THE GERSON INSTITUTE • DEDICATED TO HEALING AND PREVENTING DISEASE

HEALING NEWSLETTER

Vol. 7 No. 1 - 2 Double Issue 1992

$3.00

Cure of a recurrent, inoperable, chemoresistant mixed cell lymphoma (retroperitoneal lymphocytic/ histiocytic nodular diffused) through the Gerson Cancer Therapy

An interview with Dr. John Albracht

Abstract: The Gerson Therapy is a set of integrated medical treatments which has been observed to cure many individual cases of advanced cancer in man. It is a salt and water management which restricts sodium intake and supplements potassium intake. Metabolism and cell energy production are stimulated by thyroid. Hyperalimentation of macro- and micronutrients is achieved by hourly feedings of fresh, raw juices of vegetables and fruits in addition to a basically vegetarian diet. Fat is restricted to lower intake of potential tumorpromoters. Temporaryprotein restriction promotes nonspecific cell mediated immunities. Coffee enemas provide repeatable choleresis and stimulation of bowel and liver transferase enzymes for a kind of dialysis across the gut wall of tumor toxins. Although the mechanisms are not understood, it is probable that the host management of the Gerson Therapy can in some cases induce rejection of tumors.

Healing © 1992
Published by
The Gerson Institute
Gar Hildenbrand, Editor
Membership donation:
$25 / year in U.S.
$30 / year outside U.S.
GERSON INSTITUTE
PO Box 430
Bonita, CA 91908-0430
(619) 585-7600
Charlotte Gerson, Pres.

Major portions of *Healing Newsletter* were composed on a *Kaypro* 10 computer, donated and maintained by Andrew Kay and Kaypro Computers, Incorporated.

Healing Newletter is computer typeset by Michael Jablonski, using Xerox Ventura Publisher™.

Cure of Lymphoma an interview with Dr. John Albracht

by Gar Hildenbrand

Dr. John Albracht with three of his **13** grandchildren.
Left to right: Samantha, Brennan, and Alex

This 59 year old doctor of chiropractic medicine was first treated for mixed cell lymphoma in 1963. Surgery was performed by Charles Y. Mayo, Jr. On laparotomy, Dr. Mayo discovered a large, inoperable, irregular retroperitoneal tumor pushing up through'the mesentery of the small bowel. Dr. Albracht subsequently submitted to 20 fractions of cobalt radiotherapy. Exposure was 3,900 roentgens anteroposterior and 3,900 roentgens posteroanterior, for a total of 7,800 roentgens. The mass shrank rapidly, and Dr. Albracht remained in remission for 24 years.

On December 1,1986 he presented to High Plains Baptist Hospital with severe gastrointestinal bleeding, diaphoresis, weakness, gas, belching, indigestion, epigastric fullness, diarrhea, tachycardia, hemoglobin of 8, and hematocrit of 26.

On December 5, 1986, a small bowel resection with end-to-end anastamosis was performed by Dr. Gregorio Matos. An extensive lymphoma involved one third of the small bowel and extended to the mesothelium, involving the whole jejunum down to the proximal ileum. A tumor the size of a cantaloupe was removed with seven feet of small bowel. The laboratory finding was ,malignant lymphoma, diffuse, mixed small and large cell type, sclerosing (mesentery).

Dr. Albracht was evaluated for chemotherapy by Dr. Karim Nawaz, and plans were made for systemic treatment with Cytoxan, Adriamycin, Vincristine, Bleomycin and Prednisone. He tolerated two treatments, January 11 and February 3,1987, and voluntarily discontinued after losing weight from 185 to 130 pounds.

He was admitted with residual abdominal disease to the Gerson Therapy Center of Mexico on February 17, 1987. His treatment was uneventful. He remained in follow up with Dr. Matos and Dr. Nawaz, and was seen for radiotherapy evaluation by' Dr. Joseph Arko on July 17,1987. He was found on examination to still have some palpable residual disease, a **4** by 7 cm mass just to the right of the umbilicus, although both Dr. Matos and Dr. Nawaz reported that the mass was getting smaller. Dr. Arko felt that the previous treatment (1963) was extensive enough to rule out further radiotherapy because all relevant tissues were near total maximum radiotherapy tolerance. Dr. Arko noted that the patient appeared younger than his stated age.

By the close of 1987, with Dr. Albracht following the Gerson diet therapy for cancer, the mass was no longer detectable.

Dr. Albracht was interviewed in early 1992 by Gerson Institute Executive Director Gar Hildenbrand.

Hildenbrand: Hi John, it's Gar Hildenbrand.

Dr. **Albracht**: Yeah, Gar, how're you doing?

"You can't just do part of it, or pieces of it. When I read this book by Tropp, I became so convinced that this philosophy that Gerson had about cancer — that this was not a single lesion type of thing, but you have to deal with the whole body — it was the only time that anything made sense to me about cancer. I thought, maybe these people have got the answer."

— Dr. Albracht

Hildenbrand: I'm doing well. How about you?

Dr. Albracht: Very well.

Hildenbrand: Are you on a busy schedule today?

Dr. Albracht: Just my usual work schedule. I get home around 12:30 or 1:00 and then go back at 2:00 and work till 6:00.

Hildenbrand: I'd like to interview you, if I could, for our newsletter. Would that be alright?

Dr. Albracht: Sure. Go ahead.

Hildenbrand: Good. How long has it been since you had a bump on your body would you say?

Dr. Albracht: Well, I would say that probably that mass was pretty well gone, from what the surgeon told me, by the end of 1987. I had a palpable mass in the right upper abdominal quadrant, and that was very evident when I came back from Tijuana. Of course it was there when I went to Tijuana. The surgeon, Dr. Matos, repeatedly told me over a period of check-ups that it was getting softer, and then getting smaller and smaller and softer and smaller. Eventually, it got to the point, I don't know exactly when, but I would imagine sometime the end of '87 or the middle of '88, somewhere in there, he said it was practically gone as far as he was concerned.

Dr. Albracht with his wife, Ann (far left), Grandaughter Alex and daughter, Lynn (youngest of his **6** children

Hildenbrand: Let me ask you a couple of background questions, here. I love the consistent follow-up by Dr. Matos.

Dr. Albracht: I still go in every 5 months.

Hildenbrand: Every 5 months, OK. Now you're a medical professional yourself. When did you train?

Dr. Albracht: I'm a chiropractor. I went to Chiropractic College from 1952 to 1955.

Hildenbrand: 1952 to 1955. Where was that?

Dr. Albracht: That was in Port, Iowa and San Antonio, Texas.

Hildenbrand: Port, Iowa and San Antonio, and you've been treating since then.

Dr. Albracht: I've been in practice since '55.

Hildenbrand: Would you say that the chiropractic education predisposed you to be maybe a little bit more open to the alternative dietary management?

Dr. Albracht: You would think so, but the first time this developed was in 1963, and I went to a chiropractor of course and got an opinion. He said, John, you got something there that needs attention. So I went to Mayo clinic. Dr. Charles Mayo did surgery on me.

Hildenbrand: The Charles Mayo?

Dr. Albracht: There's three of them. My surgeon was Charles Mayo, Jr., the son of the original Charles Mayo. He's dead; killed in a car accident in Omaha back in the middle 60's. Anyhow, he opened me up, biopsied me and closed me up as inoperable in '63. He recommended cobalt treatments. I had 26 — or was it 29 — cobalt treatments. And I got a very, very rapid response to that; faster than what the radiologist and the surgeon thought I would have gotten. You know, when I came out of surgery, Dr. Mayo warned me about being around volatile oils, esters, paints, fumes, sprays and toxic pesticides, herbicides, and those kinds of things.

Hildenbrand: He did?

Dr. Albracht: He told me that the Mayo Clinic was of the opinion that the lymphomas like I had were due to contact with the environment, and inhalation of fumes and vapors. He warned me about paints, oils, sprays...

Hildenbrand: I'll be damned.

"(Dr. Charles Mayo) told me that the Mayo Clinic was of the opinion that the lymphomas like I had were due to contact with the environment, and inhalation of fumes and vapors. He warned me about paints, oils, sprays ..."

Dr. Albracht: To the point that, to this day, because of what he told me, when I drive down the street and someone is spraying weedkiller, "Weed-be-gone" or 2-4-D, using the heavy sprays, I pick it up. I am extremely sensitive, nosewise, to that stuff.

Hildenbrand: And you avoid it?

Dr. Albracht: Yes.

Hildenbrand: *(People Against Cancer* Science Director,) Dr. Samuel Epstein, who wrote *The Politics of Cancer,* a professor of occupational medicine at the University of Illinois at Chicago, is the man who has been hollering warnings for years, as a witness in front of Congress, and in many professional journal articles, that the unregulated use of toxics in the U.S. is behind the cancer rates. That's very much in keeping with what Charles Mayo II told you, that the cancer problem really isn't an unsolvable riddle. We know enough to say that these environmental challenges are behind a lot of the cancers.

Dr. Albracht: In my discussions with patients, or lectures about the subject, I always tell them the story of Dr. Mayo. He asked me, "have you been around any real strong toxic fumes?" And I told him, at the time, "no". I couldn't think of any. But later, I remembered I'd worked as a young man with latex rubber. I worked with liquid latex rubber with floor coverings, seaming carpets. I used quite strong glues to adhere hard surface coverings to floors.

Hildenbrand: That stuff is awful. If you're talking about linoleum tiles, that stuff is horrendous.

Dr. Albracht: Yes, it is. Many years later, I was talking to a guy who collects film from us, which he melted down to get the silver out. He told me how one of his employees almost got in trouble working with liquid molten lead. And I said, "that's interesting." And then it dawned on me that I had worked for about four months in a non-ventilated basement in Davenport, Iowa. It was at a newspaper. They were on strike, and I was in charge of melting the lead from a Linotype machine into solid bars. And I did that 6 days a week, 8 hours a day for about four months. I remembered that when I poured that lead my face was directly over it. I thought "Jiminy Christmas!"

Hildenbrand: All the things that we used to take for granted that we could just go ahead and do are subject to challenge, especially the handling of metals like lead and mercury, and all of the outgassing adhesive and paint and solvent products.

Dr. Albracht: I have also worked in either new or remodeled buildings in my profession, on three occasions.

Hildenbrand: The U.S. needs a "fresh air law" that requires forced outside air ventilation of new buildings for a reasonable period of months.

Dr. Albracht: During that same period of time, 1959 - 1986, I also lived in two new homes, with all the vinyl wall coverings and floor coverings and carpeting.

Hildenbrand: Not to mention the plywood in the structure outgassing formaldehyde. New carpet.

Dr. Albracht: I remember when Norman Fritz talked about that in Tijuana when I was there, and I thought, "holy mackerel!" I remembered sometimes the vapors would be strong enough to practically knock you down.

Hildenbrand: Isn't that the truth? It really is. Here in Southern California, we're lucky, because when you put those new things in, its possible, for the most part, to leave all the windows open.

Dr. Albracht: In this part of the country, like today for example, it's in the high 30s and it snowed last night. If you're installing floor covering, or painting in a home, or in a new building, or a remodeling job, you have to keep the windows closed or you'd freeze to death.

Hildenbrand: So you'd do well to do that in the summer when you can keep it open.

Dr. Albracht: They do it year round.

"When I tell people about the Gerson Therapy, I tell them that it changed my life immediately, because it was a whole new approach to life."

Hildenbrand: Let's go back to our discussion of the cancer. It looks like exactly the same malignant cell recurred after 24 years.

Dr. Albracht: It was in the same location, and it was the same diagnosis.

Hildenbrand: Everything was the same the second time around?

Dr. Albracht: Yes. It was a mixed cell lymphoma. It's a slow growing tumor, and I was well aware of it before I had surgery. It was a large palpable mass in 1963. In 1986, when this thing recurred, I thought "ugggh, same deal," because the symptoms were *exactly* the same. They were mainly symptoms of obstruction. I observed it, and I was "going to do something about it eventually," and I finally made arrangements to have tests done in Amarillo. Two or three days before I was to go in on an elective basis, I started hemorrhaging very severely. Even up to this point, I wasn't thinking about going with an alternative method, because I really didn't know what I know now as far as the Gerson. I had used, in 1963, a little bit of Kelly's diet, but it was kind of hit and miss from what I knew. I did for a period of time. I changed my eating habits. I went on more of a vegetable diet, with much, much less protein; but no coffee enemas.

Hildenbrand: When I asked you about your chiropractic training and whether it left you more open to alternatives, you said that, basically, it didn't. Were you at one of the more conservative schools?

Dr. Albracht: That was my original training. But I went into nutrition later. At that time, I didn't really have the concept that once a tumor formed you could do anything about it. I didn't have that philosophy.

Hildenbrand: You didn't think of diet as a potential tumor modifier?

Dr. Albracht: Not even along the lines of a good diet as a preventative measure.

Hildenbrand: What do you remember of the time? You were probably just starting up a practice when that first cancer came along. What do you remember of the impact that had on your life?

Dr. Albracht: When I tell people about the Gerson Therapy, I tell them that it changed my life immediately, because it was a whole new approach to life. But in 1963, my philosophy of living was totally different. After a relatively short few years, I was busy, successful, raising kids, family, and I went right back to the routine I'd always been in. I reverted back to being a typical American, eating, drinking and smoking; all those things.

Hildenbrand: The recurrence was more than twenty years later, wasn't it?

Dr. Albracht: Yes, twenty-four years later, actually.

Hildenbrand: Was that in 1985?

Dr. Albracht: 1986 was when it recurred.

Hildenbrand: Did you know what it was? Did you recognize it?

Dr. Albracht: I could feel it. I could feel this mass for a long time before I did anything about it.

Hildenbrand: How long?

Dr. Albracht: From March to December of 1986, when I had surgery.

Hildenbrand: You really held off.

"The second time, when they opened me up here in Amarillo, they removed a tumor the size of a cantaloupe, and 7 feet of my intestine."

Dr. Albracht: I wasn't real gung ho about going into the hospital. There was a lot going on in my life, two sons in school, one of them had a pregnant wife — I mean girlfriend — and they were getting married. There was all kinds of stuff going on. All the stress and tension I was under at that time was a contributing factor, in my opinion. I was using it as an excuse, putting it off, putting it off, putting it off. You know, I thought maybe some of these symptoms would subside when things settled down. But as time went on, the obstruction continued to increase. The palpable mass increased to the point that it was really obvious.

Hildenbrand: Did you know what it was?

Dr. Albracht: For all intents and purposes, I was sure it was the same thing. Ironically, both when I went to Mayo and the second time around, when I went here locally and had all these tests done, the results were exactly the same. Everything was negative. All they could find was a palpable mass, and a slight shadow on an x-ray.

"I think that's the magic answer they give all patients who have just had surgery: 'We think we got it all."

Hildenbrand: Did you have a biopsy both times?

Dr. Albracht: Yes. They did an exploratory both times.

Hildenbrand: A laparotomy?

Dr. Albracht: Yes. Both times. They said it was inoperable at Mayo. The second time, when they opened me up here in Amarillo, they removed a tumor the size of a cantaloupe, and 7 feet of my intestine.

Hildenbrand: Who was the surgeon in 1986, and what was the facility?

Dr. Albracht: It was here at High Plains Baptist Hospital. Dr. Gregorio Matos was the surgeon. He's the one who still does the follow up.

Hildenbrand: Did the surgeon take everything he could see?

Dr. Albracht: That's what he said. But, within three days the oncologist was telling me about the chemotherapy I was going to need. I asked "What for? They told me they got it all." He said, "You can still feel that mass in there, can't you?" And I said, "Yeah I can." You know, I was thinking maybe the swelling was from the surgery yet.

Hildenbrand: Was there actually residual tumor mass left?

Dr. Albracht: Oh, yes.

Hildenbrand: Why did they tell you they got it all?

Dr. Albracht: You tell me. I think that's the "magic answer" they give all patients who have just had surgery: "We think we got it all."

Hildenbrand: What was the oncologist basing his impressions on?

Dr. Albracht: I think he probably had reports from the surgeon that didn't conflict with what he was now telling me. I've never confronted him about that, but that's what I think.

Hildenbrand: That's kind of spooky.

Dr. Albracht: Yes, it is, when you go from, "we got everything" to turning around within less than a week saying, "we're going to have to start you on chemotherapy to try to get the balance of that; there's an obvious palpable mass," — and I could feel it myself.

Hildenbrand: You could feel it and the oncologist could feel it.

Dr. Albracht: Yes, no doubt about it.

Hildenbrand: Were you surprised that radiotherapy wasn't advised the second time around?

Dr. Albracht: No, I wasn't, because I felt, and I later confirmed this, that I've had all the radiation I can tolerate in that area. Last week, I was reading through some reports I ran across. I believe they said that my left kidney, a portion of my left kidney, was scarred or sclerosed, and I wondered how much of that may be due to the radiation that I had. In 1963, when they were giving me the radiation, they gave me eleven minutes a day.

Hildenbrand: Wow.

Dr. Albracht: I'd lay on my back and they'd give it to me for eleven minutes. The next day I'd come in and they'd turn me over and do the other side for eleven minutes.

Hildenbrand: What were the symptoms associated with that?

Dr. Albracht: Nausea. Vomiting. Some diarrhea.

Hildenbrand: Did you have trouble eating?

Dr. Albracht: Oh yeah. I'd go to the table and I never knew if I was going to have an appetite, eat, or throw up.

Hildenbrand: How long did that go on, do you recall?

Dr. Albracht: Well, they put me on Dramamine, or some sort of antinausea medication. As the treatment proceeded, the symptoms increased and increased. After they discontinued the radiation, I don't know how long it was before I really got back to normal. Ironically, I lost my appetite for everything but fruits and vegetables.

Hildenbrand: Is that right?

Dr. Albracht: Light, easy to digest fruits, vegetables, and juices. That's all I could eat. I lived on them.

Hildenbrand: Through a fortunate physiological reaction, you ended up on a dietary that was almost devoid of tumor promoters.

"By innate instinct, I would say, my *appetite was altered,* my *diet was altered."*

Dr. Albracht: By innate instinct, I would say, my appetite was altered, my diet was altered. Meat and gravy, and things like that, even a lot of the heavily cooked fruits and vegetables, didn't appeal to me.

Hildenbrand: How about butter and cheese?

Dr. Albracht: Nope.

Hildenbrand: Ice cream?

Dr. Albracht: It just didn't appeal to me.

Hildenbrand: How long would you say that persisted?

Dr. Albracht: How long? Until the effects of the radiation were over. I imagine it was six months.

Hildenbrand: That's very interesting. Before you told me this, I was thinking to myself that I would have to credit Dr. Albracht's 24 year remission to the sole influence of radiotherapy. But in light of this information, I don't think one could argue that persuasively anymore. You employed protein and calorie restriction, fat .restriction, high beta carotene feeding, high micronutrient feeding, and probably other aspects of nutritional immunology.

Dr. Albracht: I was following some of Kelley's dictates.

Hildenbrand: You're referring to William Donald Kelley?

Dr. Albracht: Yes. He'd had one of these spontaneous remissions through diet. They gave him up for dead. He healed himself by following the dictates of his body.

Hildenbrand: Did you eat the "fourteen grain cereal" that he had at that time?

Dr. Albracht: I ate a lot of the things he talked about in his book. The name of his book is *One Answer to Cancer.*

Hildenbrand: Yes. I know it well, because Norman Fritz of the Gerson Institute did the interview with Kelley which appeared in his book, *One Answer to Cancer.*

Dr. Albracht: Really? As far as vitamins, niacin, and heavy vitamin C, I forget all the things he recommended in that book, but those are the things that I started following.

Hildenbrand: You know John, all of Kelley's work, at that time, was closely derivative of Gerson's work. It is more evidence that radiation can't take total credit for your long term remission. It undoubtedly blew the tumor out of the water, but the reason you didn't have a recurrence for 24 years may be grounded more solidly in your dietary treatment. That's my view. To return to 1986 and the second manifestation of the cancer, this was biopsied, and it was found to be a recurrence of mixed cell lymphoma.

Dr. Albracht: That is correct.

Hildenbrand: Then you saw the oncologist. How long after surgery did you start taking the drugs.

Dr. Albracht: Surgery was performed on the 5th of December and my first chemotherapy was January 11, 1987. My second chemotherapy, and last,

was February the 3rd. I was programmed for what they said was a minimal amount of chemotherapy and yet they gave me five different kinds. They said I'd probably "only need about eight" treatments. After the second one, boy I'll tell you what, my life started ebbing away very rapidly.

Hildenbrand: You were still at High Plains?

Dr. Albracht: No, I was dismissed as a patient about the middle of December, on the 16th actually. So roughly a month later they started the chemotherapy. I was doing that as an outpatient.

Hildenbrand: And who was the doctor then?

Dr. Albracht: Dr. Nowaz was the oncologist.

Hildenbrand: Do you remember the drugs, off the top of your head?

Dr. Albracht: Prednisone, and vincristine was one of them.

Hildenbrand: Periwinkle chemotherapy. Did you know that comes from flowers?

Dr. Albracht: Yeah.

Hildenbrand: What do you recall of the first day of treatment?

Dr. Albrachtr It took about an hour and 45 minutes to give me the chemotherapy, and they gave it to me in an IV, of course. They started out with an injection to counteract the nausea so I wouldn't throw up all over the place. And that evening when I came home, I lost it all.

Hildenbrand: Did you feel anyting right there in the doctor's office?

Dr. Albracht: Well, the only symptom I felt there was a hot rush to the testicles from the antinausea shot they gave me, which they warned me about. I didn't feel too much at the time. I couldn't put my finger on it and say boy I feel bad. I had a lot of anxiety and fear, of course. But I was positive I was not going to let my emotions influence my becoming nauseous, I was very adamant that I was not going to let that happen. I had been told to expect all these symptoms. If it happens I want it to be for real, not from my brain. But I started experiencing symptoms like crazy. In fact, I refused to even read the material they gave me that explained what the symptoms were. I didn't want to be influenced. When I was reading it to my daughter several weeks later, it dawned on me why I was feeling like I was feeling. I had the nausea and vomiting; the diarrhea started; abdominal cramping, pain, irritation, hoarseness, chest pains, shortness of breath, coughing, pain in the lower back and testicles, burning and swelling in both arms where they gave the injections.

Hildenbrand: And how long did you keep this up?

Dr. Albracht: I had the second one on February the third, and the side effects came on again very rapidly. They had tapered off after the first treatment in about 10 days or two weeks, and I felt pretty decent. Then I went back in and had that second treatment, and it seemed like everything was compounded.

Hildenbrand: Did you notice any shrinkage of the abdominal mass?

"I thought, 'damn, if I die, at least I'm gonna do this and I can die in comfort'."

Dr. Albracht: No. I didn't. In fact, I was losing so much weight at that point, that I didn't feel any improvement at all. I'd lay there at night trying to get comfortable to go to sleep, feeling my abdomen, and it did not feel good.

Hildenbrand: After you had the last chemotherapy, I assume you had another couple weeks of lousy symptoms.

Dr. Albracht: Yes. About a week after that last 'chemotherapy treatment, my nephew told me about a book he wanted me to read. He was telling me about the Gerson diet. He asked me to read this book by Jack Tropp, called Cancer, a *Healing* ***Crisis.*** He encouraged me to go to Tijuana. And I said, "no, I'm doing real well. I don't think I'd be interested." He said, "well just read the book, at least. We'll talk about it. In fact if you want to go down there, I'd be willing to go with you." So, I read the book, started reading it on my birthday, Feb. 11. It was a Wednesday afternoon. By 5:30 that evening, we started the Gerson diet.

"So, I read the book... It was Wednesday afternoon. By 5:30 that evening, we started the Gerson diet."

Hildenbrand: That was a pretty fast turn around.

Dr. Albracht: Respectable. I quit salt, alcohol, protein. Ann fixed me some Hippocrates soup as best she could from what's in Tropp's book. We got a juicer and started juicing vegetables. I had my first coffee enema. I did it absolutely backwards. Every way you could do it wrong, I did. But I did it. Next morning I had another coffee enema before I went to work. I was working two hours in the morning and two hours in the evening, see. I insisted on working. How I did it, I don't know. Anyhow, I was. That evening, I came home and had another one. In 24 hours my diarrhea dropped from 20 times a day to three, and that was a helluva a marvelous change!

Hildenbrand: Wow. In one day.

Dr. Albracht: In one twenty-four hour period. I thought, "damn, if I die, at least I'm gonna do this and I can die in comfort." The chemotherapy and the cancer had me so sick that when I would go from home to work — I only live 2 and a half miles — that's the last thing I did before I left was go to the bathroom, and I didn't know if i'd make it home or not. In fact, I traded vehicles. My vehicle was a four-wheel drive Toyota. It was so rough driving on smooth streets, my intestines hurt so bad, I traded it off. When I'd go anywhere, I never knew if I'd make it or not, the diarrhea was so bad. Every time I moved, I'd have another bowel

movement. Anyway, in 24 hours, that changed. And I thought "boy, this makes sense to me." Then, I was looking through my books, and low and behold, I found Gerson's book on my own book shelf. It had been sitting there for 3 or 4 years. Saturday morning, we called Gerson the Gerson Institute and talked to Charlotte. She recommended that we make arrangements to come, and we came the following Tuesday, which was the 17th.

Hildenbrand: Who was your doctor at the Gerson hospital?

Dr. Albracht: Dr. Melendez.

Hildenbrand: Dr. Alicia Melendez. Yes. She's almost got it down to a routine now, taking people who've recently had chemotherapy which didn't work and made them sick, and getting them going again. She's very conservative. She really mollycoddles them.

Dr. Albracht: I really, really was impressed with that woman. She gave me a lot of good solid advice. I really appreciate her.

Hildenbrand: She's a fine physician. She's senior staff physician now at CHIPSA, and the only difference between now and then, is that she has more experience behind her, and more drug damaged patients to deal with.

"I became so convinced that this philosophy that Gerson had about cancer — that this was not a single lesion type of thing, but you have to deal with the whole body."

Dr. Albracht: Yes. Sure. I was dealing with a patient this morning. He's in his late 60's or early 70's. He told me just this morning that he had what must be a rapid growing lung cancer, and he was having upper thoracic pain. He wanted to know if I, as a former patient, could help him. I said, "sure, but I don't want you to get the impression I'm treating your cancer. We'll try to get you some pain relief." I asked him, "how long have you known about that?" He said, for nine months. I said, "it ain't moving too fast then." He said, "I refused all treatments." I said, "well, my opinion is this: you're going to live longer without treatment than you certainly will live with treatment." I had talked with him about the Gerson Therapy two or three weeks ago. Anyway, I said, "there are more damn people dying of cancer treatment than from cancer itself. You're a lot better off with no treatment rather than with chemotherapy."

"There are more damn people dying of cancer treatment than from cancer itself. You're a lot better off with no treatment rather than with chemotherapy."

Hildenbrand: Do you recall, when you first met Dr. Melendez, what impressions you had of her?

Dr. Albracht: Well, I met her, of course, the first day I was there. I felt very comfortable with her. She seemed very compassionate, and a very caring person. Even though all this was very new to me, she appealed to me because she's a very warm and caring type person. In my notes, I made a notation that my abdomen started to feel real hot. She said that was good, that I had a normal inflammatory process going on there. I bought everything she told me, hook, line and sinker, let's put it that way.

Hildenbrand: I understand that. You went into that Mexican independent innovative cancer management center as a physician with a whole lot of medical training. You didn't go to the new facility, but to a converted motel that was serving temporarily to replace the fire-gutted La Gloria. As you experienced the medical model of this alternative treatment system, did any attitudes change?

Dr. Albracht: I'd been in a brand new, ultramodern hospital. Going from here, to Tijuana and the hospital there, I thought this was certainly primitive. But by the same token, I've told a lot of people, *everything I needed was there.* Whereas everything I needed was *not here.* When I'd tell people about going to Mexico, I'd say, don't be impressed by the buildings. Remember one thing, if *this* doesn't work, you *have* no alternative, this is your only hope. If you're serious about it, you have an excellent chance of getting help. You have to buy it, hook line and sinker. You can't just do part of it, or pieces of it. When I read this book by Tropp, I became so convinced that this philosophy that Gerson had about cancer — that this was not a single lesion type of thing, but you have to deal with the whole body — it was the only time that anything made sense to me about cancer. I thought, "maybe these people have got the answer."

Hildenbrand: Well, it was certainly an answer for you. Was your course of recovery steady then?

"I'd been in a brand new, ultramodern hospital. Going from here, to Tijuana and the hospital there, I thought this was certainly primitive. But... everything I needed was there."

Dr. Albracht: I think it was, yes. Of course, Melendez told me that I'd be having this reaction. I was there nine days before I had my first flare-up. It was a lulu. I remember the depression was intense, like Gerson says in his book. *I never knew what depression was before.* I only thought I did. I had terrible depression, nausea, vomiting, and I was insistent on getting well. I refused to give in to the symptoms. Dr. Melendez told me that to make it, I was going to have to eat. I was going to have to keep the juices going. Someone convinced me that the more I ate of that diet, the better I was going to do. I

went after it. There were times, though. I remember one night, I was in my room eating because I was too sick to go into the dining room. Right in the middle of the meal, I got up and lost it all, and I came back and finished my meal because I was *convinced.* That's where I was coming from.

Hildenbrand: You had a sort of soldier's attitude about it.

Dr. Albracht: Yep.

Hildenbrand: How would you define depression, having experienced it then?

Dr. Albracht: Well, I guess, the way I look at it, there was no hope. Everything in the world was going sour. Everything I looked at was gloom, despair, and misery. Everything was negative. There was nothing good in practically anything. I had tremendous doubt and lack of confidence.

Hildenbrand: Did you feel out of touch, isolated even when you were with people?

Dr. Albracht: Yes. I remember one occasion. My wife was going to go shopping one day in Tijuana. I cried like a baby, and said "please don't go, don't leave me today, I don't want to be alone."

"You have to buy it hook, line and sinker. You can't just do part of it, or pieces of it."

Hildenbrand: Clinical depression is really an astonishing illness. And when it hits, like it hit you for purely biochemical reasons — it is all pervasive. We all remember those Psychology 101 films of the rats with probes down in their brains. They'd be docile, next to each other in the cage, and the next minute they'd be fighting because a researcher had stimulated a certain area of the brain. That is absolutely the way clinical depression hits. It turns on like you opened the door to a blast furnace.

Dr. Albracht: You know, the thing that amazed me was that in Gerson's book he explained that before you have these flare ups, as I understand it, this depression is part of the reaction. And do you know I never could remember until it was past, thinking back all the times that I had these flare-ups.

Hildenbrand: You don't remember it because part of the prodromal syndrome of the healing reaction can be that you may lose some of your acute perceptions and perhaps some of your memory, to a certain extent. Part of being depressed is not being able to remember how or why you got there.

Dr. Albracht: Looking back, I would say, "oh, *that's* why it was that way!" I had reactions every 9 days, and then all of a sudden it went to 13 days. Then it stayed on that basis for a while, then it went to once every 28 to thirty days.

Hildenbrand: Isn't that fabulous?

Dr. Albracht: I kept a diary of that time. I am always so amazed when I go back and read this, how it all begins to fall in place. The more I read of other people, the more I read Gerson's book — I've read that two or three times, it became so solid in my mind that this was working — when I read West's book about lymphocytes, and I read Jaquie Davison's book, I'd say, "yeah, I know exactly what you're talking about."

Hildenbrand: When you started the Gerson Therapy, all you had was this one big mass.

Dr. Albracht: Right, that was the only place I had it. Retroperitoneal lymphoma. In fact, before they dismissed me from the hospital in December, they did the lymphangiograms on me, they did bone marrow tests, and everything was negative exceptthat mass in the abdomen.

Hildenbrand: Did your oncologist and your surgeon have trouble with you doing an alternative treatment?

Dr. Albracht: Let me put it this way, I left and explained when I came back.

Hildenbrand: You didn't ask their permission.

Dr. Albracht: No. I thought I knew what their impression would be.

Hildenbrand: Were you right?

"I thought, 'maybe these people have got the answer'."

Dr. Albracht: I didn't bother to get their opinion, because I could care less. But, when I came back from Tijuana, ironically, when I stepped off the plane — well, I wasn't stepping, I was riding a wheelchair — who should I run into but my oncologist, getting on the same plane I was getting off of. I stopped in the hallway and said, "in case you wonder why I didn't keep my last appointment, I've been to Tijuana, Mexico. I'm on a nutritional treatment and in a few days, I'll call you and let you know what's going on." He just said, "if you're doing fine, no problem." I was shocked that he was so open about it. This guy is not American. He is Arab or Indian or something. Anyway, he's a gung ho oncologist. I called at his home one night two or three weeks later. He lives just down the next block from me. I said, "Dr. Nowaz, this is John Albracht. I want to explain why I haven't been coming in, why I'm not coming back." And he said, "well, hey, if you're doing well, and its working for you, no problem. OK." Then, I did have an appointment coming up with Dr. Matos. I kept that appointment because I thought I might need someone here for lab work, etc. And so I went in to see him. I explained to him where I was, where I'd been, and what was going on. I told him I'd gotten back from Tijuana on the 11th of March. On the 20th I went to see Matos. I told him where I was, and how things were going, and I was feeling so much better, and how a lot of the symptoms I'd had were diminished. And I'd stopped the chemotherapy and I wasn't going to take any more. I was on B-12 and liver shots. I kinda gave him a little bit of an overview; not real detailed. He made a comment. He said, "the way you were going downhill, your health was deteriorating. And I think you did the

right thing to bring your health back up, and your weight and strength, and to get some sunshine. And after you get better, go back to Nowaz." And I said, "no way, I'm not even thinking about that." Anyway, he did his usual palpation examination on my abdomen. He outlined the tumor and said it was about the size of a golf ball. He said it seemed like it was smaller and softer though.

Hildenbrand: This was about how long after the chemotherapy stopped?

Dr. Albracht: My last chemotherapy was on the 13th of February, and this was the 20th of March.

Hildenbrand: OK.

Dr. Albracht: Anyway, he said the abdomen felt better. I was doing well. He recommended a wait to resume the chemotherapy. I said I was going to talk to Nowaz about this before I do anything, but I don't think I will. Anyway, I came back about a month later, and each time he would check me over and essentially the same thing. April the 24th I went in, and Matos said everything was going well. The tumor mass in the right quadrant was 3-4 centimeters in size. He recommended radiation. I told him, "I suggest we wait at least six weeks to think it over before I do anything." He said, "basically, you're doing fine, we'll wait." I wasn't aggressive enough to do anything like that. I was just stalling for time. He was, at that point in time, pretty open with me. When I went in May, he said again the tumor was smaller and softer. He said the chemotherapy had apparently done a good job and I would need some more. He insisted that I continue to rest for at least two more months and be rechecked in July. I think he was going on a trip or something. So I went back in July, and — let me see if I have a note to that effect — I went in July, and he said the remnant of the lymphoma was smaller and softer yet. And he wanted me to go see Dr. Arko, a radiologist, for consultation. I told him I would go, but I was not going to allow anything as far as any treatment was concerned. No radiation and no chemotherapy. So, I did go in and he checked me over. Essentially, he reviewed what the Mayo clinic had given me. He confirmed that I couldn't have anymore radiation. That would be out of touch with reality. I kept up the monthly visits to the doctor. It was just more and more good news every time I'd go in, you know.

Hildenbrand: When was it again that the lump was totally gone?

"I told (Dr. Matos), 'look, you know damn good and well that I'd be dead if I hadn't gone on that diet.' He said, 'yes, your case was terribly mismanaged'."

Dr. Albracht: Let me see if I can figure that out. At one point, Matos said that he was very concerned about my color. So he went to check some notes, and he came back and told me what he had learned. My color was so bad that he wondered if I'd had some kind of toxic effect from all of the beta carotenes, the carrot juices. And I *really got upset.* That's the one time where I got upset and I told him, "look, you know damn good and well that I'd be dead if I hadn't gone on that diet." He said, "yes, your case was terribly mismanaged." In September of 1987, Matos said that all he could feel was a little bit of nothing. He said he couldn't figure out or understand how or why the diet was working so well. One little note about all this: when I was in Tijuana, Dr. Matos used my case as a case study at the hospital here. One of the doctors was a friend of mine; one of my associates. One of his friends was on the staff there at High Plains when they were doing this luncheon case study and they used my case. He said that they told the group that I had maybe three to six months to live. The meeting was either in the last part of February or the first part of March. I think that's one of the reasons why he was concerned or alarmed that I kept getting better. I have a note that here in March of 1989, everything was gone as far as he was concerned.

Hildenbrand: Took a while, didn't it?

Dr. Albracht: Like Gerson says in his book, slow growing tumors go away very slowly.

Hildenbrand: Yes, especially when they're in the lymph nodes and they're plugged up at both ends, and the immune system has to take them apart one cell at a time from either end. I have one last "yes or no" kind of question. Have you noticed, since the Wilk vs. AMA decision was upheld in February of 1990, that things have gotten any more amicable between the chiropractors and the allopaths?

"I kept up the monthly visits to the doctor. It was just more and more good news every time I'd go in, you know."

Dr. Albracht: Oh yes. Much more so. Of course, by the same token, the way finances are those suckers will take any referral. I don't know how much of it is economy.

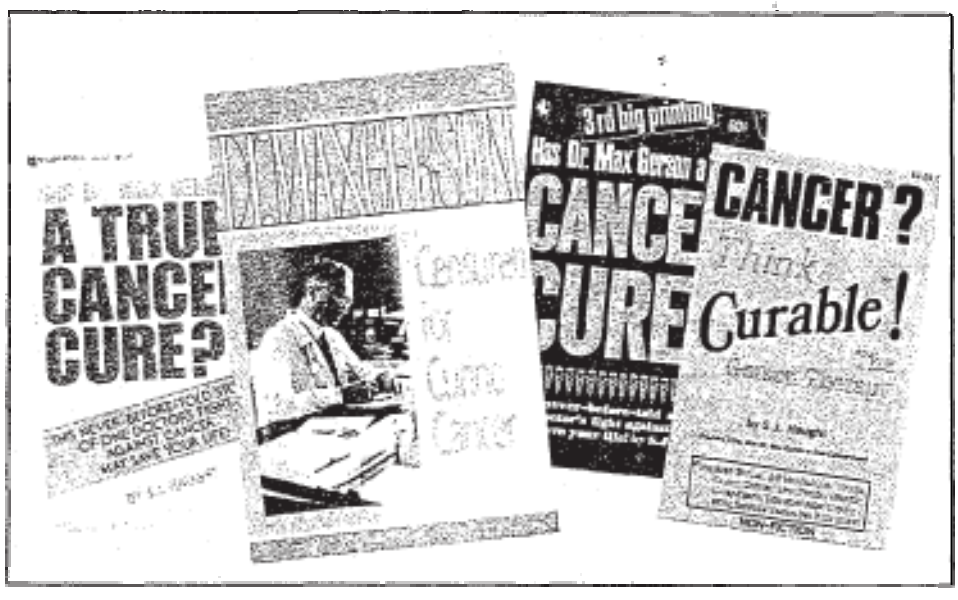
Hildenbrand: A change of heart is something that can't be ordered by the court. I guess a modicum of cooperation can be. Of course, the economy has been brutal to everyone in medicine, and everywhere else. I'm glad to hear that John. I want to thank you for giving me the chance to ask all these questions. We'll be putting them together. I'll nip, tuck and flip things around a little bit to make it flow. Have a good day at the office. ■

Now Available!
Censured for Curing Cancer:
The American Experience of Dr. Max Gerson

After a year of delays, mostly involving computer incompatibility problems, the first shipments of *Censured for Curing Cancer* have arrived at the Gerson Institute office.

Censured for Curing Cancer: The American Experience of Dr. Max Gerson, edited by Gerson Institute Executive Director, Gar Hildenbrand, is the newest incarnation of an enduringly popular book about the American political experiences of Dr. Gerson. Written in 1959 by investigative news reporter S.J. Haught, this insightful look into the dramatic story of Dr. Gerson was originally titled *Has Dr. Max Gerson a True Cancer Cure?.* In 1983, *Cancer: Think Curable,* with its now-familiar, brightly colored red, blue, and yellow cover was the edition created by Norman Fritz. In its new format, with an all new design, *Censured for Curing Cancer* is a "quality paperback" with a hardhitting Foreword and Afterword written by Gar Hildenbrand, himself a veteran of the political intrigues surrounding unconventional cancer treatments. Also new is a special eight page layout of photographs of Dr. Gerson, his family, his famous friends, his foes, and his former patients.

S.J. Haught originally intended to expose the "quackery" of Dr. Gerson's then-revolutionary diet therapy for cancer. Instead, his expose became a classic documentation of Dr. Gerson's remarkable success in curing both adults and children with cancer, and the story of his courageous and lonely fight against the forces of organized medicine. The book includes personal stories, case histories, and Dr. Gerson's 1946 testimony before Senator Pepper's committee during which he presented five thoroughly documented, astonishingly healed cancer patients who testified on his behalf. Read it for yourself.



***Censured for Curing Cancer: the American Experience of Dr. Max Gerson* flanked by three earlier incarnations.**

The original text used initials instead of names to identrfy the doctors who supported Gerson, to protect them from harassment. Initials were also used to protect the writer from potential lawsuits which would surely have followed publication of the names of the men in positions of power who led organized medicine in a crippling boycott against Gerson. Those initials have now been replaced with names. Hildenbrand painstakingly searched the Gerson archives for letters and documents which identified those important players.

It took many hands to make this edition of Dr. Gerson's story available. Thank you to Charlotte Gerson who opened her family scrap books and took the time to share some of her private memories. Our thanks to Chip White who had the idea to "update and upgrade" and who entered the text of the book into the first of the many computers we used. Special thanks to Michael Jablonski who finally got the computers to speak to each other and who produced the final layout. And thank you to the folks at Station Hill Press. *Censured for Curing Cancer: the American Experience of Dr. Max Gerson,* $6.95 U.S./$8.25 CAN ($1.50 shipping U.S. & CAN) is available through the Gerson Institute. For a limited time, order 10 or more for ½ price and free shipping. Order now! ■

What has chemotherapy done for you lately?

by Gar Hildenbrand

Will *it* work? Will it hurt? Will I live? These are the questions that scream in the minds of people with cancer as they listen to proposed chemotherapeutic treatment plans.

Talking to an oncologist who prescribes chemotherapy is talking to a true believer. Most are sincere in their belief that chemotherapy is appropriate treatment for most types of cancer.

And of course they believe in drugs. Everywhere in the U.S., and in most other countries where modern pharmicocentric medicine is the norm, the pep talk floods forth. Cheerleading articles appear regularly in newspaper business pages, enthusing about the growth in biotechnological issues. The stocks are on the rise, they say.

Will it work? Will it hurt? Will I live?

In newspaper front page sections, and on network news, the spin is that finally, in this 21st year of the "War on Cancer", our new genetic understanding of cancer is leading to better drugs, hybridomas, cytokines, improved radiation techniques.

Chemo edges surgery

And in the medical press we are told, "In the 1980s, drug treatment eclipsed the surgical treatments of the 1970s. While it remains the most effective means of debulking solid tumors, *surgery is an adjunct to radiation and chemotherapy,* often after these methods have been used" (Beverly Merz, *American Medical News,* "War on Cancer Marches On", Dec. 16, 1991, pub. American Medical Association, Chicago).

The professional environment for cancer chemotherapy has far too many parallels to major league sports, including the pep squad, the pay, and the high price of admission. It is the twenty-first consecutive losing season, and the bleachers are empty.

Patients avoid chemo trials

According to *American Medical News,* patients are avoiding clinical trials of cancer drugs. "Although the Community Clinical Oncology Program encompasses 300 hospitals and 2,575 physicians, there are only about 5,000 patients currently in clinical trials." Why?

Word of mouth, probably. Although it is not true that all chemotherapeutic treatments cause extreme side effects, the word chemotherapy has become a synonym for diarrhea and the dry heaves. And it is a reputation that can't be shaken.

But what is the other side of the coin? What about the claims for increased survival? Quality of life?

Leading statistician challenges claims

This question was addressed last year by a leading statistician, a number cruncher for the German Federal Cancer Research Center in Heidelberg. Dr. Dr. habil. Ulrich Abel, medical scientist, university lecturer, chief of the Institute of Epidemiology and Biometry in Heidelberg, published an outwardly unassuming 65 page booklet (92 pages including the 290 citations).

Chemotherapy has become a synonym for diarrhea and the dry heaves. And it is a reputation that can't be shaken.

Its title, *Chemotherapy of Advanced Epithelial Cancer: A Critical Survey,* and its publisher, Hippokrates Verlag of Stuttgart, inform the reader that this is a medical monograph: "a learned, detailed, and thoroughly documented treatise covering exhaustively a small area of a field of learning" *[Webster's 3rd New International Dictionary* (unabridged), G&C Merriam Co., Springfield, MA].

This document is not a "blow to the cancer establishment". Dr. Abel IS the cancer establishment.

Its thesis, in Abel's words, is that *"after decades of intensive clinical research and development of cytotoxic (cell killing) drugs, there is no evidence for the vast majority of cancers that treatment with these drugs exerts any positive*

"After decades of intensive clinical research and development of cytotoxic (cell killing) drugs, there is no evidence for the vast majority of cancers that treatment with these drugs exerts any positive influence on survival or quality of life in patients with advanced disease."

— Dr.Dr.habil. Ulrich Abel

influence on survival or quality of life in patients with advanced disease."

This monograph [available from People Against Cancer, **(515) 972-4444** for about $40.001 is considerably more than the work of one man. Its first draft, which synthesized input from about **150** oncologists and research units throughout the world, was revised after being circulated to about 300 oncologists in German- speaking countries.

Although some cancer industry critics have sensationalized the Abel monograph, waving it from the podium, or creating banner headlines in newsletters and magazines, both the subject matter and the author deserve much more conservative and sober treatment.

This is the result of a collaborative effort by hundreds of oncologists. Rightly, it should be considered a consensus document.

In the first place, it should be read slowly, and its referenced citations should be reviewed. What at first glance looks like a quick ***65*** pages rapidly expands to thousands of pages of technical reading.

But taking the sober-sided approach leads one to conclusions different from those who created the "first wave of publicity".

Consensus document

This document is not a "blow to the cancer establishment". Dr. Abel *is* the cancer establishment.

"The reproach that clinical oncologists correctly raise against therapists favoring unconventional methods, that they are unable to give scientific support to their claims, reflects on (the oncologists) themselves."

— U. Abel

Neither is it an attack on oncologists. On the contrary, this is the result of **a,** *collaborative effort by hundreds of oncologists.* Rightly, it should be considered a *consensus document.*

What it shows us is a profession in flux, dissatisfied with ineffective or marginally effective drugs, disillusioned by the failure of clinical trials to produce replicable results, willing to admit the failure of chemotherapy to live up to most expectations.

First **hand** experience

The story behind the report is that Abel himself spent 10 years in yeoman's service as a clinical oncology statistician. He kept track of the data, beginning each clinical trial with a series of methodology meetings where decisions were made regarding the endpoints of the study. Did physicians expect patients to feel better, live longer, experience partial or complete remissions of tumors?

A clinical trial, by itself, is not the start of anything; it's the middle. Much has gone on before. At most research centers around the globe, most clinical oncology trials are extensions of previous labors. In other words, trials are based on the results of previous trials. Someone says it works. Someone else gets excited and tries it.

As Abel collected and interpreted data over the ten year period, he was disappointed by the results of treatment. And he began to wonder about the veracity of reports by people who said the drugs worked.

A clinical trial, by itself, is not the start of anything; it's the middle.

Questioning claims

He began the practice of reading and evaluating anew the data of trials whose published conclusions were behind each current methodology meeting. His efforts revealed *'Yhat while oncologists often refer to results of clinical trials for various chemotherapy regimens and use these results as a basis for new studies, a sober and unprejudiced analysis of the literature*

has rarely revealed any therapeutic success by the regimens in question. Such a misjudgment is by no means harmless; it is not only ethically serious, for it may result in unnecessarily burdening patients with toxic effects, but it is also questionable from a scientific point of view. From my own experience and as documented in the literature, it leads to an almost dogmatic belief in the efficacy of chemotherapy.

Perhaps the most valuable aspect of Abel's work can be best seen through the lens of medical sociology. Abel has questioned the methods used by clinical oncology to acquire knowledge, and he has tested the acquired knowledge of the field for limits and validity.

Oncologists agree

It was time for the door to be opened. Abel was concerned that his review would devastate, emphasizing as it does the failure of chemotherapy to extend survival in almost all cancers, and the wide-spread fallacies within the profession. "Surprisingly," he writes, "the conclusions regarding the effects of chemotherapy on the survival of cancer patients have met with almost unanimous agreement in the numerous personal communications I have received. Although critical publications on the value of chemotherapy in epithelial cancers do exist, the personal views of many oncologists seem to be in striking contrast to communications intended for the public."

Such cancers are considered advanced when they have spread, recurred, or are inoperable or incompletely operable.

Indeed, as Abel recounts it, many oncologists wrote to him stressing that they use chemotherapy not in an attempt to extend survival, but only to palliate, to relieve symptoms, and improve the quality of life.

And Abel cautions, "While by its very nature, a general refulation of this argument is impossible, a close analysis of the controlled clinical trials addressing the question of quality of life of cancer patients shows that, again, reality does not quite agree with the ideas and wishes of many therapists."

From the enlightened perspective of the epistemologist, Able comments on the big picture, "given the lack of success, the present concentration of clinical capacities on chemotherapy trials is hardly justified."

No room to criticize

And in a sentence, Able suggests rather a level playing field by saying, "the reproach that clinical oncologists correctly raise against therapists favoring unconventional methods, that they are unable to give scientific support to their claims, reflects on (the oncologists) themselves."

The monograph is not a finished product, in that it was intended by Abel to inspire animated scientific discussion.

DeVita's enthusiasm was dismissed by Abel, who referred to DeVita's conclusions as "an enormous extenuation of reality."

Subject of the report

More than 8 out of every 10 cancer deaths are due to epithelial malignancies. The epithelium is a layer of cells forming the epidermis of the skin, and the surface layer of mucous membranes and serous membranes. Epithelial malignancies are the ones most people get: bladder, breast, colorectal, ovarian, cervical, uterine, liver, pancreas, stomach, lung, bronchial, tracheal, and head & neck.

The monograph deals with positively reported clinical trials of chemotherapy for advanced epithelial cancers. Such cancers are considered advanced when they have spread, recurred, or are inoperable or incompletely operable.

Names attached to some of the most influential claims of positive results are Vincent DeVita (former NCI chief), Bruce Chabner (currently of NCI). Abel points out that DeVita considers all people with spreading inoperable cancer appropriate candidates for chemotherapy.

"While oncologists often refer to results of clinical trials for various chemotherapy regimens and use these results as a basis for new studies, a sober and unprejudiced analysis of the literature has rarely revealed any therapeutic success by the regimens in question. Such a misjudgment is by no means harmless; it is not only ethically serious, for it may result in unnecessarily burdening patients with toxic effects, but it is also questionable from a scientific point of view. From my own experience and as documented in the literature, it leads to an almost dogmatic belief in the efficacy of chemotherapy."

— U. Abel

DeVita discounted

DeVita's enthusiasm was dismissed by Abel, who referred to DeVita's conclusions as "an enormous extenuation of reality." DeVita concluded that the observed 30% increase in 5-year- survival rates since 1950 was due to the introduction of chemotherapy. Abel points out that a statistical mirage was

created by researchers who mistakenly pooled the data from local and disseminated disease, and failed to account for improvements in early detection, earlier and perhaps more definitive primary therapy (usually surgery), and "stage migration" (Feinstein, 1985; also, please see *Healing* 20&21, Jul.-Oct., 1987, "Comprehensive Government Report Challenges NCI Claims" for a complete discussion of "lead time bias", "length bias", "stage migration", "overdiagnosis", "self-selection", and "improved reporting" as the major statistical influences leading to DeVita's impression that 5-year-survival rates had climbed since 1950). Abel denied the validity of comparisons to historical controls. He also stressed that only randomization can provide the basis of comparison either to historical controls, or between multiple patient groups receiving simultaneous treatment in different hospitals.

Criticizes Bailar and Smith

While industry skeptics may applaud Abel for debunking DeVita, one would expect less enthusiasm for his critique of Bailar and Smith ("Progress against cancer?" *NEJM* 314:1226-32). He holds that therapeutically increased survivals in the absence of increased cure rates would be missed by the methods of Bailar and Smith due to the inclusion of both healthy and diseased persons in their death rate analyses. Their method confused the effects of risk factors (incidence rates) with therapy (lethality of diseased persons), Abel said.

In another surprising acknowledgement, Abel allows that subgroups of patients may exist in which there is a beneficial effect of treatment by chemotherapy. Either the groups or the effect might be undetectably small by statistical analysis. This is actually a consideration of interest to advocates of unconventional cancer managements, as well.

Tumor growth rate

While reminding the reader that unusually long survival of individual patients cannot be regarded as proof for the effectiveness of chemotherapy (because untreated patients can enjoy the same unusually long survival), Abel points out that the best prognostic indicator may be the growth rate of the tumor. Pearlman ("Doubling time and survival time" in *Cancer Treatment: End point valuation,* pub. J. Wiley, Chichester, NY) concluded that tumor doubling times follow a log-normal distribution; and that the number of tumor doublings until death is always the same regardless of varying treatments.

Upholds need for randomization

In another note at variance with the intellectual trends popular among advocates of unconventional treatments, Abel adamantly refutes those who claim that he overemphasizes randomized studies and fails to do justice to modern complex treatment strategies which are geared to individual patient difference~.If the therapy follows rational criteria, it can be evaluated in controlled clinical trials, he says. Ethically, any therapy aimed at routine clinical practice must be so evaluated.

Cancer by type

Small-cell lung cancer is the only advanced epithelial carcinoma for which good direct evidence of extended survival exists. However, the survival edge amounted to only 2-3 months when compared to untreated controls. Interestingly, with far fewer side effects, hemibody radiotherapy produced survivals of seven months compared to the chemotherapy group's three months. It should be noted that untreated people tended to die within a median of 2 months. Due to extremely low rates of partial or complete response (duration of minimum one month), and lack of effectiveness in attempts at long-term palliation, none of the treatment options should be considered standard for this disease.

Non-small-cell lung cancer, like small-cell, benefits only slightly from chemotherapeutic treatments alone or in conjunction with radiotherapy. The studies promoting survival advantages in chemotherapy treated patients were small and less well designed than those for small-cell. The survival difference between treatment groups and controls was never more than several months.

Colorectal carcinoma is not affected by chemotherapeutic treatments. Abel cites Moertel's 1982 retrospective study ("Large bowel" in *Cancer Medicine,* Lea & Febiger, Philadelphia) of comparable groups, one intensively treated and the other minimally treated, which found very similar survival curves: Citing Moertel's 1990 publication (NEJM322:352-58), Abel called it a well designed 3-arm trial which showeb a statistically significant disease free (time before recurrence) survival advantage for levamisole and 5FU when compared to levamisole alone or observation (no treatment). However, the significant data were restricted to only one stage of the cancer, and this could not be logically explained. The study, by itself, is inconclusive. The survival edge could be measured in months.

Gastric cancer is not manageable by chemotherapy for any length of time with any one agent or any combination of agents at any dosage for any duration. Only three randomized studies, all negative, have addressed survival.

Pancreatic cancer is always treated with chemotherapy when patients consent. Response rates are 30%, but survival rates in the three randomized studies which addressed them cannot be said to have been positively affected. In the study with the most dramatic conclusions for survival extension (Mallison, *Brit.Med.J.* 281:1589-91), of 40 patients, only 15 cases had spreading cancer, and 14 were not biopsied.

Bladder carcinoma responds to combination chemotherapyfrom 30% up to 80% depending on the regimen. Zero clinical trials have addressed the question of improved survival. In the published studies there have been no noticeable survival differences between any of the groups.

Small-cell lung cancer is the only advanced epithelial carcinoma for which good direct evidence of extended survival exists. However, the survival edge amounted to only 2-3 months when compared to untreated controls.

Breast cancer receives the greatest share of chemotherapeutic drugs. In all of the published trial results, there is no direct evidence that chemotherapy prolongs survival of breast cancer patients. There have been no controlled trials with untreated people. Neither have there been trials which establish either sole agent or combination therapy as superior. Abel says that it is really amazing that, with the enormous number of Phase III trials which have been conducted, never have there been any findings of a distinct or reproducible survival advantage. In reality, the only increase with more aggressive treatment is in toxicity. Two strong statements are found in the concluding remarks for this disease. Abel writes, "After close and critical consideration of all available relevant data and studies, one has to conclude that there is neither direct nor indirect evidence that, on the whole, cytotoxic chemotherapy improves the prognosis of patients with advanced breast cancer." Abel quotes Macaulay and Smith ("Advanced breast cancer" in *Randomized trials in cancer,* Raven Press, NY), "There is no evidence that asymptomatic patients need any form of active (chemotherapeutic) treatment."

Ovarian carcinoma is considered sensitive to chemotherapy. Most oncologists are convinced that chemotherapy extends survival for this malignancy, even in advanced stages. There never were randomized trials with untreated controls. There have been no randomized pure dose-effect studies. The ranges of published remission rates, even for the same drug or combination, are extraordinarily wide. Cisplatinum achieves the highest response rate. There is no correlation between high response rates and extended survival. None of the combinations was found to be an improvement. Cisplatinum-containing regimens probably can prolong the survival of some ovarian cancer patients in a not too advanced stage of the disease, but its toxicity is great and many patients are forced to discontinue it. Abel concludes, "Contrary to published and widely accepted statements by oncologists, one should note that, to date, there is definitely no evidence that patients with advanced ovarian carcinoma (whether of stage FIGO III or IV) can be cured."

'Contrary to published and widely accepted statements by oncologists, one should note that, to date, there is definitely no evidence that patients with advanced ovarian carcinoma (whether of stage FIGO 111 or IV) can be cured."

— U. Abel

Cervical carcinoma and carcinoma of the corpus uteri have not been subjected to much study. Radiotherapy is the treatment of choice in most centers for cervical cancer. In metastasized cervical carcinoma, there appears to be a survival advantage for chemotherapy and radiation versus radiotherapy alone. There may be a slight radiation enhancing effect in the drugs. Again, survival advantages are measured in weeks or, at best, months. Only two randomized trials have been conducted for endometrial cancer, and no survival benefit was observed, as with cervical cancer.

Head and neck cancer is a cancer in which chemotherapy may relieve symptoms effectively in some cases, but survival has not been affected by the drugs in any of their usages, including induction therapy aimed at making cancer more treatable by surgery and/or radiation. There is no added value in combinations versus single agents.

Unwarranted optimism

Well over four decades have passed since the first malignant tumors shrank in response to David Karnofsky's clinical applications of nitrogen mustard chemotherapy. At the time, the recent advent of the wonder drug penicillin made the magic bullet concept plausible. Generous media attention, tremendous enthusiasm on the part of pioneering clinicians, and desperate public need all fed a feverish zeal for more research. And there was more research.

Tons of research

Former NCI chief Vincent DeVita called cancer the most "treatable" disease. I think we should refer to it instead as the most "researched" disease. It is really quite impossible for the mind to grasp how much research was conducted by NCI alone last year with its $1.6 billion budget. There have been twenty consecutive years of such NCI budgets (adjusting for inflation). NCI is the world's largest, but certainly not its only centralized research machine. Huge budgets feed many other institutions in the U.S. and around the globe.

With so many scientific initiatives aimed at testing anticancer drugs, how did it come to pass that we did not know, and many still do not, that most cytoxic drugs perform poorly, if at all, in aggressive treatment efforts to extend survival or even to improve quality of life for the great majority of people with cancer?

Truth be told, methodology and biometry forty, thirty, and even twenty years ago were nowhere near the rigorous disciplines we now take for granted. People collected inappropriate data, asked questions toward which the data were ill suited,

and reached fallacious conclusions with inadequate support.

Aggressive true believer

And yet, believers understandably want to go on believing. The more passionate, the more adamant. I well remember June of **1987,** as the U.S. Office of Technology Assessment review of "Unconventional Cancer Treatments" (UCTs) got underway with its first advisory panel meeting. Quite a few members of the panel were convinced that only the UCTs lacked solid backing data. I was the lone critic at that first meeting as I suggested that Martin Shapiro (Assoc.Prof.Med.UCLA) and others had recently found the methodology for a large number of randomly selected chemotherapy clinical trials so flawed that they declared their conclusions for survival benefits invalid.

The question on the floor was "How should one go about evaluating UCTs?" I pointed out that modern critical reassessments strongly suggested that even conventional treatments had not yet been adequately evaluated.

"I can still hear panelist Grace Monaco trying to drown me out — she literally jumped up from her chair and shouted her objections — as I forwarded the suggestion that the question should instead be 'How should one go about evaluating any cancer treatment?'"

— G. Hildenbrand

I can still hear panelist Grace Monaco trying to drown me out — she literally jumped up from her chair and shouted her objections — as I forwarded the suggestion that the question should instead be "How should one go about evaluating any cancer treatment?"

Panel chair Rosemary Stevens deftly steered the meeting back to high ground. Her skills prevented numerous train wrecks during the study's emotionally charged sessions.

What went wrong?

In his monograph, Abel takes pains to explain each of the common errors of method which have dominated clinical trials since the introduction of cytotoxic chemotherapy forty-five years ago. Where possible, he offers solutions.

Misinterpretation of data is called bias. Uncorrected bias can totally invalidate otherwise sound research.

It is probable that the apparent survival gap between groups is made to appear larger because of accelerated deaths of weaker patients damaged by the toxic drugs whose side effects are better tolerated by the stronger patients.

Time-to-response bias and solution

Abel suggests a correction for the now-classic error of comparing "responders" (who are likely to be stronger and live longer regardless of treatment) to non-responders (who are likely to be weaker and die sooner). This error produces a "time-to-response bias", which has been, and unfortunately remains the most frequent methodological error.

Abel's suggested solution could revolutionize cancer chemotherapy clinical trials, pointing to J.R. Anderson's "Analysis and interpretation of the comparison of survival by treatment outcome variables in cancer clinical trials", Cancer Treatment Rep. **69, 1139-44.** The "landmark" method suggested by Anderson, says Abel, can completely eliminate differences between responders and non-responders. Essentially, observers should wait, Abel asserts, until a set point in time, say 3 months or 6 months, and then compare only survival information. The "landmark" method has not caught on.

Overtreatment **of** non-responders

In many cytotoxic drug trials with flawed designs, it can be argued that their time-to-response bias has a complicating factor built in. Weaker patients are probably more susceptible to damage from drug side effects. Therefore, it is probable that the apparent survival gap between groups is made to appear larger because of accelerated deaths of weaker patients damaged by the toxic drugs whose side effects are better tolerated by the stronger patients.

Selection **bias**

Failure to insure that all arms of a trial have patients whose tumor growth rates and other variables have been properly randomized creates a selection bias. If evaluators fail to take into account the interval between surgery and recurrence, or the rate of tumor doubling, it is possible that one or another of the treatment groups will have a greater number of slow growing tumors. This will create the illusion of survival benefit.

Even if there may be a few who actually receive survival benefit from chemotherapy, if the same drugs cause earlier deaths in others, this becomes a kind of "trade off" which may be completely unethical.

Ethics

Abel raises the very real concern that, even if there may be a few who actually receive survival benefit from chemotherapy, if the same drugs cause earlier deaths in others, this be-

comes a kind of "trade off" which may be completely unethical. It is ironic that numerous trials exclude treatment related deaths on various grounds, evaluating only those who were not harmed by treatments.

Basic postulate

In the U.S. and abroad, the cancer research industry operates on the assumption that better tumor kill leads to longer life. All funding and efforts are essentially channeled in that direction. While Abel does not agree with the prevailing logic, he feels that it can be studied.

Abel suggests a testable postulate (P) based on the hypothesis that more tumor kill in more patients indicates increased survival rates. "Of *two therapies yielding different response rates, the one giving the higher rate should be superior as to survival; this difference must be demonstrable in randomized studies and it must be reproducible."*

Eliminating the existing literature

How does one, whether deeply trained in statistics or not, learn to evaluate the conclusions of studies as they appear in the literature? One may infer several clear suggestions from Abel, all of which stem from the above postulate.

1. Throw out any studies which eliminated patients. Look for the key words "evaluable patients".
2. Throw out any single, unreplicated studies on the grounds of probable selection bias.
3. Throw out overview papers which suggest statistical correlation between response and survival in *multiple single studies.* (Abel points out that viewing such reviews under the lens of P reveals that groups with the better prognosis *always* end up in the same arm of the trial, and that should not be possible.)

Hallmark variables affecting response rates

Abel offers a laundry list of variables that must be randomized in order to eliminate as much error as possible. They are:

1. Extent of spreading disease
2. Organs or structures infiltrated
3. Biology (behavior) of tumor, e.g.: rate of doubling
4. The treatment (which drugs, etc.)
5. The dosage, timing, and duration of treatment
6. Any previous treatments
7. Criteria for response (how to measure remission)
8. Judgment errors (how good is the researcher's eye?)
9. Exclusion of patients (which Abel disagrees with)
10. Statistical variability

Comparison of randomized trials

Since much has been made of randomized clinical trial generated proof that multiple drug regimens *do* indeed yield remarkably higher response rates, such treatments have virtually become the worldwide standard. But do people receiving those treatments live longer?

However, looked at individually, one trial's 50% response is coupled to a median survival of only 13.5 months, whereas another's response rate of 45% has a median survival of 15 months, and yet another's response rate of only 40% shows a median survival of 19 months!

In a critical review of all randomized studies greater than forty patients which pitted cisplatinum combinations (A) against non- cisplatinum combinations (B), survivals did not follow responses.

Responses for A ranged from a low of 8% to a high of 50%, while median survival spanned from a low 9.8 to a high of 18.5 months.

Responses for B ranged from a low of 11% to a high of 62%, while median survival spanned from a low of 11 to a high of 20 months.

In 27% of the trials, survival in the lower response arm actually exceeded that of the high response arms.

However, looked at individually, one trial's 50% response is coupled to a median survival of only 13.5 months, whereas another's response rate of 45% has a median survival of 15 months, and yet another's response rate of only 40% shows a median survival of 19 months! Clearly, there is no evidence to support the claim that increased responses yield increased survivals. Abel states that this is true even when one drops the requirement for statistical significance — there is still no direct evidence under the lens of P.

Survival in lower response arms

Although R.P.A. A'Hern argued that his survey of 79 studies provided convincing evidence for survival benefit in the high response arms of trials ("Does chemotherapy improve survival in advanced breast cancer? A statistical overview", *Brit.J.Cancer* 57, 615-618, 1988), Abel points out that in 27% of the trials, survival in the lower response arm actually exceeded that of the high response arms. *This* observation is the one of note, says Abel. It strongly undermines the argument that high rates of tumor response correlate to increased survival. In fact, Abel is uncompromisingly critical of the fact that A'Hern's findings are exactly those one would expect if responders are actually a selection of patients with favorable prognosis.

Abel expresses more interest in a new look at such studies as one conducted by T. Buroker and Chas. Moertel ("A

Questions for study

Abel suggests research aimed at two questions. For each of the questions, he has suggested multiple possibilities. They are listed below for convenience.

I. Why does complete remission not imply clinical cure? Because tumors recur due to:

A. Biochemical resistance to cytotoxic drugs.

1. The larger the tumor, the more resistance.
2. Cells can become resistant to all drugs.
3. Complete remissions are not reproducible in the same patient, even with new drugs.
4. Drugs themselves cause the resistance.

B. Genetic instability of tumor cells.

1. Cells change genetically—a moving target.
2. Metastases change even faster.

II. Why does partial remission not prolong survival?

A. 50% reduction may not be enough.

B. Location must also be considered.

C. Drugs themselves can *enhance* malignancy.

1. Drugs can suppress immunity.
2. Drugs can cause vascular damage.
3. Drugs can cause genetic mutation.
4. Drugs can alter gene expression.
5. Drugs can amplify genetic resistance.
6. Drugs can cause metastases in sites where they would not usually occur.

randomized comparison of 5-FU containing combinations with 5-FU alone in advanced colorectal cancer," Proc. Amer. *Soc. Clin. Oncol.* 3:138, Abstr. C-537, 1984). In this study, combination chemotherapy produced a 32% response rate with median survival of 8 months, whereas 5-FU alone mustered only a 15% response rate but median survival was **12** months or ***50%*** greater than the high response group.

Macaulay and Smith

Abel was sufficiently impressed with the conclusions of V. Macaulay and I.E. Smith (Advanced Breast Cancer in Slevin, M.L., Randomized trials in cancer: ***A*** critical review by sites, Raven Press, NY), that he quoted them, and the quotes are certainly worthy of repeating here verbatim:

"The single most disturbing feature of the trials reviewed here has been the great emphasis placed on the response rate as the most important and frequently the only parameter by which therapeutic benefit is assessed."

"Response rate alone is a poor parameter by which to assess therapeutic benefit in advanced breast cancer; it does not predict survival, and its effect on quality of life is very much determined by the nature of the treatment used."

Chemo after surgery

Once it had become apparent to many in oncology that chemotherapy in all forms, combinations and modalities had failed to answer advanced epithelial cancers, hopes shifted to adjuvant usages, intent on boosting the effectiveness of potentially curative surgeries, Abel recounts. Because the hope for this type of benefit pervades modern oncology, Abel evaluated literature often cited to support it.

Only works in premenopausal breast cancers?

His conclusion, stated flatly, is that "good and consistent evidence of beneficial effects of adjuvant systemic chemotherapy on survival exists only for breast cancer, and more specifically, for patients with at most three positive nodes." Moreover, he says that it remains unclear whether adjuvant treatment actually produces more cures and lowers mortality rates, or whether it only delays recurrence and progressive disease.

It is possible that the survival benefit conferred on premenopausal breast cancer patients by chemotherapy does not result from any cytotoxic effect of the drugs,' but rather from an inadvertent chemical suppression of ovarian function.

Abel notes, in passing, that although no chemotherapy studies show survival benefit for postmenopausal patients, "some effect can be obtained with hormonal therapy (tamoxifen)."

Why?

Pursuing what must be regarded as a "strange" susceptibility of only premenopausal breast cancer to adjuvant chemotherapy (out of all epithelial cancers and even against postmenopausal breast cancer), Abel puts forth an appealing argument. It is possible that the survival benefit conferred on premenopausal breast cancer patients by chemotherapy does not result from any cytotoxic effect of the drugs, but rather from an inadvertent chemical suppression of ovarian function. He holds that this is an opinion widely accepted in Great Britain, citing a personal communication with M. Baum.

Removal of ovaries has been shown in randomized trials to confer survival benefit in premenopausal breast cancer. Results of chemotherapy and ovarectomy have never been compared. An alternative to ovarectomy, "ablative" treatment with leutinizing hormone release hormone analogs (e.g.: Zoladex), is currently the subject of a randomized *trial* begun in 1990.

"Response rate alone is a poor parameter by which to assess therapeutic benefit in advanced breast cancer; it does not predict survival, and its effect on quality of life is very much determined by the nature of the treatment used."

— V. Macaulay and I.E. Smith

Colorectal

Abel nods, as well, to literature (Soybel, 1987; Metzger, 1989) which provides good evidence that, after potentially curative surgery, disease free survival for completely resected colorectal cancers may be prolonged by adjuvant chemotherapy, including non-systemic approaches like intraportal infusion.

Quality of life

Abel points out that the U.S. Food and Drug Administration requires evidence of either prolongation of survival or improvement in quality of life (QL) for approval of new cancer drugs.

QL is a quagmire. Quoting I.C. Henderson (in *Oncology colloquium I. Therapeutic strategies for metastasized mammary carcinoma,* Walter de Gruyter, Berlin and New York), "It is almost impossible to separate subjective response from the individual judgment of response. Thus there are patients who can endure severe pain but who are unable to suffer the slightest nausea. Others accept all kinds of side effects if only their pain is alleviated so that they can work or actively take part in daily life. In addition, the results from studies that assess QL cannot be generalized and applied to other countries because QL depends very much on the specific culture area; and it will be defined in a rather different way by individuals living, e.g., in Great Britain, the U.S., or in Germany."

Early studies of QL in chemotherapeutic trials discovered the obvious. People feel worst when they take the drugs, and gradually recover from the toxic effects. This prompted R. Gelber and A. Goldhirsch to propose a new variable as endpoint, "Time Without Symptoms of disease and Subjective Toxic effects of treatment" (TWIST) ("A new endpoint for the assessment of adjuvant therapy in postmenopausalwomen with operable breast cancer," *J.Clin.Oncol.* 4:1772-79, 1986).

So why do people get chemotherapy?

Chemotherapy can. sometimes provide dramatic relief of symptoms, as in the case of pleural and other types of effusions, severe pain, and the endocrine effects of lung and kidney tumors or endocrine tumors. Abel rightly states that the effects are so clearly visible that they need not be verified by clinical trials. But these palliations do not justify giving the drugs to people without symptoms.

Oncologists are egged on by the literature.

Abel lists three reasons chemotherapy is given to people who do not need it and will not benefit from it.

1. Oncologists believe the drugs will work.
2. Oncologists follow protocols of clinical trials.
3. Desperate people with cancer ask for the drugs.

Oncologists are egged on by the literature. Take, for example, the following quote from the protocol of the Mannheim Oncology Center, "For the reasons given above (achievement of a high rate of complete remissions with the chance of a real prolongation of survival) it appears justifiable to use this relatively toxic but obviously highly effective combination in primary treatment of metastasized breast cancer."

Perhaps the strongest argument against positive findings in clinical trials which have attempted to measure quality of life is that patients who suffer most from toxic effects of drugs simply die and are excluded from follow up.

Abel names Drings, Greenfield, Breslow and Cumberland, and I would like to add Chabner and DeVita, as authors who advocate greater and more aggressive use of chemotherapy routinely in virtually all palienis.

Others, according to Abel, lead the crusade toward ever higher dosages. Named are Chokski, Israel, Hryniuk, Hillemanns, Karrer, Sheel and Aumeuller, who is quoted as saying, "a small compromise in the dose may cause an enormous loss of success."

The dead are silent

Perhaps the strongest argument against positive findings in clinical trials which have attempted to measure quality of life is that patients who suffer most from toxic effects of drugs simply die and are excluded from follow up. Abel asks us to imagine a treatment that is lethal to all nonresponders, and points out that a trial of such a treatment under popular methodologies could actually lead to positive QL findings.

"To date, there have been no randomized studies yielding clear evidence for an improvement of QL by means of chemotherapy," Abel says.

QL measured in randomized trials

K.R. Durrant ("Comparison of treatment policies in inoperable bronchial carcinoma," *Lancet* i, 715-19, 1971) wrote, "Our results provide no evidence that immediate treatment by irradiation or mustine leads to prolongation of survival or to prevention of incapacitating

symptoms in patients with inoperable carcinoma of the bronchus."

"Good" or "excellent" quality of life lasted longer in untreated patients who enjoyed freedom from symptoms and ability to get out of the house, while responders in the treatment group who escaped the 2 month 48% death rate had the best control of symptoms in A.H. Laing's "Treatment of inoperable carcinoma of bronchus", Lancet ii, 1161-65, 1975.

Theodore Lad ("Immediate versus postponed chemotherapy for unresectable non-small cell lung cancer: A randomized trial," Cancer Treatment Rep. 65, 973-78, 1981) wrote, "Little benefit from immediate combination chemotherapy is evident. Such treatment for patients with unresectable non-small cell lung cancer with minimal symptoms should not be considered beneficial until well-controlled trials demonstrate improvement in the quality of life or a survival advantage."

"To date, there have been no randomized studies yielding clear evidence for an improvement of QL by means of chemotherapy," Abel says.

Criticism of the Coates trial

A. Coates ("Improving the quality of life during chemotherapy for advanced breast cancer," New *Engl.J.Med* 317:1490-95, 1987) has inspired many oncologists to use chemotherapy with the intention of getting results like his. He wrote, "Those concerned about the toxicity of chemotherapy will find reassurance that continuous treatment was perceived by our patients as providing a better quality of life during chemotherapy for metastatic breast cancer."

Abel points out, however, that QL was assessed only after patients recovered from each treatment, when they were coming back in to receive another. Naturally, descriptions of toxic effects and their resultant symptoms were largely absent in responses to questions from physicians who administered the evaluation. Just the fact that the doctors themselves asked the questions could easily have prompted more positive responses than might have been given a neutral party. Also members of the responding group had many more contacts with physicians than did the comparative arm, leaving the impression of a bias created by intensity of care. Abel concludes that the results of the study "are of little value with respect to QL."

"There cannot be any doubt that, at present, clinical oncology is in a sort of deadlock which it will leave only by small steps and after possibly painful insights," summarizes Abel.

Use your imagination

Abel admonishes that modern study designs which allow complex therapeutic strategies tailored individually, and sequential plans, should be used. He says, "the ethical concerns are largely devoid of any foundation; rather they witness a lack of scientific imagination."

Don't give it; I wouldn't take it

Abel points out that a 1988 Consensus Development Conference (Munich Med. *Wschr.* 130:93-102, 1988) advised against overuse of chemotherapy saying, "For most patients with metastasized disease one should start with endocrine therapy as a first-line treatment."

Polls have indicated that oncologists themselves would refuse chemotherapy (H.H. Hansen, "Advanced non-small-cell lung cancer: To treat or not to treat? *J.Clin.Oncol.* 5:1711-12; and M.J. Moore, "How expert physicians would wish to be treated if they developed genito-urinary cancer," Proc. *Amer. Soc. Clin. Oncol.*, 7:118, 1988).

Deadlock

"There cannot be any doubt that, at present, clinical oncology is in a sort of deadlock which it will leave only by small steps and after possibly painful insights," summarizes Abel.

It is impossible to convince ethics committees to use no-treatment or postponed-treatment arms, because chemotherapy is widely regarded as the "best available treatment". Oncologists believe in it. The efficacy of chemotherapy, Abel says, assumes the character of a dogma.

Abel asks us to imagine a treatment that is lethal to all nonresponders, and points out that a trial of such a treatment under popular methodologies could actually lead to positive QL findings.

Although good evidence points to treatment of only certain select symptomatic patients, those without symptoms are routinely treated. Other valid, well researched possible treatments are simply not studied. Clinical oncology has become a prisoner of its own tenet, according to Abel.

There are other ways

Abel himself has advocated serious study of the antineoplastic effects of fever inducing bacterial toxins ("Die antineoplastische Wirkung pyrogener Bakterientoxine," in Hager & Abel (Hrsg.): *Biomodulation und Biotherapie des Krebses, Bd.* 2, Verlag feur Medizin, Heidelberg, 1987). He says that "for an outsider it must be incomprehensible why therapeutic concepts that have shown antineoplastic effects in animal experiments for decades and whose anticancerous effects in man are documented by promising

evidence are not examined in controlledclinicaltrials."

He points to striking and encouraging results in adjuvant immunotherapy published by Hoover, Watanabe and Iwa, Windle, and the Cervical Cancer Immunotherapy Group which should have lead to many more studies but, because of the pervading atmosphere, have not.

Abel asks us to imagine a treatment that is lethal to all nonresponders, and points out that a trial of such a treatment under popular methodologies could actually lead to positive QL findings.

It seems certain that almost all forms of innovative cancer management suffer neglect for the same reasons. Such studies are justified. "However, the author of this report, like some of his colleagues, has had the regrettable experience that proposals for study designs in this direction are rejected for ethical concerns and without serious consideration. This situation is complicated by the fact that many clinicians who are convinced of the value of immunotherapy or certain unconventional methods (mostly without a sufficient proof) have similar reservations concerning the use of chemotherapy in randomized studies."

Yet, Abel remains optimistic that imaginative trial designs can solve most problems, even the mutual skepticism of both sides.

Summary of a summary

Abel has made his findings concrete. Reduced to the vernacular of middle America, they are:

- 80% of cancer deaths in western industrial countries are caused by advanced epithelial malignancies.
- Chemotherapy isn't worth a tinker's dam.
- Chemotherapy probably nudges a small survival extension out of small-cell lung cancer, but it hurts most patients.
- It may do the same, a tiny amount of good and a lot of bad, for ovarian cancer patients.
- Tumor shrinkage caused by chemotherapy does not imply extension of survival.
- Chemotherapy has not been shown to improve quality of life.
- Oncologists shouldn't give chemotherapy to most patients, but they do anyway.
- No one is studying the problem properly.

"For an outsider it must be incomprehensible why therapeutic concepts that have shown antineoplastic effects in animal experiments for decades and whose anticancerous effects in man are documented by promising evidence are not examined in controlled clinical trials."
— U. Abel

Last comment

Chewing through Abel's monograph and the cited literature was a big job, rewarding, enlightening, and terribly frightening. He's right.

Every day, everyone here at the Gerson Institute talks to people with cancer who have had chemotherapy that hasn't worked and, for many, has made them sicker. But chemotherapy maintains its standing in the marketplace of medicine. Why?

Don't ask me. I just work here. ■

Gerson Institute seeks books for loan library

The Gerson Institute is building a loan library for patients and companions to use during their stay at CHIPSA. Books, video tapes and audio tapes have been donated by past patients and companions, including such diverse subject matter as medical physiology textbooks, political writings, practical living, organic farming, fiction, and the spiritually uplifting reading found in poetry and religious material.

The library was started with a generous donation of books and tapes from June Pollak, former secretary at the Gerson Institute.

"We want people to share whatever helped them," states Christeene Hildenbrand, recovered patient, and the impetus behind this project. "I love going to old bookstores. Now I arrive with a list, looking for copies of the books that helped me so much while I was on therapy. This has been my way to give back, to say thank you... to help."

If books and/or tapes were a vital part of your therapy, please write Christeene and let her know the names and authors, "I'll add them to my list" — or even better, donate a copy. All donated books and tapes will be identified with a label thanking the donor, and will be placed in the library at CHIPSA. Send books, tapes and correspondence to the Gerson Institute, PO Box 430, Bonita, CA 91908..

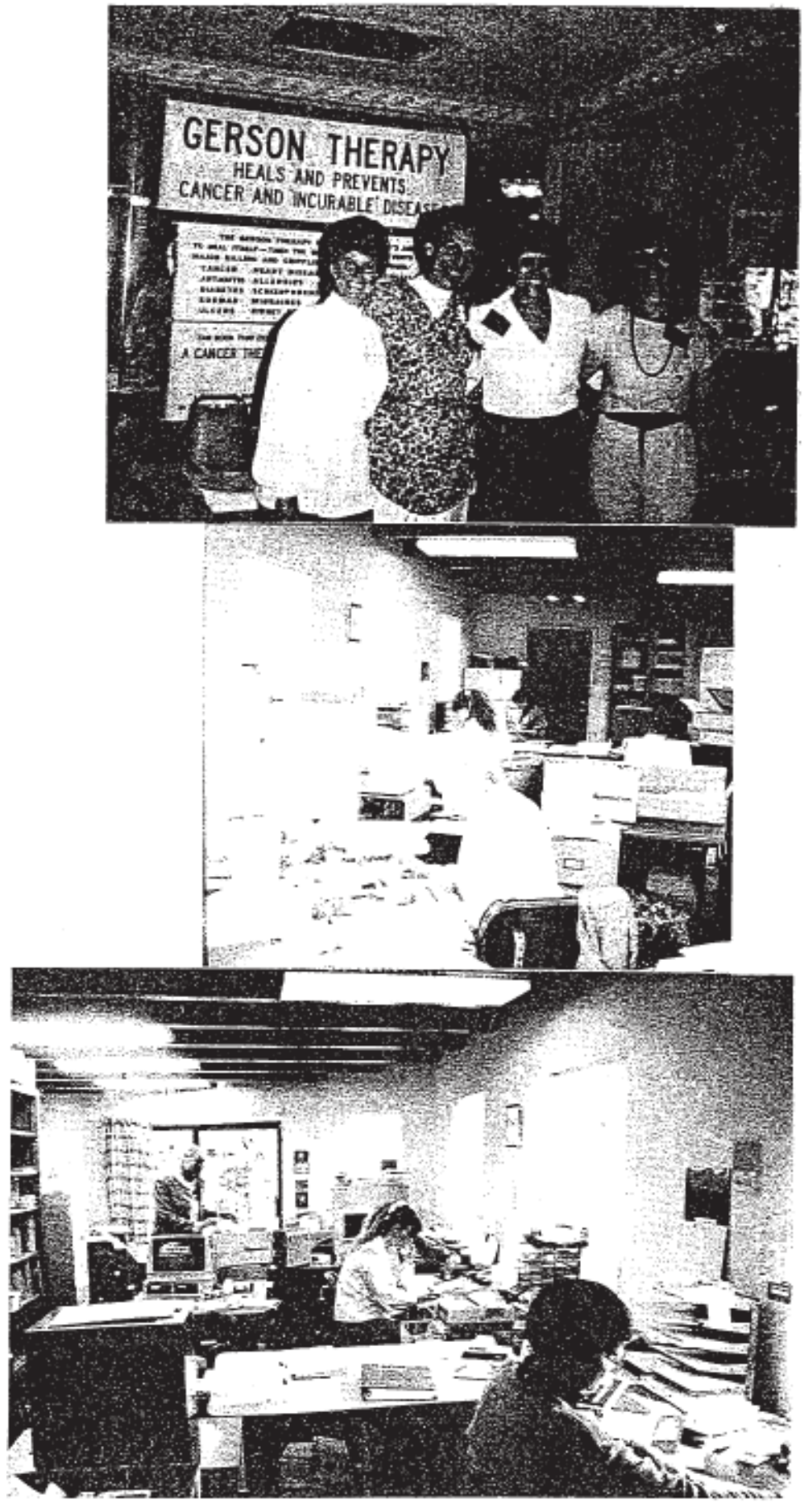
Gerson Institute Update

1991 saw many changes in the Gerson Institute. June Pollak, secretary since the Gerson Institute's early days, retired and moved with her new husband John to a beautiful, lakefront estate in Oklahoma. Her retirement well-earned, her presence in the office, her cheerful, gentle, helpful rapport will be sorely missed.

Norman Fritz and Charlotte Gerson began a series of seminar workshops crisscrossing the United States and Canada. Networking with existing organizations and individuals and saturating different areas with mass mailings, the seminars have reached thousands of people with information about nutrition and diet therapy. In the autumn they were joined by Marilyn Barnes, who augments their educational lectures and presentations of "cured incurables" with beautifully prepared "Gerson Meals," and at conventions she presents the "Gerson Organic Cafe". The Gerson organic food booth exclusively offers delicious completely organic dinners and a la carte foods similar to those served in the Gerson Therapy hospitals. What better way to learn about diet therapy than to eat the food and drink the juices?

Filmmaker George Powell, of Powell Productions, has just completed a beautifully made video to introduce people to the Gerson Diet Therapy. He is in the process of making educational videos to be used at CHIPSA, as well as documenting people who have been cured of disease while using the Gerson Therapy.

The opening of the CHIPSA facility in Mexico marked a momentous occasion, a milestone in the work of the Gerson Institute. We look forward to a rich and rewarding new year. —Ed. ■



CHIPSA opens
Thank you, donors!

George & Lillian Abrachinsky
Jamell J. Acree
Dr. Karl & Kiri Tamm Adam
Robert.& Doris Ahlers
Clarence & Ellen Ahlgren
Pat & Ron Ainey
Sulo I & Florence Alden
Lenora I Allan
Lee & Silja Allen
June Allen
Wendell & Virginia Allred
Dorothy Altman
Alfred & Jane Arnorosi
Jane Anderjack
Keith & Hanorah Anderson
John & Helen Anderson
Rosemarie Andrews
Dominic & Florence Antico
Fred Applegate
Rita Arditti
John E. Ashbaugh
Victor Ashby
Thomas Atherton
Yolanda G Attianese
Shirley Atwood
Virginia D Austin
Harry & Hilda Azoff
Roger Alan Bacon
Louis Bagi
R. Baker
Edna Baker
Kenneth John Baker, DO
John M Barry
Oliver J Barton
Mr & Mrs Thomas Bates
Thomas & Linda Bauer
Julius Baum
Jean Baxter
Frank A Bell

Robert A Belz
Gary Benson
Irving D. Berg, M.D.
Richard & Deborah Berry
Anthony & Olivia Berting
Bandel & Elizabeth Bezzerides
Richard A & Jane A Bialosky
Sister Mary Ann Bigos, MSC
Patricia M Billingsley
Maurine Binnie
Jerry P Birge
George Birnie
Winston K & Della M Bishop
Melva M Blackburn
Dr. Kem & Annie Blackmore
Ronald I Blewitt
Carl J Bodge
Evert & Ann Boerrigter
Richard A. Boger
Gerard J & Annette Bosse
Ernest & Fannie Joe Bouey
R. Bourque
Verna Bourquin
J.D. & Julia Braddock
Arthur & Martha Brady
Henry & Olive Branch
Beatrice M Braveman
William Breezny
Ardee Bridges
James & Louise Briggs
Hilda & Arthur Brodsky
De Louis Broughton
Elizabeth Brunette
Anton Brykeski
Willis H & Margaret Bucher
William A Bucke
Amy Buckheister
C. Budelier
Dr. G.A. Bullock

Elaine L Bultreys
Irene Burckhardt
Arthur H & Lois V Burgess
Francis M Burns
George Burns, Jr.
Mrs. Gerald Butler
V.N. Calasa
Eleanora S Calderon
Mrs. Patricia Caliva
Charles & Laura Call
Edward Carnmack
Bonnie & Sante Camo
Victoria Campbell
Lester Carl
John Carlson
Nancy C Carrison
Joseph John Case
Patrick Champigny
Tom & Judy Chilton
Phyllis & Arthur Choyke
Rose Shields Christensen
Jonathan S. Christie
Dr. Ruth Cilento
John & Iva Lea Clark
Bea L. Cleary
Hugh & Joan Cleary
Barbara Jeanette Cline
Arthur C & Mollie Cline
Ernest Coccari
Delores A Cogbill, NMD
J Crawford Compton, Jr
George & Hiltrude Conable
Lloyd & Elinor Conley
George & Wilma Cooke
Barbara J & Roy C Coons
W.L. Corbin Sr.
George & Dorothy Cornish
Raymond & Ora Coste
Celeste Counihan

July 1, 1991 the doors of Centro Hospitalario International del Pacifico, S.A. (CHIPSA) opened. CHIPSA is the first accredited hospital in the Western Hemisphere dedicated to the care of people with a wide range of diseases and using the Gerson Therapy as primary treatment. The Gerson Institute wants to thank the donors who helped make this hospital more than a dream. Today CHIPSA is a reality. Thank you.

J. Coutre
John & Annie Couwenberg
Viola & Alexina Craig
Mary L Cranstoun
Randy & Judy Craven
Thomas E Crawford
Lorna Crosby
Mrs. Lucette Cupparoni
Jane Ann Cutcheon
Norman F. Dacey
Anthony A Dargis
Binod & Nilima Dash
Richard S & Mary I Davies
Bettie Davis
Miss Zoe Ethel Davis
Agnes S. Davis
John R Davis Jr
John Dawson
Bobbi Giella & James Dawson
Athena De Felice
Mary & Tony DeBone
Marianne Delagnes
Barbara S Demarest
David & Flora Denison
Gisela Dennert
Ann Marks & Joram Diamant
Margaret A Dole
Robert Dorough
Herbert B Douglas
Abraham & Beverly Dowden
Thomas Doyle
Benjamin Drell
Emerson K Droullard
Bernadette Dumont
Jennie P. Dundas
Edwin C Dundas, Jr
Dr. Letty Dunning
Bernadette Duont
Madelaine A Dykema
Donald & Sophy Erdman
Mr & Mrs Clarence Ebey
Hans & Ingeborg Eckert
William Eddingfield
Leonard & Diane Edelman
Eva B & Jason Z Edelstein
Seyhan Nurettin Ege
Eugene J Egger Jr
Emma G Ehlke
Samuel & Rhea Eisman
Donald Ellison
Paula Engan
Evelyn R Engelberg
Mr & Mrs Don Erdman
Richard Ericson
Violet M Esterman
Elina G Estevanez
Orren Yuel Evans
Meta Eyerly
Arturs & Arija Ezergailis
A. Ezergailis
Mr & Mrs Lester Fabro
Irma & Peter Fahr
Nancy Fahrer
B Douglas Fahy
Mr & Mrs C.E. Fanning
Mrs Jean M Faoro
Terry & Myra Farling
John Favicchio
John F Fawley
William & Eileen Fedick
W.W. Fedoriw
Walter F. Felber
Paul L & Ruth M Fenton
Mrs James Ficher
Richard A & Frances Fife
Cleare & Anne Filer
Anthony J Filicicchia
Richard D Fischer, DDS
Mrs James Fisher
Roy & Priscilla Fisher
Mr & Mrs Edward Fitchard
Albert & Jilda Fitchett
Volney G Fleischman
Christa Fletcher
Roberta B Floden
David Forbes
Everett & Janice Ford
Bill Fortinberry
Agnes A & Mary Jane Fox
Frank & Shirley Fraser
Bob Fredricks
Iris Freelander
Robert O & Lonnie Frick
Eleanor Sufferin Friebely
Ruth Frifield
Lorna G & Glen Fry
Mrs Gertrude Fuehrer
Elizabeth L Fuller
Peggy E Futrell
Ralph G & Loretta Gabiner
Frank Gailey
Evan & Marie Galbraith
Katherine R Gallahar
Andrea Garnette
Charles & Cleo Garriott
Walter H Gehlert
Charles C Gerleman, DC
Gordon Gerstenkorn
Ilamae & Mark Gibson
Jeanne Yvonne Gignac
Dolores Gillelaw
Pearl O Gillis
Peggy Glasco
Linda Gochfeld, MD
Rose Gold
Judy G Golvin
Ludmila Goncharow

Eric & Friedel Goodman
Mrs. Ruth Goodman
Gregg & Margaret Goossens
Frances Gosling
Donald Gould
Ann Graham
Ivan Green
John C & Nina Green
Helen Greene
Patricia P Greenhood
Eugene S & Treva Griffin
Rebecca H Griffith
Henry B Groot
Constance Guertin
Daniel & Diana Guetzkow
William Gunn
Dr. Stanley & Floria Gutman
Susan B Hacker
Stanley & Elgera Hall
Roy S Hamaji,DDS
David S Handwerker
Mr & Mrs Ben Hansche
Doreen A Hantz
Dr & Mrs William Happ
William F Hardy
Dennis & Josie Hargrave
Roberta R.S. Harjes
Fannie L Harn
Irene S. Harrison
Mrs Grethe Hartelius
Willaim B Harvard
Oscar & Frida Hauben
Robert & Betty Haven
Roger A Hawley
Irene Hecht
Harry & Vivian Heid
Charles & Jeanette Heimbach
Mr & Mrs H A Hellberg
Norma Helwege
C.B. Henderson
Terry & Claire Hess
John E Heumann
Wilbur Hey
Norman Hickey Jr
Cynthia J Hicks, DC
Frederic & Frances Hill
Mrs Robert L Hirshberg
R.M. Hodges
William F Hoey III
Mike Hoffelt
Ronald & Ursula Holcomb
Marx M Holder
Carl A & Mabel G Holmblad
Marietta B Homberg
Charles & Peggy Homer
Vincent Homolka
Joseph & Donna Ifill Hooban
Ross Horne
William G & Jeanine Housley
Gwen Howard
Taras P Hrycyshyn
William & Blanca Hubbell
Marylo Hulscher
Margaret Hurley
H. Brooks & M. Huston
Lawrence & Marion Hutson
Roger A Hwley
Donna Iden
Robert & Alice Iliff
Pat Imperato
Mr & Mrs David Inhaber
Mr & Mrs K.L. Jackson
Madalyn Jenkins
Zelia M Jensen
Louis Jeranek
Shirley Ann Jobe
Robert F & Ruth Johnson
Clay H & Margaret R Johnson, Jr
Michael & Kathleen Jones
Carolyn Jones
Robert & Leona Jones
Carl & Phoebia Jorgensen
Martin & Maria Jung
Irene N Jurs
Robert & Rosemarie Kaas
Raymond Kabaker
Arnold Kadue
Charles R Kaelin
Edwin & Janet Kaiser
Patricia Kalebaba
Patricia Karnes
William Karstens
Rabbi Elihu Kasten
Duane & Mary Kaye
Paul Keene
Ruth Keisling
William & Dorothy Keller
Donald N. Kempen
Melvin Kent
Rebecca R. & Renee Ketcham
Ralph A Keyes
Mrs. Norman Kiel
Marcella King
Kim & Harvey King
Carl King
Diana B King
Matilda Kish
Stephen Klicek
S.H. & Faith Kline
Joseph & Sarah Ida Klipper
Dr & Mrs Verner Klotz
Jane Johnston Knapp
Evan & Vida Knodle
Fiona & Douglas Knox
June E. Koenig
Charles Kohlhase
Allan & Fern Kohn
Aaron L & Senta Kolom
Donna R Kontos
Karl Korn
Betty Jean Kraker
John Krueger
Chet & Eudora Kruppa
Curtis Kuehnast
Thomas & Bari Kurgan
Albert & Marjorie La Vigne
Peter & Carol LaGrasse
Mary Alletta Laird
Patricia Lambert
Conway & Mildred Lanford
Mrs. John Langhorne
John & LaVersa Langmacher
Chauncey L. Larmer
Dorothy Larson
Edward & Ruth Laskette
Waldtraut Seifert Lavroff
John V Lawyer
John E. & Lydia A LeCraw
Eugene & Miriam Lee
Nancy B Leibrock
Dale & Margey Lemly
David Lessner
Virginia L Lewis
Joyce E Lewis
Allison Lindau
Owen & Aiko Lindsay
Don Lindseth
Chen Hsieh & Sui Yee Ling
Florine J Linhares
Baye C Lippert
Mr & Mrs Joseph Lisa
Mary-Louise Littlefield
Janet Lonnegren
Dorothy Lourien
Gary Lucas
Bill Luce
Wilford H Luce
Otto M Ludwig
Henry W Ludwig
Louise E Luoma
Ruth H Lyle
Mrs. G. Lyons

Harold & Grace MacDonald
L.B. Maddison
Michael & Nickie Maffie
Michael D & Dorothy Magruder
Violet P Maguire
Larry Mallet
Yehuda Maner
Anni Mann
Ralph Marchese
Dr Walter & Betty Marcyan
Mr & Mrs Gerald Marholz
Robert L Marietta
Ann Marks
Donna R Marks
Igor Markstein
Karen G Marquardt
James Marshall
Ruth B Martin
Paul Martin
Mary R Mason
David Mathews
Sarah Lynne Mattick
Pat McClendon
Mrs James Ray McCleskey
Berk McCollom
Mr & Mrs W.H. McConnell
Darlene McCoy
Mary E McCracken
Kenneth E McDonald
Mary Alexandra McFadyen
Martin McGlinn
Helen McGugan
Bernard J & Theresa McHugh
Robert & Ann McMillen
Katie McPherson
Alton E & Olive D McQueen
Hazel L J Mease
Toselle & Germaine Meconi
L.T. Medveson
Sara Mellan
Donald & Doris Mellison
Ilya & Eteri Melnikov
Richard & Thelma Melvin
Joseph J & Josephine Merhar
Elizabeth Messina
John H Meursinge
Gordon & Rosanna Mickelson
Arnold L Milette, DC
Estolene Miller
Lillian W Miller
Elliott Miller
Maxine Miller
Ralph & Barbara Millett
Joe & Sandra Minich

Mrs S.E. Mitchell
James & Jean Mitchell
Susannah Mitchell
Jean J Mansuri
Osborne & Mildred Moe
Vera Mokretsky
Lily Monsen
Maxwell & Elaine W Moody
Joseph & Evelyn Moore
John & Judy Moore
Patrick Morey
Berry & Frances Morgan
L.J. & Lenore E. Moser
Bruce & Ivy Mounsey
Joseph J Mroz
Albert M Mueller
Victor Mueller, DDS
Jim Mullaney
Earnest C Muller
Merrill P & Audrey Munk
Mr & Mrs B.J. Munyard
Ralph W & Joyce L Murch
Steven & Claudia Muse
Marvin & Frances Naftal
Frances Gould Naftal
Dora Deanie Nauman
Bill & Berdeen Nelson
Robert J Nelson
Myrel A Neumann
Eileen Nichols
C.C. Nickel
Eleanor S. Nilsson
Eric Nilsson
Enrique & Olga Novella
Edgar & Margaret O'Brien
Charlotte O'Cheskey
Charles & Violet Oglesby
Carl & June Ogren
Joseph A Oless
David & Mary Ormesher
Richard Osorio
Anna D Osso
William & Cheryl Owen
L.J. Owens
Peter & Marth E Palese
Larry Pall, DDS
Mr & Mrs Tom Palumbo
Wilson O & Erma O Pane
Dr. Bob Pangemanan
Allyn Paparo
Ellen Paso
Hubert & Barbara Peck
Virginia A Pennington
Luis Perez

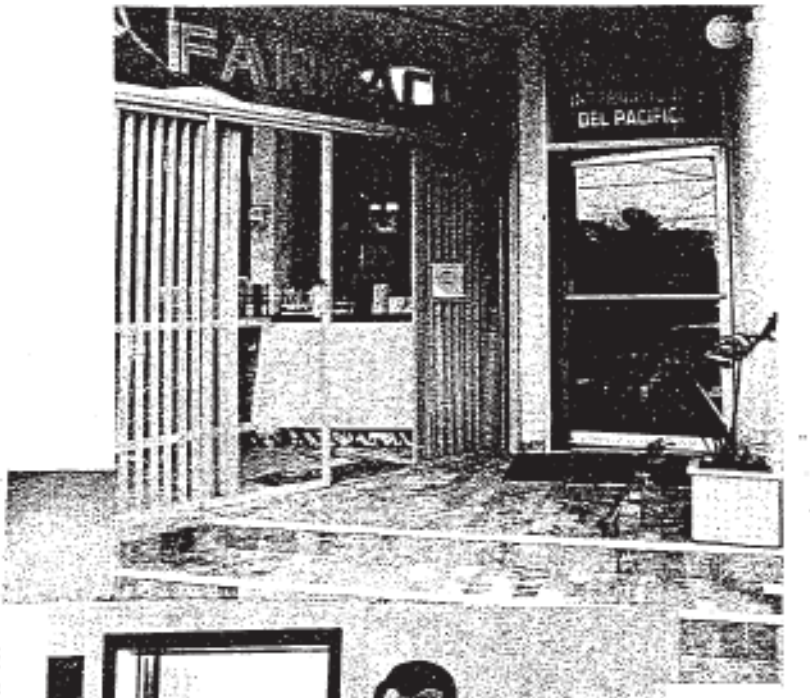
Arthur & Esther Perkins
Mr & Mrs Robert G. Peterson
Loretta & George Petrillo
Hazel M Pew
Lorraine & Helen Pflug
Michael N Phillips
John M & Margaret C Phillips
Richard & Diana Pterro
Mr & Mrs Ed Pilarczyk
Donald L Pirl Jr.
H.W. & Christine Plendl
Jean-Marie & Annette Ploe
William & Marilyn Pollin
Joseph & Jo Marie Porcelli
Marge Porterfield
Georgina Potter
Lucy D & Dean Potter
Thomas Robert Powers
Mr & Mrs Richard B Price
Clifford R & Ruth M Procter
Geoffrey Dennis Proust
David J & Ingeborg S Radel
Jon Radel
Lee Radermacher
Dan & Donna Radke
Earl & Cleo Raleigh
Dr. Ranne
Steve Raty
David Joseph Redding
George Redpath
Vernon W Reese
Clyde & Edith Revilee
Paul & Waldine Ribley
Kenneth L Richards
John & Irdean Richardson
Donald & Emilie Richter
Norman & Jewel Rickli
Mabel Riedel
Inez Riemer
George A Rigby
Charles & Dorathy Robbins
J.D. Robbins
Carl & Jean Roll
Thomas & Rachel Rose
Eleanor Rosenast
Albert Rosenberg
Elinor de L. Ross
Col & Mrs David Ross
Marilyn & Charles Rouse
Lance Rubin
Cornelia Rude
Mr & Mrs Sterling J. Ryan
Imogene Rybolt
Mary Salonia

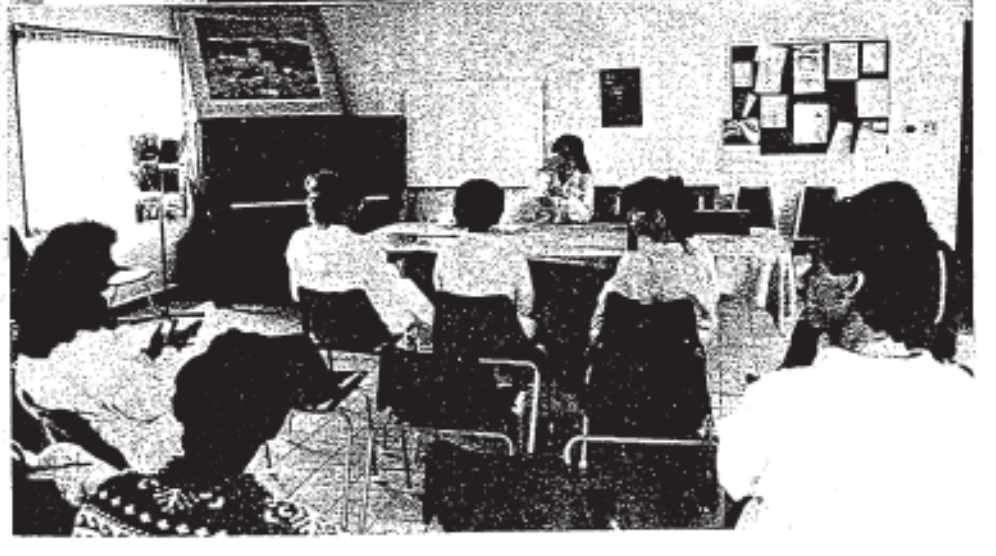
Everett & Puline Salser
Paul & Lottie Salz
Tauba Sass
Abraham & Ruth Satlow
Albert Schaefer
Roland Schenk
Mr & Mrs William J Schickel
Alan & Pam Schmeiser
Margaret Schmidt
Wes & Wilma Schmill
Mr & Mrs Albert Schnaible
Ralph J & Aldina R Schooley
Edward Schoppe, Jr
Mr A.T. Schroeder
Frank & Mary Schubert
Sara Schultz
Susan L & Leo M Schwaiger
Mr & Mrs W. H. Schwan
Philip & Hilda Schwartz
F.T. & Dorothea Scott
Jack Seaton
Mary Jane & Paul E Seaward
Rabyn Blake Sercarz
Morris D Serwin
Doug Shakespeare
Gordon & Carolyn E Shurtleff
Myron & Constance Silton
Doris J & John E Smedley
Forest Smith
Elizabeth D Smith
James Smith
Russell Smith
Troy A & Mary E Smith
Stanford H & Anna M Smith
Vernell Smith
Adelene Smith
Glenn Snyder
Paul Sotos
Ray J & Pearl E Soularie
William & Canace Spaet
Mrs Sam Speerstra
Dr & Mrs William Spellman
Paula Spellman
Louis & Janet Squerzi
Reid & Edith Stafford
Sarah T Staples
Mr & Mrs R. Starkweather
John & Hazel Stearns
Dorothy Stein
Andrew & Clara Stenseth
A Janice Stevens
Sara Stevenson
Velta Stewart
Clayton L Stewart
Melville & Lillian Stewart
M.W. Stewart
Florian J Storca
Olive Stout
Mr Albert Strassburger
Charlotte Gerson Straus
Arnold & Karon Strorn
John Such
Richard M Suffern
Mr & Mrs Walter Sundberg
Maureen J Swain
Gertrude Syria
George F Tansey
Mr Clifford Taylor
Burl Taylor
Dr Charlotte C Taylor
Dr & Mrs Phillip Tell
Richard Tester
Daniel & Sylvia Thomas
Mrs Rosemary Thomson
Alec Thompson
David & Ann Thompson
John A Thomson PhD
Paula Thone
Douglas Thorburn
Kathryn & John Thorp
Philip P Thorpe
Marian Thrush
Shirley Ann Tice
Frances Van Tighem
Salome Tobey
Edward H Trathen
Theodore & Josephine Turchick
Ruth E Turk
Mr & Mrs E.R. Turner
Mary & Josephine Uram
Marian M Vaeth
Jesus Lechuga Valdes
Tom Valentine
Mary T Valentine
Renae & Dan Van Thiel
Mr & Mrs Norman Vansickel
Peggy Vanstone
James R & Margaret R Martin-Vegue
Sharon I Veith
Maria R Vendetti
Wm H & Donna Vinton, Jr
Helen E Vogt
Beatrice W. Wagner
Phil B & Thelma L Wahl
Mary Wahl
Joanne Waiter
Arthur & Helen Walker
J.O. Wallace
Cliff Wanzer
Mrs Robert Paul Ward Jr
Mrs Morton G Ware
E.T. Warner
Herb Weber
Beveridge & Frances Webster
Marc Weinberg
Joan Welch
John B Wentworth
Philip Werlein
Alexander & Patricia Wert
Betty Alice West
Ervin Wetzel
Sandra M Whitwell
Joanne Wiater
Ernest & Betty Wicker
Fred Wiesinger
Rey L Williams
Mr. & Mrs. John R. Williams
Henry C Williamson
Howard Williamson
Eric D & Luella Wilson
Jack Wilson
Douglas S & Elaine Wilson
Mrs Niles Winchester
John & Vernarnae Winter
Florence S Wipf
Joseph & Rosalie Wisotzkey
Mrs Elliott S Wood
Luane Woodall
David E Woodling
John F Woods
George Wright
Bernard & Shirley Wright
Gene K Wycoff
I. Ceunis & S. Wynant
Evelyn Y Young
Ante Zafranovic
Ervin & Dona Zarske
Russell Zasadny
Hedwig Marie Zaunmuller
Ken Zeno
Richard & Helen Zibolski
Leon J Zimolong
Glenn & Diana Zweygardt ■

CHIPSA

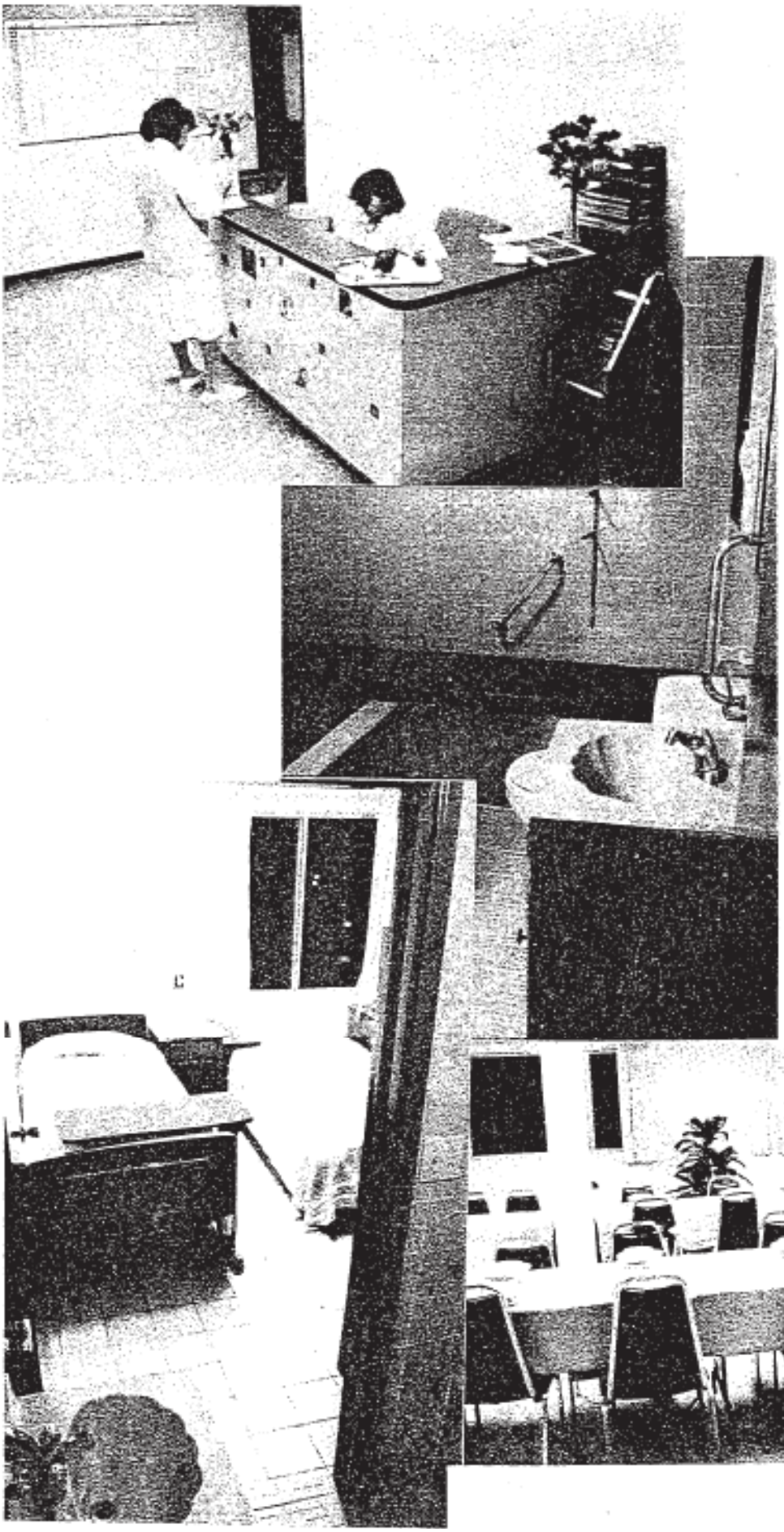
Centro Hospitalario Internacional del Pacífico SA

Scenes from a busy hospital





We thought our Appleseed donors might appreciate seeing a few photos of the "bricks and mortar" their dollars purchased. It hasn't been "just add water and stir" instant pudding. But those little seeds have become the world's first Gerson Therapy hospital. Congratulations to us all!



Follow-up program set in place

The Gerson Institute will be sending follow-up questionnaires to all past patients in the files. Patients treated in CHIPSA will receive a follow-up call if the questionnaire is not returned by March 1. The Gerson Institute is working closely with Dr. Nick. Ortuno, follow-up and consult physician, to maintain contact with the patients who come through CHIPSA.

The Gerson Institute files contain approximately 4,000 names. In 1988, a questionnaire was sent out, but less than 10% responded. A random sample of known cured patients revealed that only 22% of them had responded to that mailing. In an effort to increase response rate, the Gerson Institute will make the response cards postage paid. In addition, a phone calling campaign is being set in place to contact the most recent patients, those who were treated at CHIPSA.

The Gerson Institute is also seeking patients who are not presently in our files. If you are, or know of, a person who used the Gerson Therapy to heal, please let us know by calling (619) 472-7450. ■

CONVENTION SCHEDULE & OTHER APPEARANCES

MARCH **14, 15** (SAT & SUN)
— MIAMI BEACH, FL
Gerson Workshop (SAT) 7 - 10pm,
Gerson Therapy lecture (SUN), part of the Healing Continuum Convention, Deauville Hotel
67th St. & Collins Ave. on the beach.
Visit the GERSON ORGANIC CAFE

MARCH **22** (SUN)
— SAN **DIEGO, CA**
Gerson Therapy One Day Convention
Al Bahr Shrine Temple
5440 Kearny Mesa Rd at Hwy 163
Behind Hampton Inn

APRIL **11** (SAT)
— SANTA BARBARA, CA
Gerson Therapy One Day Convention
Mountain Home High School
501 Bomber Blvd off Hwy 62

MAY **16,17** (SAT & SUN)
— SAN FRANCISCO, CA
Gerson Therapy lecture, part of National Health Federation Convention, Cathedral Hill Hotel
1101 Van Ness Ave. at Geary

JUNE ***6*** (SAT)
— DALLAS, **TX**
Gerson Therapy One Day Convention
Unity Church of Dallas 6525 Forest Lane in North Dallas off LBJ Frwy (I-635), exit Hillcrest

JUNE ***20*** (SAT)
— VICTORIA, B.C., CANADA
Gerson Therapy One Day Convention
co-sponsored by Cancer Victors & Friends, Victoria Chapter
Metropolitan Church
907 Pandora St.,
downtown Victoria

JUNE **21** (SUN)
— VANCOUVER, B.C., CANADA
Bonsor Park Recreation Complex
6550 Bonsor Ave Burnaby, B.C.,
2 miles east of Vancouver on Kingsway next to Sears Centre

Try the Gerson diet. Healthy organically grown foods, Hippocrates soup, raw juices served at most of the above conventions.

Call us (619) 472-7450 to receive a free 8-page brochure for details, book/tape/video list, and 53 recovered "incurable" cases compiled, with photos, by Norman Fritz.

Help get the word out. We'll send free brochures to health food stores, co-ops, Gerson Institute friends and supporters, and anyone who needs them.

We want you to come to our conventions, so admission is FREE to the first lecture "Healing and preventing 'incurable' diseases: The Gerson therapy" and appearances of cured "incurables".

The Gerson Institute is a non-profit, public benefit corporation dedicated to helping people and advancing the Gerson therapy. Please make your tax-deductible contribution today to help us keep our conventions going, mailings, printings, airfare and more.

Admission to the "How to do the Gerson therapy" workshop is $25 (with special consideration given in cases of financial hardship).

Gerson Institute
PO Box 430
Bonita, CA 91908-0430.

ADDRESS CORRECTION REQUESTED

NON PROFIT ORG.
U.S. POSTAGE
PAID
BONITA, CA
Permit No. 27

The *Healing Newsletter* is the membership organ of the Gerson Institute. You can become a member of the Gerson Institute simply by making a donation of $25 or more ($30 foreign).