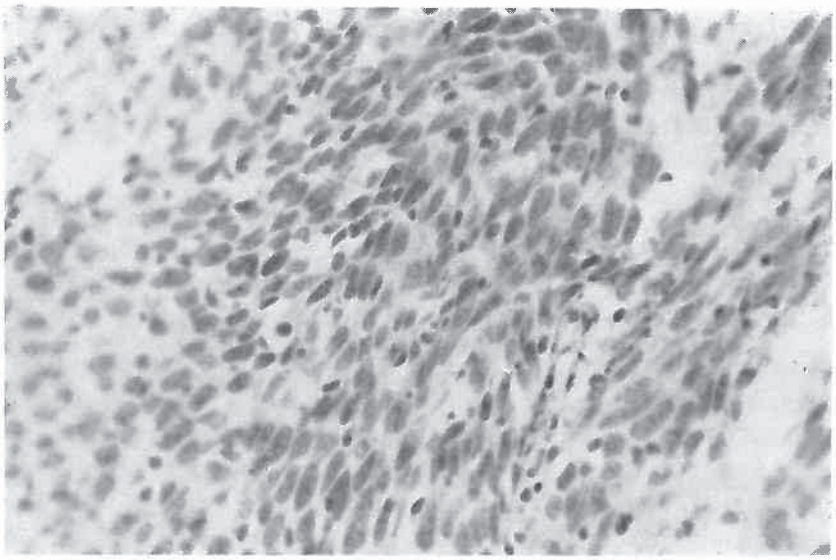
Photograph of the Biopsy slide showing its perfect condition.



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



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



High Power Microphotograph by Mr. Rinelander (675X)

Mrs. M. W. came under Dr. L....'s care just a few months before her death in December 1950. At the time of her death he was not aware of the sub-total 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. It is very possible that the survival factor was destroyed sometime between June 1944 and her death in 1950 and that a subsequent malignancy developed in the lower end of the large bowel where Dr. L.... observed the foul-smelling mass during the autopsy.

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 the 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 therefore 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 occures.

LYMPHOCYTIC LYMPHOSARCOMA*

Treated in collaboration with
Dr. Frank Richards

Neoplasia As In Diagram IV

Mrs. S., 38 years of age, came under my observation on October 27, 1944. She gave a history of a persistent crop of axillary boils that cleared up on an autogenous vaccine, but no other remedy helped. These appeared in April, 1943, and per-

DOWNTOWN CLINICAL LABORATORY
MICHIGAN STATE REGISTRATION NO 726
711 STROH BUILDING
DETROIT 26, MICH
Randolph 4532

CLARENCE I. OWEN M D DIRECTOR

NO. E-1589 Oct. 18, 1944

PATIENT Mrs. M S DOCTOR J.M. Jones

SOURCE OF SPECIMEN Neck gland

Gross examination:

The specimen consists of a nodular mass of tissue which measures approximately 2½ cm in size.

Microscopic examination:

The specimen is a lymph node with complete loss of architecture. The lymphoid follicles and germ centers no longer exist. There is a widespread lymphoid hyperplasia with a considerable amount of variation in size of cells although most of them are small. An occasional one is multi-nucleated. The cells have large hyperchromatic nuclei and very little cytoplasm. In some areas there is considerable amount of hyalinization.

Diagnosis:

Lymphosarcoma.

EXAMINED BY C. I. Owen

sisted for nearly a year. During the latter part of this period the right side of her neck became stiff and painful. She could not stand a draft of air on it. It did not respond to diligent treatment of any kind. Instead swelling and stiffness was noticed in the region, advancing deeply into the pharynx. Many doctors attempted to help in vain. In this bewildering condition she stepped on a nail and sustained a severe infection of the foot. The condition in the neck became much worse then. A mass became evident that involved the neck structures of the right side. Biopsy done October 14, 1944, and examined by several good pathologists gave the diagnosis of *lymphosarcoma*, lymphocytic cell type, as reproduced below.

Two weeks later my examination revealed a marked cachexia, and the lymphatic glandular system quite widely involved with tumefactions. The gland in the neck that was biopsied was about five centimeters by seven in its diameters and involved all the structures of the region including the tonsil area.

The glands of the groin and axillae were also involved and the largest of all was the size of a grapefruit encountered in the upper abdomen. It bulged, was hard and fixed. One injection was given, the serial system of carbonyl groups, at 11 o'clock at night. The next day at two in the afternoon, just fifteen hours later, a marked reaction developed, fever, chills, general achiness and a relaxation in the neck. Improvement in all of the neoplasms went hand in hand with these feverish chilly spells for about three weeks. This improvement was definite each day, and the stiffness and swallowing difficulty was gone by the end of the third week. In three months no tumors could be found. However, reactions came the twenty-fourth, thirty-sixth, seventy-second, eighty-fourth, and ninety-sixth weeks, and even later, one or more reactions were observed. But her health was better in some way after each, in spite of the fact that her health had already become much better than usual, or what was normal for her. This was noted in her energy, her ability to take care of a large house and of her family, and work in a clothing shop besides. Her prognosis at the time of treatment was probably two or three months to live. Following the absorption of the neoplasm there was no focal reaction in the foot

or the axilla where the infections were so persistent before the growth came. We expected some evidence of reaction as occurs in the tonsil area of the same side as the breast from which a malignant neoplasm had just been absorbed, at one of these points and watched for it, but she remained in good health without any such reaction for ten years, when in August 1955, a keloid condition developed in the scar of the biopsy incision.

On October 10, 1955, this patient received an injection of diphenoquinone. No significant reaction or improvement followed until the seventy-second week as happens in benign tumors. (See the case of Miss G.) The lymphosarcoma and the keloid had independent origins. A more detailed discussion is given in Chapter XVI. Following her seventy-second week reaction the keloid continues to undergo absorption and she feels very good.

CANCER OF THE COLON* **

Treated in collaboration with
Dr. F. L. Richards

Neoplasia As In Diagram IV

Mr. J. K. was 42 years, when X-ray studies and exploratory operation showed widely metastasized carcinoma of the splenic flexure of the colon, which caused complete obstruction. A colostomy was performed at the Henry Ford Hospital, Detroit, Michigan. The neoplasm perforated the abdominal wall in three different places, forming large cauliflower masses that discharged very foul necrotic and fecal material. As this condition developed he suffered a great loss of weight. His normal weight which was 180 had dropped to below 113 pounds. The biopsy report: Metastatic carcinoma of colon. The Henry Ford Hospital doctors had diagnosed this case as Fungating Carcinoma of Colon with a terminal prognosis.

The Surgical Pathological Memo from Ford Hospital is reproduced:

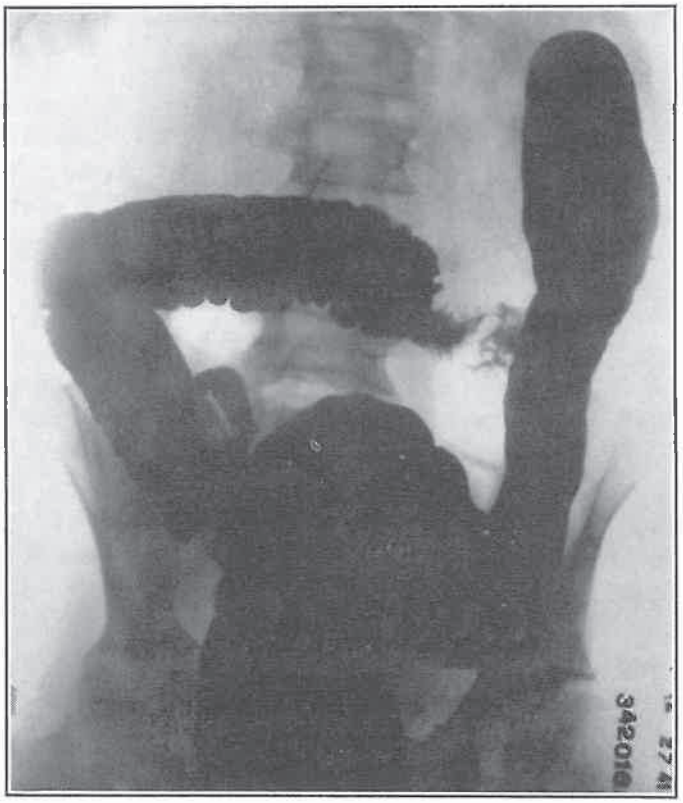
HENRY FORD HOSPITAL
Surgical Pathological Memo

Photo:
Name: K. J.
Sex: Age: 42
Path. No. 66933
Case No. 342016
Date: 2/27/42

Pathological Diagnosis 101.62 CUTANEOUS SYSTEM: SKIN OF ABDOMINAL WALL: METASTAC ADENOCARCINOMA

Location of Lesion Abdominal wall
Clinical Diagnosis
Operation
Operator Dr. Fallis
Gross Pathology

The specimen consists of a piece of skin measuring 14x14.5 cm. The central portion is destroyed and partially filled by a friable gray tumor mass which involves the underlying structures and has been cut through upon removal. The tumor shows extensive necrosis. The edges of the speciment are cauterized.



This X-ray was taken of Mr. J. K on
December 27, 1941 before treatment

IMPRESSION: Secondary carcinoma of abdominal wall.

MICROSCOPIC: Section shows a tumor mass invading the subcutaneous tissues. The normal epithelium is absent over the mass. The cells of the tumor are large, hyperchromatic and show many mitotic figures. Poorly differentiated tubular glands are formed by these cells. A massive necrosis affects large areas of the tumor.
ea/

Our examination revealed a very cachectic condition, and extreme emaciation. The abdomen was bulging from the tumor material within, and a colostomy opening on the right side was found which performed well. The rest of the abdomen presented large and small cauliflower growths ranging from 4 to 8 cm. in diameter, three in number. They were very necrotic in places and discharged fecal material. He was given one dose of two cc. of the serially arranged carbonyl groups on April 3, 1942. He improved some each day. On Sunday, during the third week, he hemorrhaged. This occured again on the following Saturday. He was given a second injection and some Calcarea for the bleeding. The hemorrhage stopped and he started to im-

Henry Ford Hospital

DATE 2-27-42

NAME K JOHN I 2 CASE NO. 342016

GENERAL MEMO

DIAGNOSIS: Fungating Carcinoma of Colon

OPERATION: Electro Coagulation of Tumor Mass.

OPERATOR: Dr. Fallis

ANESTHESIA: Ether and Nitrous Oxide by Miss Bilyea

PREPARATION: Hexylchloro-M-Cresol

OPERATION: As we commenced the operation, we do consider the possibility of resection of the left half of the transverse colon. With the radio knife, we therefore cut around well beyond the margin of the fungating mass and strip back the skin flap. As we encounter the left rectus muscle, we find that the tumor mass is infiltrating throughout, so that resection is out of the question.

With the electric cuatery, we therefore cut off the bulk of the tumor and coagulate all the protruding mass. The skin flaps are then undermined and brought together with interrupted wire sutures. Copious dressings are applied and the patient is returned to the floor in good condition.

This is entirely a hopeless case

prove very rapidly. His weight became around 113 pounds by the end of June and by the time he returned to work the latter part of August it was over 160 pounds. After the second treatment the obstruction left and the bowels moved normally within nine weeks. In September, 1942, the fistulae had completely healed and his health had returned so we sent him back to the Henry Ford Hospital to have the colostomy closed. This was done and examination at that time could find no trace of the neoplasm. He made a splendid recovery.

The radiograph shows the obstructive neoplasm and its rupture through the bowel. The operative findings are decisive.

In a case of this type, Benzoquinone would not be sufficiently active as an initiator of oxidations to serve well. The serial systems of carbonyl groups is more efficient. Here we observe that the recovery rate is a function of the rapidity with which the disease develops. Also we see that normalization is possible when the basic oxidation defect is corrected.

LYMPHOSARCOMA*

Treated in collaboration with
Dr. Garret Warnishuis

Neoplasia As In Diagram IV

This is the case of Mrs. G. G., age 40, at the time of treatment with carbonyl catalyst on May 17, 1937. The disease first showed its malignant nature eight weeks previously when a small cervical lymph gland began to grow rapidly. A biopsy was made but at the same time several other glands enlarged in the posteriolateral cervical region. The biopsy was performed three weeks before her appearance at the Koch Clinic. In the meantime the remnants of the gland that was biopsied grew rapidly so that it became as large as the ball of a man's thumb in the intervening three weeks.

Besides this, several other glands began to show more rapid developments but were still small.

The biopsy report taken from the hospital record reads as follows:

copy

5M...5.37

DIAGNOSTIC LABORATORIES
MIAMI VALLEY HOSPITAL
DAYTON, OHIO

SURGICAL PATHOLOGY

Name C , George Mrs. Path. No. 95(-K
Last Name First Name Initial

Station C.P. Room Age 45? Public / Private

Clinical Diagnosis
(Must be stated by surgeon before operation)
Gland from neck

Surgeon's Pathology
(Must be described by surgeon following operation)

Surgeon P. Shank

Date of Operation 4-27-37

PATHOLOGIST'S REPORT

Gross pathology

Cherry size mass of firm grayish-white tissue

Microscopic Examination

The normal lymphnode architecture is largely replaced by diffuse hyperplasia, including localized areas containing large pale lymphoblasts. The microscopic appearances are those of early lymphoblastoma of the lymphosarcoma type. (Does the peripheral blood show evidence of an excessive number of abnormal immature white cells? Such histological findings in the lymphnodes may or may not be associated with leukemia).

Walter M. Simpson, M.D. *Pathologist.*
(The original sheet is to be placed on the patient's chart)

The carbonyl catalysts were given and a month later no trace of the growth could be found. It had been fully absorbed. The other glands returned to normal size. Her health remained good without recurrence of the disease. She met with an accident several years later that proved fatal. An autopsy was made which showed that no trace of malignancy could be found. Hence her recovery was complete. If this were not true there would have been extensive evidence of the recurrence of the disease and death long before the fatal accident and autopsy took place.

ENDOTHELIAL SARCOMA OF BONE*

Treated in collaboration with
Dr. Garrett Warnshuis

Neoplasia As In Diagram IV

A much slower growing but regularly fatal type of sarcoma is presented in the case of Harold B., age 41, when trouble de-

veloped in his right arm. Pain in the arm so that it could not be used and a swelling over the scapula brought him to the University of Michigan Hospital. X-ray films, blood chemistry exploratory operation and biopsies established the diagnosis as sarcoma of endothelial cell origin and involving the shaft and head of the humerus, the shoulder joint and scapula as well as the muscles posterior to it. A hopeless prognosis was given but he was offered an operation to remove the arm and shoulder girdle which he refused. He was then sent to me. The biopsy reads as follows:

Record R.

UNIVERSITY OF MICHIGAN
UNIVERSITY HOSPITAL
PATHOLOGICAL SPECIMEN

Name Harold B No. 554100 Date 9-1-54

Service Surg. SS Age Sex Pathological No. 1716-AM

Address Occupation

History of Case Tumor mass over right scapula posteriorly. ? myeloma.

Operated by Dr. Iglesias. Nature of Operation Biopsy. Incision.

Question

Gross Description I. Numerous bits of cancellous bone.
II. Soft tissue from right shoulder: Bits of soft brown tissue, some pieces apparently blood clot. (I bits decal, II bits ns).

Pathological Diagnosis II. This is a malignant neoplasm, the final classification of which is in doubt. It is composed of round cells, only a small proportion of which show the eccentric nucleus and basophilic cytoplasm usually seen in the plasmocytoblastomas. The arrangement of the cells is suggestive of an endotheliosarcoma, probably hemangiosarcoma. Further report after decalcification. Pathologist

H. Gordon

Pathological Diagnosis After decalcification: Bone is in large part replaced by neoplasm showing the same general histological characteristics as in the soft material. This is a spindle cell hemangiosarcoma. Pathologist

H. Gordon

UNIVERSITY OF MICHIGAN

UNIVERSITY HOSPITAL

SURGERY

HISTORY SHEET

Name B , Harold -S- Case No. 552162 Date 8-31-54

PHYSICAL EXAMINATION

GENERAL: The patient is a well developed male of 41 years of age appearing not to be acutely ill. Color good. Nutrition good.

HEAD: Scalp:Hair is normal in amount and distribution. No exotoses or areas of tenderness present.

EYES: The conjunctivae are of normal color. Sclerae are not icteric. The pupils are equal in size and round. They react normally to light.

EARS: No discharge. Hearing seems to be normal.

MOUTH: Mucous membranes are of normal color. The throat is not injected. The tonsils are present, not enlarged. The tongue papillae show no atrophy. The teeth are in fair condition.

EARS: No discharge.

NOSE: No discharge.

NECK: Neck symmetrical showing no abnormal masses or pulsations. The veins are not abnormally engorged. The thyroid is not enlarged or nodular.

THORAX: Percussion reveals no abnormal areas of dullness. The breath sounds are normal. No rales heard. The thorax is symmetrical. Considerable pain was complained of in the right upper chest posteriorly in the region of the scapula. Heart; LBCD 7 cm. Rate and rhythm normal. No murmurs. Blood pressure:100/80. No edema of the ankles.

ABDOMEN: Symmetrical. No areas of tenderness present. No masses could be felt. The liver and spleen are not enlarged. No signs of inguinal hernia.

GENITALIA: Testicles are normal. No nodularities of the vas. Shows normal development.

LYMPHATICS: No enlargement, of the cervical, axillary, epitrochlear or inguinal glands.

EXTREMITIES: Biceps, triceps, reflexes are present, equal and active. The fingers are clubbed. Examination of the right scapula revealed a lemon sized mass below the spine of the scapula. This mass was firm, and rubbery in consistency; much tenderness complained;of; the overlying skin was not discolored. The mass moved with the scapula. Pain was complained of on passive movement of the shoulder joint, however muscular motion seemed normal. There appeared to be no noticeable disturbances of the right arm. Pain was complained of in the upper dorsal region of the spine. This, he states, has been present for a considerable time. Lowers: Patellar reflexes are present, equal and active. The Achilles reflexes could not be obtained even with reenforcement. Babinski negative.

IMPRESSION: Spindle sarcoma of the scapula, with questionable metastases to the dorsal spine. Infiltrative involvement of the right shoulder joint.

AS

db

Dr. Smith

Form M-2041G5-J-54-10ZM-193381

46

My first examination was made September 17, 1934. The arm was found to be painful on motion. There was swelling of the shoulder and a tumor mass firmly fixed to the scapula as large as a man's fist laying over the spine of the scapula. Nearer the dorsal spine was a mass of similar nature about the size of an English walnut. There was some cachexia, but no abdominal tumor masses could be found. The treatment of 2 cc. of the 12X dilution of the serial system of carbonyl groups was given. Recovery was steady and slow. In a few months he could use his arm without trouble. In a year the tumor masses were entirely absorbed, and X-rays showed a nearly complete recovery in the bone.

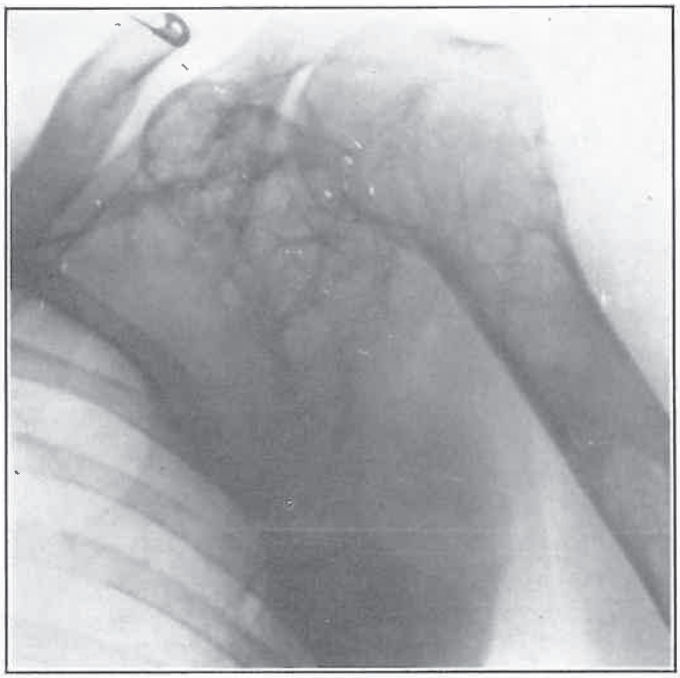
His major reactions were at the twenty-fourth and thirty-sixth weeks. He continued to work and made a full recovery. We did not have opportunity to make another radiograph before 1942. This showed complete recovery. Comparison of the pre-treatment and post-treatment radiographs show a considerable thickening and strengthening of the bone where the disease tissue had to be absorbed. This is seen in other cases of bone destruction by sarcomas or carcinomas, and appears to be a general compensatory repair reaction, and not dependent upon the type of disease that had to be removed. His health remains good and there has been no further trouble of this kind. Radiograph II shows the condition after full recovery.

In this case we observe a slower development in the neoplasm, and no metastases to the vital organs in the year it had been progressing and producing symptoms. The nature of this disease as described by Ewing, our leading authority, p. 361, Text Book on Cancer, 1942, is:

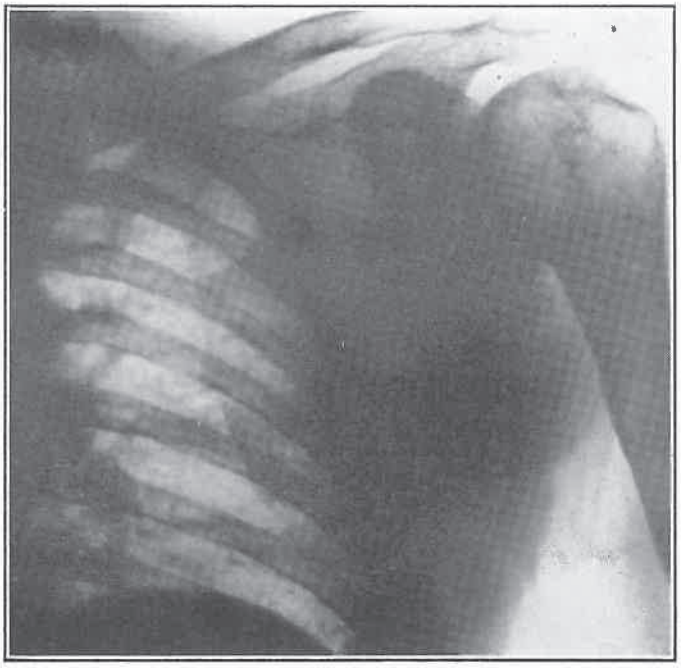
"Angio endothelioma, multiple endothelioma, diffuse endothelioma, or endothelial myeloma, the entire group, is characterized by predilection for the bone shaft, a tendency to multiplicity, a cellular and vascular structure, marked osteolytic properties, failure to produce tumor bone, and a relatively slow but fatal course."

The recovery was complete and perfect health was reported in 1950 when he was last heard from.

Thus a slow growing malignant neoplasm, makes a slow recovery. This is our consistent experience.



Radiograph I, showing condition before treatment.



Radiograph II, showing condition after full recovery.

The recovery process must therefore not be forced beyond its natural course by unnecessary repetition of the dose.

CANCER OF THE LIVER

All primary tumors of the liver are malignant whether or not they are associated with cirrhosis. Biopsy in such tumors is not practiced and indeed is not done except as an experimental or academic procedure. The autopsy material and biopsy material together with the clinical history have established this fact. Ewing may be consulted in support of this statement.

Cancer of the liver is interesting to us however much like the anaplasias or atrophies of nerve cells consequent to integration with a toxin or virus, where function is abolished, and yet the cell may not be dead as yet though affected for many months or years, and gradually passing on the way to death. Such cells we show are able to reconstruct themselves and function again after the toxin or virus has been separated away in the correct manner. Live cells, parenchyma or duct cells, may go malignant and completely anaplastic so as to never function again and with the recovery process are digested away as so much debris, but the deficiency left in the organ by such anaplastic loss of the neoplasia can be compensated for by reproduction of the Grade A cells that still remain. A primary tumor of the liver will therefore be able to be absorbed and leave a large defect in functioning tissue. This can be repaired with good return of function of the organ, in time to meet the requirements for function. This is not the case with secondary cancer of the liver always. If a large amount of liver substance has been destroyed by secondary invasion, there may not be enough reconstruction of liver tissue with the absorption of the tumors to support the liver function required by the body in general and to take care of the metabolism of the tumor material absorbed, and death may follow because of hepatic insufficiency. The far advanced cancers of the liver of primary origin are therefore more favorable to recovery than the secondary neoplasms that invade the organ by infiltration and metastases because of the presence of a certain amount of restorable anaplastic cell that we previously described as Grade A.

CANCER OF THE LIVER*

Treated in collaboration with
Dr. David Arnott

As Diagramed in IV

Dr. Arnott was called in to treat Mrs. M. G. by the patient's husband. Earlier, Dr. Arnott had been consulted by Dr. E. W., the surgeon.

From the hospital records and speaking with the surgeon, it was evident that an operation was performed upon Mrs. G. on June 29, 1931, in which the surgeon opened the abdominal wall over the gall bladder area. The gall bladder was brought up to the surface of the incision by forceps and held there while a tube was inserted to drain off the blood and then the gall stones were found and removed. Then a permanent drainage for treatment was left there after the operation and it was still in position when Dr. Arnott saw her over three weeks later.

At the operation an examination was made and no gall stones found to obstruct the flow of bile into the bowel. It was found at this time that there were tumors on the liver. An obstruction of the gall bladder was thought responsible for Mrs. G.'s yellowish looking skin. If nothing else happened, her skin would become normal as the condition was corrected. However, Mrs. G.'s liver had numerous tiny firm nodules which would obstruct the free normal functioning of the liver so that the bile would be absorbed into the blood and would also result in the yellowing of the skin. It appears from the hospital record of July 7th that the patient is intensely jaundiced and is feeling very miserable.

This would suggest that the liver condition was responsible for her failure to recover after the gall stones were removed. Upon this same day the hospital record says that her condition is poor and the prognosis is poor; that is, hope for her recovery is poor. Reports on July 13th and July 22nd, 1931, of the hospital record, indicate that the patient still feels very sick, nauseated, and that the intense jaundice persists with prognosis still poor.

On July 24th, the hospital record indicated that the patient

is still very jaundiced, has no relief from gastric pain and nausea, and that prognosis is bad; in other words, no hope of recovery. It was about that time that Dr. Arnott first visited the patient. Dr. Arnott stated:

"I gave Mrs. G. the treatment in the morning as I remember, and when I saw her in the afternoon her jaundice seemed distinctly relieved to me and by the next morning anybody could see it. From July 26th until August 10, I was out of the country. When I returned to Canada I went to see her at Victoria Hospital. Her condition was much improved. She had lots of stomach distress, but the jaundice was much relieved and her vitality was distinctly better. I saw her at the hospital and two or three visits afterwards. She was making distinct improvement. It is my opinion that Mrs. G. would have died within a few weeks if she had not had the benefit of this treatment." . . . no x-ray treatment, or operation could have cured the patient. The opinion of the hospital itself stands on the record as no hope for recovery. She was comatose; the gravity of this serious state was increasing."

Mrs. M. G. made a complete recovery within six months after receiving one injection of the carbonyl catalyst in July 1931. She has remained in perfect health to date (1943).

SARCOMA OF THE SPLEEN*

Treated in collaboration with
J. W. Kannel, M.D.

As Diagramed in IV

B. G., a young girl, age 6. She had pain in the stomach and chest with some fever. There was an enlargement of the spleen and the axillary and inguinal lymphglands. She was taken to the hospital. Her blood count the first day was 7,200 white cells. On June 23, 1943, it was 16,700 and on the twenty-fourth just before the operation it went up to 22,400. Dr. Kannel knew at the time she had a very virulent disease and he thought it was an abscess.

On June 24, 1943 he did an exploratory laparotomy and

closed her up. Nothing was removed nor did he change the condition of any of the organs. No abscess was found. He did find an enlarged spleen extending 2 inches below the ribs, and compressing about two-thirds of the lower part of the left lung. The upper third was patent. The ribs caused pressing or indentations in the spleen. There was a nodular condition of the spleen. It was irregular and very hard. A normal spleen would have been more soft. It would be so small that it would not have projected down below the ribs nor would it have compressed the lung.

She was sick only five days before Dr. Kannel put her in the hospital. He operated on her because the progress of this case was so rapid. She was sent home on the seventh or eighth day after the operation.

Dr. Kannel's first diagnosis, before the operation, was an abscess under the ribs in the left hypochondriac region. His post operative diagnosis was enlarged spleen, possibly malignant. No biopsy was taken because he felt that the removal of tissue would result in her death. His final diagnosis was sarcoma of the spleen. This diagnosis was made June 24, 1943, and was based upon the clinical findings and the child's case history.

On July 2, 1943, she received an injection of the serially arranged carbonyl groups. Her improvement was gradual and she made a complete recovery. Dr. Kannel ascribed her recovery to this treatment.

Recent reports confirm the good health of this patient.

The hard nodular spleen of rapid growth and great increase in size, showing the elevations where it could grow more rapidly forward between the ribs, is pathognomonic of sarcoma of the spleen.

SARCOMA OF THE UTERUS

Neoplasia As In Diagram IV

Mrs. Mc A., age 43, was first seen on July 29, 1929. She was bedfast, emaciated, and exhausted. She had not rallied well from an abdominal exploration done by a very good surgeon two weeks previously to ascertain the cause of severe and frequent

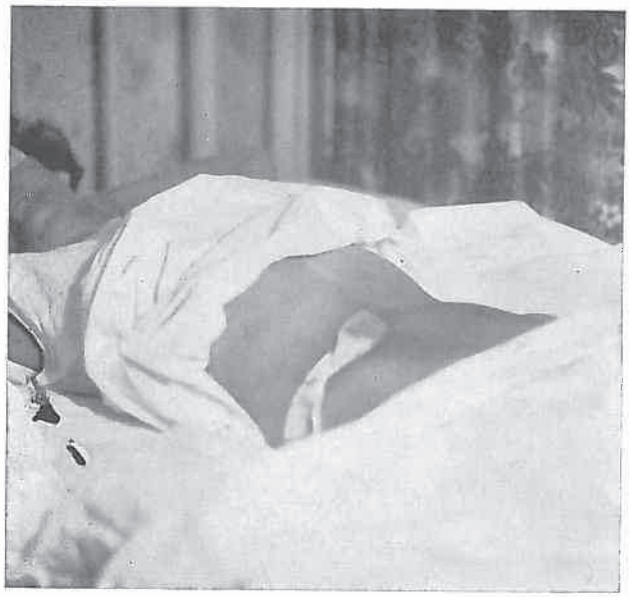
crises of vomiting and pain in the gall bladder region. The abdomen was found widely involved with neoplastic development from deep in the pelvis to the diaphragm, with the stomach and liver and intervening structures heavily invaded. This was identified as the cause of the pain. A biopsy specimen was removed. The abdomen was closed as inoperable. A biopsy report was given to us personally by the surgeon, Dr. Trimby, when he referred the patient. It showed a small round cell sarcoma of high grade malignancy.

Our examination revealed a patient in bed, exhausted with weak pulse, sighing respiration, vascular shock, cyanosis, and an abdomen bulging with tumor masses, particularly on the lower left side. The liver and epigastric involvement could be readily palpated besides. The incision was not healed and appeared to be infiltrated with neoplastic extensions. This incision was made over the largest tumefaction within and it seemed that the abdominal wall had been invaded by the neoplastic tissue underneath. A photograph was taken and the treatment of serially arranged carbonyl groups given.

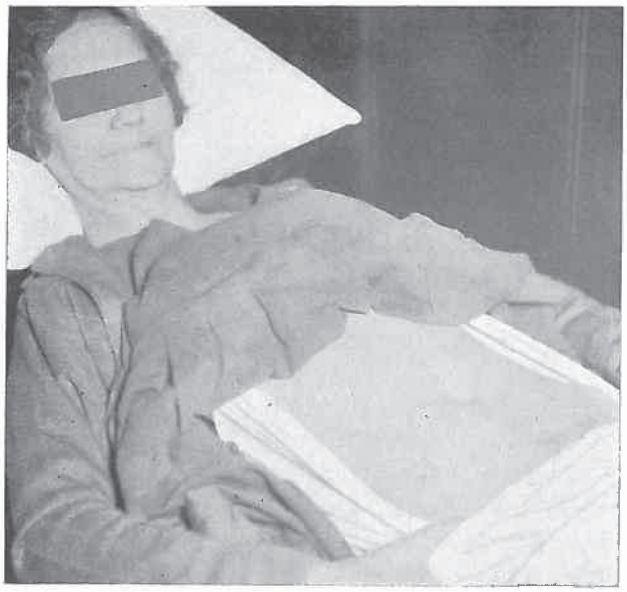
She responded well up to the sixth week, gaining in strength and becoming rapidly free of the pain and vomiting attacks. However, at the beginning of the sixth week she started a reaction that continued to the middle of the ninth week.

It featured vomiting of a quite continuous nature whether she took food or not. No food was held. The pain feature that was so severe before treatment was a minor matter, however. She lost weight and strength, and the dehydration was difficult to overcome. However, with the closing of the reaction at the middle of the ninth week she became very hungry and took on weight rapidly. For a few weeks she gained at the rate of five pounds a week, then at the rate of two pounds a week until she had reached 180 pounds. A slow gain followed to 200 pounds and then a slow loss to 180 pounds. Her health was fully established. All the tumefactions had disappeared before the end of the twelfth week after the treatment. She is still in perfect health, according to our last report.

Photograph I shows the condition at the time of treatment. Photograph II shows the condition after the neoplasms were absorbed.



Photograph I, taken at time of treatment.



Photograph II, taken after neoplasms were absorbed

RECURRENT METASTASIZED CANCER OF THE PALATE FOLLOWING SURGERY* **

Neoplasia As In Diagram IV

It is well established that unless cancer is fully and completely removed by surgical operation, so that not even one trace of it remains, it will usually come back with much increased malignancy and destructiveness and a more rapid tendency to spread. The case of A. J., here given, shows that even in a simple, readily accessible case of low grade malignancy, surgery can fail and be followed by a rapid recurrence as a wide-spread dissemination of the disease. When the disease is made inoperable, the restoration of the natural immunity can prove curative. This is demonstrated in this case.

Mr. J., age 60, was first seen by Dr. Koch on December 1, 1932. His condition was cancer of the palate and of the glands in the neck. Examination showed the palate, hard and soft, to be covered with a large growth and about a dozen smaller ones. Some of the glands under the jaw and in the neck close by were enlarged and hard, showing fixation.

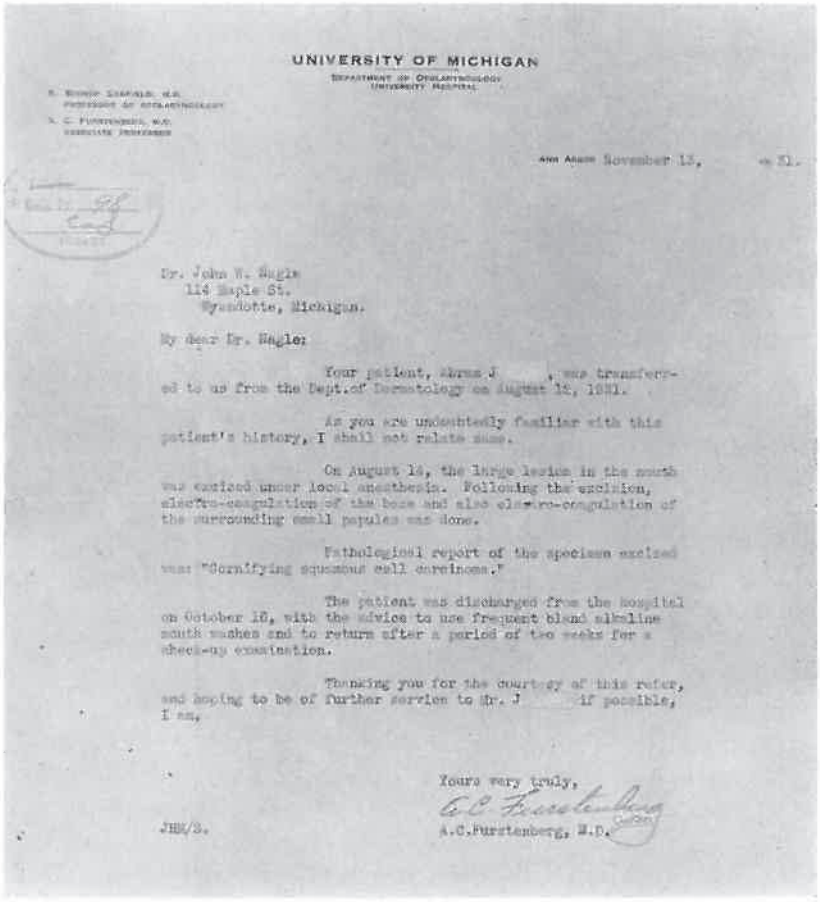
He gave a history of having been at the Hospital in Ann Arbor, Michigan, October 15, 1931, where an operation and touch up with electric cautery was done. The areas healed and all was well for a number of months. Then the same type of growths returned, but they were more widespread and in larger number locally, with extension to the chin and neck glands.

The report of the University Hospital on the biopsy is given as, "cornifying squamous cell carcinoma."

After the carbonyl catalysts were administered in December, 1932, he had a series of reactions with grippiness, chills, and fever at intervals and there was appreciable improvement even in a week. The recovery progressed steadily so that in less than a year it was complete, all tumors had been absorbed and healing was perfect. He also gained good body weight, became much stronger and enjoyed better health than he had experienced for many years and still remains well without recurrence of the trouble. The recovery reactions showed very little focal disturbance, whereas the constitutional symptoms were severe, thus

indicating some distant unidentified focus of infection as the source of the carcinogen. To illustrate this situation, we give the patient's own description of this first recovery reaction following the treatment.

"About the third day I felt pretty badly. I became cold. I thought I was going to freeze. The wife put me in bed. We had the hot water bottles and about all the blankets we had to cover the bed with on me. It lasted possibly an hour. About three weeks from that time I had another cold spell, for, I would say, six months, I believe, every three weeks, but they kept getting lighter."



UNIVERSITY OF MICHIGAN

DEPARTMENT OF OTOLARYNGOLOGY
UNIVERSITY HOSPITAL

Ann Arbor November 13, 1931.

Dr. John W. Eagle
114 Maple St.
Wyandotte, Michigan.

My dear Dr. Eagle:

Your patient, Abram J , was transferred to us from the Dept. of Dermatology on August 14, 1931.

As you are undoubtedly familiar with this patient's history, I shall not relate same.

On August 18, the large lesion in the mouth was excised under local anesthesia. Following the excision, electro-coagulation of the base and also electro-coagulation of the surrounding small papules was done.

Pathological report of the specimen excised was "Cornifying squamous cell carcinoma."

The patient was discharged from the hospital on October 16, with the advice to use frequent bland alkaline mouth washes and to return after a period of two weeks for a check-up examination.

Thanking you for the courtesy of this refer, and hoping to be of further service to Mr. J if possible, I am,

Yours very truly,

A.C. Furstenberg

JHK/B. A.C.Furstenberg, M.D.

In this case there appears to have been a systemic intoxication that was supporting the malignant change in the epithelial cells. The constitutional symptoms of reaction were so severe that they indicate this to be the fact, and the rapid recurrence after the surgery indicates that the toxic stimulus was abundant as well.

CANCER OF THE STOMACH*

Treated in collaboration with
Dr. Harrison

Neoplasia As In Diagram IV

Mr. Wesley R. had a past history of severe gastric ulcer from 35 years of age until he reached 50. When he was 69 he had a more serious stomach trouble, pain, and vomiting, with rapid emaciation, and loss of strength. Pyloric obstruction became complete. Several physicians made examination and found a tumor at the pyloric region. He was operated by Dr. Demling, June 28, 1926. A gastroenterostomy was done and a part of the tumor removed. The pathological report follows.

It is evident from this pathological report that the whole neoplasm was not removed and this is confirmed by the early recurrence of obstruction by the neoplasm.

Improvement was noted for only a few weeks and then the trouble recurred with more pain than ever and constant vomiting, rapid emaciation and cachexia. He was brought to me by Dr. Harrison on August 20, 1926. My examination revealed a large fixed tumor mass filling the epigastrium and extending below the level of the umbilicus. It was fixed to the liver, and bulged outward so as to be plainly visible and caused practically complete obstruction of the gastric outlet. The supraclavicular space on the left side showed a fixed lymphatic tumor as large as a walnut. There was considerable hemolysis. One dose of the serial systems of carbonyl groups was given and recovery set in so that its effects were observed in a few weeks. The obstruction soon disappeared and he regained about twenty pounds

PATHOLOGICAL LABORATORY

3

Patient R (Last Name) W. S. (First Name) Ft. Wayne (Room) Steele (Doctor)

Date 8/7/26 Clinical Diagnosis (Stomach tissue)

Slide No. 268 Gross No. _____ Museum No. _____

GROSS EXAMINATION

Tissue of stomach.

MICROSCOPIC EXAMINATION

Small alveoli combined with a diffuse growth of atypical proliferating epithelium fwem the structural picture of this neoplasm. The epithelial cells are generally polyhedral or round in shape, with large hyperchromatic nuclei. One portion is necrotic - a superficial ulceration. This may be classified as the diffuse type of gastric carcinoma. I am unable to determine this point exactly as it is necessary to know something of the gross appearance. If there were extensive involvement of the wall, this would be the correct interpretation. If the growth were sharply defined, rounded and ulcerating, it would bw placed with the circumscribed types of carcinoma simplex.

This type is always infiltrating and early invades the lymph nodes with wide-spread metastases.

U. S. DIST. COURT, E. D. OF MICH. Plff. Ex. _____ Deft. Ex. 539-3 REPORTER

DIAGNOSIS Carcinoma of the stomach. (Type dependant upon the gross pathological anatomy.)

28-

Andrew Waltham —

to reach his normal weight in five months. Examination after the twenty-fourth week revealed no tumefaction. Radiographs show no tumefaction, but a stomach about one-third normal size, motility good. Only at the third, twelfth and twenty-fourth week periods were there reactions of note. Fever, tenderness in the stomach, and loss of appetite and a general achiness lasted about three days and then a much more pronounced improvement set in after each reaction. This improvement continued until full recovery was established. He has not had any stomach trouble since and enjoys vigorous health, works every day and walks to town in all sorts of weather as well as he did at fifty years of age. We heard from him last when he was 92 and he was in good health, twenty three years after treatment.

CANCER OF THE STOMACH* **

Treated in collaboration with
Dr. H. E. Mantor

Neoplasia Diagramed in IV

This was a case of cancer of the stomach equally far advanced as the former. His trouble started as indigestion in 1940. Radiographs revealed no pathology then. It soon changed to a progressive stomach complaint with constant pain and frequent vomiting, rapid loss of strength, and a weight loss from 150 to 120 pounds in less than a year. Several well reputed clinics were tried in this year but the disease progressed. Radiographs made May 12, 1941, at the Tyler Clinic at Omaha gave a firm diagnosis of cancer of the stomach. At least two-thirds of the stomach wall was involved as the plates show. Exploratory operation at the Mayo Clinic within a week revealed massive involvement of the stomach wall, the pancreas, the glands about the aorta and the liver. The supra-clavicular glands of the left side were also involved. They gave a diagnosis of far advanced cancer, primary in the stomach, entirely inoperable, and hopeless, and sent him home.

On June 16 he was carried into Dr. Mantor's office for treatment. Dr. Mantor's description includes the following, "extreme exhaustion, anemia, hemolysis, cachexia. No crenation of

Neoplasm B
17/41 V2

SURGICAL CARD
MAYO CLINIC — ROCHESTER, MINNESOTA

No. 1-15-560 Age 58 Sex M Sect LOGAN Date of Ex. 5-24-41

Name Mrs. J. J. Address HANOVER, KANSAS

Name of Dr. ..... Dr's. Address .....
Not Referred | Accompanied Patient | Sends Letter to CLAGETT | Referred Only | Wishes to be notified date of operation

Name of Relative ..... Patient accompanied by .....

Operation advised by Consultant C. W. BROWN Surgeon WALTERS

Preoperative Diagnosis ULCER vs CARCINOMA STOMACH

Operation Indicated EXPLORE.

Considerations affecting risk RISK 114 LEFT RECTUS INCISION.

Former operation here or elsewhere Date ..... No former operation here or elsewhere.

A2-R(2-)- B B2 Col.

Date oprs 5-26-41 Opr. Room I-4 Surg Walters 1st Giffin 2nd Strom Recorder MKM

Antist J. McDonald Antic. $C_2H_4 + O_2 + C_6 + T$. Time of Anes. 1:10 – 1:55 Op. 1:20 2:00

Oper. Diag.: Carcinoma of the stomach (inoperable).

Oper.: Abdominal exploration.

Drainage

Add. cond. to index:
Detail

Primary upper left rectus muscle splitting incision. There was a carcinoma forming a mass about 12 cm. in diameter on the posterior wall in the fundic end of the stomach with invasion of the pancreas. There were several enlarged apparently involved nodes along the aorta. The condition was inoperable and the wound was closed as an exploration, using five buried silk sutures in the fascia. Closure by (first).

A-82-b—Revised 2-10-41.

red blood cells in a one per cent NaCl solution (all should crenate). Linear scar from exploratory operation, massive induration of the epigastrium, readily palpable and bulging forward so one could see it easily as he lay down. Since one year previously an X-ray of the stomach showed no pathology whatsoever, this neoplasm was very malignant and rapidly progressive and destructive".

One injection of 2 cc. of the 12X dilution of the serial system of carbonyl groups was given June 16, 1941. In a few days he started to feel better and soon took up the farm he had to leave because of the sickness. Nine weeks after the treatment,

examination could reveal no tumor mass whatever. He had gained weight, color improved and was more active. By the 12th week he could walk down the street rapidly without losing his breath and reported he was eating well and was feeling fine. By that time he had been working on his farm. There was no more cachexia. Dr. Mantor gave him a second injection on September 8, 1941, during his 12th week. He continued towards complete recovery. A third injection was given two years later, September 1943.

Radiograph III, taken on June 14, 1944, shows his stomach after complete recovery. He was still well in 1947 when we last heard.

MAYO CLINIC
ROCHESTER, MINNESOTA

CLINICAL SECTION
OF
DR. ARCH H. LOGAN
DR. PHILIP W. BROWN
DR. J. ARNOLD BARGEN
DR. E. G. WAKEFIELD

October 13, 1941.

A-1-158-500

Dr. H. E. Mantor,
Sidney, Nebraska.

Dear Dr. Mantor:

Mr. William J. S of Hanover, Kansas, asked that we send you a report, and the following is a copy of the letter which Dr. Walters wrote to Dr. Hurtig on May 28, 1941. As you will see by this report, the situation certainly looked none too favorable and it is gratifying to know that Mr. S says he is feeling fairly well at this time. Both Dr. Walters and I would appreciate hearing from you if there are any additional findings in his case.

"I operated on Mr. S on the twenty-sixth. There was a carcinoma forming a mass about 10 cm. in diameter on the posterior wall in the fundic end of the stomach with invasion of the pancreas. There were several enlarged, apparently involved, nodes along the aorta. The condition was inoperable and the wound was closed as an exploration.

"Mr. S withstood the exploration satisfactorily. We are very sorry, indeed, that the lesion proved to be inoperable. While we fully realized the seriousness of the patient's condition, we are disappointed that we were not able to accomplish something that would afford him at least a measure of relief."

Yours very truly,

pwb—cn

Philip W Brown

Philip W. Brown, M.D.

Radiograph I, taken at the Tyler Clinic before treatment.

Radiograph II, taken at the Tyler Clinic a few weeks after treatment showing marked improvement.

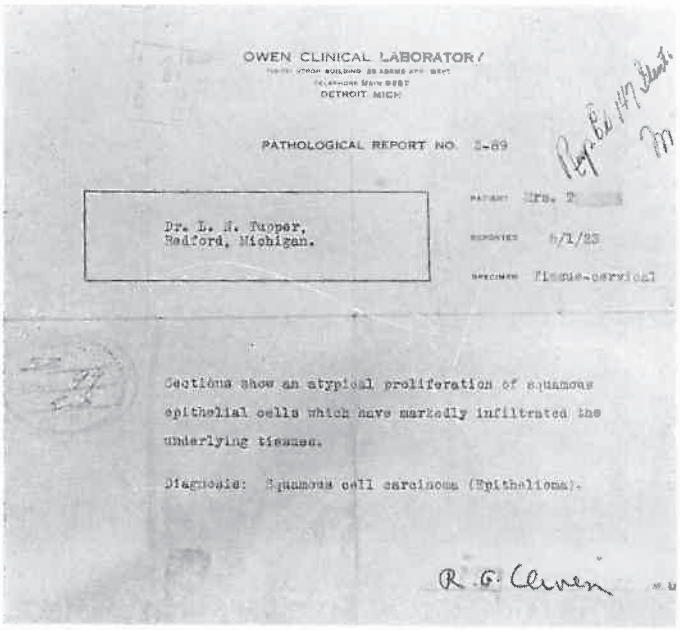
Radiograph III, taken June 15, 1944, after recovery.
These radiographs are court exhibits

CARCINOMA OF CERVIX UTERI* **

Treated in collaboration with
Dr. McCosh

Neoplasia As In Diagram IV

In August 1923, Mrs. T. was 31 years old. For over a year previously she had profuse irregular bleeding, muco-purulent discharge, and increasing pain with progressive reduction in the capacity of the urinary bladder. She consulted a surgeon who made a biopsy. A very responsible laboratory in Detroit made the diagnosis of squamous cell carcinoma of the cervix as follows:



OWEN CLINICAL LABORATORY
DETROIT, MICH.

PATHOLOGICAL REPORT NO. 3-89

Dr. L. H. Tupper,
Redford, Michigan.

Mrs. T.

6/1/23

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. Cleven

My examination was made a few weeks later and the findings were a typical cancer of the cervix that had spread to involve the corpus uteri and adnexia but mostly on the right side. The mass was fixed and involved the other structures so as to obliterate all normal contours. The bladder wall was also affect-

ed. This was a far advanced hopeless case from the standpoint of the surgeon or the radiologist. The bleeding was profuse and the condition advanced following the biopsy.

We gave her two injections of the oxidation catalyst, 12X dilution, one on August 7, and the other on August 21, 1923. The bleeding and discharge soon improved, and her yellowish color cleared with the return of blood to the circulation. Pain disappeared and the growth was found to soften and recede more every few weeks. At the thirty-sixth week no more evidence of the disease was to be found. The cervix was somewhat deficient on the right side. This evened out several months lat-

er. Her reactions were most marked during the twelfth and twenty-fourth weeks. She later became pregnant and gave birth normally to a normal boy after a normal gestation period. Each two years thereafter another normal child was born after normal gestations and with normal deliveries, four children in all. There has been no return of the disease, but instead extra good health has been her lot ever since. She still remains well more than thirty years after treatment.

The photograph shows Mrs. T. with the first three children born after her recovery.

This case illustrates the destruction of the toxic cause, return of function, and tissue restoration following the administration of a single agent, the oxidation catalyst in high dilution. We have many such cases in our records. Full restoration of function was part of the cure. There have been no miscarriages since treatment as had happened in February 1922.

The uterus is perfectly normal with full reconstruction and the trauma of four parturitions did not cause a return of the disease. We see here that more than injury is required to cause cancer, and that factor no longer existed in this patient following the treatment.

CANCER OF THE LIVER

Treated in collaboration with
Prof. Dr. R. S. Lopes

Neoplasia As In Diagram IV

Mr. G. A., Brazilian, early in March, 1941, in Barbacena, State of Minas Gerais, where he lived, suddenly showed inappetency (lack of desire for food—no appetite), progressive decrease of weight, and general weakness. Dr. Omar Araujo Lima, of that place, upon examination of the patient, noticed a large abdominal tumor. The patient was conveyed to Rio de Janeiro, was interned in the Hospital of the Beneficencia Portuguese, where he was operated by Professors Doctors Thomas Rocha Lagoa and Jorge Morais Grey, helped by the assistant physician. Laparotomy disclosed an extensive neoplasm of the liver and large infiltration of the colon. The tumor had so largely spread about and so extensive were the infiltrations that the operators

decided not to go on with the surgical intervention, due to the danger which the patient would be exposed to and the uncertainty of favorable results. By decision of physicians an operators biopsy was not made, it being supposed unnecessary, so evident was the case. In the opinion of operators such studies were superfluous. He examined the patient about seven days after the surgical intervention and thus noticed the extension of the tumor under the abdominal wall and the extreme weakness of the patient. On the 15th of July of the same year an injection of 6X dilution Benzoquinone was administered. The patient, who, up to that moment showed only light pyrexia, shivered intensely in the afternoon of the 18th, and his temperature raised up to 39 degrees. On the 25th he belched out and had intensive gastric pain. Both symptoms disappeared after a short time.

Proportionally to the gradual decrease of the tumoral volume, the recovery progressed, he regained color, and his body weight increased 10 kilos; he went back to Barbacena where his health gradually returned. On the 3rd of October another chill took him and his temperature was 39 degrees; also a general oedema was shown; everything yielded spontaneously and the patient, gaining then over 20 kilos, was completely recovered and devoted to his daily work, having not been submitted to any other treatment besides that of Dr. Koch. Report in April 1953 shows this patient to be in perfect health still (12 years).

SCIRRHUS CARCINOMA OF BREAST

Treated in collaboration with
Prof. Dr. R. S. Lopes.

Neoplasia As In Diagram IV

Miss C. F., 50 years, Brazilian, was brought to Dr. Lopes by Professor Artidonio Pamplona, of the Escola Fluminense de Medicina, a well known clinical physician. The patient was suffering, for about six months, from a large tumor in her breast; the nipple was completely retracted, as it generally happens in such cases. For instance the patient felt local pain; she was frightened by several surgeons, upon consultation. No improvement was shown after her submitting to 12 applications of deep radiotherapy.

On November 17, 1941, one injection of 2 cc. 6X dilution of Benzoquinone was administered. A second injection was given six months later. She began to recover generally, the tumor was disappearing and the nipple resumed the normal aspect. In 1942, one year after the first injection, no tumor was noticed and the patient was considered clinically cured.

CANCER OF THE BREAST

Treated in collaboration with
Prof. Dr. R. S. Lopes.

Neoplasia As In Diagram IV

Mrs. M. S., age 42, Portuguese, married, late in 1938, in Lisbon, Portugal, where she lived, complained of a ganglion in her breast, which was then operated.

The anatomo-pathological examination revealed a cancer. Sometime in April, 1941, a large tumor appeared in the very same place of the operation and the patient refused the extirpation of the breast.

On October 14th, 1941, we administered to her an injection 2 cc. of Benzoquinone 6X. We examined the patient seven months later and found, in that place, a small isolated scar not larger than a grape. Her general condition was excellent.

DUODENAL ULCER

Treated in collaboration with
Prof. Dr. R. S. Lopes.

Mr. F. G., age 38, Brazilian, chemist. Some 5 years ago he began feeling disturbance and "seasickness"; later on he felt hunger pain, which ceased upon eating. Frequent heartburn.

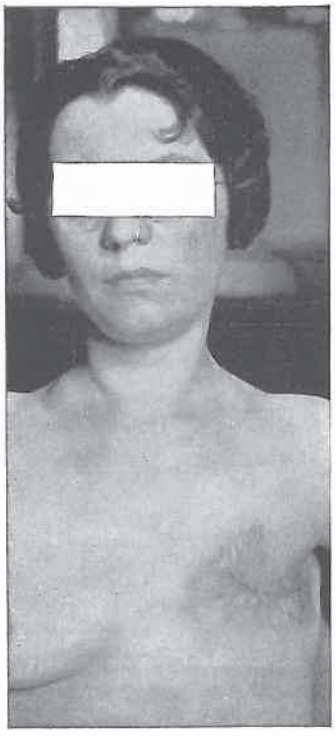
Good appetite. The liver had grown beyond the costal border more than 3 fingers transversely. The radiographic examination, made in November 11th, 1941, confirmed the clinical diagnosis—"duodenal ulcer"—and disclosed deformation of the bulb, with the aspect of a chronic ulcer where one could see the central niche. One injection of 2 cc Benzoquinone 6X was administered on November 9, 1941, and the patient was submitted to the diet

recommended by Dr. Koch, that is to say, deprived of any albumin of animal origin.

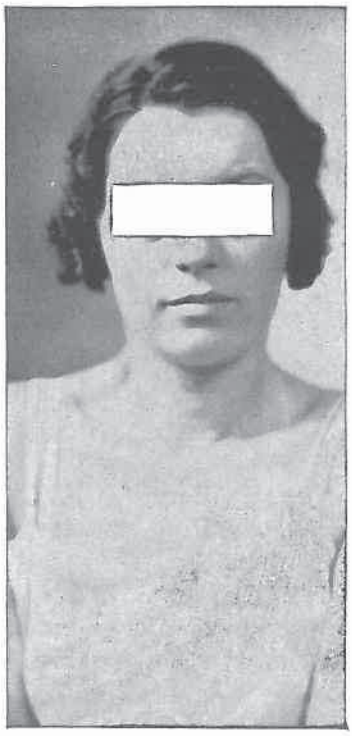
Considerable improvement was shown and he is cured at present. The last radiographic examination, made on September 29, 1942, shows a normal anatomic aspect of the duodenal bulb.

METASTATIC CANCER OF THE BREAST

This case is given in brief by photograph. It shows cancer of the breast removed radically gave rise to deep metastases within the mediastinum which spread up into the right supraclavicular space as a hard fixed metastasis. At the time of treatment the lung envolvement was evident in her dyspnoea,



Miss H. P.
Before Treatment.

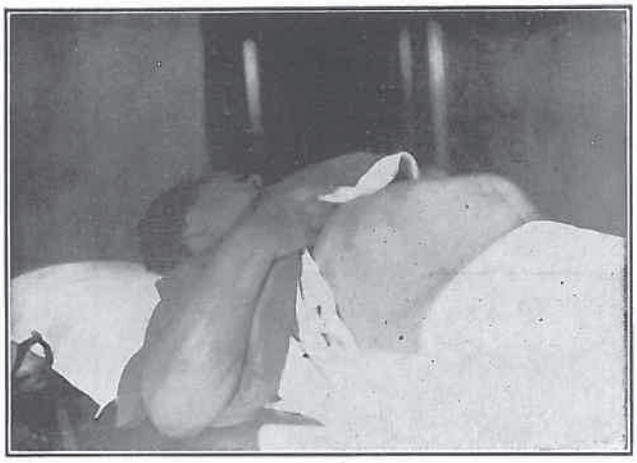


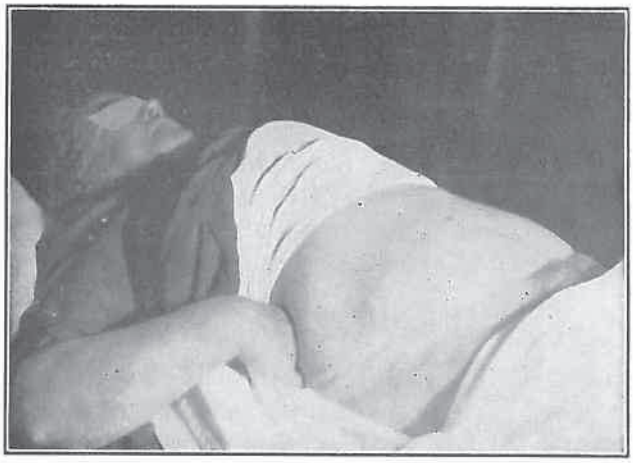
Miss H. P.
After Treatment

and was observed by the breath sounds and by percussion. Miss P. was treated in 1927 with carbonyl catalyst and in six months was free of visible or palpable evidence of cancer and has so remained up to the present time. We take pleasure in presenting cases that remain cured for long periods demonstrating the permanency of the survival factor instituted by this treatment, which did not exist when the disease was spreading at the time the treatment was given. She was reported to be in very good health in March 1955 when we last heard about her case.

RECURRENT CANCER OF THE BOWEL

Mrs. S. before treatment. The photograph shows the exploratory incision, with the cancer mass grown high above it. Operative attempts were not successful.

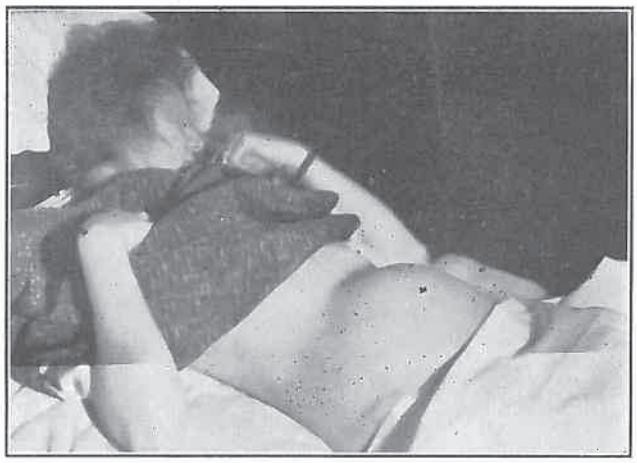




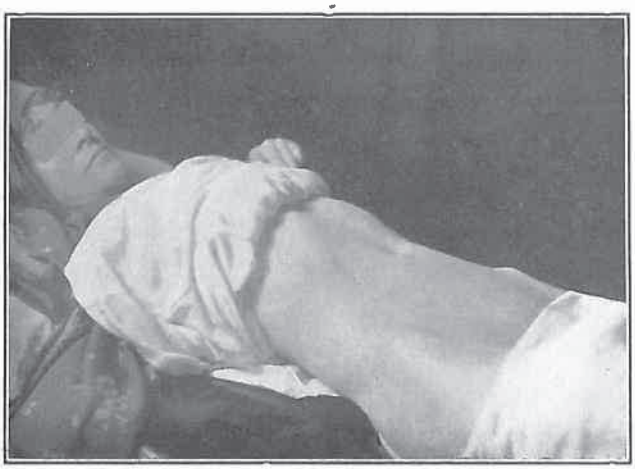
Mrs. S., age 60, was treated May 2, 1932, with 2 cc. of the carbonyl catalyst. This photograph shows the disappearance of the neoplasm. The line of incision is still visible. Palpation revealed no trace of the neoplasm.

FIBROMA OF UTERUS

Miss G., age 45. Two photographs are shown of this patient, one taken before treatment and the second taken after



Photograph I, before treatment.



Photograph II, after treatment.
The recovery was complete, no vestige of the growth can be found.

treatment for an enormous fibroid that possibly underwent malignant change. She received three injections of serially arranged carbonyl groups: one on December 2, 1930, May 31, 1931 and May 9, 1932. Her recovery was complete before the end of 1932.

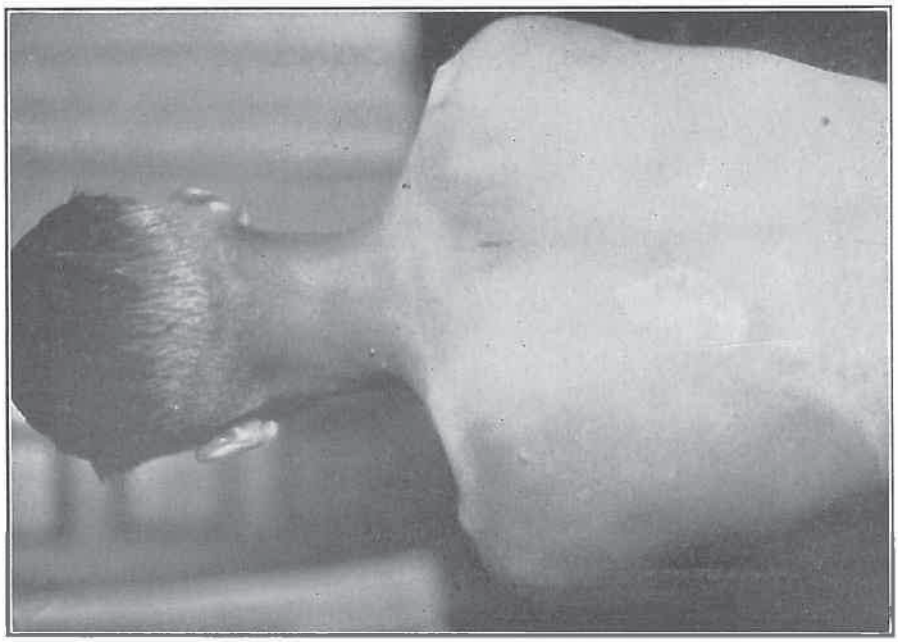
TERMINATION OF MALIGNANT STATE

Demonstrating the Survival Factor

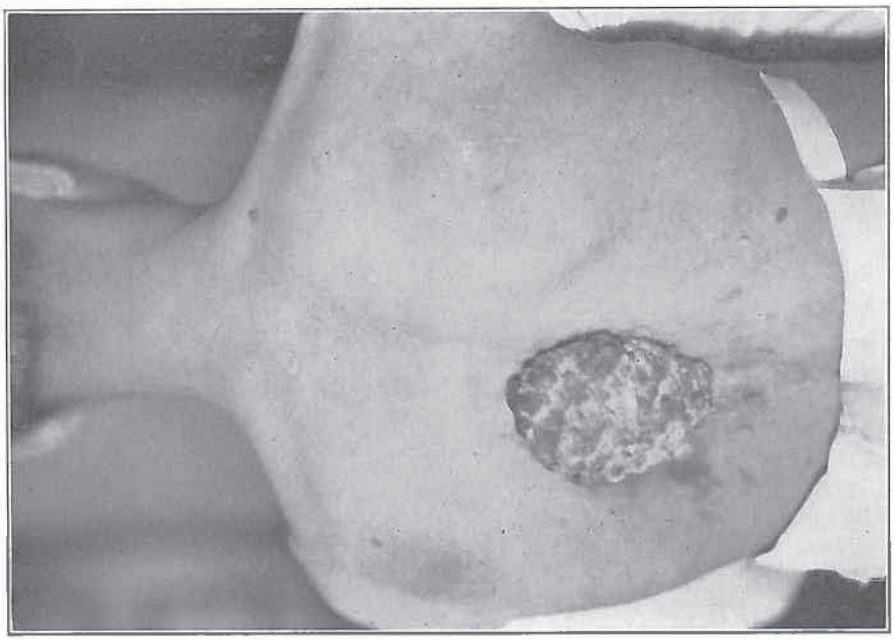
The time of termination of the uncontrolled cell division, is readily demonstrated when the tumor as a whole swells to undergo digestion and then rapidly disappears by absorption. This can be observed en mass. Microscopically it is seen when the tumor cells undergo a coagulation change with calcification, as the microphotographs show. However no one can be sure from such observation that each and every cancer cell has taken part in the destructive change. One must apply a more certain test. It is true that the cancer cells become foreign material or tissue debris requiring digestion and removal as soon as they can no longer use energy for function or reproduction and hence must die. This is early after the treatment is given when the whole trend is set in reverse. The better test is to wait till the metastases and infiltrations have been absorbed and then to re-

move the rest of the growth that is being absorbed. Non-recurrence is final proof.

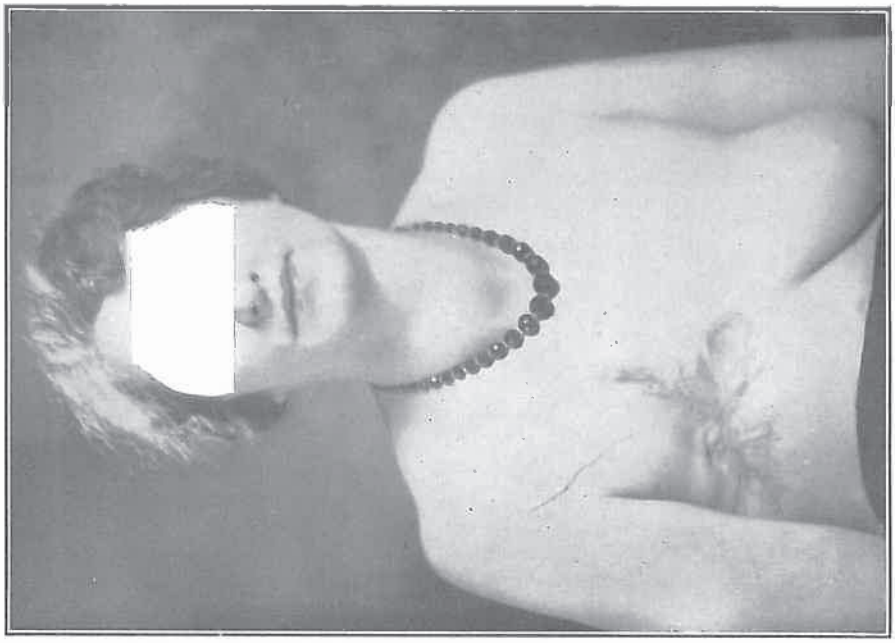
If this portion were taken away without treatment, the disease would be stimulated, recurrence would soon occur, and death would come quicker. But after the carbonyl catalyst treatment, the absorption of the last extensions shows that the causative factor is removed and an involution of the progression is now taking place. Then with the cause removed surgical stimulation by pinching and cutting has no factor at hand to give rise to a spread of the disease, or to hinder its complete absorption and healing, provided no chemical stimulus is used of a carcinogenic nature. In the following cases where it was easy to see when the metastases and infiltrations were well absorbed, and the growth proper was undergoing digestion and was virtually dead, we did crude removals, and watched the much quicker return to health than if the patient had to absorb all the toxic debris present in the infected necrotic mass. The pictures show the state before removal after the absorption of the extensions, and after the removals after healing was completed. Both patients were permanently cured. The breast case came to testify about ten years later at one of the Federal Court trials. But valuable as the case was we could not use her in view of the large number of cured patients who were waiting to testify. Both cases were found malignant at biopsy. The breast case was an adenocarcinoma of duct origin, the skin case was a squamous cell carcinoma with melanotic changes. The photographs show the conditions before and after receiving this treatment followed by the surgical tests. It is to be noted in the Mr. L. case that the areas of malignant pigmented infiltration were not touched surgically but cleared up entirely because of the treatment thus showing that the carbonyl catalyst served as the survival factor. The two non-malignant pigmented moles, however, remained unchanged.



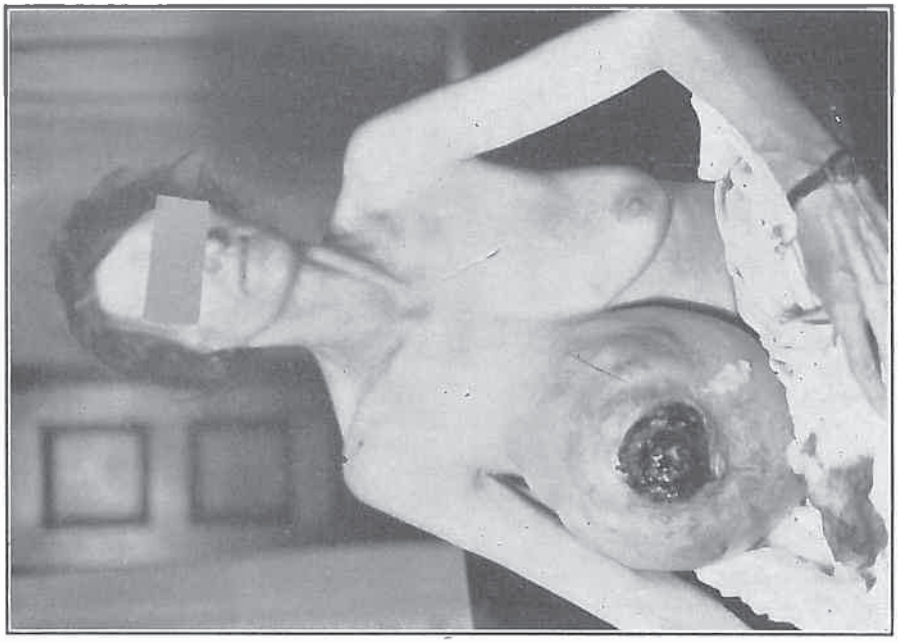
Mr. L. after complete recovery



Mr. L. after treatment when the growths were undergoing digestion just before crude removal.



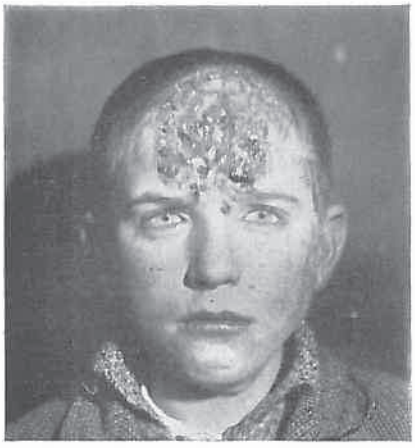
Miss N. after complete recovery.



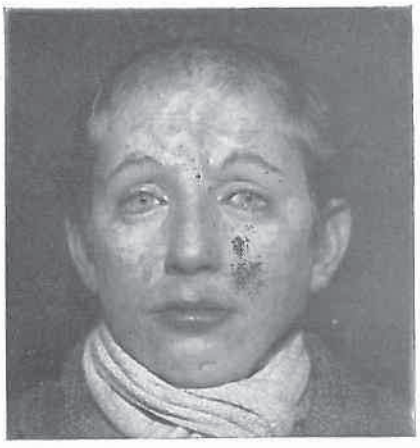
Miss N. after the growth started undergoing digestion after the carbonyl catalysts were given, and before crude removal was done.

SYPHILIS

This subject will be amply aired in the completed text, we here just give a case in photographs, to touch on the subject. This boy was sent into the hospital at Louvain University, Belgium in 1934 with a diagnosis of cancer of the skull since he did not respond to antisyphilitic treatment though given expertly and with vigor. We found on biopsy and serological tests that he had syphilis. However the neoplastic taint was not ruled out thereby, and his resistance to antisyphilitic treatment may be due to a neoplastic agent that may have been present. He was given a dose of the carbonyl catalysts and at that time his photograph showed as in No. 1. Six months after treatment he was serologically cured and the photograph shows good healing of the area. The necrosis had gone into the middle layer of the bone, and the healing involved bone reconstruction as well as skin healing. One year later the fibrosis shown in the second photograph was replaced by perfectly normal tissue and could not be detected.



B. W., — Photograph No. I, taken before treatment.



B. W., — Photograph No. II, after treatment.

BLOOD RECONSTRUCTION IN CASES OF HEMATOPOIETIC EXHAUSTION

These cases are cited to show the similarity in the destructive action of irradiation and of a biological pathogen on the bone marrow, as well as their correction. The cases were diagnosed as lymphatic leukemia by the use of sternal marrow biopsies at the institutions where the patients had gone. In each case, blood transfusions failed to stop the hematopoietic failure which steadily progressed in a malignant fashion. In the first case, the leukopenia was of the terminal type. In the second case, it was produced by irradiation. The third case was an acute case of leukemia. In all three cases there was correction in both red and white blood cell production, thus showing the physiological position of the reagent used.

LYMPHATIC LEUKEMIA
With Terminal Hematopoietic Exhaustion In A Boy

Treated in collaboration with
Dr. Baldor.

Neoplasia as In Diagram IV

Teddy S., 14 years, diagnosed as lymphatic leukemia six months earlier, was extremely depressed, unable to walk, suffered with pain and fright, had offensive odor from the mouth, profuse gingival hemorrhages, and evening fever of 102°. The onset was acute with fever, chills, pains in legs, and finally severe anemia with lymphocytosis. He had 57 blood transfusions in three months without help. Blood count when admitted, February 25, showed red cells 2,150,000, hemoglobin 40%, leucocytes 15,000. He showed enlarged tender spleen and liver and enlarged cervical and groin glands and bloody patches over the entire body. Increased tubular respirations in the right pulmonary base and moist rales over the whole lung field. Two cc. of carbonyl catalysts were given after two days of fasting and colonic lavage. In one week he was sent home with a normal temperature, the spleen was much reduced in size and the bloody patches had absorbed very substantially in this time turning from their dark blue to light green, to yellow and then finally disappeared. Nine weeks later he returned to Tampa for a

check-up. He was then able to walk, had gained 12 pounds in weight, and the blood picture was as follows: red cells 3,350,000, hemoglobin 52%, leucocytes 8,000. He gave a twelfth week reaction with slight pains in the extremities and a little epistaxis. The red cells numbered 4,000,000, hemoglobin 72%, leucocytes 6,500. He had gained 25 pounds weight and felt perfectly normal. It is to be noted, Dr. Baldor points out, that without even one blood transfusion after the catalysts were given, the blood no longer underwent destruction but began to pick up without any aid but a vegetarian diet. Thus the infection was eliminated very early after the catalysts were given. He remains well and had gone without blood transfusions since 1949. He was last seen in June 1957 at which time his blood count was normal.

The exhaustion of the blood forming organs in this case was seen in the peripheral blood stream and in the sternal marrow biopsy. Dr. O. Z. Culler's report, at the time of referring this case, stated: "Chronic Leukemia (proved by bone marrow biopsy) with hemhorrhagic diathesis." Here the immature forms accounted for the inability to produce white blood cells for the general circulation and thus showed where the exhaustion lay. The exhaustion was therefore extreme and the blood picture in consequence was atypical as occurs in terminal phases of disease generally when scrutinized carefully. It had run its course.

This case with the few others of the leucemia classification are offered to show that the structural pathology as the blood or marrow picture is really a result of the integration of the pathogen with the host cell so as to make the latter nonfunctional. In this case an actual atrophy of blood cells or rather an anaplasia results just as a hyperplasia resulted from the first or stimulating action of the pathogen. The cases also demonstrate that the oxidative removal of the pathogen from its combination with the host cell leaves the latter in a good functional status. We showed earlier that the pathogen can not be removed hydrolytically and that an oxidative cleavage is required. Here it is demonstrated that normalcy does result as a result of this oxidative cleavage and the pathogen is no longer to be found.

MYELOGENOUS LEUKEMIA
With Irradiation Leukopenia
In An Adult

(Contributed by Dr. Baldor of
Tampa, Florida)

Neoplasia as In Diagram IV

A similar case in an older person should be described.

Mrs. J. W. L., age 47 years, came in on December 7th, 1948. She gives a history of an acute process with chills, fever, nausea and perspiration, six months previously following an influenza attack. Examination showed an enlarged liver and spleen and cervical lymphatic enlargement. The breath was offensive with gingival bleeding. Dental abscesses were present. Her blood picture showed red cells, 3,160,000 hemoglobin 57%, leucocyte count 14,800, with poly. 88%, lympocytes 10%, monocytes 2%. Both myelocytes and premyelocytes were present. She had received two courses of X-rays over the spleen and long bones each of 600 R at an interval of six weeks. This did not improve her condition. The bleeding went on and the weakness, fever and pains continued on their course. Bone marrow slides showed definite abnormalities suggestive of Myelogenous Leukemia. Two doses of the carbonyl catalysts were given because of the irradiation, one on December 13, 1948, and the other five days later. Improvement showed up soon. The fever was gone in five days. The painful enlargement of the liver subsided slowly. The oral bleeding and infection likewise cleared up. The blood count March 15, 1949, showed red cells 3,850,000, hemoglobin 69%, leucocytes 8,500. Up to August 5, 1949, she remains well, does her housework normally, and has gained ten pounds in weight. On June 16, 1949 the red cells were 4,000,000, hemoglobin 72%, leucocytes 7,000. She received no blood transfusions after the catalysts and the blood improved naturally. The chest signs in this patient, like the former, improved slowly. By the end of 1950 her enormous spleen, which formerly had reached to the left hip area, had receeded to a normal position under the left hemithorax. The last blood count which

was taken in May 1955 showed red cells, 4,150,000, hemoglobin 70%, leucocytes 3,500. She remains well and has not had a blood transfusion since the time of treatment in 1948.

ACUTE LYMPHATIC LEUKEMIA

In A Boy

Contributed by Dr. Arturo Guzman
of Montevideo, Uruguay

Neoplasia as in Diagram D

F. H.—No history of leukemia in the family.

P. H.—P. F. age 12 years, treated January 8, 1956, in Paris France. The onset was rather rapid after a period of ill health. The symptoms were classical with the petechial hemorrhages under the skin and in the mouth, cough, and symptoms of anaemia with great weakness. The red cell count was 1,500,000, the whites were 232,000, lymphocytes in very great predominence, large mononuclears and immature forms.

P. E.—Blanched-out appearance with hemorrhagic spots of various sizes under the skin generally, especially legs, arms and body. Foul breath, gingival bleeding. Some mediastinal dullness increase observed on right side, spleen and lymph glands only moderately enlarged . Very weak, slight fever, cough.

The treatment. Two cc. of carbonyl catalyst and supportive measures were instituted. The recovery was steady with occasional reactions of achiness, periodically.

Results. In August, 1956, all signs of the disease had left. His strength had normalized, and the blood counts were platelets, 350,000, red cells 5,100,000, white cells, 7200, Polymorphs, 76%. No spleen or lymph gland enlargements were found. Blood coagulation normal. All bleeding and its effects had disappeared. The increases in red cells will possibly give way to a count slightly less than normal and then increase to normal again. No reaction for a focus of infection as a starter was identified except the sore throat which is difficult to interpret in this respect. This case should be followed for the accepted 5 year period before establishing it as a cure. The results that were obtained are gratifying and for this reason the case is reported at this time.

CHAPTER VII

ANTERIOR POLIOMYELITIS[1]

The group of cases offered here illustrate the two well recognized types of host cell virus integration, the lytic and the symbiotic types. The third type, which we have to assume on the basis of clinical data, receives no contribution from the cases to be discussed here as it receives from the cases of virus infections in animals we have to report. This is because the "Polio" cases given below were never vaccinated against "Polio." Nor were any serological tests reported showing a response to some "Polio" virus. They are instructive in other directions however, and have been proven factually uncontradictable in the United States Federal Court. They show that in the acute lytic and symbiotic types of integration the virus can be separated from the host cell leaving the latter normal as to functional ability, and the virus is no longer found, or at least is harmless. Moreover, in the long standing symbiotic types of integration, after years of extensive paralysis and muscle atrophy and even developmental failure, 90% of the defects have been restored to normal even after twenty years of complete invalidism. These cases therefore are of intense professional and public interest under ordinary sociological circumstances.

In the first place viruses are recognized because of the diseases they produce, and because they fall in the filterable category. To produce disease they must draw energy off from the host cell's vital processes, and the energy stored in vital host cell structures during their synthesis. Such energy must have a place to go to be withdrawn. That is, there must be an appropriate synthetic process into which the energy can pass and be used for its activation. To do this there must be a full set of structural units to enter a viral synthesis. Incomplete structural material cannot engage in the synthesis and so no host

[1]To save space here other virus diseases in man will be discussed in the complete text. Paralytic diseases in animals as distemper and rabies will be given in the section on animal infections.