

The Journal

of the

NATIONAL PROCTOLOGIC ASSOCIATION

Vol. XIII

AUGUST, 1941

No. 12

CONTENTS

	Page
PRESIDENT'S PAGE.....	314
DIVERTICULOSIS AND DIVERTICULITIS.....	317
C. C. Patchen, M.D., Jacksonville, Ill.	
THE SURGICAL AND CHEMICAL ASPECTS OF CANCER AND ALLERGY AS A RESULT OF RESIDUAL FOCAL INFECTION.....	320
Wm. F. Koch, Ph.D., M.D., Detroit, Mich.	
CRYPTS.....	326
H. J. Andrews, M.D., Hollywood, Calif.	
NEW ADVANCEMENT IN THE INJECTION TREATMENT OF HERNIA.....	329
Marcos Jimenez, M.D., Monterrey, N. L., Mexico	
SURGERY OR NOT?.....	336
Eugene H. Pitts, M.D., Sacramento, Calif.	
CORRESPONDENCE.....	338
THE ECONOMIC VALUE OF PROFESSIONAL INTEGRITY.....	339
Quoted from the first issue of The Bulletin of Ambulant Proctology, January, 1927	
INDEX OF SUBJECTS.....	341
INDEX OF AUTHORS.....	343

Published Monthly by The

NATIONAL PROCTOLOGIC ASSOCIATION

448 South Hill Street

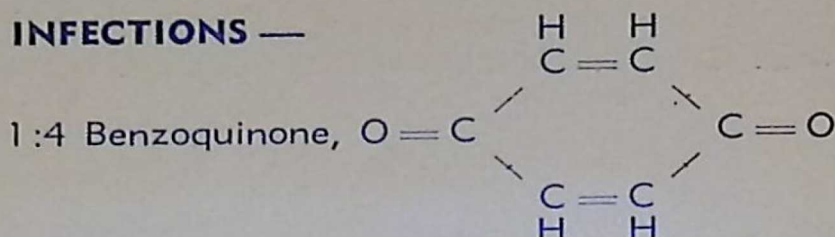
Los Angeles, California

EIGHTEENTH ANNUAL CONVENTION

STEVENS HOTEL, CHICAGO, SEPTEMBER 23-24-25-26

SYNTHETIC ANTITOXINS

For the INFECTIONS —



Price, four ampoules for ten dollars

For the ALLERGIES —

Malonide, $\text{O}=\text{C}=\text{C}=\text{C}=\text{O}$

Ketene, $\text{H}_2\text{C}=\text{C}=\text{O}$

Price, ten dollars per ampoule with correctly prepared syringe and needle.

For CANCER, and the DEGENERATIVE diseases —

Glyoxylide, $\text{O}=\text{C}=\text{C}=\text{O}$

Price, twenty-five dollars per ampoule with correctly prepared syringe and needle and advisory service

PROOFS OF THE EFFICACY OF THE KOCH TREATMENT IN CANCER ARE COMPILED IN THE PROCEEDINGS OF THE CANCER COMMISSION OF THE ONTARIO GOVERNMENT, CANADA, reproduced verbatim in a 400 page book by David H. Arnott, M.D., price one dollar to cover cost of printing and mailing.

KOCH LABORATORIES, INC.

8181 E. Jefferson Avenue

DETROIT, MICHIGAN

and

DELRAY BEACH, FLORIDA

ments, proctologists should also be gastroenterologists, or else be associated with a gastroenterologist.

237 1/2 W. State St.

Surgical and Chemical Aspects of Cancer and Allergy as a Result of Residual Focal Infection

WM. F. KOCH, Ph.D., M.D., *Detroit, Mich.*

THE HISTORY OF NEOPLASIA AND ALLERGY is that of an unsuccessful battle against infection in which the host gains only a partial mastery and the infection takes up a position where the oxidations are not rapid enough to destroy it. Thus, a residue of the infection persists. If there were no anaerobic recesses, injured areas, or scars where the circulation is too poor to supply plenty of healthy blood, focal infection could not take place.

From such a position toxic germ products diffuse into the circulation. If the blood immunity is high, such poisons are burned and do not reach the tissues. In due time, too, the focus of infection may even be cleaned out. But as a rule the feeble oxidation mechanism that permitted the infection to make an invasion and become residual, still remains in sufficient degree to permit the circulation of these poisons. Thus they have occasion to diffuse into the tissues and bring about specific changes.

Of course, the tissues most susceptible to injury are those that are least able to burn the poisons that find entrance into their cells. Here they are absorbed into the colloidal structures that carry on the various functions and by certain specific photochemic properties they disturb function and produce allergy in a way that I shall describe farther on.

What should be stated first as clearly evident is that cancer is an uncontrolled hyperactivity or allergy of the structures that conduct cell division, just as in asthma there is an uncontrolled hyperactivity of the contractile fibrillae of bronchial muscle cells and in hay fever there is an uncontrolled hyperactivity of the fibrillae that produce secretion. Likewise, hyperactivity of the conductile fibrillae and synapses of the neurones associated in certain concepts, reflexes, etc., constitute the mechanism of the fixed ideas of insanity, the spasms and inhibitions of the neuroses, psychoses, etc.¹

It is, therefore, reasonable to suppose that the surgical removal of a cancer without also removing the various foci of infection that

feed the stimulus to malignant activity is rather neglectful and cannot bring about a true cure, for in due time, even aside from the spread of metastases, other cells will respond to the same toxic attack and also go malignant. Moreover, such metastases as remain have a richer supply of stimulus and, therefore, have a chance to multiply much more rapidly than the parent growth. Indeed, this experience is very common.

The greatest malignancy is exhibited where the neoplasm develops at the site of the infection focus since the allergenic toxin has direct access to the cancer cells and is not lost by diffusion from the blood into other tissues or excreted. The same situation arises where the germs themselves gain a footing in a neoplasm and produce their poison in close proximity or within the neoplastic cells. These cells are fine culture media for the germs, too, for they are essentially anaerobic and possess practically no activated oxygen available for destruction of the germ or its poison. So it happens that a neoplasm developing in a badly injured area, in a gumma, tubercle, or in the tonsil, usually displays the highest grade of malignancy. The germs that Glover² has demonstrated as etiologic to cancer are actually found in the cancer cells, but they need not be so always since their active agents can be transported by the blood stream.

In the surgical attack on cancer and allergic disease in general, the proper procedure is to clean out all foci of infection when they are identifiable and accessible whether or not further therapy is employed.

It is of far greater importance that we restore the oxidation mechanism to a good normal or even better, so that the very basis of the syndrome is removed and focal infection is completely wiped out.

The restoration of efficient immunizing oxidations is a very interesting procedure and it is practicable to the extent that advanced cases of malignancy, psoriasis, asthma, or other allergy expressions and certain degenerative diseases of the nervous system can make splendid recoveries. Indeed in our experience the majority of cases that recover do so on one or two doses of the reagent used. This is possible because when the catalysis of oxidation is once re-established it tends to go on like any other chain reaction that generates its own carrier and is self-perpetuating.

A study of the chemical structure of the various known poisons that cause allergy reveals an atomic arrangement, that is common to all, which is responsible for the pathogenesis in each instance.

This arrangement is the occurrence of free valencies between carbon atoms, between carbon and oxygen, and between carbon and nitrogen. This arrangement, by virtue of the ponderous structure of the rest of the molecule, has two effects, a tendency to depress the normal oxidations and the ability to shift energy from the ordinary exothermic reactions going on in the cell, to the chemical processes of some colloidal functional unit that can serve as acceptor for this energy.³ The specific characteristic that permits this shift and acceptance of energy to occur is the similarity in the spectral ranges of energy absorption and emission of the functional unit and the allergenic substance respectively. The process of energy transfer is a form of fluorescence which resides in the free valency just described.

The destruction of both the negative catalytic activity toward the oxidations, and the fluorescence is accomplished by saturating the responsible free valencies with nascent oxygen in so active a manner that the oxidation process goes on to completion with destruction of the pathogenic arrangement. Wherever a pathogenic germ depends upon such a molecule for its survival, the destruction of the molecule must end in the death of the germ. Then the scavenger system, congestion and round cell infiltration, clean out the area that gave shelter to the infection. The focus is thus wiped out, not by cutting but by the excellency of the immunity mechanism which the body now possesses.

Therefore, we may say that recovery is complete: and since after the death of the germ the prison of scar tissue is no longer needed, it is autolysed and absorbed and replaced with functional elements. On the same score, the restoration to normal of an area from which malignant tissue has been absorbed does not take place by scar formation but by replacement of the normal tissue elements.⁷ For, since there is no pathogenic germ able to exist there, there is no need of a scar prison for such germ. The recovery process is identical in each instance.

The course of recovery is the reverse of that of the pathogenesis. Thus the first changes to come are the last to go and the last to come are the first to go. This is the rule of every true recovery and was first observed by Hahnemann. It is so here, too, and since the focal infection was the first change to come, its disappearance is the completion of the recovery process; or we may state the argument in reverse and say that, since the last event of the recovery is the destruction of some focal infection, the latter is the first step in the pathogenesis.

The recovery process is periodic, being made up of cycles in

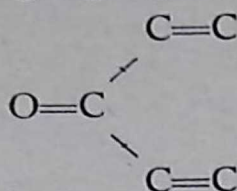
which the shortest time unit is three hours. This period is multiplied expansively into twenty-four hour periods and multiples of the latter where the numerator is three and a half or multiples of three and a half. Cycles as long as sixty weeks or seventy-two weeks are common.⁴ Generally at nine or twelve week periods or their multiples the most active negative phases appear and in each the dominating symptom is grippiness. Indeed so common is this symptom, and so frequent is the history of influenza that was never completely overcome that one suspects a virus associated with influenza as an important etiologic factor. Often, too, some suppressed symptom comes forth during the reaction, such as a rash of the scarlet fever type, and there is the history of scarlet fever that was mild and never developed a marked rash. In fact, during the last part of the recovery, the patient's feet may peel and so the job of recovery from the cancer or present disease includes the completion of the recovery from the scarlet fever or whatever the early disease may have been. During this recovery period a suppressed psoriasis may also come forth and then clear up or an obliterative endarteritis may make a transient appearance, especially if this disease caused the death of one of the parents. So both the personal and hereditary past ills are reflected in the recovery process.

The period between the establishment of the focus of infection and of the allergic response may cover many years and be marked by many toxic symptoms. When the allergic response happens to be a malignant growth, the pregrowth toxic period may give expression to several allergic changes.⁵ Therefore, we may suspect that when a person exhibits allergy at all he is possibly on the road to cancer for his oxidation mechanism certainly is subnormal and he is open to the influence of a carcinogenic molecule when it comes along. This defect is also hereditary and is correctable by restoring the best oxidation catalysis. In other words all allergic cases are potentially cancerous.

In the common food allergies at least two sources of allergenic toxicity exist, firstly that originating in the germs of the focal infection, which so quenches the oxidations that certain food elements with fluorescent properties are not burned, and secondly these fluorescent food or foreign protein elements, such as contain the imidazole ring as in histamine, the imide group of guanidine,⁶ the ethylene linkages of benzopyrine, etc.

The chemical structures that serve most efficiently in oxidizing the pathogenic free valencies are represented by four extremely reac-

tive molecules. They are Glyoxylide, $O=C=C=O$, Malonide, $O=C=C=C=O$, Ketene, $H_2=C=C=O$, and 1:4 Benzoquinone,



We have used them for more than twenty

years with splendid results whenever the material was properly prepared. They act upon a fundamental atomic arrangement in a specific way and are effective in the broad field where this atomic arrangement is pathogenic.

The following case history gives clinical evidence of the points developed in the text of this discussion. It is a typical history of malignancy in which focal infection played its etiologic role exemplified by the following case:

Mrs. C. A., age 50. *Past History*—She had been well all her life except for frequent tonsillitis. The tonsils were imbedded and frequently acutely infected in the winter months and occasionally off and on throughout the year. They were removed in 1913 and thereafter the throat was badly inflamed for over a week with loss of voice for three weeks.

Three years before the tonsils were removed several small lumps appeared on the arms. They were diagnosed to be lipomata, but the later history identified them as neurofibromata for they spread in great numbers over the body and limbs with typical characteristics.

In 1935, two years after the tonsils were removed, a lump appeared in the right breast. It was removed and two years later another lump came in the same breast. It was promptly removed, but recurrence was well established in December, 1939, when I first examined her.

Early in 1939, because of abdominal distress, an exploratory operation was made and an adenocarcinoma of the fundus uteri was found. It had spread throughout the abdomen and several metastases were observed in the liver. A biopsy was made which revealed the high grade of its malignancy which, of course, was confirmed by the history of widespread metastases, the hemolysis, and the ultimate large dimensions of the tumefactions which in size exceeded the volume of a man's head and were firmly fixed in the abdomen. She had received some x-ray treatments which had no beneficial effect, but rather stimulated the growth and were therefore discontinued and the patient was given up as hopeless.

Physical Findings—The general appearance of the patient was good except that hemolysis was intense and the tissues water-logged and fatty. There was some cyanosis and dyspnoea and easy fatigue. Many small neurofibromata covered the body, arms, and legs, ranging in size from that of a pea to a lima bean. The right breast showed malignant infiltration in moderate amount. The abdomen bulged especially on the right side because of enlargement by the growth. Palpation showed two-thirds of the abdomen well involved with the tumefaction.

The neck and throat region showed nothing extraordinary except slight induration of the right tonsillar fossa.

Recovery Process—One injection of two cc. of our treatment was given in the upper arm and a steady recovery followed. Negative phases showed up regularly every three weeks and after each such reaction recovery hurried along more quickly. First of all the color improved and she felt "more natural."

The masses in the abdomen were digested and absorbed most quickly so that by the tenth week nothing definite could be felt by careful moderate pressure. By the twelfth week the right breast was clear and during the twelfth week a sudden and

severe sore throat set in first on the right side spreading to the left and disappearing completely in seven days. This twelfth week reaction gave a fever of 102 degrees for a few hours and general achiness for a week. Thereafter, her recovery was hastened and one could observe slight improvement in the neurofibromata.

Every third week thereafter showed some reaction, general achiness principally, but the more prominent reactions came at twelve week intervals. Even the sixtieth week gave a little achiness and some headache from which she had suffered considerably in early life. By the sixtieth week most of the neurofibromata had been absorbed and her health was excellent. Thorough examination of the abdomen and breast revealed no abnormality and no pathology whatsoever. The throat region was also free from induration. She had gained nearly thirty pounds in weight.

Discussion—It will be noted that after the malignant cells had been absorbed, very promptly during the twelfth week reaction, an acute inflammation of the region of an old infection took place. This was the tonsillar area and was more severe on the right side where some induration existed and where, no doubt, the old infection that caused her frequent tonsillitis was still imprisoned. The congestion and small cell infiltration that accomplished the cleaning up of this focus and restored normalcy, removing both infection and scar tissue, took place after the malignant cells were disposed of and so it followed the reverse sequence of the pathogenesis, like the clearing up of the breast and the abdomen. This is our universal experience and we, therefore, conclude that the focal infection is the first step in the pathogenesis, except one, namely, the loss of protective oxidations which permitted the infection to invade and localize.

By therapeutically wiping out this first departure from the normal, that is by restoring an immunizing oxidation catalysis, the basis for the disease is removed and normalcy returns, "pressing the disease back through the door where it entered" and out from the system. This is the rule of true recovery, the first to come is the last to go and the last to come is the first to go.

SUMMARY—We may summarize as follows: fatigue, exhaustion through exposure to cold, the absorption of toxic imides and amines from a putrid colon depress the oxidation mechanism. The resistance to infection is thus lowered and some pathogenic germ successfully invades the body. It is only partly routed out and such germs as are located in comparatively anaerobic points, as scars, injured areas, and occluded tonsillar crypts, etc., remain or are imprisoned by scar tissue as a protective measure.

From such foci the allergenic toxins gain access to the circulation and tissues and produce their specific effects. The germs also are spread, when the resistance drops low enough, and start new foci, thus tending to infect the tissues that have gone allergic. Hence multiple foci of infection are produced in addition to the metastases of malignant cells sent out from the neoplasms themselves.

Inasmuch as surgical removal of infected foci, the tonsils, and teeth, for instance, tends to leave residues of the infection incapsulated in scar tissue, and since these foci are not always identifiable or accessible one would scarcely look for a successful outcome from surgical effort alone. Yet it should be attempted when propitious.

The logical procedure is illustrated in the case histories here presented—the boosting of the oxidation catalysis. It is eminently successful, too, and a nice assembly of proofs is contained in the

transactions of the Canadian Cancer Commission of the Ontario Government, recently compiled regarding the Koch treatment.⁸

BIBLIOGRAPHY

- (1) Koch, Wm. F., *The Chemistry of Natural Immunity*, 1939; Christopher Publishing Company, p. 47.
- (2) Glover and Engle, *Studies in Malignancy*, The Murdock Foundation, July, 1938, p. 1.
- (3) Griffith and McKeoun, *Photo-Processes in Gaseous and Liquid Systems*, Longmans Green & Co., 1929, pp. 315, 495.
- (4) Koch, Wm. F., *Cancer and Its Allied Diseases*, Koch Cancer Foundation, 1929, p. 150.
- (5) Koch, Wm. F., *Cancer and Its Allied Diseases*, p. 52.
- (6) Koch, Wm. F., *Journal of Biological Chemistry*, Vol. 12, p. 313, 1912; *Journal of Biological Chemistry*, Vol. 15, pp. 43-61, 1913; *Journal of Laboratory and Clinical Medicine*, Vol. 1, p. 299, 1916.
- (7) Koch, Wm. F., *Medical Record of New York*, Oct. 30, 1920.
- (8) Arnott, D. H., M.D., *Proceedings: Cancer Commission Province of Ontario, Canada*, 1938-1940, obtainable from Dr. D. H. Arnott, 226 Queen's Avenue, London, Ontario, and Koch Laboratories, Inc., 8181 East Jefferson Avenue, Detroit, Michigan.

CRYPTS

H. J. ANDREWS, M. D., *Hollywood, Calif.*

THESE LITTLE POCKETS, under the anal lining membrane, known as the crypts of Morgagni, are often a nuisance both to the patient and the proctologist, and are usually overlooked entirely by the general practitioner.

The opening may be situated between papilla (some statements in print to the contrary, notwithstanding), or they may open directly behind a papilla, above Hilton's white line. Normally there may be pockets formed by a fold of mucous membrane, only one-eighth of an inch deep, but as the membrane is stretched continuously, especially when the external sphincter is tight, they may become elongated until they may reach out under the skin, outside the anal margin. They may not produce any symptoms except a little discomfort, unless they become inflamed.

Cryptitis is one of the most frequent causes of pain in the anal region. We have found that when a patient comes to us complaining of aching or pain in the anus during or after defecation, that in a large majority of cases, we find either cryptitis or anal fissures. It is quite important to know which of these pathologic conditions we are dealing with, as the treatment is quite different. In either event, if the sphincter is tight, it should be divulsed.

A crypt directly posterior may appear much the same as a fissure. The crypt though it may be posterior, will usually have the usual anatomic land-marks, while a fissure which has grown over, and become the so-called "buried" fissure, may have an internal opening