THE SIDE EFFECTS OF THE BIG THREE –
SURGERY, CHEMOTHERAPY, AND RADIATION

By Dr. Michael John Badanek, BS, DC, CNS, CTTP, DACBN, DCBCN, MSGR./CHEV

Part I

Cancer, the most dreaded diagnosis a patient can receive. However, it is estimated that one out of two males and one out of three females will develop cancer in their life. It has been medically proven that all humans are born with 75,000,000 cancer cells. Every day of your life you secrete 5,000-10,000 active cancer cells in your blood stream which are destroyed by a healthy, vibrant immune system. It is only when your immune system is compromised does these cancer cells have the one thing that they need and that is "TIME". These stressors on a healthy immune system occur with psychological/physiological stress, poor health habits, dental issues or any combination of these and many other stressors. We will be exploring in this 6 part series things you should be aware of in tradition Cancer Treatment Protocols what you must be aware of to which you the patient are not told by your traditional health care provider(s).

What are the real statistics on conventional medicine's "big three" cancer treatments today? Unfortunately, nobody knows. Nobody can know when there are no data in mainstream medicine that reflect real cures. The only data we have to work with are figures that reflect the phony re-definition of the term "cure" that talk about short-term results, and that are recorded selectively in the first place in ways that defy correct statistical methodology. Thus, trying to figure out the true cure-rate statistics for conventional cancer treatments is a lot like trying to figure out which cup the magician's red ball is under.

Having said that, there are a number of things you can learn about conventional cancer treatments efficacy. For instance, out of all of the conventional cancer treatments available today, it is probably safe to say that surgery alone has the best tract record. Cancer researcher, Dr. Ralph Moss, claims that most of the conventional cancer cures today can be attributed to surgery alone. However, the types of cases where surgery can be effective in a long-term way apply to only a small percentage of cancer patients. For instance, everyone agrees that surgery is virtually helpless as a curative procedure in any case where the cancer has already metastasized, and unfortunately, the majority of cancer patients are told they have metastasized cancer at the time they are first diagnosed.

Thus, for most people with cancer, surgery is no more than a "palliative" treatment (meaning it cannot save the patient, but is merely performed in the hope that it will buy the patient some time). For surgery to have a chance at usually being curative, it must be performed at a very early stage, before the cancer has spread past the primary site. Even for many of these cases, surgery cannot guarantee recovery. Some medical experts believe that there are early cancer situations where surgery may even cause the cancer to spread through the body by releasing free-floating cancer cells into the bloodstream or lymph system. But overall, the use of surgery alone probably still accounts for the largest number of long-term survival cases in conventional cancer treatments. And the best chance for long-term recovery through surgery may be when an entire organ is removed (such as the thyroid gland, prostate gland, uterus, ovaries, etc.)

After surgery, we have radiation and chemotherapy. Unfortunately, the true long-term effectiveness of these methods can only be seen as dismal. Some studies have even produced evidence that cancer patients may be able to live longer without these treatments. For example, a Science News article, published August 1, 1998, presented a review of data about radiation treatment after surgery for lung cancer. The immense amount of data, which was collected from nine studies over a 30-year period, actually showed the two-year survival rate after lung cancer surgery to be 48 percent for patients who got post-surgical radiation treatments and 55 percent for patients who underwent surgery alone. ***In other words, more patients who did not receive radiation treatments after surgery lived to the two-year mark than those who did receive radiation after surgery.***

When it comes to chemotherapy, which is prescribed to about four out of five people with cancer in the United States today, Ralph Moss states in his book "Questioning Chemotherapy:

A close look at chemotherapy yields some major surprises. Few would dispute its usefulness in acute lymphocytic leukemia. Hodgkin's disease, testicular and ovarian cancer, and a handful of rare tumors, mainly of childhood. But evidence for the life-prolonging effect in other common malignancies is weak, even for those cancers in which almost certainly it has some marginal success. And proof

is simply non-existent for the majority of cancers, especially the advanced carcinomas.

Even for the common cancers in which chemotherapy "works" such as small-cell lung cancer, the actual survival benefit is reckoned in weeks or months, not in years. And, during this time, the patient is likely to experience major, even life threatening side effects from the treatment. Thus the overall advantage to the patient is moot. "Chemotherapy does not kill cancer stem cells which produce cancer cells; on the contrary chemotherapy makes cancer stem cells more aggressive and vibrant." This also holds true for radiation therapy.

Thus, the official claims of success for toxic treatments such as radiation and chemotherapy often refer to short term effectiveness only. We will be going into more detail about radiation and chemotherapy in the next few pages, but first, let's look at the very important difference between "short-term" and "long-term" effectiveness.

Short Term Versus Long Term Effectiveness

Studying and quoting short-term effectiveness is just one tactic of a medical establishment that is not having success with long-term effectiveness. Since mainstream medicine is losing its war on cancer, it is very beneficial for those in charge to only study short-term effectiveness. This way, the actual long-term effectiveness (or real effectiveness) of conventional treatment does not have to be considered. Better yet, long term side effects of treatment (which may kill the patient a few years down the line) do not have to be considered.

For example, we see that many European studies showed the use of Tamoxifen for breast cancer to have no overall long term survival benefit at all. According to Dr. Lee, Tamoxifen can temporarily suppress tumors, and that is why the short term studies done in the United States made Tamoxifen look so good. However, the long-term studies done on Tamoxifen in Europe showed breast tumors coming back at just about the period of time when the studies in the United States were being cut short. The short term U.S. studies did not show all the deaths caused by Tamoxifen side effects later, such as from fatal blood clots in the lungs, stoke, liver dysfunction, or from uterine cancer, all of which can be directly caused by the Tamoxifen drug treatment.

But the most ludicrous aspect of short-term attention to conventional treatments is represented by how the term “cure” is redefined. By redefining the meaning of “cure” as alive five years after diagnosis, our current conventional cancer establishment is basically saying that the medical establishment considers five year survival to be the best they can aspire to. Make no mistake – by labeling anyone with cancer who reaches the five year mark as ‘cured”, conventional medicine is proclaiming that once you have lived five years after diagnosis, they have done a great job – even if you still have cancer and have been miserably sick the whole five years. This official tactic of re=-defining the word “cure” also frequently creates the ironic situation where a cancer patient can be listed as cured in the official statistics data base, yet die from their cancer a short while later!

Maybe for some people, living another five years is a great thing. For instance, it may be wonderful for those who are quite elderly when they are diagnosed with cancer, and they just want to live a few more years. But what if you are 25 or 40 years old, or 50 or 60? Living only five more years is not good at all! Or maybe you are one of many people raising small children when you are diagnosed with cancer. Most parents do not just want to see their children become teenagers – they also want to see them become adults, go to college, get married, have their own children, and so forth. And if it is your child who has been diagnosed with cancer, then to aspire to your child living just five more years is simply unacceptable. One of the most important things to know when considering treatment for cancer is whether or not the statistics your oncologist presents to you reflect “long term” or “short-term” effectiveness. After all, you obviously want a long term, not a short term recovery!

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Part II

Response Rates

One way that short-term results are used by mainstream medicine to imply long term effectiveness is by the common conventional practice of studying and quoting cancer treatment "response rates". In mainstream medicine, the "response rate" of a particular treatment is often quoted as if it means recovery rate or cure rate. But this is just another way that people seeking cancer treatments are misled by meaningless numbers. The phrase "response rate" is not synonymous to "recovery rate" or "cure rate". Quite the contrary. Common conventional cancer studies define a "response" as simply meaning a 50 percent reduction in tumor size over a particular period of time (usually about 28 days.)

Because chemotherapy and radiation are "cytotoxic" (toxic to cells), it is easy to make malignant tumors shrink for a time when bombarded with these types of toxic treatments. However, that merely means that the tumor has died a little after being poisoned or burned. If there are any cancer cells left alive after the treatment, which there virtually always are, then the tumor will start growing again as soon as there is a break in the treatment. Since toxic treatments generally involve time breaks in their administration to let the patient's overall body recover, cancerous tumors often have a chance to grow back.

Thus, when tumor response rates are quoted, these rates do not indicate that patients regained their good health or their cancers were overcome. Response rates are just a convenient way for conventional cancer researchers to report the short term partial effectiveness of a particular treatment, As Ralph Moss, Ph.D. states,

It is one of the central fallacies of chemotherapy that shrinkages or "response rates" have been proven to correlate with increased survival time. Yet, in answer to a patient's inevitable question, What are my chances? The doctor may give impressive-sounding "response rates" of, say 60 percent.

In other words, if your doctor tells you that the cancer treatment he or she is recommending to you has a response rate of 60 percent, you should know that what that really means is this: 60 percent of the time, that particular treatment protocol will cause tumors to "shrink" by at least half for at least a month. It does not mean that 60 percent of the cancer patients who get that treatment will become cancer-free.

Since toxic cancer treatments can often damage vital organs and suppress the immune system, the use of toxic treatments that are unable to effect a long-term cure must always beg the question as to whether or not the patient might have lived longer without the treatment. W. John Diamond, M.D. and W. Lee Cowden, M.D. report on this issue in their book, An Alternative Medicine Definitive Guide to Cancer. In it, they write:

Virtually all the FDA approved anticancer drugs are markedly immunosuppressive, because they ruin a person's natural resistance to disease, including cancer. Ulrich Abel, PhD. Of the Heidelberg Tumor Center in Germany, conducted a comprehensive review of the world literature on survival among cancer patients receiving chemotherapy. He found that chemotherapy can help only 3 percent of the patients with epithelial cancer (e.g. cancers of the breast, lung, prostate and colon). These cancers account for about 80 percent of all cancer deaths. In a study of chemotherapy-treated breast cancer patients, the researcher concluded, "Survival may even have been shortened in some (breast cancer) patients given chemotherapy.

A few pages later, Dr. Diamond and Dr. Cowden follow with:

German cancer researcher Ulrich Abel, Ph.D. observes that the temporary shrinking of a tumor mass – defined as either a partial or complete remission – is not necessarily a good sign, because the remaining tumor cells often grow much faster and more virulently after the first series of chemotherapy treatments. Highly aggressive chemotherapy actually shortens survival times compared with patients in whom chemotherapy was delayed or administered less aggressively, says Dr. Abel. Paradoxically, patients whose tumors showed no response to chemotherapy actually survived longer than patients who did respond.

Dr. Diamond and Dr. Cowan also report on evidence that some men with prostate cancer may survive longer without radiation treatments. They write:

Radiation therapy – implanting radiation seeds in the prostate gland – routinely given for early signs of prostate cancer can actually hasten the development of that cancer. Prostate cells can double in as little as 1-2 months after radiation treatments while unradiated prostate cancer cells may take an average of 4 years to double.

It is extremely misleading for doctors to allow cancer patients to believe that quoted "response rates" are the same as "recovery rates". It may be that many doctors who quote response don't know, themselves. The real meaning of what they are quoting. But for you, the person trying to get well, knowing the real meaning of response rate statistics will help you to more correctly evaluate treatment methods you may be considering.

Damage To The Heart

There are many ways that short term effectiveness of conventional cancer treatments can look very good for a while; yet long term effectiveness turns out to be not good at all. For instance, radiation to the chest area for either lung cancer or breast cancer can cause damage to the heart severe enough to cause a fatal heart attack at some point in the future. If the heart attack does not occur until the patient has been pronounced in remission, then the radiation treatment will look like it was successful. Deaths from subsequent heart attacks caused by cancer treatment do not have to be folded into the cancer treatment statistics. One Study on radiation treatments given to women with breast cancer showed that the use of radiation did reduce deaths from breast cancer by 13.2 percent, and this was most likely the figure that was publicly advertised. However, this same radiation increased deaths from other causes (mostly heat failure) by 21.2 percent.

Can Radiation or Chemotherapy Cause Cancer?

One fact that is often difficult for many people to believe is that many of the conventional treatments for cancer commonly used today are actually carcinogenic. This means they can cause a secondary cancer to develop a few years later, provided that the patient is lucky enough to survive their first cancer that long. This is just another way that short term effectiveness of conventional

cancer treatments may look good, while the long term effectiveness may not look good at all.

Radiation-Induced Cancer

Evidence that radiation treatments can cause cancer goes back to the early days of X-ray technology. In The Cancer Industry, Ralph Moss reports:

In 1902 a German doctor recorded the first case of human cancer caused by radiation: the tumor had appeared on the site of a chronic ulceration cause by x—ray exposure. Experimental studies performed in 1906 suggested that leukemia (cancer of the blood) could be caused by exposure to the radioactive element radium. By 1911, 94 cases of radiation-induced cancer had been reported, more than half of them (54) in doctors or technicians. By 1922, over 100 radiologists had died from x-ray induced cancer, and many other research workers, laboratory assistants, and technicians had also succumbed.

More and more cases of people developing cancer due to X-ray technology were reported in the early to mid-1900's. Then, when radiation started being used as a treatment for cancer, secondary radiation-induced cancers began to be reported. Today, it is well-known that radiation treatments for cancer may also cause secondary cancers.

In her video, Cancer Doesn't Scare Me Anymore, Dr. Lorraine Day shows medical manuals that list the possibility of secondary cancers due to radiation treatment. She also talks about the many other serious and life threatening side effects that can be caused by radiation treatments for cancer. Dr. Day makes the point that the ACS, AMA, and FDA refer to radiation treatments as "safe and effective" for cancer patients, yet radiation technicians, doctors, and nurses are all urged to protect themselves against much lower, indirect doses of the same radiation by wearing lead vests and carrying out other protective measures. In other words, it is quite ironic that extremely high exposure to directed radiation is considered safe for anyone with cancer, yet low indirect exposure is considered extremely dangerous for healthy radiation technicians!

All oncologists are well aware of radiation-induced secondary cancers in patients. An example is the real-life case of one woman who was able to successfully beat

her breast cancer only to find herself facing another life-threatening cancer 10 years later. This time, she was facing inoperable metastasized lung cancer that her oncologist was convinced had been caused by the radiation treatments to her breast years before. Thus, while radiation treatments may be necessary in some cases where cancer is extremely advanced and needs to be reduced quickly, they are never without risk. Understanding this and only using radiation when absolutely necessary is important.

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Part III

Chemotherapy Induced Cancer

Many people are already aware that some sources of radiation can cause cancer because they have heard reports of cancer resulting from nuclear fallout, radiation accidents, and so forth. But it seems counter-intuitive that a carcinogenic drug would be intentionally given to someone trying to recover from cancer. A brief look at the history of chemotherapy will help to shed light on this.

The roots of modern chemotherapy go back to the early 1940s when poisonous mustard gas was being developed for chemical warfare. A potent form of mustard gas had already been used during World War and, in 1942, the U.S. government contracted with various research centers to further investigate possible war-time chemical agents. Researchers at Yale University experimented with substituting a nitrogen atom for a sulfur atom in mustard gas, which, at the time, was called “nitrogen mustard”. A Yale anatomist then came up with the idea that it would be interesting to inject this nitrogen mustard into mice with cancer to see what would happen.

As luck would have it, the first such mouse experimented on showed impressive tumor regression. Although the mouse’s cancer never completely went away, the mouse lived about four times longer than it was expected to live with no treatment at all and this got peoples’ attention.

Researchers followed with more experiments and, though they could not achieve similarly good results on subsequent mice, it was

eventually decided to try the nitrogen mustard treatments on a human cancer patient.

The first man experimented on had late-stage lymphosarcoma. Like the first mouse, he showed dramatic tumor regression after receiving nitrogen mustard. Researchers were ecstatic. But as with all the mice, the man's cancer was never cured. Within the first month of treatment, his white blood cell count fell dismally low. Then his cancer regenerated in his bone marrow and he died. But because the man's tumor had regressed within the first few days, his case was considered to have been a "success". One hundred sixty more cancer patients were then administered experimental chemotherapy. The results showed that not one of these patients recovered from their cancer. In other words, all the evidence from early chemotherapy experiments indicated that the use of chemotherapy to treat cancer was an unqualified failure!

But in the early 1940s nitrogen mustard was the only synthesized chemical agent that had ever shown anti-tumor activity, and some people in positions of power were too excited about this to let it go. Chief of the U. S. Army Chemical Warfare Service, Cornelius "Dusty" Rhoads, was one of these people. Rhoads became a powerful advocate of chemotherapy when World War II ended and he became head of the Memorial Sloan-Kettering Institute for Cancer Research. He initiated tests on more than 1,500 different types of nitrogen mustard, and by 1955, about 20,000 of these types of chemicals were being looked at every year.

Because chemotherapy was developed out of poisonous chemical warfare agents (and is still poisonous), there has always been a fine line between giving a therapeutic dose and killing the patient. In his outstanding book, When Healing Becomes a Crime, author Kenny Ausubel notes that in one clinical trial on the chemotherapy drug called

"ICE", 8 percent of the patients dies from the drug treatment directly, and in another trial on a chemotherapy drug studied for leukemia, 42 percent of the patients died from the drug treatment directly.

From the days when chemotherapy was first used to the current day, this mode of treating cancer has never shown significant long-term effectiveness. Dr. Dean Burk was a chemist at the National Cancer Institute from 1939 to 1974. He also taught biochemistry at Cornell University Medical School from 1939 to 1941. When he retired in 1974, Dr. Burk left the position of chief chemist at the National Cancer Institute. The year before he retired, Dr. Burk wrote a letter to Dr. Frank Rauscher, a higher – up member in the NCI. In it, Burk wrote:

Ironically, virtually all of the chemotherapeutic anti-cancer agents now approved by the Food and Drug Administration for use or testing in human cancer patients are (1) highly or variously toxic at applied dosages; (2) markedly immunosuppressive, that is, destructive of the patient's native resistance to a variety of diseases, including cancer; and (3) usually highly carcinogenic (cancer-causing) ….These now well established facts have been reported in numerous publications from the National Cancer Institute itself, as well as from throughout the United States and, indeed, the world…

In your answer to my discussion of March 19, you readily acknowledged that the FDA-approved anti-cancer drugs were indeed toxic, immunosuppressive and carcinogenic, as indicated. But then, even in the face of the evidence, including your own White House statement of May 5, 1972, all pointing to the pitifully small effectiveness of such drugs, you went on to say quite paradoxically it seems to me, "I think the Cancer Chemotherapy program is one of the best program components that the NCI has ever had. One may ask, parenthetically, surely this does not speak well of the 'the other program areas?'

Ralph Moss clarifies the subject of chemotherapy being carcinogenic even further in this book Questioning Chemotherapy, where he writes:

Perhaps the strangest thing about chemotherapy is that many of these drugs themselves are carcinogenic. This may seem astonishing to the average reader – that cancer-fighting drugs themselves cause cancer. Yet this is an undeniable fact.

It is sometimes said that only the alkylating agents, such as busulfan, carmustine, and melphalan, are carcinogenic. But this not true. The authoritative International Agency for Research on Cancer (IARC) has identified 20 single agents or regimens which cause cancer in humans, and about 50 more in which such effects are suspected (236,248). Many, but not all, of these are alkylating agents. The offending drugs include doxorubicin and streptozocin (toxic antibiotics used as cytotoxic agents), BCNU (a nitrosourea), as well as the various hormone-like products. Perhaps the distinction between alkylating agents and other drugs in this regard is moot, since alkylating agents are predominantly included in most of the regimens commonly used in cancer.

To give just one example of carcinogenicity, doctors looked at one-year survivors of ovarian cancer from five randomized trials. The incidence rates for acute nonlymphocytic leukemia and for pre-leukemia were about 100 times more common in women who got the drug melphalan than in those who received no chemotherapy.

“The magnitude of these risks suggests that the drugs are casually related to leukemia.’ NCI epidemiologists cautiously concluded. However, they add, characteristically, that ‘the identification of a carcinogenic effect does not preclude its use for treatment in patients.’ In other words, the fact that these drugs cause is immaterial in the doctor’s decision to administer these cytotoxic agents.

Using my home copy of The PDR Family Guide to Prescription Drugs (New Second Edition, copyright 1994), I looked up one commonly used chemotherapy drug called "Cyclophosphamide," which is also referred to as Cytoxan." One page 167 of the physician's Desk Reference, where side effects of Cytoxan are listed, I found this statement: "One possible Cytoxan side effect is the development of a secondary cancer, typically of the bladder, lymph nodes, or bone marrow. A secondary cancer may occur up to several years after the drug is given."

Cyclophosphamide, or Cytoxan, is an alkylating agent. It is also an integral part of the following commonly used chemotherapy protocols:

BACOP	CHOP	COMLA	MACC
CA	CHOP-B	COP	M-BACOD
CAMP	CISCA	COP-BLAM	Pro-MACE
CAP	CMF	CVP	Pro-MACE-cytaBOM
CAV	CMFP	CyVADIC	
CFPT	CMFVP	FAC	
COAP	Hexa-CAF	VAC	

Cyclophosphamide is also known as "Neosar" in the United States and "Endoxan" in Germany. According to Dr. W. John Diamond:
A study of over 10,000 patients shows clearly that chemo's supposedly strong track record with Hodgkin's disease (lymphoma) is actually a lie. Patient's who underwent chemo were 14 times more likely to develop leukemia and 6 times more likely to develop cancers of the bones, joints, and soft tissues than those patients who did not undergo chemotherapy.

Dr. Badanek has been and currently is 35 years into active/private practice in the Ocala/Marion County, Florida region. Find him online at Dr.Badanek.com and wwww.alternativewholistic.com, and see what the facility has to offer the sick and health challenged. To schedule an appointment call 352-622-1151

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Part IV

And, the March 21, 1996, issue of the distinguished New England Journal of Medicine, reported:

Children who are successfully treated for Hodgkin's disease are 18 times more likely later to develop secondary malignant tumors. Girls face a 35 percent chance of developing breast cancer by the time they are 40 – which is 75 times greater than the average. The risk of leukemia increased markedly four years after the ending of successful treatment, and reached a plateau after 14 years, but the risk of developing solid tumors remained high and approached 30 percent at 30 years.

Some people may be willing to take the risk of developing a secondary cancer from the treatment they receive to rid themselves of their current cancer. But other people might not like the idea of seeing their cancer go into remission only to have to go once again into battle a few years later against a secondary treatment induced cancer. (Especially when there are non-toxic, non-carcinogenic treatments they could choose from). Do not assume your oncologist will tell you whether or not the chemo he or she wants to prescribe to you is carcinogenic or not. Generally, this subject is not addressed at all.

Also, the fact that so many chemotherapy drugs actually cause cancer is a very real threat to the public at large as well as to the environment. When cancer patients receive chemotherapy, much of their drug treatment gets passed into the public sewage systems through their urine. It thereby becomes an environmental poison that may eventually cause health problems or cancer to occur in other humans

or animals. Remember, whenever we put poisons in ourselves, we are putting them in the environment too.

False Hope?

How many times are doctors prescribing chemotherapy or radiation when there is very little evidence that this type of treatment will improve long-term life expectancy? About 80 percent of all cancer patients today are given chemotherapy. Yet some researchers believe that chemotherapy may only show long-term effectiveness in as little as ***2 to 3 percent of all cancer cases***. And how often are radiation treatments prescribed to cancer patients when there is **little evidence** that doing so will help achieve long term recovery for their particular type of cancer situation?

I know of a woman whose elderly father-in-law was prescribed radiation treatments for his late-stage, metastasized prostate cancer. When this woman called her father-in-laws' oncologist directly to find out what his life expectancy was, she was told by the oncologist that he had only about six months to live. The woman, being a clear thinker, then asked the oncologist if the prognosis for her father-in-law was "with" radiation treatments, or "without". The unbelievable answer she got was "either way". Yet her father-in-law had been prescribed radiation treatments and was not told that ***his survival chances were exactly the same whether he did the treatment or not.*** Both this elderly man and his wife thought the radiation treatments could cure him. These people were never told the truth, but instead were given "false hope" by their conventional oncologist.

I believe that the following statements are accurate. It is false hope when patients are prescribed a conventional cancer treatment and not told that the treatment is only considered to be **palliative (not expected to cure the patient). It is false hope when response rates**

are quoted and presented in a way that implies long term recovery. And it is false hope when any cancer cure rate statistic that has been "fudged" is presented to a cancer patient as representative of his or her chances for real recovery and survival. Since all these things happen on a daily basis in conventional oncologists' offices, the logical conclusion is that conventional medicine is the biggest source of false hope given to cancer patients today.

Does New Mean Better?

It is wrong for the mainstream medical establishment to mislead patients about the actual long term effectiveness of conventional cancer treatments. But one thing that plays into this problem is the readiness of the public to think that anything "newer" is "better". One of the most distressing patterns I have come across when talking to people who have recently been diagnosed with cancer, is their frequent willingness to overlook the proven long term effectiveness of many alternative, non toxic cancer treatments- and to eagerly look for the most recent conventional cancer drugs or procedures for their healing instead. I have heard people say things like, "There is a new cancer drug that is showing great results in clinical trials. I'm going to talk to my doctor about that."

Moreover, the media supports the newer is better fallacy, even when some of the new cancer drugs have not been tested for more than a few months. These drugs are often given great acclaim as possible "magic bullets" in newspaper or magazine articles. Ever since antibiotics were developed, and ever since strides in technology helped to make medical accomplishments soar, people in the modern world have come to think that anything new in medicine must be better. But cancer is not a simple bacterium that can be targeted by a simple antibiotic, not is it a type of wound that can easily be closed up by modern technology and hardware. Therefore, the "newer is better"

stance does not necessarily apply to cancer, especially when cancer research continues to stick to the paradigm that cancer drugs must be toxic poison in order to work and must be patentable.

Doctors play a role in the "newer is better" syndrome as well whenever they recommend that a cancer patient take part in a "Phase I" clinical trial. You, yourself may have been recommended this and are possibly considering it. But, what all cancer patients should know about Phase I clinical trials is that they are little more than toxicity tests. They are clinical trials used to establish "safe" doses of new toxic drugs. In any Phase I trial, medical researchers have established acceptable response rates in laboratory animals, but they do not yet know the safe dose of that particular treatment for humans. So they put a bunch of patients through various doses of the new treatment in a Phase I trial and watch for side effects. Sometimes the doctors recommending Phase I trials don't even believe that the patient will be likely to benefit from the trial at all. But they hope that, in the long run, patients in the future may benefit from the trial. Basically, in Phase I clinical trials, you are little more than a guinea pig being used for determining human dosage levels. Phase 2 clinical trials are somewhat better because they have already done the Phase I for establishing toxic dosage levels, but they are still far from determining whether the new drug is truly effective for humans. Usually, Phase 2 trials show temporary shrinkage of tumors in some patients, but don't result in any long term recoveries.

Of course, some new drugs may actually show promise. They might put a certain percentage of people into temporary remission. But, remember, remission simply means that all clinical evidence of the cancer is gone. It does not mean that all the cancer cells in the body are gone. Thus, remission often does not equate to long term cure either. Basically, if a treatment has only been tested for a short time, then the only results available on it are short term. In looking for a long

term recovery, it makes more sense to go with a treatment that already has a good long term track record.

When an oncologist says to a patient, “I’d like you to try this new treatment that clinical trials are just starting on”, one has to wonder if this isn’t just a little bit like a pilot saying, “Well, I don’t have a plane available right now that I know can get you to where you want to go – but over here, on this other runway, is a brand new type of plane we are just trying out. It’s never been flown successfully before, but the pre-flight tests show it to be very promising.” If it were me, looking for a plane to get me somewhere, I’d much rather walk a couple blocks down the road to another airport with a tried and true plane that has already successfully made the trip many times. This is what you do when you avoid the “new is better” syndrome and look into which treatments (conventional or alternative) have actually worked in a long term way for many people before you. Again, it all boils down to a simple question: ***Are you interested in surviving your cancer short-term or long term?***

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Part V

A Deadly Double Standard

One of the things I have heard over and over from people looking into alternatives for cancer is: "What formal, large scale studies have been done on this or that alternative cancer treatment?" When the person then hears that no large scale studies have been done, they often figure the treatment approach much not be any good and no longer consider it.

The first thing to understand is that the developers of most of the alternative treatments mentioned in this book did try for many years to get formal, large scale studies done on their innovative cancer treatments. If these approaches had been fairly evaluated by mainstream medicine, as they should have been, there would be large scale formal studies to quote from. But only the richly funded mainstream research organizations (backed by pharmaceutical or government money) can afford to do these types of studies. So, if a treatment approach is not considered by pharmaceutical companies to be something that could be extremely profitable for them, large scale formal studies will not be done. And, unfortunately, the government agencies involved in cancer treatment research, such as the National Cancer Institute and the FDA, simply act as watchdogs and protectors of Big Pharm's profits.

In 1946, a congressional committee looked into the Gerson therapy and officially concluded it was a sound and effective cancer treatment.

In 9154, a team of 10 reputable doctors studied the clinical records of patients using the Hoxsey therapy and found it to be an effective cancer treatment. They strongly recommended it over other cancer treatments of that era.

Between 1972 and 1977, Memorial Sloan Kettering's head research scientist, Dr. Kanematsu Suguira, studied Laetrile's effects on cancer in laboratory animals. He found Laetrile to be effective against cancers of all types, and pronounced it more effective than any substance he had ever tested for cancer.

Iin the early 19080's, Dr. Nicholas Gonzales performed a detailed scientific analysis of 500 cases of cancer patients treated with Dr. Kelly's enzyme therapy with a focus on pancreatic cancer. He found it to be significantly more effective than anything conventional medicine had to offer.

Several scientific studies done in the U.S. and Japan on Dr. Bursynski's antineoplaston therapy showed it to be significantly better than conventional methods for numerous types of cancer, and phenomenally so for brain cancers and lymphomas.

In the early 1990's, in vitro studies done by the National Cancer Institute on Jim Sheridan's formula now called Protocel showed results that were much better than chemotherapy results for a variety of different cancer cell lines. Yet they declined to study it further.

Generally, the public is not aware that any of these studies have been done, nor are they aware of their highly positive results. What most people want to see are modern large scale clinical trials on alternatives for cancer. This is understandable considering that in most cases these people's lives are at stake. However, these types of expensive studies will not be done until the current medical climate changes.

But more importantly, people expect there to be unbiased, third-party large scale studies done on everything, without realizing that these types of studies have not even been done on conventional cancer treatments. In other words, cancer patients rarely say to their oncologist. "Doctor, I can't consider this particular type of chemotherapy or radiation treatment unless you are able to show me positive results from unbiased, large-scale studies showing that people who use this treatment got well – really got well, not just managed to live with their cancer for five years after their diagnosis." This is largely because patients assume that the studies for conventional treatments have already been done. They haven't

What is so ludicrous about this double standard is that radiation and most chemotherapy agents are still officially listed as "unproven" cures by the FDA and are legally in many cases to be classified as "experimental". The fact is that many doctors and most of the public mistakenly assume that anything approved by the FDA has been rigorously proven to be effective in scientific studies. In his June 6, 2003, newsletter, Dr. Moss shows us that this is not the case and gives an example of the process of officially approving a new cancer drug:

The FDA has approved the drug Iressa (gefitinib) for the treatment of non-small cell lung cancer, despite evidence that it does not prolong the lives of patients. Approval came after an FDA panel heard testimony from patients, one of whom claimed to feel much better after taking the little brown pill. Her moving story helped convince members of the Oncologic Drug Advisory Committee to give final approval.

… Some critic are beginning to wake up to the fact that the FDA is now approving drugs that emerge from "Big Pharma" without requiring the rigorous proof once considered necessary. In fact, when proof is offered that the drugs in question do not work, it seems that

the FDA is quite willing to throw out the studies and revert to anecdotal accounts.

When extremely high standards of clinical results are required for underfunded alternative treatments but are not required for richly-funded conventional treatments, then we are dealing with a deadly double standard.

But it is not only Big Pharma that is biased toward their types of conventional treatments. There is also often a strong personal bias among conventional doctors against alternative treatments for cancer. Here is one story to illustrate some problems people face when they discuss treatment options with their oncologist. This was from a man whose wife was suffering from late stage cancer, most of which was in her brain and growing fast. She didn't have much time. The man claimed he had looked into many alternative treatments for his wife, but said "The problem with those is that so many of them turn out to be bogus." I found out later from him that the way he decided they were bogus was by asking his wife's doctor what he thought of the alternative treatment every time he heard of one. Since the doctor looked at all alternative cancer treatments as bogus, that is what he replied in every case, without having any knowledge of the specifics of the therapy.

This man's wife died of her brain cancer a few months later. None of her doctors had anything effective to offer her, and yet they were all quite effective at keeping her from trying any alternative treatments – treatments they were totally uninformed about, but adamantly claimed were ineffective.

Unfortunately, most conventional doctors are completely uninformed or worse, misinformed, about any treatment that is not conventional.

By this, I mean that they usually know very little about anything not endorsed by pharmaceutical companies (or by medical organizations that are influenced by pharmaceutical companies). Thus, there is a very real problem in thinking that your doctor is going to know the truth about alternative cancer treatments. And doctors are not motivated to find out more about alternative cancer treatments because, in most U.S. states, it is illegal for them to prescribe any treatment for cancer other than what is specifically approved by the FDA.

We have been brought up to regard doctors and medical organizations as experts. We have been brought up to think that if we don't get our doctor's approval on some treatment approach we are interested in, then we are being irresponsible, maybe even killing "ourselves". We have not been brought up to believe that big industry, and not true science is affecting which medical treatments are available to us.

Our office is a highly qualified facility capable of evaluating and treating patients. We pride ourselves in using the very best ancillary diagnostic facilities along with the specific products especially designed in addressing the health challenge(s) presented by our patients. Contact our office for a consultation regarding your health issues or concerns at 352-622-1151 or check us out at our websites at Dr. Badanek.com or alternativewholisitc health.com

THE SIDE EFFECTS OF THE BIG THREE –

SURGERY, CHEMOTHERAPY, AND RADIATION

By Dr. Michael John Badanek, BS, DC, CNS, CTTP, DACBN, DCBCN, MSGR./CHEV

Part VI

New Cancer Drugs Are Big Business

It is difficult to accept that the most effective non-toxic approaches to treating cancer are not being used by oncologists and cancer clinic everywhere – and that toxic treatments that do not show significant effectiveness are being used. The only answer to this is that cancer treatments are "big business". In particular, new cancer drugs are big business. And the effectiveness of new drugs can easily be exaggerated and promoted in press releases by drug companies. Ralph Moss, PhD shows how this can happen in his June 13, 2003, newsletter; Dr. Moss first states that,

On July 30, 2001, Erbitux was hailed in a Business Week over story, "The Birth of a Cancer Drug." The drug, then called IMC-225, was celebrated as a 'blockbuster' that halts the spread of cancer'. In an editorial entitled "the Dawn of a New Era', the magazine claimed that Erbitux seems effective against cancers of the colon, pancreas, head and neck and lungs. It suggested that victory might be within sight in the war on cancer.

Then, Moss goes on to explain that the Associated Press, CNN, and Wall Street, all joined in with incredible excitement about this amazing new cancer drug. But what these news organizations never did was to look at the studies themselves. If they had, they would have found that, on average, the studies done on Erbitux, showed the overall response rate to be only about 10 percent. (And we know that response rate is not equivalent to recovery – it just means that a 50 percent reduction in tumor size was achieved for a short while). Plus, the studies on Erbitux showed an average of just 45 days to progression. This means that the

common length of time that Eribitux could slow the cancer was only about one and one half months before the cancer would progress and grow out of control again. Moreover, about 50 percent of the patients given Erbitux in the studies suffered what were considered *severe side* effects.

Yet, with so little effectiveness to boast, Erbitux went into clinical trials to get approval by the FDA as a cancer drug. If approved, Erbitux could be worth billions of dollars a year in sales no drug companies.

Apparently, FDA, itself appears to operate in ways that involve huge conflict of interest. This organization is supposed to protect public safety where drugs are concerned, yet many of its personnel, including heads of departments either have had or will move on to highly paid jobs in pharmaceutical companies. The FDA personnel are not unbiased! Not only are they not unbiased, they are practically autonomous and untouchable because much of what they do is not under direct control of Congress. Unbelievably congressional hearings that uncover problems in the FDA are only allowed to "make suggestions" to the FDA where they think change is warranted. ***It appears that the FDA does not have to do anything Congress says!***

Questions to Ask Your Oncologist

What can you do to protect yourself? At the very best, cancer patients have the right to know what the long-term efficacy of a treatment being offered them is, as well what the side effects they might experience. In other words, they have a right to make a truly informed decision. To make sure that you are able to make a truly informed decision for yourself, you can start by asking your doctor the right questions. Some questions I highly recommend that you ask your oncologist regarding the conventional treatment he or she is recommending to you are the following:

1. “What kind of long term effectiveness does this type of treatment offer for my type of cancer? In other words, what are my chances of living longer than five years and becoming cancer free?

2. If your oncologist quotes “response rates” to you, you might want to say “I am not interested in hearing about tumor response rates because I know that they only refer to short term tumor shrinkage: What are the long term cancer free statistics on this treatment?

3. If you have a child who has been diagnosed with cancer, you might want to ask your pediatric oncologist. “What are the chances that my child will recover using this treatment and grow up to be a healthy adult? Have you seen any children fully recover from this type of cancer with this treatment and go on to live totally normal lives?”

4. “Is the treatment you suggest considered a curative treatment in this case, or just a palliative treatment?” (remember, a palliative treatment is considered to be one that is not expected to save the patient’s life, but is simply administered in the hope that it will prolong the patient’s life. Sometimes this expectation for longer survival is only a few months.

5. “What will this treatment do to my quality of life?”

6. “How long do you think I will live if I do not undergo any treatment at all? And how long do you think I will live if I follow your treatment suggestion?”

7. “Can you give me any phone numbers of other patients you have successfully treated with the type of treatment you are suggesting to me?” Or, if you can’t give out phone numbers, can you at least describe to me any cases of people who fully recovered from their cancer using the method you want to prescribe to me?”

8. “If I go through this treatment, what are all the serious or even life threatening, side effects I might experience? For example, is it possible this treatment could cause me to die from heart failure or a blood clot? It is possible this treatment could cause me to develop a secondary life threatening cancer within a few years?

Do not be shy about asking these direct questions. This is information you have a right to know. You may be about to make a decision that your life depends on. Also, if your oncologist is not comfortable with these types of questi9ons, then you should consider seeking out another oncologist who will answer them honestly. Remember, you are paying your doctor – he or she is working for you.

Hopefully, this information will help you to evaluate conventional methods that may be recommended to you, and allow you to make a truly informed decision about the treatment method you want to go with. I suggest you be just as open and objective about considering the treatments your conventional oncologist recommends to you as you are when you consider any alternative treatment for your cancer. However, do not fall prey to a double standard. Do not let yourself be **“rushed**” into treatment before you have considered your options. Understand the terminology and statistics that are presented to you by your doctor. Be aware of short term versus long term effectiveness. Be aware of all

possible side effects for any treatment you are considering, whether it is a conventional or alternative approach. And try to find out if other cancer patients have used that approach successfully to become cancer free (**not to just live 5 years after *diagnosis).*** Never forget that your goal is to recover from your cancer and regain a normal cancer free life!

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