

Practice of Gerson's diet therapy in neoplastic diseases:  
A tissue-centric nutritional immunotherapy  
that anticipated Matzinger's Danger Model  
with its tissue-based effector class control

Gar Hildenbrand

Dir Epidemiology - Gerson Research Organization  
Dir Research – Centro Hospitalario Internacional del Pacifico SA

Lecture and PowerPoint presentation  
to the American Academy of Anti-Aging Medicine  
Fellowship in Integrative Cancer Therapy: Module II

June 25, 2011

Las Vegas, Nevada

Fellowship Dir: Mark Rosenberg, M.D.



Gerson Research Organization  
7807 Artesian Rd  
San Diego CA 92127

<http://www.gerson-research.org>  
[garhildenbrand.com](http://garhildenbrand.com)  
email: [ghildenbrand@earthlink.net](mailto:ghildenbrand@earthlink.net)

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**Abstract**

*Gerson labored alone at first, and later with extraordinary support, to develop a nutritional immunotherapeutic approach to tuberculosis. This disciplined clinical investigation led to some unconventional ways of conceiving of and monitoring the immune response of tissues per se, and manipulating them through diet. Gerson translated this new approach into a method of cancer management. Matzinger's Danger Model predicts that an improvement in tissue function will lead to more effective effector class control.*

**Lecture**

Gar Hildenbrand: What if the immune system is not a surveillance army of specialized lymphocytes with advanced knowledge of self and not-self? What if Charlie Janeway was wrong? What if the tissues, themselves, initiate, tailor, amplify and signal the completion of immune responses? What if T-regulatory cells express helper functions according to instructions from the tissues? What if we're misidentifying T-regulatory cells due to the culture media and the assays we are using in our experiments? What if we are missing the tissue responses that govern the class of effector?

Christeene and I had dinner and too much wine a couple of months back with Polly Matzinger, who's the Chief of the T-cell Tolerance Memory Section of the Immunology Lab at NIAID and a co-conspirator along with Steve Groft, the Director of the Office of Rare Diseases Research, to go back in on the Coley question, to start with large animals and live streptococcus pyogenes infections, because the large animals, like Arabian horses, can get melanomas, for example; dogs can get sarcomas, that are much, much closer than murine models to human beings. And really, if we want to know what makes tumors clear, we need to know what aspect of immunity is evoked. And of course, at this point, "what aspect of immunity" becomes a much larger question.

Students generally learn that the immune system matches the effector class to the pathogen that it is fighting (for example, making IgE against worms, and cytotoxic T lymphocytes (CTL) against viruses and intracellular bacteria). But it is not easy to see how the immune system could discriminate between worms, viruses or intracellular bacteria, as T cell receptors bind peptide-MHC complexes, B cell receptors bind small epitopes on proteins, carbohydrates and lipids that are present in most living organisms; ...

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Matzinger PC, Kamala T. Tissue-based class control: the other side of tolerance. *Nature Reviews Immunology* 2011;11:221-230

*(cont)* and the 'innate' receptors, such as the Toll-like receptors (TLRs) and NOD-like receptors (NLRs) are so promiscuous that they don't distinguish between ligands from different phyla, or between pathogen-derived and self-derived signals ... So, what controls the effector class of an immune response? The idea that it might be the tissues, rather than the immune system, has grown slowly over the 13 years that we have been studying immunity from the perspective of the danger model.

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Matzinger PC, Kamala T. Tissue-based class control: the other side of tolerance. *Nature Reviews Immunology* 2011;11:221-230

*(cont)* Initially, the model did not offer any clues as to how one effector class might be chosen over another, as it was designed to cover only the immune system's first decision (whether to respond or not). It proposed that perturbed tissues initiate immune responses by sending alarm signals that activate local antigen-presenting cells (APCs), whereas healthy tissues display their own antigens or allow 'resting' APCs to display those antigens to induce peripheral tolerance...

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*(cont)* In effect, this model suggested that turning immune responses on or off was the prerogative of the tissues. It takes only a small step to suggest that tissues may also control the effector class, such that the class of an immune response is tailored to the tissue in which it occurs, rather than to the invading pathogen.

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I'm going to do what Dr. Pauling always did in his lectures, and he told us that we should do this. I'm going to read what is up on the screen instead of say something else, which always drove him crazy when a speaker would do that.

Gerson labored alone at first — we're talking about Max Gerson back in the 19-teens and twenties, in Germany, in Bielefeld — later with extraordinary support, to develop a nutritional immunotherapeutic approach to tuberculosis. This disciplined clinical investigation led to some unconventional ways of conceiving of and monitoring the immune response of tissues per se, and manipulating them through diet. Gerson translated this new approach into a method of cancer management — I could say via tuberculosis, which is where he started — Matzinger's Danger Model predicts that an improvement in tissue function will lead to more effective effector class control. Sounds interesting.

From a February publication of Polly Matzinger, in the February issue of *Nature Reviews Immunology*, this year, *Students generally learn that the immune system matches the effector class to the pathogen — matches the effector class to the pathogen — that it is fighting (for example, making IgE against worms, and cytotoxic T lymphocytes (CTL) against viruses and intracellular bacteria). But it is not easy to see how the immune system could discriminate between worms, viruses or intracellular bacteria, as T cell receptors bind peptide-MHC complexes, B cell receptors bind small epitopes on proteins, carbohydrates and lipids that are present in most living organisms; and the 'innate' receptors, such as the Toll-like receptors (TLRs) and NOD-like receptors (NLRs) are so promiscuous that they don't distinguish between ligands from different phyla, or between pathogen-derived and self-derived signals ... So, what controls the effector class of an immune response? The idea that it might be the tissues, rather than the immune system, has grown slowly over the 13 years that we have been studying immunity from the perspective of the danger model.*

Continuing ... *Initially, the model did not offer any clues as to how one effector class might be chosen over another, as it was designed to cover only the immune system's first decision (whether to respond or not). It proposed that perturbed tissues initiate immune responses by sending alarm signals that activate local antigen-presenting cells (APCs), whereas healthy tissues display their own antigens or allow 'resting' APCs to display those antigens to induce peripheral tolerance. In effect, this model suggested that turning immune responses on or off was the prerogative of the tissues. It takes only a small step to suggest that tissues may also control the effector class, such that the class of an immune response is tailored to the tissue in which it occurs, rather than to the invading pathogen.*

Just think about it, if you had a T-cell response in your gut, or your brain, or your eye, you would lose those structures and organs, be-

cause it is such a destructive response. So an Ig response is required in those tissues. How in the world could the immune system know to respond that way?

Again with Polly ... *In fact, we should perhaps redefine the immune system to include every tissue in the body.*

This is “girlfriend,” here. Polly is 73 years old. She started out as a cocktail waitress in the Playboy Lounge where some scientists were talking and she overheard them. They were talking about biomimicry and she asked, as she was serving the cocktails, “Why doesn’t anything mimic a skunk?” To which, to her delight, the scientists responded by engaging her in a conversation and, over a period of time, one of them became convinced that she had a gift and talked her into pursuing studies in the sciences. And as I said, she is now the long-term head of the Ghost Lab, so-called because for the first nine months there was no one there, because Polly had gotten it into her head that string theory might be important. So she was off trying to dig up something on that. Formally, it is called the T-cell section, the T-cell Memory and Tolerance Section of the Immunology Laboratory at NIAID.

Let’s take a ride in the Wayback Machine to the University of Munich, Department of Tuberculosis, and meet Division Chief Professor Doctor Max Gerson.

This guy has a PR problem, currently. There is a sort of Doctor Pangloss promotional effort regarding his work that trivializes and virtually extinguishes most of the nuggets of wisdom, discovery, and disciplined inquiry that this man was responsible for as a division chief of the department of tuberculosis at one of the two top medical schools in the world at the time. This was a time when, if you wanted to perfect your training, you left the U.S. and went to Germany because their sciences and their opportunities, laboratory and clinical opportunities, were so vastly superior to our own. This is the real Max Gerson.

From his last monograph, titled *A Cancer Therapy: Results of Fifty Cases*, published in the year of his death, 1959, ... *The concept of totality should not let us forget that each sick organ, even each node and gland, has its own pathological anatomical conditions, on which the method of healing essentially depends.*

From the same monograph ... *From observation of the skin, I could learn what types of proteins and fats are favorable, at what time the reserves of the tissues must be refilled, and what is necessary to produce the best healing reactions and, finally, how to keep them at the level necessary for healing purposes. For these tests, therefore, we had to select cases which had skin cancer or, better still, such*

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Polly Matzinger (and disciple)

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Prof. Dr. Max B. Gerson, Div Chief, Dept Tuberculosis, University of Munich

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This is an extension of Gerson's work prior to, and in, and subsequent to his appointment at the University of Munich where he enjoyed extraordinary support.

Looking at Matzinger again, we can see the modern scientific view echoing — they say that “history doesn't repeat itself,” Mark Twain said it, “but it rhymes”. Matzinger writes ... *Tissues are not simply passive recipients of immune protection, but are active participants in their own defense. They express TLRs. They produce antimicrobial peptides and antiviral cytokines, such as type I IFNs. They produce 'eat me' signals to activate local APCs, class-influencing signals to modulate local immune responses and chemokines to recruit cells for repair, remodeling and immunity.*

Now when we look at Gerson, talking about general stimulation, with the Coley fluid in conjunction with his hyper-sensitizing protein-restricted diet, which we will get into in detail: *Bacterial preparations (Coley and others) or Pyripher, or any similar preparations are effective, as far as they can stimulate the visceral nervous system in connection with the liver and the mesenchymal defense and healing apparatus ... However, I have had no experience with it. We do not know what stimulus acts first and what tissue should be activated.*

This becomes a very profound question as we move forward. Gerson's therapy wasn't based on fever vaccines, but it was a fever therapy. It was a nutritional immunotherapy. Mark asked me for a practicum on Gerson with a dollop of Matzinger, so let's have a look at Gerson's diet therapy, and see what we're talking about.

There are key principles that span the different forms of Gerson's diet therapy and they are not odd: (1) *salt-and-water management of edema*, (2) *protein restriction* — we'll get quite a bit into that, (3) *nonspecific (allergic inflammatory) sensitization*, and (4) *detoxification through medicated enemas, castor oil and clay*. Gerson's critics used to call him a naturopath.

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**There are some key principles that span the different forms of Gerson's diet therapy.**

1. Salt-and-water management of edema
2. Protein restriction
3. Nonspecific (allergic inflammatory) sensitization
4. Detoxification through medicated enemas, castor oil and clay

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#### Edema

1. The tendency toward edema is not limited to tuberculous pulmonary tissue alone, but extends to other tissue compartments in most chronically ill patients, who retain water and sodium chloride.
2. The edema of the tuberculous lung is a component of its inflammation and, as such, an obstacle to the development of its elasticity. The absorption of the edema allows greater shrinkage of the individual regions.

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Gerson MB, *Diet Therapy in Pulmonary Tuberculosis*, 1934;Leipzig + Vienna: Franz Deuticke, pub.

Looking at edema: this is from the monograph, *Diet Therapy in Pulmonary Tuberculosis*, published by Gerson on Franz Deuticke in 1934: (1) *The tendency toward edema is not limited to tuberculous pulmonary*

tissue alone, but extends to other tissue compartments in most chronically ill patients, who retain water and sodium chloride. (2) The edema of the tuberculous lung is a component of its inflammation and, as such, an obstacle to the development of its elasticity. The absorption of the edema allows greater shrinkage of the individual regions. Now it's always, I think, important when you're reading this to remember that Gerson was treating — this is going to sound so Heilpraktiker — he was treating the organism, the body, and not the disease. There were no disease-specific treatments used, but instead, an attempt was made to enhance the function to as near the function as it was at birth as possible; to get back to those near-embryonic capacities of the newly born.

This reminds me of the work of Christine Waterhouse publishing in the journal *Cancer* back in 1956, when she pointed out that all cancer patients have non-detectible, but measurable, extensive edema. You can't see it clinically, but it is there. And if you try to force-feed patients fat, as she found, to increase their metabolism, or metabolic rate, what we do is add to the water weight and unleash the growth of the disease; and in her experiment she wasn't able to shut it off, once she started aggressive growth.

(3) *This reduction of the edema can mimic regression of processes or even the disappearance of caverns; this "passive" contraction initiates the healing of caverns, it is often a required prerequisite, but it is never identical to the healing.* In other words, getting rid of the water is just the first step.

(4) *The absorption of edema distinguishes two types of tissue fluid retention: Edema that is accumulated in the body of the patient through predisposing events irrespective of the cumulative infection — he's talking about tuberculosis, but there have been other events that have added to this — and edema that appeared as a direct consequence of the infection, the fever, and other recent disturbances. The latter "specifically-allergic" edema is relatively quickly resorbed under the influence of the diet, the former is often much more difficult to regress.*

(5) *In the emergence of "nonspecific" edema, a variety of factors of physical, chemical and internal secretory nature must be involved; accordingly, the number of their absorption-promoting factors is very large. For this reason, in the dietary treatment of pulmonary tuberculosis, first and foremost, healing foods come into consideration.*

Can you believe this guy had the budget for this kind of stuff? And it was a big budget. It was an entire division at one of the top schools. This is the last time a major university engaged in the support of whole-food interventions, the last time. And we have no cultural or scientific or social memory of it. In fact, none of you would know that this stuff existed unless you read medical German, because I translated this. There is no English translation available. I translated it last week.

#### Edema

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#### Edema

- The withdrawal of rock salt is essentially involved in the anti-edema effect of the diet; this effect is enhanced by enrichment of potassium, calcium, phosphorus and bromine in the sense of transmineralization; hormone preparations and vitamins are possible additions in the event of endocrine disorders of water balance.

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Gerson MB, Diet Therapy in Pulmonary Tuberculosis, 1934;Leipzig + Vienna: Franz Deuticke, pub.

**Protein restriction**

The digestion of protein does not take place in the intestine alone, after all – in the human body every healing process is a digestive process – and resorption processes in infiltrations, already described, show us how through the growth of young connective tissue and new capillary vessels, viz. through the opening up of capillary reserves, digestion of protein masses takes place in the disease foci...

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Gerson M, von Weisl W. Fluid rich potassium diet as treatment for cardiorenal insufficiency. Wien Med Wochenschr 1935-04-11;82(15):571-574

**Protein restriction**

*(cont)* Now it seems, just as with the healing of scars on the skin, that even the input of a small amount of certain nutritional protein factors would be capable of inhibiting parenteral protein digestion, i.e., the resorption of disease foci. It also seems to me that, especially in the first weeks of the diet, foods as low as possible in protein can quickly initiate healing processes and keep them rapidly moving, which would be impossible to achieve on a more protein-rich initial nutrition.

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Gerson M, von Weisl W. Fluid rich potassium diet as treatment for cardiorenal insufficiency. Wien Med Wochenschr 1935-04-11;82(15):571-574

**Protein restriction**

Slide 22

Even animal protein factors cannot be simply compared in (calorie) tables. Liver acts differently from kidney, yogurt acts differently from milk ... the former are useful, the latter harmful to the healing process ... To my surprise, tests have shown that animal substances highest in purine (sweetbreads) and animal substances lowest in purine (brain) were tolerated equally well, while other types that are halfway between, such as muscle flesh, kidney, etc., were not easily fitted into the TB diet.

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**Protein restriction**

We must therefore consider factors other than just the nitrogen or purine contents of the food as causative. The influence of hormones probably plays a role, too, that is much larger than we know at present.

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Mark didn't ask until too long ago. And then my mom was sick and we had to put her in assisted living — so I was up against the wall to get this done.

*(6) The withdrawal of rock salt ... we're talking sodium chloride ... is essentially involved in the anti-edema effect of the diet; this effect is enhanced by enrichment of potassium, calcium, phosphorus and bromine in the sense of Transmineralization ...* That's not a spooky word; "Transmineralization" in this usage refers not to alchemy, but to the replacement of intracellular sodium and chloride with potassium, where all the electrolytes are obliged to switch places. Okay ... *Hormone preparations and vitamins are possible additions in the event of endocrine disorders of water balance.* Back then a hormone was ovarian tissue, thyroid tissue, pancreas tissue. They've got their estrogen and they've got their insulin, but it's a little bit more crude than we're used to.

Now we turn to protein restriction which — I would preface this by saying, "Damn you Justin von Liebig, and every one of your acolytes" — meat is not necessary to build muscle, and carbohydrates don't power the muscle that is built by meat. This is all nonsense.

*The digestion of protein — we are talking about disease lesions here — does not take place in the intestine alone, after all – in the human body every healing process is a digestive process – and resorption processes in infiltrations, already described, show us how through the growth of young connective tissue and new capillary vessels, viz. through the opening up of capillary reserves, digestion of protein masses takes place in the disease foci. Now it seems, just as with the healing of scars on the skin, that even the input of a small amount of certain nutritional protein factors would be capable of inhibiting parenteral protein digestion, i.e., the resorption of disease foci. It also seems to me that, especially in the first weeks of the diet, foods as low as possible in protein can quickly initiate healing processes and keep them rapidly moving, which would be impossible to achieve on a more protein-rich initial nutrition. Even animal protein factors cannot be simply compared in (calorie) tables. Liver acts differently from kidney — this is shocking stuff to me, you know, and anybody that's thinking, "if it's got a face, I won't eat it," because it's wrong all the way across the board; or, you know, all animal products have the same deleterious effects, as in the teaching of T Colin Campbell; you'd never come to these conclusions. But Gerson actually had the ability to conduct disciplined inquiries in the clinic, right? ... Liver acts differently from kidney; yogurt acts differently from milk ... the former are useful, the latter harmful to the healing process ... To my surprise, tests have shown that animal substances highest in purine (sweetbreads) and lowest in purine (brain) were tolerated equally well, while other types that are halfway between, such as muscle flesh, kidney, etc., were not easily fitted into the TB diet. We must therefore consider factors other than just the nitrogen or purine contents of the*



*food as causative. The influence of hormones probably plays a role, too, that is much larger than we know at present. However important the creation of protein hypersensitivity is in the first months of the cure, let me say that in my experience severe pulmonary TB will not be cured if the patient is not given animal protein in the form of egg yolks and (not quite so important, but serving the purpose, liver, brain, and sweetbreads) in measured amounts.*

This is totally non-canonical to the natural cure advocates and it represents an astonishing sort of side development of these investigations. But, think about it, Gerson was trying to replete people who had been in a wasting state, so that the egg yolk is an understandable way of getting them plumped back up again if it doesn't cause recurrent edema, or infiltrate, or add to the problems of the growth potential of tuberculosis.

I was astonished to learn that in Gerson's work, egg whites were not — you know how you can buy a little container of egg whites because the yolks are so terrible? — in this medical treatment system, the egg white was the worst possible protein you could give; the worst. And fish was next to it on the 'don't go there' list — fish, my god, I thought fish was the easy stuff, you wanted fish first — muscle behind that, and then you're at liver and sweet bread and brains, and then you get to dairy as being first introduced and tolerated, egg yolk and, preceding it, dairy. It was very surprising.

This is not from the pulmonary monograph, this is from a paper called "Fluid rich potassium diet as treatment for cardiorenal insufficiency." This was published in the *Wiener Medizinische Wochenschrift* in 1935 ... *It would equally be a mistake not to accustom cured TB patients to other protein factors, above all to milk; but here we must carefully draw a boundary line: the cured TB patient should be able to tolerate milk, sour cream, etc., and occasionally even a piece of beefsteak or a portion of fish, precisely in order to get used thereby to insensitivity to protein, which he needs in order to be able to resist the commonplace stimuli of daily life.*

Now I didn't extract any of Polly's recent paper on tissue-based class control on the subject of oral immunization or tolerization, but the question of oral antigens provoking an IgA response in the gut is central to that article and I think we have in Gerson a survey of the types of animal products, animal food products, that alter the intestinal tissues immune initiation and, to a certain degree, we may be seeing something that looks like tolerization, with the feeding of these more dangerous products, when you're doing a diet therapy, *per se*, to fight an infectious disease, and later cancer; Polly says it's not really a switch to tolerization, but just a switch in class control; it is from the tissue's point of view anyway, but from the organism's point of view, tolerization results. Okay? I've always thought you don't want to keep your gut full of heavy proteins because you're just going to shut down your own immune system. You might as well take steroids.

*But the patient should not overdo it in this respect, he should not forget that an overload of these substances might diminish in him the ability to react which he will need to protect him from re-infection for the rest of his life.* And you'll recall that Colin Campbell bases much of his argument for exclusively plant feeding on an experiment by Indian scientists

#### Protein restriction

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**Experimental protein restriction**

The first experiments with mice, rats, guinea pigs, and monkeys showed that antibody production is decreased quantitatively by protein or protein-calorie restriction. On the other hand, T-cell-mediated immunities actually increased with protein-calorie or even amino acid restriction ...

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Good RA. Zinc and immunity. Clin Immunol Today. 12 Jan 1985

demonstrating that aflatoxin is highly carcinogenic in mice fed a diet with 20% casein protein, but not at all carcinogenic in mice fed a 5% casein protein diet. This is the same type of observation as in resistance to reinfection with tuberculosis. Now we can turn to the great pathologist, Robert Good.

Good, you know, was at MSKCC. He was the head there. He was the head of the Sloan Kettering Research Institute. His other life was this kind of experiment ... *The first experiments with mice, rats, guinea pigs, and monkeys showed that antibody production is decreased quantitatively by protein or protein-calorie restriction.* – In other words, IgA in the gut. *“On the other hand, T-cell-mediated immunities actually increased with protein-calorie or even amino acid restriction.* This from, at the time, the most published pathologist in the western medical literature, the father of bone marrow transplantation, the guy who named the bursal cell lymphocyte. Right? He did more of this kind of research, I think, than he did in transplantation.

**Experimental protein restriction**

*(cont)* Common bacterial infections, e.g., streptococcal or pneumococcal infection, were enhanced in underfed animals, but heightened resistance to certain viral or fungal infections was present. We thus faced a dilemma — malnourished humans showed all kinds of immunity depression, but under laboratory conditions T-cell-dependent immunities, even tumor immunities, were regularly increased by dietary deficiency.

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This is again, Robert Good ... *Common bacterial infections, e.g., streptococcal or pneumococcal infection, were enhanced in underfed animals, but heightened resistance to certain viral or fungal infections was present. We thus faced a dilemma — malnourished humans showed all kinds of immunity depression, but under laboratory conditions T-cell-dependent immunities, even tumor immunities, were regularly increased by dietary deficiency.*” And I would just add, I think that the enhanced susceptibility to infections was probably due to the laboratory conditions and the nature of the food. You know, mice in the wild, and guinea pigs in the wild, would never be satisfied with the equivalent of grape nuts for breakfast, lunch and dinner, dry food. They’d be eating plants. Have you ever had mice in your kitchen and they take out your apricots? This overlooks fresh, live-food feeding, which could easily account, in the Gerson model, for a failure to be able to prevent common — I mean streptococcus? — common infections.

**Experimental protein restriction**

Chronic (4 weeks or more) moderate (4-12%) protein malnutrition frequently produces ... vigorous phagocytic and T-lymphocytic immunity and well maintained cell-mediated immunity responses.

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Kramer T, Good RA. Increased in vitro cell-mediated immunity in protein-malnourished guinea pigs. Clin Immunol Immunopathol. 1978;11:212-228.

Again, this is Cramer and Good writing in *Clinical Immunology and Immunopathology* ... *Chronic (4 weeks or more) moderate (4-12%) protein malnutrition frequently produces ... vigorous phagocytic and T-lymphocytic immunity and well maintained cell-mediated immunity responses.* Who knew? You know, people go on their vegan kicks or they start eating vegetarian and first thing your mother says is, “What are you doing for protein? Have some steak.”

**Nonspecific sensitization**

It becomes clear now that limiting the protein in the dietary has many multifaceted possible effects in the sense of an unspecific sensitization, by creating a desired hypersensitivity to protein. Contrary to other allergy therapies, we do not wish to desensitize the TB patients; on the contrary: thus we understand that, on the one hand, von Noorden is right when he warns against an exaggerated protein phobia, ...

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Gerson M, von Weisl W. Fluid rich potassium diet as treatment for cardiorenal insufficiency. Wien Med Wochenschr 1935-04-11;82(15):571-574

So those were animal models. Gerson’s work hints that translational research, now, would be amply justified.

Here we go back to Gerson’s cardiorenal insufficiency paper ... *It becomes clear now that limiting the protein in the dietary has many multifaceted possible effects in the sense of an unspecific sensitization — now we’re talking about, this is before we named the T-cell and B-cell, but this is ... read “unspecific” as “nonspecific,” and think innate immu-*

nity, and think tissue — *creating a desired hypersensitivity to protein. Contrary to other allergy therapies, we do not wish to desensitize the TB patients; on the contrary: thus we understand that, on the one hand, von Noorden is right when he warns against an ex-*

*aggerated protein phobia, but on the other hand we also understand that for those patients whose bodies are cram-med full of protein waste products, it is precisely the creation of such a sensitivity that is needed to evoke hyperergic reactions to those waste products which until then have lain stored in the tissues for want of a sufficient body reaction.*

Think of Matzinger's danger signals which we will cover in some detail in the course of this module ... *This train of thought allows us to understand why febrile diseases, above all TB, lead to heightened protein collapse; why at the onset of the disease the body must have a 'negative protein balance'. It is a self-healing tendency that tries here to eliminate protein that has become unusable. — Protein that has become unusable would be danger signals. — The dietary therapy deliberately supports this self-healing tendency by giving protein-poor nutrition precisely at times of high fever. — Did I say that Gerson's therapy was a fever therapy? It routinely generated fevers as we'll see when we get to case reports in cancer. — The diet helps to dissolve the unusable protein in the body, and to destroy and eliminate it quickly. — We are hearing this is in archaic terms. This is 1930's language. But it's language from a major university. — We can see in this, just as in the formation of caverns and edemas, something logical and above all, at the onset of the healing process, something vitally important. Contrary to the view that has gradually become popular since Graves, and which claims that "a fever should be fed", we don't want to disturb the tuberculous organism through protein input at the very moment when it is already burdened with masses of protein waste products, which came into being through the mutually destructive battle of leukocytes against bacilli, of the tissues against the toxins. — What a cogent statement that is, from the modern perspective through the view of the danger model, the lens of the danger model.*

Now we turn to one of the most feared medical textbook authors, Stanley Robbins, because we've been talking about allergic inflammatory reactions in the diet therapy, the nonspecific sensitization. Robbins wrote, *While it is clear that allergy materially modifies the basic character of the inflammatory response to the infection and is responsible for the development of the characteristic caseous necrosis and the tubercle, one of the most perplexing problems in the entire study of tuberculosis is the question of the relationship of the allergy to immunity. Is allergy immunity? Are the two processes identical or closely related? Or is immunity distinct from allergy?* — In Gerson's view and in the views of his collaborators, allergy was a form of immunity and allergy could be restored to the tuberculous patient and, as it was, simultaneously radiological findings and clinical measurements would show regression of the disease, which I find quite fascinating. We will return via Gerson and his seminal writing to this subject.

#### Nonspecific sensitization Slide 31

*(cont)* but on the other hand we also understand that for those patients whose bodies are crammed full of protein waste products, it is precisely the creation of such a sensitivity that is needed to evoke hyperergic reactions to those waste products which until then have lain stored in the tissues for want of a sufficient body reaction. This train of thought allows us to understand why febrile diseases, above all TB, lead to heightened protein collapse; why at the onset of the disease the body must have a 'negative protein balance'...

Gerson M, von Weisl W. Fluid rich potassium diet as treatment for cardiorenal insufficiency. Wien Med Wochenschr 1935-04-11;82(15):571-574

#### Nonspecific sensitization Slide 32

*(cont)* It is a self-healing tendency that tries here to eliminate protein that has become unusable. The dietary therapy deliberately supports this self-healing tendency by giving protein-poor nutrition precisely at times of high fever. The diet helps to dissolve the unusable protein in the body, and to destroy and eliminate it quickly. We can see in this, just as in the formation of caverns and edemas, something logical and above all, at the onset of the healing process, something vitally important ...

Gerson M, von Weisl W. Fluid rich potassium diet as treatment for cardiorenal insufficiency. Wien Med Wochenschr 1935-04-11;82(15):571-574

#### Nonspecific sensitization

*(cont)* Contrary to the view that has gradually become popular since Graves, and which claims that "a fever should be fed", we don't want to disturb the tuberculous organism through protein input at the very moment when it is already burdened with masses of protein waste products, which came into being through the mutually destructive battle of leukocytes against bacilli, of the tissues against the toxins.

Slide 33

Gerson M, von Weisl W. Fluid rich potassium diet as treatment for cardiorenal insufficiency. Wien Med Wochenschr 1935-04-11;82(15):571-574

#### Pathology of allergic inflammation

While it is clear that allergy materially modifies the basic character of the inflammatory response to the infection and is responsible for the development of the characteristic caseous necrosis and the tubercle, one of the most perplexing problems in the entire study of tuberculosis is the question of the relationship of the allergy to immunity. Is allergy immunity? Are the two processes identical or closely related? Or is immunity distinct from allergy?

Slide 34

Robbins SL. Pathology, 1967;Philadelphia & London;WB Saunders

**Detoxification**

In my opinion, primarily because comprehension of the detoxification has always been overlooked in clinics, we are not sufficiently trained in that direction.

Slide 35

Gerson MB, A Cancer Therapy 1959; NY, Dura Books

**Caffeine/chamomile enemas**

Severely ill patients receive enemas in the morning and evening; less advanced patients receive an enema at night before going to bed.

Basic rule: with a high fever, exudative processes, diarrhea, and in suspected recurrence of pulmonary hemorrhage, many enemas, at least 2 - but sometimes 3 per day. In particularly threatening acute conditions (galloping consumption), I've given even four enemas daily.

Slide 36

Gerson MB, Diet Therapy in Pulmonary Tuberculosis, 1934; Leipzig + Vienna: Franz Deuticke, pub.

**Caffeine/chamomile enemas Slide 37**

So many enemas would weaken the patient too much if they were not treated with caffeine. In general, the enema is given according to the following recipe: one liter of warm chamomile tea with 20 drops of a 10% caffeine/sodium benzoate solution; can be run slowly and under low pressure!

After several days, infrequently after several weeks, the patients begin to evacuate massive quantities of dark-colored or black, very foul-smelling stool. Sometimes oily, light-to-dark-green masses swim on the surface of the faeces. With moderately-ill tuberculous patients, the number of enemas can be reduced after the disappearance of these stools.

Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig & Vienna; Franz Deuticke:1934

**Caffeine/chamomile enemas**

At this point it should be recalled that in highly febrile pneumonia my teacher KRÖNIG ordered an intestinal tube, which remained until the fever resolved; ORTNER has also regularly prescribed enemas for pneumonia.

Slide 38

Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig & Vienna; Franz Deuticke:1934

Detoxification .. *In my opinion* — Gerson writing in *A Cancer Therapy* — *primarily because comprehension of the detoxification has always been overlooked in clinics, we are not sufficiently trained in that direction.* — There is no real training in detoxification, per se, at any of the major teaching hospitals and medical schools.

Now, Gerson, in his tuberculosis days relied on caffeine/chamomile enemas ... *Severely ill patients* — this may be unorthodox but this is what was done to cure 51 cases in the textbook of bilateral lung tuberculosis that was refractory for at least three years to all efforts — *Severely ill patients receive enemas in the morning and evening; less advanced patients receive an enema at night before going to bed. Basic rule: with a high fever, exudative processes, diarrhea, and in suspected recurrence of pulmonary hemorrhage, many enemas, at least 2 - but sometimes 3 per day.* — Many is a relative term when we get into cancer. — *In particularly threatening acute conditions (galloping consumption), I've given even four enemas daily. So many enemas would weaken the patient too much if they were not treated with caffeine. In general, the enema is given according to the following recipe: one liter of warm chamomile tea with 20 drops of a 10% caffeine/sodium benzoate solution; can be run slowly and under low pressure! After several days, infrequently after several weeks, the patients begin to evacuate massive quantities of dark-colored or black, very foul-smelling stool. Sometimes oily, light-to-dark-green masses swim on the surface of the faeces. With moderately-ill tuberculous patients, the number of enemas can be reduced after the disappearance of these stools.*

I can't resist noting an Australian veterinary pathologist by the name of Ian Gawler, whose own miraculous recovery from chest-wall-metastasized osteosarcoma, status post amputation of a lower limb, through diet therapy under the treatment of Ainslie Meares, published in the 1978 — one of the 1978 issues of the *Australian Journal of Medicine*. Gawler came up with a diet for dogs that borrowed from Gerson, but adapted it to the species. We had a Labrador who was 18 years old and suffering hind quarter paralysis, that is pseudoparalysis, she was losing it. We put her on Gawler's diet and it didn't take two

weeks, it was a day. And this exact phenomenon occurred with a black, oily, wreaking discharge and the dog recovered hind-quarter mobility. And we had her until she was 19½ years old. A Labrador.

**Chamomile tea enema**

This recipe can be used as a tea to drink, very soothing comforting — or as part of an enema if prescribed by your physician.

4 Tbsp chamomile flowers, dried

1 quart distilled water

Place flowers in boiling water and allow to boil for 5 minutes, strain

Slide 39

**Amounts for 3-day supply of CONCENTRATE using Wilsons "blond" coffee OR "black" light-roast coffee**

Rx:	Total enemas	Black coffee	Wilson's coffee	Water
3/ day	9	2 1/4 Cups	1 3/4 Cups	9 Cups
4/ day	12	3 Cups	2 1/4 Cups	12 Cups
5/ day	16	4 Cups	3 Cups	16 Cups

Slide 40

**Coffee enemas**

Slide 41

FULL-STRENGTH "READY TO USE" COFFEE RECIPE

If making 5 enemas using Wilson's "blond" coffee, it is legitimate to round up from 15 tablespoons to 16 Tbsp (which equals 1 cup) coffee to 5 quarts of water. When using organic "black" coffee you would use approximately 20 Tbsp (which equals approximately 1-1/4 cups) coffee to 5 quarts of water. Cooking instructions are the same as for the concentrate. After straining, it is okay to replace boiled-away liquid, adding purified water to bring the batch back to 5 quarts of "ready to use" coffee.

All right, Gerson writing in the pulmonary textbook ...*At this point it should be recalled that in highly febrile pneumonia*—this is in his own defense—*my teacher KRÖNIG ordered an intestinal tube, which remained until the fever resolved; ORTNER has also regularly prescribed enemas for pneumonia* ... He's just saying, hey, you know, I'm not the first (Slide 38).

We've included a recipe for the chamomile tea; you can review it when you get the pdfs from Liz. I just sent her ... what's in your book is pretty much place markers. A lot of this stuff isn't in there, so when she emails it to you, you'll have it. (see Slide 39).

And this is how to do coffee. The Wilson coffee we're referring to here is manufactured by Canada's sawilsons.com and the reason we suggest people take an interest in it if they're going to be using coffee enemas in the treatment of disease and cancer, per se, is that it's only roasted enough that the rollers don't clog. It's blond. It smells like peanuts and you certainly would not want to drink it, but it's highly effective for coffee enemas because the beans that were selected by Wilson are the highest in palmitates, the medically active substance in coffee, the palmitic acid salts of kahweol and cafestol (see Slide 40).

Moving forward. Again, we won't spend any time on this. You can study it later from the pdf. Full-strength "ready to use" coffee recipe. Making coffee enemas.

The diet: There were tuberculosis and cancer diets at different times. In cancer there was a move from a brewer's-yeast-centered to a liver-juice-centered diet. There's a lot of back story to these. I just wanted to cover the primary development, which is the tuberculosis diet; and bear in mind that the cancer diet was described by Gerson as the "modified Gerson diet". I emphasize this because you can't pick up *A Cancer Therapy* or any book subsequently authored, say by Straus and Walker, or any other text book, and actually get any Gerson, or any of the sciency stuff.

**Making coffee enemas**

Slide 42

1. Combine coffee and water in a large pot.
2. Place over high heat, uncovered.
3. Bring to a rolling boil for 5 minutes or until foam is visibly decreased.
4. Cover, lower heat and simmer for about 6 hours when using Wilson's "blond" coffee. If you are using "black" coffee you only need to simmer for about 20 minutes. Strain – NO PAPER OR CLOTH FILTERS!
5. Replace water that has boiled away by rinsing grounds and adding liquid to container of concentrate.

To use concentrate: Combine 1 Cup concentrate + 3 Cups boiled purified water (warm enough to make solution slightly warmer than body temperature 102-104? ).

**Diet**

- a. Tuberculosis
- b. Cancer
- c. Brewer's yeast and liver

**The diet for tuberculosis (the original development)**

**OUTLINE OF DIETARY STAGES**

**Strict diet stages**

- I. Raw food: as an introduction to the dietetic treatment, 3-4 (very rarely 5-7) days; further, in certain forms of tuberculosis as a catalyst 1-2 times a month, 3 days each.
- la) Liquid pureed raw foods: for the severely ill, for highly febrile patients, for laryngeal tuberculosis, and for severe diarrhea.

Slide 44

**Diet stages (cont)** Slide 45

II. Basic diet: after the initiation of the dietetic treatment at stage I, 3-14 days.

III. Basic diet + egg yolks: subsequent to stage II; 1-3 weeks.

IV: Basic diet + egg yolks + liver: subsequent to stage III; gradually increasing 100-600 g of liver, brain, sweetbreads and spleen are added.

Gerson MB. Diet therapy for pulmonary tuberculosis. 1934;Vienna & Leipzig;Franz Deuticke

**Diet stages (cont)** Slide 46

Less restrictive diet stages  
(With far-advanced recovery.)

V. Basic diet + egg yolks + liver + pot cheese: pot cheese and later yogurt are gradually added to stage IV. In addition, cream and other culinary ingredients are allowed.

VI. Stage V + 100 g meat: towards the end of the dietetic treatment, 100 g meat once a week, later 1 or 2 egg whites a week, and more abundant culinary ingredients.

Gerson MB. Diet therapy for pulmonary tuberculosis. 1934;Vienna & Leipzig;Franz Deuticke

You get a whole lot of the, what I call Thomsonian stuff. Anybody familiar with the Thomsonian movement back in the 1800s — a self-help herbalist kind of Tupperware network. Alright.

Outline of dietary stages for tuberculo-

**Diet stages (cont)** Slide 47

Aftercare.

VII. To stage VI are added 80-100 g fish once a week, one egg white a day, more abundant sugar and pastries.

VIII. *Permanent diet for allergy burdened tubercular patients:* egg white, flour and sugar according to taste and digestability; milk to 1/2 liter a day, meat 2 or 3 times per week, cheese occasionally 100 g.

IX. Transition to a normal diet: Coffee and tea. Several times a week moderately salted food.

Gerson MB. Diet therapy for pulmonary tuberculosis. 1934;Vienna & Leipzig;Franz Deuticke

sis, as you can see, started with raw food and only raw food for 3-4 days, rarely 5-7 days. This would be a non-antigenic feeding. There would be very little antigens, very low hormones in this; none of the complex materials you would find in eggs and meat and fish and fowl and so on. *Liquid pureed raw foods: for the severely ill.*

The basic diet in stage II (slide 45). In stage III we add ... the basic diet ... well, it's all in the slides. The basic diet plus egg yolks, then we add liver, then we add pot cheese and finally there's some meat towards the end of the treatment, even, as you see, finally getting to one or two egg whites a week.

**Diet stages (cont)** Slide 48

Intervention diets.

A. *Raw food days as Stage I:* 3-4 days in a row, with minimum 10-14 day interval.

B. *Apple-potato days:* 3-4 days in a row, with minimum 12-15 day interval.

C. Special conservative diets: 1. for loss of appetite, 2. for biliary colic and gastrointestinal disturbance, 3. intestinal tuberculosis, 4. nontuberculous intestinal disturbances, 5. Basedow, 6. diabetes, 7. kidney damage.

Gerson MB. Diet therapy for pulmonary tuberculosis. 1934;Vienna & Leipzig;Franz Deuticke

At stage VI you get the fish once a week and one egg white. This is fascinating stuff because protein restriction was actually the medical strategy to evoke nonspecific immunities and allergic inflammatory responses that cured many cases of pulmonary tuberculosis that were refractory to prior treatments. Transition to a normal diet, finally, down here. You can see that his effort was to get you off this, not to put you on it for life.

There were several intervention diets. And I find the apple-potato days particularly interesting. I've included a little slide with an explanation by Gerson why he was doing this. Why would we put you on raw food and then give you as much apples and potatoes as you can eat? And then special conservative diets, this would be like a BRAT diet.

**Diet stages (cont)** Slide 49

All these forms have certain requirements, and certain prohibitions, in common. These prohibitions and requirements define the uniform nature of Gerson diet, and the necessity of specially adjusted kitchen technology.

In order to avoid repetition in the discussion of individual diet stages, we deal first with these common principles.

Gerson MB. Diet therapy for pulmonary tuberculosis. 1934;Vienna & Leipzig;Franz Deuticke

**Diet stages (cont)** Slide 50

Prohibited

In all diet levels up to the transition to normal diet, *rock salt* (even in small quantities, such as in cakes etc), *nicotine*, *canned foods*, certain *spices* (pepper, vinegar, curry powder), chocolate, cocoa, refined sugar, factory-made fruit juices, fruit wines, pastries, cakes, etc. from *wheat flour*, candies, *meat soups*, alcohol, coffee and artificial coffee, Russian tea (drinking forbidden, but allowed as medicine), *pasta* (noodles, macaroni, etc.)

Gerson MB. Diet therapy for pulmonary tuberculosis. 1934;Vienna & Leipzig;Franz Deuticke

This is a unified field statement here ... *All these forms have certain requirements, and certain prohibitions, in common. These prohibitions and requirements define the uniform nature of Gerson diet, and the necessity of specially ad-*

*justed kitchen technology. In order to avoid repetition in the discussion of individual diet stages, we deal first with these common principles.*

*In all diet levels up to the transition to normal diet, rock salt (even in small*

*quantities, such as in cakes etc), nicotine, canned foods, certain spices (pepper, vinegar, curry powder), chocolate ... You can see it (slide 50). These are things he said, you just don't want to put in the gut. One of the reasons was he was making your gut transit real fast; he was filling you full of raw juices and giving you enemas and pumping your gut. He was making the hypersensitivity, making you really hypersensitive, so you could get colicky; he was trying to avoid that.*

*In addition to these strict prohibitions, there are others that are somewhat less categorical prohibitions. So, without exception dry legumes and chestnuts, and polished rice ... cucumbers, plums, pears... This is gastrointestinal sensitivity. He says he allows nuts, almonds and hazelnuts as ingredients only quite finely ground and in small quantities. Prohibits water because you won't drink enough juice. He was just trying to get plant materials in the body, that's why no water.*

**Diet stages (cont)**

In addition to these strict prohibitions, there are others that are somewhat less categorical, but which must also be observed carefully, at least for more severe pulmonary disease. So I prohibit without exception *dry legumes* and *chestnuts*, and *polished rice* up to stage VI (longer with gastrointestinal sensitivity). I also prohibit cucumbers, plums, pears with gastrointestinal sensitivity. I allow nuts, almonds and hazelnuts as ingredients only quite finely ground and in small quantities. Water (as a drink) is also prohibited, first of all because the patient would not drink enough juices, and secondly would get gastric discomfort from the juices + water.

Slide 51

Gerson MB. Diet therapy for pulmonary tuberculosis. 1934;Vienna & Leipzig;Franz Deuticke

**Diet stages (cont)**

Finally, the diet is further complicated by the fact that, at least up to stage IV, milk and cream are also virtually forbidden as culinary ingredients, moreover that the use of fine wheat flour remains restricted to just a few grams per week, and that raw sugar and honey as well may be used only in modest quantities.

Slide 52

Gerson MB. Diet therapy for pulmonary tuberculosis. 1934;Vienna & Leipzig;Franz Deuticke

Slide 53

Raw food diet	Cal	Protein g	Fat g
Fruit (a total of 800-1600 g)			
To 600 g oranges, tangerines, grapefruit	300	4.8	
To 300 g bananas	300	3.9	
To 600 g apples, peaches, cherries sour cherries	375	3.4	
5-10 g walnuts, hazelnuts (as ingredients)	30	0.8	2.7
5-10 g oatmeal (as ingredients)	49	1.4	0.7
To 300 g raw vegetables e.g. carrots, tomatoes, kohlrabi, radishes, lettuce	87	4.8	1
To 5 g olive oil (as ingredient)	45		5
To 5 g honey (fruit salad)	17		
To 20 g dried figs, plums (fruit salad)	55	0.6	0.2
<b>Total</b>	<b>1258</b>	<b>19.7</b>	<b>9.6</b>
Approx 600 g fruit juice and Approx 1000 g vegetable juice	<b>550</b>	(?)	<b>12.1</b>
<b>Total</b>	<b>1808</b>	<b>31.8</b>	

Slide 54

Range g	Avg g	Basic diet in addition to raw food	Cal	Protein g	Fat g	Carb g	NaCl mg
300-500	400	Warm vegetables: Cauliflower, carrots, kohlrabi, cabbage, spinach, brussel sprouts, incl butter, oil	552	14.4	36.0	39.2	372
200-600	400	Potatoes (values for raw)	360	8.0		80.0	368
	20	Oatmeal (for porridge)	79	2.8	1.4	13.4	20
80-125	80	Butter (after deduction of butter for steamed vegetables)	628	0.6	69.0	0.6	552
	100	Rye bread (with 10% soy flour)	250	9.0	2.4	46.4	20
	10	Raw sugar	37	0.1		9.2	
0-30	20	Potato flour, rye flour, etc.	68	1.2	0.1	15.4	11
		<b>TOTAL</b>	<b>2595</b>	<b>44.5</b>	<b>121.7</b>	<b>467.7</b>	<b>1734</b>
		Plus: Juice as in raw food	550	12.1		48.0	?
20-24		2 Tbsp cod liver oil = 22 g	218		21.1		
		<b>TOTAL</b>	<b>3363</b>	<b>56.3</b>	<b>186.8</b>	<b>508.7</b>	<b>?</b>

Slide 55

Basic diet + 6 egg yolks

	Cal	Protein g	Fat g	Carb g	NaCl G
Stage II	3363	56.3	186.8	508.7	1734+?
6 yolks	342	15.0	29.4	0.24	48
Total	3705	71.3	216.2	509	1782+?

Gerson MB. Diet therapy for pulmonary tuberculosis. 1934;Vienna & Leipzig;Franz Deuticke

Finally, the diet is further complicated by the fact that ... complicated in terms of making it taste bad ... up to stage IV, milk and cream are also virtually forbidden...wheat flour remains restricted to just a few grams per week...

Here's the diet, it will be in your pdf when it's sent to you. I just want to point out that the total calories is 1,808 and 32 grams of protein, so approximately 7% plant-based protein.

When we move to the basic diet after we're in the switch between raw foods and apple potato days, here we see a repleting diet, so we've got more calories than you or I probably would want to eat unless we're out on the tennis court or taking hikes. But again, the protein remains at 7% even during the repletion phase of tuberculosis.

My comment here is that Gerson used egg yolks because they worked to help him resolve tuberculosis infections and get the people eating again; eating normally again. He used them because they worked. Nobody knew what was in egg yolks, we still don't really know. Listen, we have a fantasy world when it comes to food. We look at food and we say, "Yogurt, it's got calcium." What kind of reductionist, simplistic silliness is that? Same with a plant. We look at a plant. It's got more than 10,000 phytochemicals, each plant is different, and we're going to say, "it's got vitamin A" or it's got lycopene, proanthocyanidins, come on. It's got stuff we haven't even dreamed of yet. So the logical approach, which Gerson did, was empirical, trial and error, under closely controlled clinical conditions with graduate students and technical assistance and expanded laboratory support. My god, if only, right? This is the first place I've looked that I've found "what does an individual food actually do to a sick body?"

Again, the basic diet once you add the egg and the liver, we're up to 3779 calories. Protein is now just over 9% and cholesterol is over the moon.

Apple/potato days, okay, there's what they are. About — now this is strict — about 4% plant-based protein and obviously a modest calorie input, about 2661. Now, tuberculosis used to

have labor-sparing diets, and they were always low-carbohydrate, low-calorie diets because it was assumed that, you know, these would lead to CO2 build up in the lungs of the tuberculosis patient. If you look at the literature of the past, you will see that was a strategy used universally in the tuberculosis sanatoria around the world.

Okay, apple/potato days; what do they do? *The blood picture of healthy subjects* — really, he used controls? How clever. — *during apple/potato days also shows an increasing leukocytosis with a shift to the left*, — we've got bandemia happening because we're eating apples and potatoes — *It appears to be clear that this 'potassium*

Slide 56

Basic diet + egg + liver

	Cal	Protein g	Fat g	Carb g	NaCl G
Basic diet + 6 yolks	3705	71.3	216.2	509	1782+?
Up to: 93 g liver	165	18.7	7	5.3	131
Less: 45 g vegetables	61	1.6	4	4.3	41?
30 g potatoes	30	0.6	---	6	28?
Diet stage IV	3779	87.8	219.2	504	1844+

Gerson MB. Diet therapy for pulmonary tuberculosis. 1934;Vienna & Leipzig;Franz Deuticke

Slide57

Apple/potato days

Dosage g		K <sub>2</sub> O mg	Na <sub>2</sub> O mg	NaCl mg	Protein g	Cal
1600	Apple juice from approx 3 kg apples	2.46	480	60	?	?
1200	Apples	984	192	24	4.8	708
1000	Potatoes with skins	6.67	270	820	20.0	900
50	Butter	31	212	345	0.35	393
400	Lemons, oranges, grapefruit	2.20	24	12	2.0	160
	Total	12.345	1178	1261	27.15	2661

Gerson MB. Diet therapy for pulmonary tuberculosis. 1934;Vienna & Leipzig;Franz Deuticke

Apple/potato days

The blood picture of healthy subjects during apple/potato days also shows an increasing leukocytosis with a shift to the left, which quickly diminishes after protein is increased with an otherwise unchanged diet. It appears to be clear that this 'potassium thrust' owes its stimulating effect largely to simultaneous protein underfeeding.

Slide 58

Gerson M, von Weisl W. Fluid rich potassium diet as treatment for cardiorenal insufficiency. *Wien Med Wochenschr.* 1935-04-11;82(15):571-574



*thrust*’ — this was the context in which he was talking — *owes its stimulating effect largely to simultaneous protein underfeeding*. I would just comment here that Gerson tends to be a little bit reductionist in thinking of apples and

potatoes as supplying a lot of potassium, but what else they supply, really, is of great interest — we don’t know, you know. Phytochemical studies at the Division of Cancer Prevention at the National Institute of Cancer (NCI) are dumping stuff on us all the time. And it’s fascinating.

Okay, let’s have a look at the cancer diet as first introduced in the *Review of Gastroenterology* in 1945: “*Essentials of the diet (Modified Gerson Diet)*” — See, he’s calling it the “modified Gerson diet,” so anybody who says that the cancer diet is the only diet that there ever was is misrepresenting what this scientist did. And this scientist is unique. You know what ... Albert Schweitzer was so grateful to Gerson for curing his wife — and I’ll present her case in the course of this module — he called Gerson, in a letter to Frau Gerson, on Gerson’s death, he said, “He was a medical Christ who walked among us.” Strong words from a Lutheran organist, Nobel-Peace-Prize-winning missionary medical man.

We don’t need to go over this right now, but it cleaves very much to the tuberculosis approach.

The cancer diet, in its forbidden list is again pretty much the same as in the tuberculosis diet. He wasn’t reinventing the wheel with cancer, he was going off label; that’s all he was doing, going off label.

The stages here, we’ve included these because they are important. I would note that patients who have their guts pumped with raw juice and the enemas are going to be more likely to have more trouble with pineapple and berries, which cause some so-called normals to have heartburn, so that is why that is in there. It has nothing to do with aromatic fatty acids or sodium content or anything like that.

This particular soup was the subject of a lot of studies at the University of Munich and to summarize, we’re talking about parsley root, leek, and celery knob. The tomatoes and potatoes that Gerson talks about, not so important, they were flavor and energy. But the medicines are parsley root, leek and celery knob. Now, this soup is capable of causing sodium-loaded diuresis. Alright, it is a very simple soup when it was originally built. It was thousands of years old. It really was Hippocrates’ soup. The real Hippocrates (Slide 63).

#### The cancer diet Slide 59

##### Essentials of the diet (Modified Gerson Diet)

1. Saltless (no salt, no sodium bicarbonate, nor other minerals belonging to the Na-group).
2. Fatless (all vegetables or foods containing fats, fatty acids or lecithin are excluded).
3. Poor in animal proteins (the first six weeks without any protein, later milk products in limited quantities).
4. Rich in mineral of the K-group (Dicalcium phosphate and selected fruits and vegetables rich in the minerals of the K-group).

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#### The cancer diet Slide 60

5. Rich in carbohydrates from plants and fruit.
6. Abundant fluid (vegetable soup and various juices).
7. Rich in vitamins (by adding Brewer’s Yeast, fresh fruit and vegetables as well as fruit juice and vegetable juices).
8. Rich in some liver substances and enzymes (including defatted liver powder from young animals, 3-5 capsules a day, and liver injections of Crude Liver Extract — 10 cc. Equal to 10 U.S. units. The first few weeks, 2 cc. Daily, then every other day, later twice weekly; injected intramuscularly, best in the gluteus medius).

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#### The cancer diet

The treatment may be divided into four stages:

Forbidden:

Nicotine, salt, sodium bicarbonate and other sodium compounds, alcohol, coffee, tea, cocoa, chocolate, spices with certain exceptions, pickles, smoked fish, sausages; all canned, preserved and bottled foods; white flour, refined sugar, candies, cakes, ice cream, butter, all animal and vegetable fats, nuts.

Temporarily forbidden:

Meat, fish, eggs, milk, cheese, bread.

Slide 61

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#### Stage One: necessary daily Slide 62

Fruits (all kinds permitted except alligator pears, pineapples, berries, pomegranates); pears and plums when stewed.

Especially required are: apples in every form, such as raw, grated, baked, stewed, and in the form of apple sauce; also spinach, lettuce, carrots, and potatoes.

Allowed are: some dried fruits, such as prunes, peaches, apricots, soaked and stewed un sulphured or carefully washed off.

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#### Stage One: necessary daily

A Special Soup: One to one and a half quarts a day. Half consists of: parsley root, leek, and celery knob; the other half, of tomatoes and potatoes. The vegetables are to be diced, covered with water and cooked for two hours.




The soup may be taken as ordinary soup or as a thick mash. It may be prepared in quantity for one or two days use and kept well covered in a refrigerator. To make it "tasty" add the following: onions, chives, horseradish, garlic, thyme, any fresh garden herbs, green pepper. Spread parsley leaves on it or powdered yeast, or add a few drops of lemon in the plate.

Slide 63

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Hippocrates soup – a sodium-losing diuretic

Slide 64

Parsley root

Leeks

Celery root

**HIPPOCRATE'S SOUP STOCK**

1 Cup celery knob chopped      Slide 65  
 1 Cup parsley root chopped  
 3 Cups chopped leeks  
 3 Cups chopped onion  
 A handful of fresh thyme (optional)  
 garlic as desired

Do NOT peel any of the vegetables; just wash and scrub them well and cut them coarsely, place them in the pan, then COVER WITH HOT PURIFIED WATER. SIMMER slowly for 2-3 hours, then strain\*. Makes about 4 quarts of soup stock (2 days worth).

These are the materials that can go in to make a clear that actually is a safely-multiple-times-daily-repeatable, sodium-losing diuretic. So if you've got a patient that is sort of skinny-fat, this is a wonderful material to use. And there is no

equivalent in the pharmacopoeia of the world right now.

Slide 66      **Stage One: necessary daily**

Potatoes: baked potatoes — as many as possible; potato and celery salad mixed, or mashed potatoes made from the baked potatoes, mixed with a little of the special soup.

Fruit salad, preferably consisting of some of the following: oranges, grapefruit, apples, grapes, tangerines, cherries, apricots, peaches, mangoes. Melon, banana or persimmons may be added.

Stewed fruit or compotes, such as apple sauce with raisins or prunes or certain other dried fruit; if they are to be sweetened, use brown sugar or molasses. Some patients are hypersensitive to dark honey, and prefer maple sugar, maple syrup, glucose, Karo, light honey or molasses.

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So let's take briefly a look at Gerson's cancer stages as they were first introduced. In stage 1, we see an emphasis in feeding potatoes, so what he was trying to do here was push or stimulate, whereas his lung tuberculosis patients couldn't handle the push of carbohydrates. Gerson felt that the cancer patients mostly could, although my suspicion is that in pulmonary disease or metastatic to lungs that one would run into a little trouble with too much carbohydrate push if you're doing strictly only diet therapy, which, frankly, at the hospital that I am research director for, we don't do just this, but this is a practicum on just this and where we go from here. It's a tool for the toolbox is what I am saying. Again stage one, these are going to be in the pdf, so we don't have to read this out loud.

**Stage One: necessary daily**      Slide 67

Salad: lettuce, watercress, tomato (less important are: endive, chicory, escarole, romaine, radishes), mixed with finely grated raw vegetables, such as carrots, cauliflower, red beets, kohlrabi, etc.

Dressings: lemon juice; also if desired, a few drops of wine-vinegar. No salad oil or other oil or fat.

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I want to point out one thing here, that in the initial iteration of the diet therapy in 1945, in the *Review of Gastroenterology*, Gerson really gave people a lot of citrus juice, four glasses of orange juice and two to three glasses of grapefruit juice, juice of half a lemon in each (slide 68). These were actually given in the tuberculosis diet as mucolytic and I would add, the Hippocrates' soup clear is also mucolytic and, therefore, it is affecting mucous membranes throughout the body not just in the respiratory tract. More on that as we get into the theory behind this and some of the practice. You know, people are familiar with a carrot juice and coffee enemas approach by Gerson. That's been popularized by modern proponents, but it really doesn't have much to do with Gerson's actual trajectory.

**Stage One: necessary daily**      Slide 68

Fluids: Since large amounts of other fluids are given, it is preferable not to give water but, instead, **three to four glasses of orange juice** and **two to three glasses of grapefruit juice**. Add the **juice of half a lemon to each** and, if possible, add **one glass of tomato juice or grape juice**; in further advanced cases **a few glasses of apple and carrot juice**, also a preparation consisting of mashed apples and carrots, mixed half and half — all freshly pressed. Do not use metal squeezer or one with a cap (the latter tends to press undesirable aromatic oils of the skin into the juice).

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His first case of cancer was treated in 1928, so he was about twenty years into treatment of cancer, nearing twenty years of treatment of cancer cases, at this point.

As you can see, he moved from steaming vegetables to waterless cooking for nutrient preservation. You gotta cover the pot, don't let the steam out, don't add any water. In the tuberculosis diet, he steamed his vegetables, just for what it's worth. You can review all this later, but it's just all about trying to keep as high a nutrient load in the food material as possible and destroy as little as possible (Slides 69, 70).

I think it's interesting that he found so much rye flour well tolerated, you know, a third of a pound a day of rye bread and you know rye flour as crust for apple pie, very interesting. But this was his conviction, that rye was a grain that was better tolerated when you're trying to make a non-specific innate immune response occur throughout the body. So, I can't talk about what's in it, or why the other grains won't work, I can only point out that the empirical approach yielded rye flour (Slide 71).

The received wisdom regarding Gerson is erroneous and disinformative, but the real diet is actually pretty interesting. So taking a quick overview, what we see is that there are some unconventional materials included, if we think about what commonly is perceived to be the correct approach, but this is the result of a clinical investigation. Remember, it's multiple interwoven disciplined inquiries.

Now, there's a fourth stage in the original cancer therapy, at which the dairy products start to come, and the second paragraph I find helpful in understanding what kind of wiggle room Gerson perceived there was. The different conditions had to be adapted to, when the ... *gastrointestinal tract is involved ... raw foods (except juices) have to be excluded ... when you're dealing with a sick intestinal tract ... the fruit must be stewed, the vegetables strained, the raw fruit and vegetable juices mixed with gruel, half and half, etc.* — very logical, very naturopathic in approach. And, as tolerance increases ... *a larger proportion of the vegetable juice is mixed with the gruel.* This is for the GI patients (Slide 72, 73).

We have medications being added. Niacin was not popularly used at that time, and these are some pretty aggressive doses of niacin; although, I would just comment, tangentially, that at Centro Hospitalario Internacional Pacifico, S.A. (CHIPSA) which is down in Playas, we use some larger doses of niacin as we get people farther out on the diet therapy. We encourage

#### Stage Two (after 2 weeks) Slide 69

The same diet as above with additions:

Among these, all vegetables are allowed (except mushrooms); to be stewed very slowly in their own juices according to the following rules:

1. With no added water or steam.
2. The vegetables are not to be scraped but washed with a brush.
3. The pot must be tightly covered so that the steam cannot escape. Adhesive tape may be used but not pressure cooker (Exception: it is not necessary to cover spinach tightly).

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#### Stage Two (after 2 weeks) Slide 70

4. Do not use aluminum pots or other aluminum utensils. Use: stainless steel, Pyrex, enamel, earthenware, iron with enamel, or enamel pots with glass cover.
5. Let the vegetables cook slowly with a low flame about one to one and a half hours, without water and without salt. If the vegetables are too dry and have been stored too long, soak them before cooking in lukewarm water not more than fifteen minutes so that they can re-absorb the lost fluid. (It is important not to soak vegetables for a longer period since their minerals tend to dissolve in the water.)

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#### Stage Three (after 4 weeks)

Add to the preceding list: pumpnickel rye bread, salt-less, 1/3 of a pound a day. Sandwiches of pumpnickel with: tomatoes, radishes, chopped parsley, lettuce, raw finely grated vegetables, especially carrots (no butter). Tomatoes or green peppers filled with brown or wild rice. Apple pie made with rye flour, raisins, etc.

Slide 71

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#### Stage Four (after 6 weeks)

In addition: one glass of buttermilk and, after one week, two glasses; pot-cheese or farmer's cheese (without salt or cream), a quarter of a pound a day, later half a pound; yoghurt or acidophilus milk without cream, one to two glasses a day.

The description of the four successive diets given above, covers only the essentials. It is obvious that they must and can be adapted to different conditions, especially when the gastrointestinal tract is involved. Then raw foods (except juices) have to be excluded — the fruit must be stewed, the vegetables strained, the raw fruit and vegetable juices mixed with gruel, half and half, etc.

Slide 72

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#### Stage Four (after 6 weeks) Slide 73

As the patient's digestive tolerance increases, a larger proportion of the vegetable juice is mixed with the gruel.

The method of preparation of the above described diet will be reported in every detail in another article, as well as the fundamentals of further treatment, and tables showing the context of the diet in minerals, vitamins, etc.

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#### Medication Slide 74

The patient receives in addition the following substances:

1. Dicalcium phosphate with Viosterol, 6 tablets a day, well chewed.
2. Niacin, 50 mg. 8 to 10 times a day, after meals or juices, dissolved on the tongue. In severe cases we start with one tablet every hour, day and night for few weeks and then repeat this for three days in intervals of one week and during the flare-ups, but patients are not to be disturbed when asleep.
3. Lubile (dried powdered bile form young animals) or Desicol, 2 capsules 4 to 5 times a day — after the first half of the special soup or juice.
4. Liver powder with iron, 1 capsule 3 times a day.

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### Medication

6. Vitamin A & D capsules, concentrated; twice 2 capsules.
7. Liver injections, crude liver extract (Lilly), 10 units per 10cc, 2 cc intramuscularly daily.
8. After six weeks, Dicalcium Phosphate with Viosterol has to be changed to 6 teaspoons of Phosphorous Compound, which is the same composition without Viosterol. In severe cases, we add at the beginning one teaspoon of Phosphorus Compound to each glass of juice for a few weeks in addition to the Dicalcium Phosphate.

No other medication should be used.

Slide 75

Gerson M. Dietary considerations in malignant neoplastic disease; preliminary report. *Rev Gastroenterol.* 1945-11/12;12:419-425

How does the gut promote the IgA response? ... TGF $\beta$ , TSLP, vitamin A and vitamin D have been shown to suppress T<sub>H</sub>1-type and DTH responses and promote the production of IgA.

Slide 76

Matzinger PC, Kamala T. Tissue-based class control: the other side of tolerance. *Nature Reviews Immunology* 2011;11:221-230

The first report on the use of a combination of dietary factors, minerals, vitamins and crude liver injections, as a possible controlling or arresting influence on the course and symptoms of malignant neoplastic disease was published by us in 1945. The results of ten cases were presented, along with the details of treatment.

Since that time, **the dietary factors have remained the same**, but several minerals and biological products have been added to the list of medications used originally. This combined dietary regime will be referred to as GDR (Gerson dietary regime) in this and subsequent articles.

Slide 77

Gerson M. Effects of combined dietary regime on patients with malignant tumors. *Exper. Med. & Surg.* 1949-11;7:299-317

7. Medication: niacin, brewer's yeast, vitamins A and D, lubile (fresh de-fatted bile in capsules), liver and iron capsules, dicalcium phosphate and viosterol, injections of crude liver extract intramuscularly.
8. **For the last 3 years**, we have added **Lugol solution and thyroid extract** to the above, as it has been our impression that the patients are benefited more rapidly by this addition.
9. **For the last 2 years**, we have added generally a **10% solution of potassium phosphate, acetate, gluconate aa**. And **pancreatin** (Armour) and **vitamin C** in far advanced cases.

Slide 78

Gerson M. Effects of combined dietary regime on patients with malignant tumors. *Exper. Med. & Surg.* 1949-11;7:299-317

them to go to a gram and a half b.i.d., divided by at least eight hours' interval, so that the liver can reload its mast cells, because if you give slow niacin at high doses you get liver enzyme abnormalities, which you don't want to do. This was learned in the big physician's study on control of cholesterol with niacin, in which huge doses were tolerated — ten grams a day. We only go for Abram Hoffer's doses, about three grams.

Also, we don't use iron. Gerson used liver powder with iron. Anybody who knows Eugene Weinberg's work out of the Iron Disorder's Institute is not going to give anybody with a chronic inflammatory disease iron, unless they are hemorrhaging. They're just not going to do it, because iron is probably the most carcinogenic metal known (Slide 74).

Here we see the introduction of the vitamins A and D, which are several of Polly Matzinger's favorite nutritional materials regarding the gut-controlled IgA response (Slide 75). In fact, let's look at what Polly says about that ... *How does the gut promote the IgA response? ... transforming growth factor beta (TGF $\beta$ ), thymic stromal lymphopoietin (TSLP) — delayed-type hypersensitivity response, right? We're talking about ... vitamin A and vitamin D ... along with TGF $\beta$  and TSLP ... promote the production of IgA ...* in the gut. In other words, they are going to be leading to an expression of innate immunity because you get the gut going and the rest of the connective tissue tends to sing along.

Just a reminder that we are still using mostly citrus juices in 1949 in the *Journal of Experimental Medicine & Surgery* when Gerson writes another article, does some modifications in the medications, we are still doing citrus juices ... *the dietary factors have remained the same ...* but, we made some changes in the name, we're going to call it GDR now, Gerson Dietary Regime, and we're changing the medications. We've added ... *For 3 years ... Lugol solution and thyroid extract ...* and, for 2 years, a ... *10% solution of potassium phosphate, acetate, gluconate aa, and pancreatin* (Slides 77, 78). The pancreatin is sort of self explanatory, the vitamin C, we don't have any problem with. Why would you use those particular potassium salts? Think about the Krebs' cycle. Those were aimed at mitochondrial function and energy production, free energy production, and the same is true of the thyroid extract. Basic rules of thumb of high loading doses of thyroid are that thyroid talks directly to the mitochondrial genome and saying, "go thou and multiply," and the second message is, "be fruitful," so you get replication of mitochondria because they have their own DNA and RNA and replicate independently of the cell, and the babies are bigger than the progenitors and make more ATP because they're running faster. So this is what Gerson was doing, trying to kick start tissue that had been hurt, and in which tissue damage syndrome had begun to take out mitochondria due to failed transport and a shift in sodium, chloride, and water content, you know, the stages of cell death as in *Guyton's Physiology* if you think about it. The stages of cell death: first you leak some sodium ... sorry, you leak potassium ...

you gain sodium and chloride, you swell with too much water, transport goes to down, mitochondria become hyperplastic, they begin to die. So, this is what was being battled.

Now, this is me ...

*The impression has been created by con-*

*temporary proponents of the Gerson Therapy that the diet published in chapter XXXIII of Gerson's text, "A Cancer Therapy" is the authentic one. However, the dates of treatment, and the corresponding dates of Gerson's publications, indicate that, of the "50 cases", only 19 were seen by Gerson during the period of the well-known "13 juices": The 1 orange juice, 5 apple-carrot juices, 4 green leaf juices, and 3 raw veal liver-carrot-apple juices (Slide 79).*

Just, for example, in the *Journal of Experimental Medicine and Surgery* published in 1949, we had case 1 equaling case 33 in *A Cancer Therapy*, published in 1959, and case 2 was case 12; case 3 was case 36 (Slide 80). So you can see that the earlier form of the diet was represented by cases published with only the latter form of the diet, and this creates confusion, but I sort of give Gerson a pass because he lost everything in the U.S. He thought fascism had been defeated in Europe, and he came to the U.S. and found out that we had a big cartel, and he was crushed by it like a maggot. He was isolated. He lost his malpractice insurance, the County Medical Society of New York took away his license, even as the Academy of Sciences was inviting him to join, and the American Cancer Society's vice president was writing and asking for copies of his latest article. So, it was a mess.

Of the "50 cases", 31 were treated — prior to introduction of liver juice and the emphasis on apple-carrot and green leaf juices — during the period of a mostly-citrus-juice regimen. There is only scant statistical evidence for claims that the last version of the diet published by Gerson may have been more effective than earlier versions.

*Of the "50 cases", 31 were treated — prior to introduction of liver juice and the emphasis on apple-carrot and green leaf juices — during the period of a mostly-citrus-juice regimen. There is only scant statistical evidence for claims that the last version of the diet published by Gerson may have been more effective than earlier versions.*

We uncovered some of that evidence during our retrospective review of melanoma patients treated over a period of twenty years at four Mexican facilities. And this is what that comparative Kaplan-Meier looks like (Slide 82).

The top line is patients diagnosed before 1985, and those diagnosed after 1985 indicating that these patients up here would have been in a treatment system before liver juice was dropped, and the lower curve is after liver juice was dropped. Admittedly, it is only associative, but it does sort of hint in the direction that there may have been a benefit to the liver which is consistent with Gerson's work at the university of Munich, where things were carefully measured.

The impression has been created by contemporary proponents of the Gerson Therapy that the diet published in chapter XXXIII of Gerson's text, "A Cancer Therapy: Results of Fifty Cases", is the authentic one.

However, the dates of treatment, and the corresponding dates of Gerson's publications, indicate that, of the "50 cases", only 19 were seen by Gerson during the period of the well-known "13 juices": 1 orange juice, 5 apple-carrot juices, 4 green leaf juices, and 3 raw veal liver-carrot-apple juices.

Slide 79

**For example**

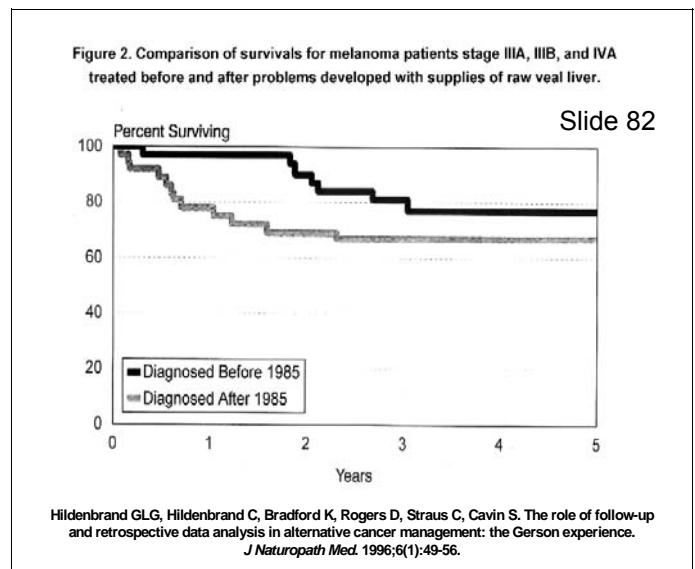
Neither the 1945 or 1949 versions of Gerson's therapy included liver juice (it was first mentioned in 1954; however, the following pre-liver-juice cases were first published in 1949 in *Experimental Medicine and Surgery*, and later republished in 1959 in *A Cancer Therapy* (which monograph gives the impression that all patients received the treatment as published):

<u>Exp Med Surg.</u>	<u>A Cancer Therapy</u>
Case #1.....	Case # 33
Case #2.....	Case # 12
Case #3.....	Case # 36
Case #4.....	Case # 7
Case #5.....	Case # 17
Case #6.....	Case # 30

Slide 80

Of the "50 cases", 31 were treated — prior to introduction of liver juice and the emphasis on apple-carrot and green leaf juices — during the period of a mostly-citrus-juice regimen. There is only scant statistical evidence for claims that the last version of the diet published by Gerson may have been more effective than earlier versions.

Slide 81





Raw veal liver juice was discontinued in the late 1980s due to outbreaks of gastroenteritis found to have been caused by *Campylobacter fetus ss fetus*.

The intriguing melanoma findings leave a lingering question: Is it possible that unintended infection/s by this weak opportunistic bacterium evoked a Coley-type shift in host resistance? Could *Campylobacter*-contaminated liver juice have functioned as an orally administered (inherently risky) fever-vaccine in patients who were infected?

Slide 83

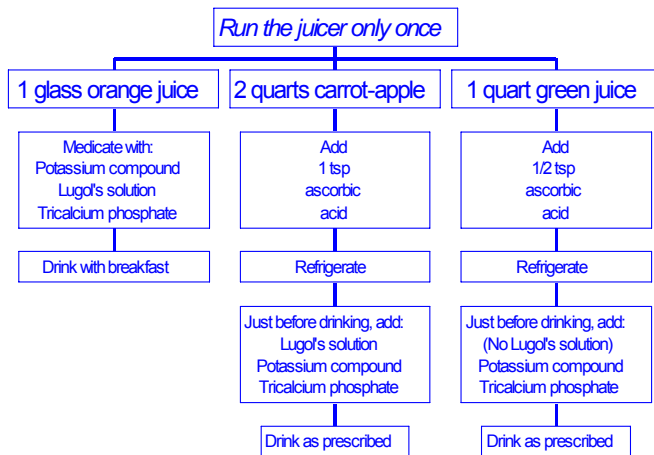
*Raw veal liver juice was discontinued in the late 1980s due to outbreaks of gastroenteritis found to have been caused by Campylobacter fetus ss fetus. The intriguing melanoma findings leave a lingering question: Is it possible — this is one of my favorite brain teasers — that unintended infection/s by this weak opportunistic bacterium evoked a Coley-type shift in host resistance? Could Campylobacter-contaminated liver juice have functioned as an orally administered (inherently risky) fever-vaccine in patients who were infected? — Just asking. We're not going to go back and figure it out.*

We did elect, at CHIPSA, to use the more modern juicing regimen that Gerson developed, because as my former colleague, the departed Eli Seifter of Albert Einstein in New York, pointed out when he was ad-

addressing the American Chemical Society in 1985, even though people weren't taking this very seriously, the way he treated patients was providing about a half a million units of beta carotene a day, so the vitamin A content would have been very important. And as Matzinger points out, that would favor a shift toward IgA production in the gut, suppressing that innate immune hypersensitivity, or delayed hypersensitivity type response.

Slide 84

### Daily juicing



We stuck this in so you would have a reference (Slide 84) — if you have anybody that's on the Gerson therapy, who comes to you, and they are complaining how they hate being on a short chain, like a choke chain, between the juicer and the bathroom all day long — that there is a practical reason for making the juicing regimen mobile. Everybody carries Evian bottles. Why not carry a juice bottle or a thermos, and drink a little every hour? That was the idea; just to get something in every hour. We can keep blood alive on a refrigerator shelf for transfusion for three days, in crude circumstances, why can't juice last a day? You know, never mind questions of "are the enzymes still alive?" Or "does it die between the time it almost gets to the glass and you drink it?" Again, there's a

lot of misinformation, disinformation, and just frank "BS" out there about what this approach is. We stabilize the juice with a little ascorbic acid. And we still use some medications. We use the diet to just make vaccines work better, really, mostly in cancer work. I'll get into that later when we get into the data, the outcomes, and the case reports.

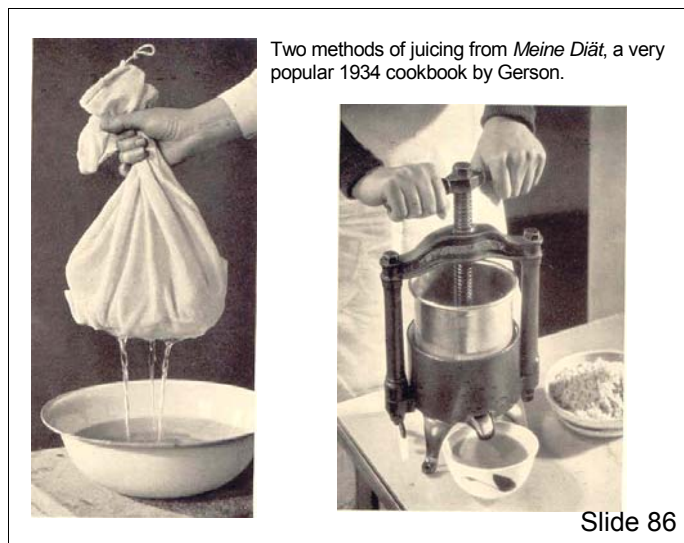
To make 1/2 Gallon (2 Qts) carrot-apple juice you will use about 5 Lbs carrots and 6-8 Green apples.

To make 1 Qt green juice you will use about 1-2 heads of romaine lettuce (depending on size), 4-5 sprigs water cress, 1/2-1 bell pepper, about a 2"-wide slice of red cabbage, a couple Swiss chard leaves, and 3-4 beet tops.

Slide 85

We included this (Slide 85) so you would have a concept of just how much the patient has to use to make the kinds of juices that are necessary to do this, because diet therapy is, if you get into immunology, even if you're doing Sylvia Formenti's approach of creating the abscopal effect in radiotherapy by adding GM-CSF, those patients are going to respond better if they're on a sensitizing diet. You can take that to the bank.

And as regards the Norwalk being the only juicer you can make juice with, because all the other juicers fail to extract everything, these are the juicers that were in Gerson's time (Slide 86). Okay?



Any juicer will work; really, it's the juice, not the juicer that matters. You're just getting more plant materials into the body.

(Dr Rosenberg: I apologize. I wanted to ask, because I'd been hearing from people that you really can't get the rotary blade juicers, it's got to be a hydraulic press. You think that's garbage?)

Gar: Oh, thank you for the opportunity to say "yes." I think that is somewhere between bullshit and badinage [*general laughter*]. I think it is a sales pitch. Essentially, the...there was one type of juicer that had a basket that wouldn't let the pulp escape. It was centrifugal; it used to be called the Acme, then the Phoenix. And it was like an old ringer-washer spinner basket, you know, when it's done, you take the pulp out by hand. And a physicist friend of Gerson's said "well, isn't that like a magneto? You have this wet pulp spinning very rapidly around an axis. Wouldn't that generate an electronic current? Maybe that would be bad." So Gerson said, categorically, don't use those. But, none of the modern ones, like Jack LaLanne's great little hundred-dollar juicer, none of those have trapped pulp. The pulp is immediately ejected; the juice is shot through a screen, and frankly, the Jack LaLanne is a lot easier to use.

And I'd also point out that someone once recently asked me about, I guess the \$4,000 Norwalk? \$4,000 as opposed to \$107 before tax with Jack LaLanne. And they said, do you know, somebody over at the Gerson Institute says this machine gets more nutrients out of the produce, and I thought about it and I said, "you know, I'm going to play the devil's advocate here." When we were studying coffee, and we were learning all about it, because Lee

Wattenberg in *Diet, Nutrition, and Cancer* in 1980, had written, along with Luke Lam and his colleague, Velta Sparnins, that coffee stimulates, in the human liver and small intestine wall, the activity of glutathione-S-transferase trebling, not trebling actually, raising it to 600-700% of normal. And Luke and I had a bunch of talks while he was looking at different types of beverage coffee. He was asking, you know, "how much detox are we getting out of beverage coffee?" He came to the conclusion, while studying Turkish coffee, that cloth or paper filters trap the vast majority of palmitate-containing microfibers, virtually eliminating the GST-stimulating effect of coffee. Paper filters in coffee makers do the same thing. If you want your GST stimulated, which has — you know, it's a mixed blessing — if you want that enzyme system stimulated with your drinking coffee, you need to use if you're going to use a Mr. Coffee, make sure you get one that has the little metal screen basket, rather than the paper filter, and you're good to go. Now, it's just a tiny step sideways to point out that the Norwalk is the only juice machine widely promoted and commercially available that uses a cloth filter. And one might ask, what kinds of microfibers with their associated nutrients might we be trapping in the cloth filter? So, it just seems to me that, contrary to what's put out there by Norwalk, which is that they get more nutrients out and their enzymes stay alive — which is crazy talk, because nobody has paid the hundreds of thousands of dollars to do those kinds of enzyme assays, I am sorry, it's just no one. Alright? It's all lies — but the fact of the matter is, it might actually have kind of a down side with cloth filters. It might actually trap some stuff that you'd rather have; I mean otherwise God would have been kind enough to build us with a sort of a cloth dam for our foods. Mark?

(Dr Rosenberg: But Gar, I didn't know this. So we should be telling our patients doing coffee enemas, "do not use paper filters.")

Absolutely, don't use paper filters or you're essentially doing a sort of a slightly enriched water enema. The coffee enema is...go ahead.

(Attendee: With all the talk about the different kinds of foods in this diet, is there any consideration or does there need to be any consideration about food intolerances because, I mean, I look at food intolerances all day long in my practice. If somebody has a severe food intolerance to your main ingredients, should that be a factor, or not?)

Well, yeah, one would have to ... there's a huge section of the literature of Gerson's colleagues on desensitization through diet of exactly that sort of thing. And I agree that, you know, food intolerances are very real. And you see

Well, yeah, one would have to ... there's a huge section of the literature of Gerson's colleagues on desensitization through diet of exactly that sort of thing. And I agree that, you know, food intolerances are very real. And you see people in deplorable shape, not able to handle items, for which there is no logical explanation, but they've got some hitch in the get along, some glitch in the mechanism, where they literally get sick eating a common material. And it might be some of the materials that Gerson chose, so obviously you would have to work with what's real in the individual. And that is why I pointed out that there was wiggle room, in a raw-food based approach, to have no raw bulk, you know, if you've got GI problems, Gerson was willing to cook it. So there's got to be wiggle room. It's got to be a common sense approach. The clinician has to be able to modify, you just have to be able to track your data, and try to build a system that works.

That's enough about the juicers. Juicing is a wonderful thing to do. And people shouldn't be prohibited from doing it because they can't afford to get another juicer, their old Champion will do. They just need to know, it's the juice; it's not the juicer.

### Coffee enemas

Coffee enemas: the science, application, precautions. I went into a little of the science, so I'll just cover this in the remaining minutes and then the break.

Slide 88

**Detoxification**

Because about 90% of all cases which come to me are so-called generalized cancer or final cases with which the usual methods had been applied in vain, the decontamination of the body in the beginning of the therapy plays the leading role. These seriously ill ones need coffee enemas during day and at night, first every 3-4 hours, later less.

Gerson MB. No cancer in normal metabolism. Results of a special therapy.  
*Med Klinik* 1954;49(5):175-179

Gerson wrote in his paper, "No cancer in normal metabolism" ("Kein Krebs bei normalen Stoffwechsel"), in *Medizinische Klinik* in 1954 ... *Because about 90% of all cases which come to me are so-called generalized cancer or final cases with which the usual methods had been applied in vain, the decontamination of the body in the beginning of the therapy plays the leading role. These seriously ill ones need coffee enemas during day and at night, first every 3-4 hours, later less.* I've got to tell you, you know, we have seen people pull out of almost comatose states and get off of morphine and shift to other types of pain management in addition to coffee enemas, and we've come to expect to be able to do it.

Gerson ... it's probably the best thing he ever did. In fact, Bill Regelson, who was a friend of mine, passed away some years ago — he was at Commonwealth University of Virginia at Richmond, Professor of oncology — he called me up one day, no, I guess I called him, and we were talking about Gerson. And he said, the coffee enema was the smartest thing that Gerson ever invented. He said — and he loved carbohydrate feeding — he said, have you ever heard of ammonia pathophysiology? He says, you wouldn't have, it's in veterinary pathology; veterinary medicine. He said, the name is Visik, I think it was, and he said it was Visik that first proposed the antibiosis of feed lot animals in order to promote carcass weight gain during stockyard feeding of animals. And the reason for this was that, you know, grain feeding, which — think about, you know, the great American feed lot, and the obesity epidemic — grain feeding creates enormously acid conditions in the intestine which over-colonizes urea-splitting microbes, which results in an elevation of serum ammonia, serum sickness, in the animals, and people. And you've got a similar effort by Gerson to replete cachectic patients, for example, with huge inputs of carbohydrates, and we'll see that later as well, and in the animals, you know, tons of grain to try to get them to beef up. So the antibiosis allowed marbled beef, which is Gaucher's disease simulated, and we eat that stuff — no, I don't. And Gerson's approach was coffee enemas in people, and Regelson said to me, "You could have gotten the same effect in the cattle but you'd never get the stockyard managers to administer coffee enemas to the cattle." You could avoid the antibiotics altogether. So that's another little nugget of take home. And that takes us up to a break.

(Dr. Rosenberg: All right, guys; noon.)

Break



Gerson's detoxification was, as I said, central and, further, he tended to avoid anything that would slow down the gut, so he didn't want to go with morphine, which is, you know, a very convenient cancer pain medication. Instead, with the coffee enemas, he would

For pain, patients receive coffee enemas and, in the beginning, a mixture of aspirin 1 gram, 50 mg niacin and vitamin C 100 mg three to four times a day. Greatest care is taken for the elimination of accumulated toxins in the body, and it still needed by those who freshly absorb toxic substance from collapsing tumors, otherwise the patients die of so-called "hepatic coma."

Slide 89

Gerson M *Med Klinik* January 1954 (cont)

use aspirin, one standard tablet of aspirin, 50 mg of niacin, and vitamin C, with lots of coffee enemas. He says ... *Greatest care is taken for the elimination of accumulated toxins in the body, and it is still needed by those who freshly absorb toxic substance from collapsing tumors, otherwise the patients die of so-called "hepatic coma."* That's only if there is a big burden of disease and, certainly, we haven't seen much in the way of liver failure.

This is from an article by Yoko Uchiyama-Tanaka (Slide 90), and it's from the journal, *Biomedical Research*. The title is "Colon irrigation causes lymphocyte movement from gut-associated lymphatic tissues to peripheral blood." And this is just to help contextualize coffee enemas, indeed any other kind of enema, whether they are medicated or water, or the use of colonics. *Since the early history surrounding ancient Egypt, colon hydrotherapy has been practiced in its most basic form, such as enemas or clysters, and has provided people with internal cleansing as an adjunct to personal external hygiene. The Ebers Papyrus, from the 14th century BC, prescribes internal cleansing for no less than 20 gastric and intestinal complaints. A number of contemporary authors have investigated gut lavage (iatrogenic diarrhea) as a means of detoxifying ingested poisons, reducing plasma endotoxins and other toxins already absorbed by the body, and increasing gastrocolic response to feeding, among other positive findings.* (Slide 91).

And I just included some of the more interesting titles; you can review those when Liz sends you the pdf (Slide 92, see addendum, pg XXX).

This is, again, from Uchiyama-Tanaka's article from 2009 (Slide 93). You'll notice that there is a statistically significant increase in peripheral leukocytes after colonic irrigation, and lymphocytes increased, and neutrophils increased. This is really unexpected if you are of the old school, which held that enemas cause bowel problems and you'll develop permanent constipation and an addiction to enemas if you use them. And it returns us to the idea that there may be some mechanisms triggered by rinsing the bowel, simply rinsing it, that are of import medically, that it is something you can do.

Since the early history surrounding ancient Egypt, colon hydrotherapy has been practiced in its most basic form, such as enemas or clysters, and has provided people with internal cleansing as an adjunct to personal external hygiene. The Ebers Papyrus, from the 14<sup>th</sup> century BC, prescribes internal cleansing for no less than 20 gastric and intestinal complaints.

Slide 90

Uchiyama-Tanaka, Yoko. Colon irrigation causes lymphocyte movement from gut-associated lymphatic tissues to peripheral blood. *Biomedical Research* 2009;30(5):311-314

### Detoxification

A number of contemporary authors have investigated gut lavage (iatrogenic diarrhea) as a means of detoxifying ingested poisons, reducing plasma endotoxins and other toxins already absorbed by the body, and increasing gastrocolic response to feeding, among other positive findings.

Slide 91

### After colonic irrigation

- The number of peripheral leukocytes increased significantly from  $5917 \pm 1215/\mu\text{L}$  to  $6610 \pm 1452/\mu\text{L}$  ( $P < 0.0001$ ).
- The number of lymphocytes increased significantly from  $1788 \pm 403/\mu\text{L}$  to  $2164 \pm 430/\mu\text{L}$  ( $P < 0.0001$ ).
- The number of neutrophils increased significantly from  $3442 \pm 1029/\mu\text{L}$  to  $3712 \pm 1236/\mu\text{L}$  ( $P < 0.01$ ).
- The neutrophil:lymphocyte ratio decreased significantly from  $58.3 \pm 8.4\%$  to  $55.1 \pm 8.2\%$  ( $P < 0.0001$ ).

Slide 93

Uchiyama-Tanaka, Yoko. Colon irrigation causes lymphocyte movement from gut-associated lymphatic tissues to peripheral blood. *Biomedical Research* 2009;30(5):311-314

### Dorland's Medical Dictionary, 2007

**glutathione** /glu-ta-thi-one/ (gloo'tah-thi'ōn) a tripeptide of glutamic acid, cysteine, and glycine, existing in reduced (GSH) and oxidized (GSSG) forms and functioning in various redox reactions: in the destruction of peroxides and free radicals, as a cofactor for enzymes, and in the detoxification of harmful compounds.

Slide 94

Modern research reveals that the liver exports glutathione into both plasma and bile at a rate that accounts for nearly all of its biosynthesis, and that the biliary concentration of glutathione is close to that of the liver.

Slide 95

Fernandez-Checa JC, et al. Regulation of Hepatic Glutathione. In: Tavoloni N and Berk PD, eds. *Hepatic Transport and Bile Secretion: Physiology and Pathophysiology*. NY: Raven Press Ltd., 1993.

Because glutathione (GSH) detoxifies genotoxic electrophiles poorly by spontaneous reaction, glutathione S-transferase (GST) is a particularly important catalyst; their combined action leads to efficient detoxification.

Slide 96

Coles B and Ketterer B. The Role of Glutathione and Glutathione Transferases in Chemical Carcinogenesis. *Critical Reviews in Biochemistry and Molecular Biology*. 1990;25(1):47-70.

Slide 97

Because the reactive ultimate carcinogenic forms of chemicals are electrophiles, the glutathione S-transferase system must be regarded as an important mechanism for carcinogen detoxification. In mice, this system is enhanced 600% in the liver and 700% in the small bowel when coffee beans are added to their diet. Because this system in lab models is close, if not directly analogous to that of humans, a parallel stimulation by coffee of glutathione S-transferase in humans is probable.

Lam LKT, Sparrins VW, Wattenberg LW. Isolation and Identification of Kahweol palmitate and Cafestol Palmitate as Active Constituents of Green Coffee Beans That Enhance Glutathione S-transferase Activity in the Mouse. *Cancer Research* 1982;42:1193-1198, 1982

Administration of enemas Slide 98

Gerson instructed patients to take all enemas lying down on the right side with knees pulled up toward the chin. Coffee enemas, specifically, were to be retained for 12-15 minutes. Patients should be instructed to hang the bag or bucket low above the hips, to control the flow with the clip in order to take the coffee slowly to avoid cramping. Enemas should be in the temperature range of 102°- 104°F. If cramps occur, patients are to release the enema and start over. Potassium gluconate can be added, 2-3 grams, to alleviate cramping. Enemas can be taken under a physician's guidance as frequently as every 2 hours for severe cancer pain. Stronger enemas can be given for severe pain, i.e., 2 cups concentrate + 2 cups H<sub>2</sub>O. Electrolytes should be monitored.

Okay, now to get into the glutathione-S-transferase. This is from *Dorland's Medical Dictionary* (Slide 94). We've got a tripeptide of glutamic acid, cysteine, and glycine, and all of you know already that it is the primary vehicle for detoxification throughout the body, in all of the cells and all of the tissues, for the most part; however, it is rather se-date. *Modern research reveals that the liver exports glutathione into both plasma and bile at a rate that accounts for nearly all of its biosynthesis*, — so it's all about the liver; and that means it's about what you eat — *biliary concentration of glutathione is close to that of the liver*. This is from a marvelous text, *Regulation of Hepatic Glutathione In: Hepatic Transport and Bile Secretion: Physiology and Pathophysiology*, a marvelous text, already outdated.

Glutathione, by itself, is not going to be able to be much help against the most challenging teratogenic or carcinogenic radicals or electrophiles. For that, you are going to need to move to glutathione-S-transferase. *Because glutathione (GSH) detoxifies genotoxic electrophiles poorly by spontaneous reaction, glutathione S-transferase (GST) is a particularly important catalyst; their combined action leads to efficient detoxification*. Again, from Coles and Ketterer and *Critical Reviews in Biochemistry and Molecular Biology*.

Now we go to Lam, Sparrins and Wattenberg. And this is actually from the *Journal of Cancer Research* in 1982. Expanding their work in the Academy of Science's *Diet Nutrition and Cancer*, for which Wattenberg was one of the primary authors in 1980 ... *Because the reactive ultimate carcinogenic forms of chemicals are electrophiles, the glutathione S-transferase system must be regarded as an important mechanism for carcinogen detoxification. In mice, this system is enhanced 600% in the liver and 700% in the small bowel when coffee beans are added to their diet. Because this system in lab models is close, if not directly analogous to that of humans, a parallel stimulation by coffee of glutathione S-transferase in humans is probable*.

*Gerson instructed patients to take all enemas lying down on the right side with knees pulled up toward the chin. Coffee enemas, specifically, were to be retained for 12-15 minutes. Patients should be instructed to hang the bag or bucket low above the hips, to control the flow with the clip in order to take the coffee slowly to avoid cramping. Enemas should be ... and I can't over emphasize this ... in the temperature range of 102°- 104°F. The gut is warmer right? and it shocks when you get down to even 98 degrees ... If cramps occur, patients are to release the enema and start over. Potassium gluconate can be added, 2-3 grams, to alleviate cramping. Enemas can be taken under a physician's guidance as frequently as every 2 hours for severe cancer pain. Stronger enemas can be given for severe pain, i.e., 2 cups concentrate — we gave you the recipe for that up further in the slides — and 2 cups H<sub>2</sub>O. That's a double strength coffee enema; you can even go just 2 cups of concentrate which is quadruple strength, because you're more or less desiccating it by half of it's fluid content. Electrolytes should be monitored.*

*Under certain physiological circumstances, very frequent coffee enemas can logically cause dilution of serum, leading to cerebral edema. Several cases of “drowning” by enemas have been reported; — I am speaking specifically of “Deaths related to coffee enemas” published in the JAMA in 1980. These patients ... were unsupervised patients who used far more, and more frequent enemas than would be prescribed by any practitioner. Literally, a woman with pneumonia, frightened, attempting to control symptoms; four one-quart enemas per hour, every fifteen minutes for eight hours, 32 enemas overnight, over an 8-hour period, resulting in death by cerebral edema and electrolyte dilution. So, you know, if you’re going to have patients doing this stuff under your supervision, you’ll want to be sure that they understand, you can drink yourself to death with plain water. You can drown per mouth and per rectum. Interestingly, toxicological attempts to isolate xanthines — under the presumption they are toxic at certain levels — from serum, urine bladder, and aqueous humor — that was the Oregon state pathologist who did this — found only traces, indicating that the colon membrane effectively screens for caffeine and its isomers, theophylline and theobromine.*

So, what we find here is that there is not systemic absorption of these materials even in extreme abuse of the substances, (and that is instructive). I mean, and it was something that I took note of. I can say thank you for doing the work. Because I would never have been able to answer the question, what about caffeinism? and what about the stimulating effects of theobromine and theophylline when it is per rectum?

#### Castor Oil

Castor Oil: I ran out of time in preparation, so let me just do this verbally. In Gerson’s *A Cancer Therapy*, we had oral and rectal use when he was starting out, when he was trying to get the toxic discharge from the intestine of a cancer patient who had been going downhill for a long time. Every other day, and in the severe cases every day, he gave 2 tablespoons, that’s 30 milliliters, of castor oil by mouth followed by sweetened — with any type of organic sweetener — black coffee to get the gut to dump it rapidly into the duodenum and start it’s work. I would point out that patients will often find themselves with a lot of duodenal distress and complain of cramping. This can be alleviated by just constant feeding on half hour intervals of small amounts of soft fruit, because what the castor oil is doing is causing the dumping of bile into the duodenum through the sphincter of Oddi, and it is alkaline as hell in an empty duodenum. But, if you’ve got acid chyme dropping from the stomach, it neutralizes it, prevents that terrible discomfort, it helps the stuff usher itself on through the gut. Gerson followed this oral dose with a castor oil enema, a common castile soap enema. And our practice now uses the coffee enema as the base, rather than just water. Gerson himself used a quarter teaspoon of bile powder in the enema, and he used twenty drops of caffeine potassium

#### Precautions

Under certain physiological circumstances, very frequent coffee enemas can logically cause dilution of serum, leading to cerebral edema. Several cases of “drowning” by enemas have been reported\*; however, these were unsupervised patients who used far more, and more frequent (e.g. 4/hr x 8 hours), enemas than would be prescribed by any practitioner. Interestingly, toxicological attempts to isolate xanthines from serum, urine bladder, and aqueous humor found only traces, indicating the the colon membranes effectively screens for caffeine and its isomers, theophylline and theobromine.

Slide 99

\*Eisele JW, Reay DT. Deaths related to coffee enemas. JAMA 1980;244(14):1608-9.

#### Castor oil

- A. Oral
- B. Rectal
- C. Topical (heated packs)

Slide 100

#### Castor Oil Day

- 6:00 am, upon rising take 2 large Tbsp castor oil immediately followed by a bit into a wedge of orange and a cup of strong black coffee with a little organic brown sugar (optional) OR a glass of orange juice.
- Take first coffee enema for the day
- 10:00 (approximately 4-5 hours after taking the oral castor oil, prepare the castor oil enema and take in place of the normal coffee enema.

Slide 101

#### Castor Oil Enema

Blend in blender:

- 4 Cups enema-coffee  
(warm approx 103 degrees)
- 1 oz castor oil
- 1 tsp liquid castile soap (Bronner’s)
- ¼ tsp ox bile

Slide 102

benzoate, which he published in his book. Later he used potassium citrate, which is okay. The castor oil and soap enema was administered five hours after the oral castor oil, and when we get to the case presentation, one of our patients gives a narrative on that, that you get from the patient's point of view.

(Christeene Hildenbrand: Bonner's makes a baby castile soap.) Bonner, the peppermint soap guys, make a baby castile that's suitable for this purpose, if you're looking for something other than Ivory soap, which is 99.99 % pure. These are traumatic experiences for most patients, especially with the castor oil and soap enema. Nobody can hold this for any time at all. Many patients can only get a little bit of it in before they have to release it. It makes tears come out of the eyes of big guys, burly people, you know. It's very, very difficult. On the other hand, boy, does it work, and patients express a feeling of having had a veil taken away and seeing and thinking clearly; so, it does have a profound effect. It is interesting for me to note that ricin, the protein isolated from castor oil, only slightly modified, becomes a chemotherapy so incredibly cytotoxic that it can't be used in humans. There is something to castor oil that deserves further study, but we quit looking at it before the big patent drug boom, with the failure of the golden age of German medicine, with

the shift of the throne of research and development, by default, to the United States. And then all our research initiatives were about venture capital and product development, and nobody wanted to do castor oil anymore.

Typically, castor oil, if it is sandwiched between layers of flannel and you protect the bed with plastic and you protect your heating element, whether it is a hot water bottle or a heating pad, with a layer of plastic, this, against the skin of the abdomen, can really give relief to people, say with pancreatic or bowel cancer. I do not pretend to know the mechanisms, they may be similar to those for clay, it may be an adsorbent. It may be something in the oil that penetrates, I don't know. We inherited it from Gerson and lacked the research funds to even ask those basic questions.

Let's see here. Clay: you can do clay packs. Montmorillonite and bentonite, according to the authors of the paper, "Bentonite, Band-aids, and Borborygmi," which was published in *Elements* back in 2009, these are basically the same clays according to the authors. Basically the same clays — and they have enormous adsorptive qualities. They have such potency that the U.S. Fish and Wildlife has studied the addition of these clays to fisheries, and it has resulted in enhanced spawning, increased birth size of fish. It's really a remarkable material. Yes?

(Attendee: Are you familiar with Azomite?)

Yes, go ahead and say something about it.)

(Attendee: It's a fertilizer. It only happens in one place in Utah. They mix it with the feed of cattle and their immune system goes up, and the meat (goes up) typically about 30% choice and they go to the slaughter house up 30% choice. The plant that uses this has root systems that are much stronger and higher resistance to pests, and the nutritional value goes up and everything. It's incredible.)

Gar: That's right, it is a mineral donor when it comes in the feed, and one can only assume that it acts as a prebiotic. On the question of food tolerances, one of the reasons that the diet therapy as Gerson devised it, was able to be used as a desensitizing diet is that it probably brought in a big shift in the microbiome of the gut and that would, of course, lead to all kinds of sequential stepwise changes in food tolerances.

(Attendee: And the silicon in it has a special property that enhances the microbiome.)

#### Castor Oil Pack

- Soak 3 pieces of white flannel with castor oil — squeeze out excess castor oil.
- Place flannel over liver or other affected area.
- Place slightly larger sheet of plastic over the flannel.
- Use medium temperature heating pad over area. Don't let the pack get cold or uncomfortably hot.
- Keep on 1-1/2 hours; apply every four hours. You can re-use the castor oil pack.

Slide 103

#### montmorillonite and bentonite

Williams LB, haydel SE, Ferrell Jr RE. Bentonite, Band-aids, and Borborygmi *Elements* (Que). 2009 April 1; 5(2):99-104.

Slide 104

Gar: We found these clays to be very, very useful by mouth as an additive, you know, a quarter teaspoon or so to a juice, you don't even know they're there, they are so silky that they just disappear into a carrot juice. And they do bring relief that surpasses, in my estimation, surpasses activated charcoal, so if you've got someone who is really hurting ... Yes?

(Attendee: You can also use that for radiation poisoning, if you don't have iodine; you can also use Azomite.)

Gar: Great to know, great to know. For radiation exposures, great to know. So we've got more than Lugol's solution.

Okay, let's look at one of the core ... oh, I'm sorry, go ahead.

(Attendee: What is the difference between rectal ... or between an enema and maybe a suppository to do the castor oil?)

Gar: With the castor oil? The castor-oil-per-rectum is part of the castor-oil-by-mouth regimen in Gerson's *Cancer Therapy*. It follows the 2 tablespoons by mouth, which are chased by sweetened black coffee and, as I said, I recommend a small piece of soft fruit every half hour to avoid getting a sore duodenum and jejunum. The castor oil enema with shaved soap, about a tablespoon of shaved soap, for example, or the equivalent in a quart of coffee. The castor oil is put in there, a quarter teaspoon of bile powder with that — it has to be stirred as it's administered or it won't stay emulsified. The bile actually is used to emulsify the oil, as is the soap. And it really is a mess, you know, it's just a mess.

#### Flare-ups

Gerson ... when I finish translating the pulmonary tuberculosis diet text, we are going to make it available so that people can imbibe this extraordinary study of what healing looks like when it's orchestrated tissues-first, by improving the tissues, and you get a generalized delayed-type-hypersensitivity response going by sort of rubbing two sticks together. I mean, eventually this builds and builds. Gerson referred to his treatment as a fever therapy, alright? We have both examples of the initial exacerbation and the periodic benign flare-ups in the case presentation. So first let's consider the prodromal improvement. Oh, and not mentioned on this list are co-reactions, which I will talk about a little.

Here's Gerson, good old German-golden-age-of-medicine Gerson: *The term "flare-up" is found more often in recent literature, although often in a different sense than I apply to it. It is graphic and compelling: just as an expiring fire "flares up" in one case to finally go out, and in another to awaken into a new fire, a chronic disease process can flare, although this pleasant medical metaphor says nothing further about whether this is the last, next to last, or next to-next to last flare-up of the disease process morphing into healing, or signals an imminent dangerous exacerbation, re-awakening of the smoldering fire into a raging blaze.* Wow. You know, if any of you have given cytokine therapy, for example, interferon, alpha-interferon, gamma-interferon, or interleukin 2, we are treading in that territory.

We're going to go in and see what happens here with nonspecific stimulation, general stimulation, induced by diet. *Every physician knows that such disease processes can have flare-ups of either kind, although the tuberculosis doctor is biased due to his bad experiences*

#### Flare-ups

- A. Prodromal improvement
- B. Initial exacerbation (intensification)
- C. Menstruation and menstrual fever
- D. The periodic (benign) flare-up in men and women
- E. In cancer management

Slide 105

#### Flare-ups

The term "flare-up" is found more often in recent literature, although often in a different sense than I apply to it. It is graphic and compelling: just as an expiring fire "flares up" in one case to finally go out, and in another to awaken into a new fire, a chronic disease process can flare, although this pleasant medical metaphor says nothing further about whether this is the last, next to last, or next to-next to last flare-up of the disease process morphing into healing, or signals an imminent dangerous exacerbation, re-awakening of the smoldering fire into a raging blaze.

Slide 106

Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig & Vienna; Franz Deuticke:1934

#### Flare-ups

Every physician knows that such disease processes can have flare-ups of either kind, although the tuberculosis doctor is biased due to his bad experiences to interpret each acute exacerbation as, without exception, a chronic process. The purpose of this chapter is to shatter these preconceptions and to demonstrate that the healing process can be initiated in tuberculosis just as with almost any other chronic illness, when the chronic illness is first brought into a state where it develops some of the symptoms of an acute process.

Slide 107

Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig & Vienna; Franz Deuticke:1934

**Flare-ups**

These acute or near-acute states occur in two different periods during the dietetic treatment: first during the first stages of treatment, in the first few days, or sometimes only after months — I refer to this first flare-up as the initial exacerbation. They go on again, from time to time, more-or-less weakened in intensity, and more-or-less shortened — these periodically recurrent reactions that subjectively impress one in the later stages as exacerbations are referred to as flare-ups. But, in essence there is probably no difference between the initial exacerbation and the periodic flare-ups.

Slide 108

Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig & Vienna; Franz Deuticke:1934

*to interpret each acute exacerbation as, without exception, a chronic process. The purpose of this chapter is to shatter these preconceptions and to demonstrate that the healing process can be initiated in tuberculosis just as with almost any other chronic illness, when the chronic illness is first brought into a state where it develops some of the symptoms of an acute process. — Boy does that sound like interleukin. Wow.*

*These acute or near-acute states occur in two different periods during the dietetic treatment: first during the first stages of treatment, in the first few days, or sometimes only after months — I refer to this first flare-up as the initial exacerbation. They go on again, from time to time, more-or-less weakened in intensity, and more-or-less shortened — these periodically recurrent reactions that subjectively impress one in the later stages as exacerbations are referred to as flare-ups. But, in essence there is probably no difference between the initial exacerbation and the periodic flare-ups. — Except, that I would add, that the initial exacerbation can be really a world-rocking event if you are the patient, because it is explosive, it is full of symptoms and, as we'll see in the case of Helena Schweitzer, it's psychoactive.*

*Prodromal improvement: In both the diet therapy of tuberculosis and its modified version for cancer, patients routinely experience clinical improvements.*

**Prodromal improvement**

In both the diet therapy of tuberculosis and its modified version for cancer, patients routinely experience clinical improvements.

Slide 109

*Clinical bounce: The Lazarus effect. Quoting Miracle Max played by Billy Crystal in The Princess Bride, "It just so happens that your friend here is only mostly dead. There's a big difference between mostly dead and all dead." I love saying that.*

Comment: "I love storming the castle."

[Laughter] That's right.

So, my friend and colleague, Peter Lechner, and his colleague, Kronenberger — Peter was the chief of the second surgery department at the Landekrankenhaus Graz, the university hospital there in Austria. He was called "der Spinat Chirurg," "the spinach surgeon," because he implemented Gerson's diet therapy as adjunct to surgical oncology at the second surgical department — and in *Aktuelle Ernährungsmedizin* (Current Nutritional Medicine) in 1990 he published essentially what we would call most of the findings of the clinical bounce of the prodromal improvement which is ... *tumor cachexia prevented or delayed, fewer post-operative complications and infections, lesser side effects of radiation and chemotherapy, significantly less analgesics and psychotropic drugs are needed. Good psychological state. Slower progression of existing liver metastases, less marked occurrence of malignant effusions.* — and the last little paragraph, where Peter's asking, is anybody else interested to kip in and study this? Zero. Except for one gal that wrote a PhD dissertation on it. Okay.

**Clinical bounce**

The Lazarus effect

"It just so happens that your friend here is only mostly dead. There's a big difference between mostly dead and all dead."

— Miracle Max (Billy Crystal)  
"The Princess Bride"

Slide 110

**Lechner P, Kronenberger I. Experiences with the use of dietary therapy in surgical oncology *Aktuelle Ernährungsmedizin*. 1990;2(15).**

After nearly six years of using adjuvant dietary therapy in conjunction with surgical oncology, we are able to report the following preliminary results:

- Tumor cachexia prevented or delayed.
- Fewer post-operative complications/infections.
- Lesser side effects of radiation and chemotherapy.

Slide 111

Okay, we're going to get fascinating here: Flare-ups and menstruation. Believe it or not, virtually all of the authorities of note were talking about this in the phthisis community, in the tuberculosis treatment and research community in

the thirties. — *The healing events of the menstruating endometrium, with its formation of placental tissues and their rejection, includes the formation of embryonic tissue, which apparently has a special developmental and organizational capacity and is subject to certain laws of cyclical stimulus and response (HALBAN 138). This stimulus-response cycle strongly affects a tissue that is, first, closely related to the autonomic processes of life while, second, it is attributed a special capacity for hormone formation and fermentation and, third, it has a connection with rejection or killing of micro-organisms.* — Sort of let that melt in your mouth for a second. That's a fascinating finding, rejection or killing of micro-organisms; really? Wish I had my period.

*In the healing events in the diseased lung — and everywhere in the diseased body — with diet therapy we are watching (in lupus — skin tuberculosis — almost macroscopically) abundant formation of pluripotent granulation tissue (DUKE), that of young capillary buds and mobile connective tissue cells whose phylogenetic relationship to embryonic tissue is obvious. It appears to me now, that these two topographically very different, yet very similar, tissues are regulated by a common, unknown control, and that this control — specifically for them — has a clear cyclical pattern.* — This is 1930's language for watching stem cells. Remember when Germany had live cell therapy and everybody over here thought it was a joke? This is really kind of space-age, this "connective tissue cells that are mobile." This means moving through tissue; stem cells; phylogenetic relationship to embryonic tissue ... How could they know this stuff with the crude technology they had in the thirties?

What's this say? You are now running on reserve battery power. That's no good. We were just talking about what wonderful battery life these things have. Yeah. This is one of my favorites. This is, again, from the tuberculosis textbook, an anecdote: *Case XXI — This is not in the presentation cases for pulmonary tuberculosis, this is in the chapter on the flare-ups — A forty year-old farmer from Barnsley in Lippe (Westphalia) came to me in 1923 with lupus vulgaris of the nose and the left side of the face — the fourth case of*

**Lechner 1990 (cont)**

Slide

- Significantly less analgesics/psychotropic drugs than controls.
- Good psychological state. Slower progression of existing liver metastases.
- Less marked occurrence of malignant effusions.

These results encourage us to continue and, within our possibilities, to intensify the use of dietary therapy measures, and we are seeking cooperation with all those who are experienced in this — at present still highly controversial — area of work.

**Flare-ups and menstruation**

The healing events of the menstruating endometrium, with its formation of placental tissues and their rejection, includes the formation of embryonic tissue, which apparently has a special developmental and organizational capacity and is subject to certain laws of cyclical stimulus and response (HALBAN 138). This stimulus-response cycle strongly affects a tissue that is, first, closely related to the autonomic processes of life while, second, it is attributed a special capacity for hormone formation and fermentation and, third, it has a connection with rejection or killing of micro-organisms.

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Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig &amp; Vienna; Franz Deuticke:1934

**Flare-ups and menstruation**

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In the healing events in the diseased lung — and everywhere in the diseased body — with diet therapy we are watching (in lupus almost macroscopically) abundant formation of pluripotent granulation tissue (DUKE), that of young capillary buds and mobile connective tissue cells whose phylogenetic relationship to embryonic tissue is obvious. It appears to me now, that these two topographically very different, yet very similar, tissues are regulated by a common, unknown control, and that this control — specifically for them — has a clear cyclical pattern.

Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig &amp; Vienna; Franz Deuticke:1934

**Flare-ups and menstruation**

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Case XXI. A forty year-old farmer from Barnsley in Lippe (Westphalia) came to me in 1923 with lupus vulgaris of the nose and the left side of the face — the fourth case of lupus that I treated with diet. After 5 weeks, I saw improvement in the scabby ulcerative areas; another 5 weeks later, the second follow-up examination showed renewed progress. As I said this, the woman laughed, "My husband did not really want to come back, because 14 days ago it looked very red and thick. But it was already that bad once, and it got better

...

Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig &amp; Vienna; Franz Deuticke:1934

**Flare-ups and menstruation**

(cont) "The first time was four weeks after we were first here, and the second time again just four weeks later. Then I said to my man: If it follows nature, then it is right; because you are having your period on your cheek." This fine observation of nature was not contradicted by the further course; 5 months later, healing.

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Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig &amp; Vienna; Franz Deuticke:1934

## Flare-ups

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Case XXII: an approximately 15-year-old son of Westphalian farmers from Schildesche was carried into my office in 1924, pale, emaciated, loss of appetite, fever more than 38 degrees, with fistulizing **osseous tuberculosis** of the left knee and lower leg. Sick for some time, he had been treated for two years at two hospitals and a university hospital with specific therapy, sunlamps, and immobilization in plaster. In the first month of the diet, the night sweats stopped, the fever dropped to normal, the boy became hungry, felt stronger, no longer looked as toxic as before ...

Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig &amp; Vienna; Franz Deuticke:1934

## Flare-ups

(cont) After a few weeks (prodromal improvement) transient fever occurred, as well as increased secretion. (Initial aggravation.) Then well-being.

At the beginning of the fourth month, I was urgently summoned: the boy had fever of up to 40 degrees for 48 hours, and complained of such severe pain in the knee as never before. The the knee and the areas surrounding all fistulas were bright red and edematous; the last 3 days only scant secretion ...

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Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig &amp; Vienna; Franz Deuticke:1934

## Flare-ups

(cont) Today, I know that this was a particularly violent, second flare-up. At that time I had never seen anything like it, and I thought about the suppression of secretions. The heart findings were not menacing, nevertheless, it was difficult to take responsibility for the deferment of a surgical intervention. When the mother asked if the disease was rampant, I dared not answer. However, the farmer suddenly said: "No, this is not worsening. If it went so well for 3 months, this can not be worsening now" ...

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Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig &amp; Vienna; Franz Deuticke:1934

## Flare-ups

(cont) I left it at that, prescribed wet compresses and enemas, prohibited solid food, allowed plentiful fluids, and waited. In three days, the fever disappeared while increased secretion occurred. Six weeks later, renewed attacks of fever (third flare-up), during which foul-smelling materials were extruded from the dilated fistula. After another 9 months, healing. Later, the boy became a bricklayer, and rode a bike, although the knee remained quite stiff.

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Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig &amp; Vienna; Franz Deuticke:1934

*lupus that I treated with diet. After 5 weeks, I saw improvement in the scabby ulcerative areas; another 5 weeks later, the second follow-up examination showed renewed progress. As I said this, the woman laughed, "My husband did not really want to come back, because 14 days ago it looked very red and thick. But it was already that bad once, and it got better. The first time was four weeks after we were first here, and the second time again just four weeks later." Then I said to my man: "If it follows nature, then it is right; because you are having your period on your cheek." This fine observation of nature was not contradicted by the further course; 5 months later, healing. — I just love it when people can see things, and somebody comes up and says, "did you see that?" And you think, God, I'm not alone!*

*Case XXII — this is fascinating to me — an approximately 15-year-old son of Westphalian farmers from Schildesche was carried into my office in 1924, pale, emaciated, loss of appetite, fever more than 38 degrees, with fistulizing **osseous tuberculosis** of the left knee and lower leg. Sick for some time, he had been treated for two years at two hospitals and a university hospital with specific therapy, sunlamps, and immobilization in plaster. In the first month of the diet, the night sweats stopped, the fever dropped to normal, the boy became hungry, felt stronger, no longer looked as toxic as before. After a few weeks (prodromal improvement) transient fever occurred, as well as increased secretion. (Initial aggravation.) Then well-being.*

*At the beginning of the fourth month, I was urgently summoned: the boy had fever of up to 40 degrees for 48 hours, and complained of such severe pain in the knee as never before. The the knee and the areas surrounding all fistulas were bright red and edematous; the last 3 days only scant secretion. Today, I know that this was a particularly violent, second flare-up. At that time I had never seen anything like it, and I thought about the suppression of secretions. The heart findings were not menacing, nevertheless, it was difficult to take responsibility for the deferment of a surgical intervention. When the mother asked if the disease was rampant, I dared not answer. However, the farmer suddenly said: "No, this is not worsening. If it went so well for 3 months, this can not be worsening now". I left it at that, prescribed wet compresses and enemas, prohibited solid food, allowed plentiful fluids, and waited. — That's got to be the hardest thing you doctors do, wait. — In three days, the fever disappeared while increased secretion occurred. Six weeks later, renewed attacks of fever (third flare-up), during which foul-smelling materials were extruded from the dilated fistula. After another 9 months, healing. Later, the boy became a bricklayer, and rode a bike, although the knee remained quite stiff.— There we have a description of the prodromal improvement, the initial exacerbation, and several difficult pursuant flare-ups. All brought about by protein restriction, by pushing with these apple-potato days to get this leukocytosis, with a shift to the left, manipulating innate immunities. You could say it's the hard way, but what it shows is the potency of this kind of approach. It sort of begs the question, why again*



do we tell chemo patients “just eat anything you want?” Why do we do that?

*For the elimination of unusable or untolerated foreign bodies or breakdown products there are two means: absorption or expulsion: Both place great demands, for which each organism must first be prepared (the role of the prodromal improvement) and which it cannot continue without interruption (the role of the intervals between “flare-ups”).*

Actually, I think I’m missing a little text about the fistula, because that boy extruded a sequestrum, a bone chip had been shattered off by the tuberculous process; and that’s what came out with the stinking mess, a thumbnail size sequestrum, ejected by the body’s own tissue capabilities. Again, I want to remind you of the three phases of inflammation: first there’s the white cells trying to figure out what this foreign object is, then there’s induration and an attempt to extrude the foreign object when you figure out, say, it’s a wood sliver, it’s cellulose, and you can’t eat it, you know. And only the third level do you get granulomas, locally destructive granulomas.

Again, Gerson on flare-ups ... *In this view, therefore, the flare-up would not be an adverse event, and would not complicate the healing process, but would itself be a healing process elevated to the highest intensity, while the nonfebrile, asymptomatic interval signifies deceleration: the rest periods vary depending on the type and severity of the disease, and on the age of the patient. There is no difference between the first and urgent treatment of a new surge of disease, and that of a flare-up accompanied by stormy symptoms — in both cases, it concerns flooding of the organism with toxic products, in one case by new production, in another by increased absorption — new production means repair of tissue, alright? — The therapy the same in both cases: immediate discharge of the intestine, bile and kidneys, as thoroughly as possible, in order to clear the enteral digestive ferments to make room for parenteral digestion of toxic substances. Nonetheless, there is of course a very important difference in the further course of the treatment as soon as we arrive at the conviction that it is not an aggravation, but a benign flare-up.*

*If an x-ray demonstrates a further improvement blossoming in the patient during, or even better after, the stormy flare-up, we return immediately to the form of diet we were using prior to the flare-up: We allow ample liver, spleen, sweetbreads, brains, we give 6 egg yolks daily, we allow relatively large amount of bread, etc. — This is different from what was done in the cancer diet, but I can tell you that now that we’ve integrated the Coley vaccine with the cancer diet, we commonly will use a restricted diet during the febrile response, and in any spontaneous febrile occurrences that happen outside of attempted ... or, outside of vaccination, and immediately get back to more protein, because we know they are using it up when they are running the fevers, they are using it up.*

#### Flare-ups

*(cont)* For the elimination of unusable or untolerated foreign bodies or breakdown products there are two means: absorption or expulsion: Both place great demands, for which each organism must first be prepared (the role of the prodromal improvement) and which it cannot continue without interruption (the role of the intervals between “flare-ups”).

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Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig & Vienna; Franz Deuticke:1934

#### Flare-ups

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#### Flare-ups

Slide 124

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Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig & Vienna; Franz Deuticke:1934

**Flare-ups**

*(cont)* If the x-ray demonstrates a new focal lesion, if the clinical findings reveal an increase in the catarrhal symptoms, we treat the patient as if he was starting over, we are a somewhat more cautious than the first time and limit not only egg white, but also wheat flour, sugar, and rice rather more than before.

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Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig & Vienna; Franz Deuticke:1934

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(Christeene Hildenbrand: We call that going “back to the strict diet.”)

Yeah, in the cancer therapy, it is “going back to the strict diet”, or starting over. In fact, in cancer, starting over often times will mean starting with another pulse of thyroid, which is never given for more than ten days at a high loading dose, five grains of thyroid, ten days. Thyroid is cumulatively active over a ten-day period, a seven-to-ten-day period, you are getting the maximum response you are going to get; you’re going to get mitochondria replication. So, this is done in pulses on the judgment of the clinician. The attending has to decide in each case.

**Flare-ups**

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What I said in 1930 still applies: “Flare-ups are a necessary part of the healing process; if they are absent even once, this indicates a disturbance. In such cases, the sick body is reacting too slowly, so I strengthen the diet by intercalation of raw vegetarian food days, etc.,” or by hormone preparations, which I maintain, however, usually only for 2 to 4 months of the diet therapy. In general, however, I have the impression that the percentage of those exceptions — where significant flare-ups are absent — becomes smaller when the diet is poorer in meat, milk and egg whites.

Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig & Vienna; Franz Deuticke:1934

*What I said in 1930 still applies — and then he quotes himself — “Flare-ups are a necessary part of the healing process; if they are absent even once, this indicates a disturbance. In such cases, the sick body is reacting too slowly, so I strengthen the diet by intercalation of raw vegetarian food days, etc.,” or by hormone preparations, which I maintain, however, usually only for 2 to 4 months of the diet therapy. In general, however, I have the impression that the percentage of those exceptions — where significant flare-ups are absent — becomes smaller when the diet is poorer in meat, milk and egg whites.*

— Milk, meat and egg whites. There was a big argument between authorities about why the Gerson-Sauerbruch-Herrmannsdorfer diet — which was higher in meat protein, because Ferdinand Sauerbruch and Dr. Herrmannsdorfer were involved, and it was being introduced more as a, you know, “you can handle this doctors, it’s not so weird, it has meat in it” — and Gerson’s diet; why the outcomes were so different. Gerson maintained, steadfastly, that it was because he was willing to restrict his animal products for longer intervals, and really cause a negative nitrogen balance, and really to cause the stripping of the organism of animal antigens which, you know, think about it, could, in fact, be triggering an IgA response in the intestines, and making it look like tolerance, and shutting off a generalized nonspecific immune response.

**Flare-ups**

**Co-reactions**

By “co-reaction” we mean those flare-ups that occur during diet therapy of pulmonary tuberculosis (as well as with other non-specific treatments, and in other diseases) in areas or organs formerly taken or morphologically altered by disease, trauma, surgery or even by stimulation therapy, injections, etc.

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Gerson MB, Diet Therapy of Pulmonary Tuberculosis, Leipzig & Vienna; Franz Deuticke:1934

Okay, finally, before lunch: Co-reactions. This is something you’ve all thought about or heard about, you know, that when you have a generalized inflammation, your old knee injury acts up. *By “co-reaction” we mean those flare-ups that occur during diet therapy of pulmonary tuberculosis (as well as with other non-specific treatments, and in other diseases) in areas or organs formerly taken or morphologically altered by disease, trauma, surgery or even by stimulation therapy, injections, etc.* In other words, by immunotherapies, or efforts to set in place exaggerated, enhanced innate immunities. You know, when, nah, we’re going to do this.

**Adding Danger Signals**

- A. Surgery
- B. Chemotherapy
- C. Radiotherapy
- D. Coley Fluid

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## Adding danger signals

One of the things that is really important in the diet therapy is that there are some pathologies that don't respond. Cancer has a couple of standouts. I'll cover them later with statistical outcomes of the reviews that we did, retrospective reviews. Recently operated ovarian, stage III, we've got patients that have responded with the diet therapy to that, and with operated Duke's C colorectal, and with melanomas at stage IIIA, IIIB, and IVA, who have been operated. As Matzinger points out, surgery introduces danger signals, damages the tissue. We've also got chemotherapy, we've got radiotherapy, and we've got Coley Fluid. What do we mean by, adding danger signals? Why do we have to do this? This is the heart of Matzinger's danger model.

Three rules govern T lymphocytes: *T cells are deleted (die) if they bind an antigen (signal 1) but are not activated by antigen presenting cells (signal 2). Activation requires both signals 1 and 2.* — So what we're saying is, you don't get effector cells if there's no activated antigen presenting cell — *Only APC (interdigitating dendritic cells and, perhaps, macrophages) can activate (co-stimulate) both virgin and experienced T cells. (An experienced T cell can be reactivated by a B cell)* — That's a side note — *T cells only stay activated for a period of days, after which they either die or return to a resting state, again requiring both signals 1 and 2 to be re-activated.*

*There is a single exception and that's in the thymus gland, the evolutionary interface between tissue and lymphocytes, young T cells have not yet developed the pathways for APC co-stimulation (signal 2). Because of this, any young T cell that recognizes APC is deleted, inducing permanent systemic tolerance for antigen presenting cells.* — If you haven't read Matzinger, I bet you didn't know that.

*With the tissue in control, the body can change, e.g., women can go through puberty and their breast can begin to make (new) milk proteins without becoming autoimmune. Because no stress signals (signal 2) are sent by the changing tissue of the breast, T cells that bind the new antigens (signal 1) are deleted and the new tissue is tolerized.* — That's how it works, isn't that cool?

*Tumors express new antigens (signal 1) in the absence of stress signals (signal 2); if a tumor cell dies, it is by nontoxic apoptosis.* — I would add that lymphomas and melanomas seem to have enough spill of danger signals by themselves that we found pockets in our retrospectives of these two cancers, with nothing but dietary influence, inducing complete durable remissions, just like the tuberculosis patients, but that's not true for a whole bunch of other cancers. *There is no reason for the tissue (innate) immunities or the lymphocytic (adaptive) immunities to see developing tumors any more than any other rapidly dividing cells, e.g., gut cells, hematopoietic cells. Spontaneous regression of, for example, a melanoma might be in-*

### 3 rules govern T lymphocytes

- T cells are deleted (die) if they bind an antigen (signal 1) but are not activated by APC (signal 2). Activation requires *both* signals 1 and 2.
- Only APC (interdigitating dendritic cells and, perhaps, macrophages) can activate (co-stimulate) both virgin and experienced T cells. (An experienced T cell can be reactivated by a B cell).
- T cells only stay activated for a period of days, after which they either die or return to a resting state, again requiring both signals 1 and 2 to be re-activated.

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### There is a single exception

In the thymus gland, the evolutionary inter-face between tissue and lymphocytes, young T cells have not yet developed the pathways for APC co-stimulation (signal 2).

Because of this, any young T cell that recognizes APC is deleted, inducing permanent systemic tolerance for APC.

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### New tissue is allowed to develop

With the tissue in control, the body can change, e.g., women can go through puberty and their breast can begin to make (new) milk proteins without becoming autoimmune.

Because no stress signals (signal 2) are sent by the changing tissue of the breast, T cells that bind the new antigens (signal 1) are deleted and the new tissue is tolerized.

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### Tumors are just new tissue to the immune system

Tumors express new antigens (signal 1) in the absence of stress signals (signal 2); if a tumor cell dies, it is by nontoxic apoptosis.

There is no reason for the tissue (innate) immunities or the lymphocytic (adaptive) immunities to see developing tumors any more than any other rapidly dividing cells, e.g., gut cells, hematopoietic cells.

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**Spontaneous regression** Slide 133

Spontaneous regression of, for example, a melanoma might be induced by viral, bacterial or physical insult resulting in activation of local APC.

APC would capture tumor antigens and present them to passing T cells in the draining lymph nodes. These and other tumor-specific experienced T cells that had not been deleted would be activated and attack the tumor, destroying it.

*duced by viral, bacterial or physical insult resulting in activation of local APC. — Nobody's ever studied it; we don't know. We just know that a bunch of melanomas went into remission with the diet therapy in the retrospective review. APC would capture tumor antigens and present them to passing T cells in the draining lymph nodes. These and other tumor-specific experienced T cells that had not been deleted would be activated and attack the tumor, destroying it.*

*Surgery damages tissue, leaving danger signals, which is the reason that transplanted organs require anti-rejection immunosuppression drugs. This can also have an effect in cancer management when immunotherapy is employed.*

**Surgery damages tissue, leaving danger signals, which is the reason that transplanted organs require anti-rejection immunosuppression drugs. This can also have an effect in cancer management when immunotherapy is employed.**

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Now, final comment, if any of you have been involved with transplant patients who have received a new liver, you may know that most hepatic transplant patients can stop taking anti-rejection drugs after a period of time. This was the big clue for Dr. Matzinger. What Polly saw was, oh my god, it's the surgical damage that's creating the rejection where the organ is reattached. These surgical sites are just streaming danger signals, and if you don't suppress immunity, you are going to essentially have an attack at the site of surgical damage, which is too much for the transplanted liver to take, and you'll lose the transplant. And it also explains why, if you just suppress for a while, then an overwhelming shift occurs and you get lymphocytes that have received only signal 1 and not signal 2, and because the liver is so big, it tolerizes rather rapidly. And this, of course, is just

the ice breaker in transplant science, now that transplant science is being driven by the Danger Model, as opposed to the other model, the Self-Non-Self, which was not predictive, whereas Danger is predictive. And Danger is also predictive if you can use damage of any type to the tumor to begin the process of effector-cell clearing of the tumor. And with that said, we are about ready to take a lunch break. We're going to come back and review some aggregate retrospective findings and then go through some luscious case histories. Okay, so see you in an hour.

### LUNCH

The first thing I want to do, before we start, is respond to a question that Mark Rosenberg posed regarding sources of information and a program of certification that is offered by the nonprofit Gerson Institute, for ... ostensibly for doctors to become expert and knowledgeable about the Gerson therapy. And I would point out that my first reaction, when I heard about the certification program, after separating from the institute — I had been it's executive director and then science director for thirteen years — I wrote a little something for Jon Collins' *Townsend Letter*, suggesting 'Caveat Practitioner'; this certification program is about branding, trademarking, and not about an in-depth education in the Gerson management. Actually, the content, especially when Liz sends you the PowerPoint, and you actually look at the charts of the diet, the stages of the diet, down to the gram weights of the food materials, you'll have more information than you would ever get from that certification education program, because it revolves around the last published variant of the diet therapy, which gives you none of the practical tools. You would not come away with the knowledge of even the way the diet therapy functions as an immunotherapy, resulting in fevers. This is not part of that program. And I say that having been, as I said, part of the Gerson Institute for the years up to and beginning the inception of the certification training program, with which I strongly disagree. It should be in the public domain. The materials that I'm translating now, a bunch of them, not the whole text, certainly, but a bunch of the materials of the basic diet and administration, the timing and the intervals, the intercalations of various formats, those will be posted on my web site, which is a Study-Web Academic site that is simply to get the info out there. As I said, it is in the public domain, it is not mark-protected,

or patented, or copyright protected, but it does represent the last time a major university funded lengthy inquiry and research, multiple levels of research, into whole-food intervention as a form of nutritional immunology. Because Mark asked, I am not a fan of certification programs like that, and I am not a fan of Gerson Therapy™. It's not science; it's business, per se. Those are my comments; and I didn't come here planning to say that, but since Dr Rosenberg asked, I'm there for him.

So, moving ahead into the more interesting aspects of this, when we did a retrospective — I'm going to give you the overview — in melanoma, we looked at around 250 patients that were treated over a period of twenty years, a consecutive series, at four Mexican facilities, the 4 original Gerson hospitals: Hospital La Gloria, Hospital Jardines La Mesa, Hospital Del Sol, and CHIPSA, all of which were assignees of the Gerson Institute, and they shared the recruitment of patients with the Gerson Institute. And, they learned how to do the therapy from the Gerson Institute and so what you see is the results of that last form of the diet therapy that we talked about, the thirteen juices, the carrot juices, the green leaf juices, the raw veal liver juices, with the notable exception that, obviously after 1987, there was no more raw veal liver juice due to *Campylobacter* infection that is endemic in animal husbandry right now.

So, what we saw: stage I and II really are not statistically significant, because the sample's too small. When we got to stage IIIA, we saw a considerable survival advantage, I mean, a big survival advantage. The ACS reported 39% of 103 patients — I chose the best databases that were comparable — 82% survivorship of 17, n=17, versus 39% of n=103. When you run a chi-square, you get significance out of that. This is a clear and discernable effect. And as we go through some case reports, you'll see how it feels when it's up close and personal with a real patient.

Even getting the aggregate of IIIA and IIIB — the difference between IIIA and IIIB is the size of the tumor — if it's stage III, you're still restricted to the original quadrant of the body. And yet, you know, we're looking at 70% versus the best comparable data base of 41% at five years. So this is a big effect. Even in stage IVA — and we used the Eastern Cooperative Oncology Group's report of a 6% survivorship of IVA of 194 comparable patients — we had 39% of 18 stage IVA patients with distant skin and lymph metastases. This is pure diet therapy. This is before the introduction of Coley's vaccine, at Gerson's suggestion in his last monograph.

Taking a look through the Danger Model and asking what would be the impact of surgery, what we see

is that *within the Gerson treatment system, a number of patients avoided surgery for recurrent melanoma. 49 patients assessable for use of surgery were admitted for metastasized dis-*

Within the Gerson treatment system, a number of patients avoided surgery for recurrent melanoma. 49 patients assessable for use of surgery were admitted for metastasized disease at stages IIIA, IIIB, and IVA with T4b (n = 1), N1 (n = 16), N2 (n = 15), and M1 (n = 17) as their most significant manifestation.

Of these, 17 (8 females and 9 males) opted against surgery (N1 = 3, N2 = 4, M1 = 10). 6 nonsurgical patients survived 5 years; N1 = 2 (67%), N2 = 1 (25%), M1 = 3 (30%). *The average 5-year survival rate for nonsurgical patients was 35%.*

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Hildenbrand GLG, Hildenbrand C, Bradford K, Rogers D, Straus C, Cavin S. The role of follow-up and retrospective data analysis in alternative cancer management: the Gerson experience. *J Naturopath Med.* 1996;6(1):49-56.

#### Cancers most responsive to Gerson's diet therapy

Data from the Gerson Research Organization tumor registry demonstrate clear responses in several cancers

- A. Melanomas (surgery doubles survival in stages IIIA & B)
- B. Lymphomas
- C. Surgically debulked ovarian carcinomas
- D. Operated Duke's C colorectal carcinomas

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Hildenbrand GLG, Hildenbrand LC, Bradford K, Cavin S. Five-year survival rates of melanoma patients treated by diet therapy after the manner of Gerson: a retrospective review *Alt Ther Health Med.* 1995;1(4):29-37

100% of 14 Stage I and II patients (local disease)

Balch reported 82% in a meta-analysis *Semin Surg Oncol* 1992;8:400-414  
The Gerson diet sample was too small for significance

82% of 17 Stage IIIA patients (early lymph mets)

ACS reported 39% of 103 *Cancer.* 1993;71:1239-46  
Significant, Chi-square 9.48, 1df, p=.002 power=.887

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#### Hildenbrand (cont)

70% of 33 Stage IIIA/B (early to late lymph mets)

ACS reported 41% of 134 alive at 5 years  
Significant. Chi-square 7.62, 1df, P<.006, power=.802

39% of 18 Stage IVA (distant skin + lymph mets)

ECOG reported 6% of 194 *Cancer.* 1993;71:2995-3005  
Significant. Chi-square 19.3, 1df, P<.0001, power=.997

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32 patients (17 males and 17 females) employed **surgery and diet therapy as complementary managements** for rT4a (n = 2), T4b (n = 1), N1 (n = 12), N2 (n = 10), and M1 (n = 7). 24 surgical patients survived 5 years; T4a = 1, T4b = 1, N1 = 11 (92%), N2 = 8 (80%), M1 = 4 (57%). **The average 5-year survival rate for surgical patients was 75%.**

The difference in means (.40), which reflects a more than doubled (114% greater) survival advantage, is statistically significant (Fisher Exact Test, P = 0.013).

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Hildenbrand GLG, Hildenbrand C, Bradford K, Rogers D, Straus C, Cavin S. The role of follow-up and retrospective data analysis in alternative cancer management: the Gerson experience. *J Naturopath Med.* 1996;6(1):49-56.

**Hildenbrand GLG, Hildenbrand LC, Bradford K, Cavin S. The role of follow-up and retrospective data analysis in alternative cancer management: the Gerson experience. *J Naturopath Med.* 1996;6(1):49-56**

Surgery/prevention of recurrence

- N=49 combined Stage IIIA,IIIB + IVA melanoma
- 75% of 32 surgical patients alive at 5 years vs 35% of 17 patients who avoided surgery
  - Significant. Fisher Exact Test, P = 0.013
  - 11 of 12 (92%) operated IIIA patients alive
  - 8 of 10 (80%) operated IIIB patients alive
  - 4 of 7 (57%) operated IVA patients alive

Slide

From: "T. Colin Campbell" <tc1@cornell.edu> [Add to Address Book]  
To: ghildenbrand@earthlink.net  
Subject: Re: Diet, vaccine & cancer documentary  
Date: May 21, 2009 6:48 PM  
Attachments: pastedGraphic.tiff unknown-649 B

Dear Gar,

Thank you for contacting me and offering the DVD. Before our book, I had used for some years your paper in my class at Cornell as evidence that the diet approach was worth considering.

My address is 8 Fiddlers Green, Lansing NY 14882

Regards,



T. Colin Campbell

Slide 141

**Formenti SC et al. Ionizing radiation inhibition of distant untreated tumors (abscopal effect) is immune mediated. *Int J Radiat Oncol Biol Phys.* 2004 Mar 1;58(3):862-70..**



Slide 142

**Silvia Formenti, Prof. and Chair, Dept Rad Onc NYU**

*ease at stages IIIA, IIIB, and IVA* — okay, and if you know your TNM staging, that's what it is. There were *8 females and 9 males who opted* — 17 aggregate — *against surgery*. So, only 6 of 17 survived 5 years of the non-surgical group, which made the average 5-year survival rate for non-surgical patients 35%. Look what happens when you put the two together — and I'm pointing out, by the way, that surgery has about the same, surgery only has about 35% five year survivorship in the same stages. But when you put the two together, the average five year survival for surgical patients using the diet therapy as immunotherapy was 75%, presumably because of enhanced danger signals in the surgical beds, and enhanced tissue reactivity promoted by the sensitizing diet, and the increased activity in the innate immune system, and increased allergic inflammatory responses. The difference in means was reflected in more than a doubled survival advantage and is statistically significant.

And this is just a little bit of a breakdown of IIIA patients 11 of 12, not too shabby, not too shabby, 92%; 80% in IIIB; and 57% of IVA patients, where ECOG reported 6%. So, this is really an example of integrative medicine at its best, and this is before the addition of agents like the Coley vaccine or radiotherapy, which can be used to introduce danger signals, if it is not overdone, or some chemotherapeutic agents like Temodar, which given in short bursts of say 3 days with a month off to do immunotherapy, can be used as a sort of vaccination *in situ* with antigens from killed cells. And you can take advantage of those antigens as danger signals in an immunized patient. And that's — again, I am speaking through the lens of Matzinger, who says we'd be curing a hell of a lot more cancers if we'd just quit thinking in the old mode of immunity and start taking advantage of the new knowledge of the way that lymphocytes and antigen-presenting cells really function.

I'm showing this because it makes me giggle every time I see it. I hadn't been aware that Colin Campbell had been using our melanoma paper for years in his class at Cornell as evidence that the dietary approach was worth considering. And it just amuses me, even though I don't see eye to eye with Colin on the strict, continuous elimination of all animal products from the diet. We do agree on the necessity of predominant plant feeding, and I love being a footnote in his book, *The China Study*.

Just to, alert you to this woman, this is where you find your best information on the use of the Danger Model to create greater than expected effect with radiotherapy. What Silvia is showing is that you can take — even as her institutional review board made her do it — you can take women who are on chemo — selection criteria said they had either no shrinkage on the chemo, or they had actual growth on the chemo — and you could grease pen them for radiation, only one tumor — they had to have at least three — and if you put them on GM-CSF in addition to radiating one tumor, you got at



least almost half of the patients shrinking other tumors outside the radiation field because of what — and this is Sylvia's term, she created it — what she calls vaccination *in situ*, which is a brilliant concept. Now, I am not saying we're on the radiotherapy band wagon, but there are times, let's admit it, when you have to. When you've got somebody with a vertebral, lytic, metastatic lesion that is threatening to pathologically fracture, and you've got to do something, why not take advantage of it and get a bigger effect? And if you're using GM-CSF, as we've found, in conjunction with diet therapy, — and we like to use it, even though we're already using Coley, because Coley is so general, and GM-CSF kind of grows the cells you want — you know, those dendritic cells that are costimulatory in nature? — that you're in new territory; you get responses you couldn't get otherwise. So, hats off to Silvia Formenti. She's got a lecture — I took this from a lecture on fora.tv, and if you find that lecture, she is so wonderful. She talks about literally wanting to scream, because she's got a clinical advancement and can't get any traction with people, because it's not a material. It's not an item that can be marketed. It's just an improvement in clinical. But she's Chair of Radiation Oncology at NYU — and she's very cool.

Non Hodgkin's lymphoma is, along with melanoma, the other tumor that will occasionally completely regress with a durable remission with just the diet therapy, so that's what we found when we did our retrospective (Slides 143, 144). We have not done retrospectives again, because this is pure diet therapy and nobody — we're not doing pure diet therapy. But that looks at — you know, these are the kinds of cases we found, even high-grade cases, and you can see their survivals.

This is, perhaps, the most astonishing: Gilda Radner's cancer, optimally debulked; but in FIGO stage III, especially FIGO stage IIIc — which is the T3 N0 M0 or any-T N1 M0 — no surgeon ever takes all the nodes. There is studding all over the place, so you sort of say, "anything smaller than a centimeter we'll mop up with chemo." So, in every instance, these women were admitted to diet therapy with residual tumor. This was reported in 1996 at a conference and, have we lost any of these to cancer? We've lost one, but it might have been old age? No? Which one?

(Christeene Hildenbrand: H.S...)

Oh, H.S. How old?

(Christeene Hildenbrand: Fifty-six.)

Fifty-six; too young. Might have been a recur ... might have been a recur.

(Christeene Hildenbrand: But, in 2009, on her web page, she had not had a recur. I've got to write a letter to her husband.)

And find out what happened, yeah. So, essentially we have, with a

Hildenbrand *et al* **Survival impact of Gerson's diet on adult NHL.** *Proc Alt Ther Symp.* Jan 18-21, 1996, San Diego CA

- To date, none of the assessable low stage, low grade patients (working formula A-C) are deceased in the Gerson system.
- To date, none of the assessable intermediate grade patients (working formula D-G) are deceased.
- Lymphoma, one of the most manageable of all cancers, has many treatment options.
- Patients whose disease escapes one or more forms of management frequently have recourse to others.

Slide 143

Hildenbrand 1996 (*cont*)

Anti-tumor effect

13 of the assessable charts documented complete regressions of adult non-Hodgkins lymphoma with Gerson's nutrition-based treatment as *sole influence*

- **2 low grade**
  - 1A - 17 years; 1C - 8 years
- **7 intermediate grade**
  - 3D - 8 years, 13 years, 45 years
  - 2E - 7 years, 4 years
  - 2F - 9 years, 5 years
- **2 high grade**
  - 2H - 10 years, 5 years
- **2 histology pending review**
  - 7 years, 17 years

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Hildenbrand *et al.* **Survival of FIGO STAGE IIIC ovarian patients (T3N0M0 or any TN1M0)\*** *Proc Alt Ther Symp.* Jan 18-21, 1996, San Diego CA

3-year survival rate: Gerson diet 75%; n = 8

SEER 25%; n=1125. X<sup>2</sup> = 8.238, 1df, P = 0.004

4-year survival rate: Gerson diet 71%; n = 7

SEER 13%; n=1016. 95% CI = 0.833 to -0.327; z = 3.933; P = 0.000

5-year survival rate: Gerson diet 67%; n = 6

SEER 2%; n=917.95%CI-0.733 to -0.527; z=8.990; P=0.000

6 Gerson diet\* patients are alive in follow-up with survivals of 3,4,5,7,12.5 and 13 years.

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\*Optimally debulked surgically, plus Gerson diet

Ovarian carcinoma 2011 tiny update

There are now 7 surgically debulked FIGO IIIC patients out > 5 years.

Slide 146

**Hildenbrand et al. 5-year survival rates of Duke's C colorectal cancer. Proc Am Ther Symp. Jan 18-21, 1996, San Diego CA**

Records of the Gerson facilities reveal 64% of 11 operated-to-cure patients alive at 5 years with dietotherapy.

Moertel et al [*Ann Intern Med* 1995;122(5):321-6] report 60% of 304 operated-to-cure patients alive at 5 years with 5FU plus Levamisole (compared to 47% of 315 controls).

While the above rates are similar, the Gerson sample size would have to be at least 45 patients with the same percentage of survivors to achieve statistical significance. Only prospective data collection can establish the validity of this early trend in the data.

Slide 147

**Limitations of Gerson's diet therapy as sole management**

- A Patients with advanced, bulky disease
- B Breast cancer of all stages

Slide 148

**Helene Schweitzer  
pulmonary tuberculosis**

Treatment duration of 28 months;  
11 months institutional treatment.  
Last report, 1 year later

Mrs. H.M.S., 51 years old. – lymphatic – mother's brother died of tuberculosis

Slide 149

*H. Schweitzer, cont.*

- 10 yrs hx pleurisy on left
- Post extirpation of 'cervical glands' recurred and later healed spontaneously
- 22-yr hx neuralgic pain after fall (spinal trauma)
- 1922 flu after bacillus (+), blood in sputum
- 3 mo Kannstadt hospital, bacillus (-)
- 1925 tired, cough, minor subj deterioration
- 1929 long sea voyage and stay in tropics High fever, then improvement
- 7/1/1930 Admitted

Slide 150

tiny update, seven patients that went out five years; one, however, deceased after more than a decade ... more like fifteen years, and we don't know the circumstances of that. But this is ... again, this is probably the result of surgery and immunotherapy multiplying each other.

And the same is true with Duke's C colorectal. Now this is a tiny sample, but you wouldn't expect to have more than half of 11 Duke's C, operated to cure, out five years. And those are the four cancers — with surgery there were 3 of them — one without.

Limitations of Gerson's diet therapy as sole management.

Patients with advanced, bulky disease in any pathology can't be reached by diet therapy alone, because Gerson is dead. You know, nobody else knows how to do it as well as he did. In breast cancer it's a shocking finding; but unless we disprove what looks to be the case, even stage I and II operated-to-cure will recur at the normal rate after diet therapy. And that is not a happy finding. But the good news is that — as you'll see in the case histories — that you can do quite a lot if you introduce some danger signals. And that's what we need to do.

Now I want to introduce you to the case of Helene Schweitzer, with a refractory pulmonary tuberculosis that Gerson treated for 28 months, and he had her in the hospital for 11 of those 28 months. And he followed her up an additional 12 months beyond the 28 months, before he wrote this report. That would take him up to the time of the monograph being written. She was admitted, 51 years old, lymphatic — remember what that used to mean? That meant "kind of quiet." Her mother's brother died of TB.

(Christeene Hildenbrand: You should say who she is.)

Oh ... she's the wife of Dr Albert Schweitzer, the Nobel-prize-winning, Bach-organ-recording, missionary physician — one of the most famous of the last century. Like when the Nobel committee read aloud the nominating letter, they called him a membrane between cultures.

She had a 10-year history of pleurisy on the left, and she'd had her cervical glands operated for tuberculosis. They recurred, but later healed spontaneously. TB was like that, relapsing, remitting, you know. Twenty-two years of neuralgic pain after a fall. She got the flu and became bacillus-positive with blood in the sputum in '22. She spent time in Kannstadt hospital and became bacillus negative, but you know tuberculosis lies latent, so being negative in the sputum does not necessarily mean its gone, and that was found to be true after a long sea voyage and a stay in the tropics — that would be at Lambarene, South Africa, at her husband's mission. She developed high fever again; she improved but she was admitted. She was sputum positive again and Gerson started to treat her. The monograph



has x-rays done by Felix Fleischner who was a professor of radiology, the preeminent reader of x-ray films in the 1930s, who wrote a special monograph that was inserted into Gerson's text on pulmonary tuberculosis explaining what a spontaneous remission of pulmonary tuberculosis looks like with charts and graphs, and then comparing those to Gerson's, as Fleischner said, "for obvious reasons." The statement was that Gerson had figured out how to make spontaneous regressions not so spontaneous but more predictable, and to validate him.

Now this is where it gets fun: *Diuresis begins slowly, as the NaCl excretion, which rises in the 2nd week first to 13-g (after the findings of Mohr), held as usual in the first 5 days. (Beginning of the treatment 2 days before menstruation; began good NaCl excretion on the last day of menses.) Current therapy: 3 days raw food, then basal diet with 3 yolks. — Because of the old adhesions, often switching from raw-food days to 3 apple/potato days in a row, first after 20 days, then after 14 days; because the latter was very straining and caused cardiac symptoms and back pain, she was transferred again to the 3-week interval.* So every time he would drive her into leukocytosis and the shift to the left, she had hell to pay, and he backed off and modified the therapy so she would not be incapable of continuing.

*Flareups here were not distinguishable by temperature increases (only exceptionally above 37), but by premenstrual symptoms of — and get this — irritation, nervousness, headaches, joint pain, etc., which differed from previous menstrual symptoms only by increasing intensity. The initial exacerbation was expressed only in nonspecific symptoms such as significant depression, nervous irritability, bad mood, loss of appetite; — sounds like someone on interferon — so much so that by the 2nd menstruation the patient wanted to stop treatment. Worse yet, these symptoms occurred prior to the 3rd and 4th menstruations, at which time she had troublesome pain and tenderness in the left chest, which was interpreted as the pleural flareup. — she had it especially in the upper — in the apex of the lung — she had pleural thickening ... After the small initial exacerbation, there was only a small subjective improvement. And here you see Fleischner's finding, the cavern has become smaller, mainly in the transverse direction.*

*Until early September, steady gain in weight from 56.50 to 60.9 kilos; tolerable well-being. The 3rd menses came 20 days after the 2nd, with strong flareup symptoms, which were interpreted as the initial exacerbation of the extensive cirrhotic foci and caverns. Aversion to food, refusal of treatment, severe irritability, patient stormily demands discharge from the hospital and could be assuaged only with great patience and loving responsiveness and persuasion of her husband (a doctor) over this time which, with small breaks over the 4th menstrual period, lasted for a total of almost 6 weeks! In this*

*H. Schweitzer, cont.*

"Diuresis begins slowly, as the NaCl excretion, which rises in the 2nd week first to 13-g (after Mohr), held as usual in the first 5 days. (Beginning of the treatment 2 days before menstruation; began good NaCl excretion on the last day of menses.) Current therapy: 3 days raw food, then basal diet with 3 yolks. — Because of the old adhesions, often switching from raw-food days to 3 apple/potato days in a row, first after 20 days, then after 14 days; because the latter was very straining and caused cardiac symptoms and back pain, was transferred again to the 3-week interval."

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*H. Schweitzer, cont.*

Slide 152

"Flareups here were not distinguishable by temperature increases (only exceptionally above 37), but by premenstrual symptoms of irritation, nervousness, headaches, joint pain, etc., which differed from previous menstrual symptoms only by increasing intensity. The initial exacerbation was expressed only in nonspecific symptoms such as significant depression, nervous irritability, bad mood, loss of appetite; so much so that by the 2nd menstruation the patient wanted to stop treatment..."

*H. Schweitzer, cont.*

...Worse yet, these symptoms occurred prior to the 3rd and 4th menstruations, at which time she had troublesome pain and tenderness in the left chest, which was interpreted as the pleural flareup. After the small initial exacerbation, there was only a small subjective improvement (see epicrisis)."

•8/18/30 XR: cavern has become smaller, mainly in transverse direction.

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*H. Schweitzer, cont.*

"Until early September, steady gain in weight from 56.50 to 60.9; tolerable well-being. The 3rd menses came 20 days after the 2nd, with strong flareup symptoms, which were interpreted as the initial exacerbation of the extensive cirrhotic foci and caverns."

Slide 154

*H. Schweitzer, cont.*

"Aversion to food, refusal of treatment, severe irritability, patient stormily demands discharge from the hospital and could be assuaged only with great patience and loving responsiveness and persuasion of her husband (a doctor) over this time which, with small breaks over the 4th menstrual period, lasted for a total of almost 6 weeks! In this case she had no fever, only temporarily increased sputum, which was sometimes tinged with blood and, during this period, for the first time, elastic fibers occurred." (Bacillus continuously +).

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*H. Schweitzer, cont.*

"Weight increased from week to week, by more than 2 kg. — X-ray images at the end of this — initial exacerbation of cirrhosis — showed further improvement. In mid-October, very good general condition, sputum decreased except for traces."

• 10/31/1930 R Apex: *no further change. L: shadows decreased substantially, have become harder & moved upward. Cavern narrowed considerably.*

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*H. Schweitzer, cont.*

- Hospitalized 7/1930-2/1931  
Dchg to home care in good condition.  
Diet: basic diet, egg yolk, 3 x 100 g of liver, brain, sweetbreads per week, small amounts of quark allowed, milk forbidden.
- 10/15/1931 XR: L & R shrinkage continues, cavern no longer recognizable.
- 11/1931 Doing well, she had flu in Sept, bacilli (-)

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*H. Schweitzer, cont.*

"The patient was instructed to continue the same diet without change for 6 months, because the focus of inflammation has shown the delicacy of the lungs after the influenza, and because the persistent sinusitis constitutes an ongoing potential danger. The only changes permitted were a reduction in the vegetable juice to 600 g, and the fruit juices to 200 g daily."

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*case she had no fever, only temporarily increased sputum, which was sometimes tinged with blood and, during this period, for the first time, elastic fibers occurred. Constantly bacillus-positive in the sputum.*

This is what you see in almost all diet-therapy patients. There are a few that are phlegmatic and they handle it well, but the vast majority will suddenly begin to complain that the diet is absolutely intolerable; they will complain that the physician doesn't speak in the right tone of voice to them; they will complain that they are not getting support from their loved ones, or from family, and at their spouse they will go off like a V-2 at the slightest provocation. Gerson came to regard those symptoms as being the same as a fever in another patient. They are predictable. Just think of it as a brain full of cytokine soup, all right? And the hormones becoming active again; her period had stopped, and then it came back, and now she's got "teenage me" to deal with, right? Who wants to go back to raging hormones, for goodness sake? I mean, I'd rather have my adult sedate ones than adolescent ones. But, oh ... and another thing you want to know is that patients will tend to become very frisky as those hormones kick in again, as we saw in a halfway house in Chula Vista, California, where people would take up residence for nine months, ten months, a year, and you wouldn't believe the Peyton Place. It just was astonishing, and these were people in their sixties, seventies some of them.

*Weight increased from week to week, by more than 2 kg. — X-ray images at the end of this — initial exacerbation of cirrhosis — showed further improvement. In mid-October, very good general condition, sputum decreased except for traces. The right apex, according to Prof. Fleischner showed no further change. On the left, the shadows decreased substantially, have become harder & moved upward. The cavern narrowed considerably. So those were her hospitalization dates, a long chunk. Discharged home in good condition. The X-ray findings show continued shrinkage; the cavern is not longer even visible by October of 1931. So, from July of 1930 to October of 1931, complete resolution of refractory cavernous tuberculosis.*

*The patient was instructed to continue the same diet without change for 6 months, because the focus of inflammation has shown the delicacy of the lungs after the influenza, and because the persistent sinusitis constitutes an ongoing potential danger. The only changes permitted were a reduction in the vegetable juice and the fruit juice.*

The patient had a recur ...

(Christeene Hildenbrand: She was readmitted.)

Yeah, she had to come back in. As Gerson explained it, she just couldn't stay really strict. And people think, "it won't hurt if I have a few bites of this or that protein;" but in fact, if you think about the oral

antigenicity of the protein and the induction of an IgA response in the gut and the systemic tolerance that goes along with that, you can see how tuberculosis could reassert itself, and that is what it did. So ...

*Therapy which, as always with such recurrences, vigorously returns to initial treatment: raw food, plenty of enemas, rubs, cod liver oil, calcium bromide; Mineralogen — which was Gerson's own brand of mineral salts — followed a week later during the transition to the basic diet. Egg yolks are added after another 3 weeks, liver and brain after the first 3 months of treatment, after the disappearance of the new foci and the cavern in the apex. In the case of fresh processes, relapses, etc., the patient must drink a large volume of juice. He may take as much of the allowed foods as he wants. But if he cannot eat a lot, — if he cannot eat a lot, then — we may not in turn restrict the juices. We must stand on principle that the juices are of vital importance for him, while it does not matter if he eats one apple or banana more or less. And this is true, the emphasis on getting the fluids of these raw juices is oftentimes all you can do when you start the cancer patients who are in far advanced condition. If you start with, you know, a few ounces of juice every hour and they sip at it.*

I want to step back into the paper that Matzinger wrote last February in *Nature Reviews Immunology*, because, whether you knew it or not, tuberculosis for a long time looked like cancer, cancer looked like tuberculosis, until you got into the histological microscopic verification of it. (Slides 161-163). *Mycobacteria also have immune-subverting effects. — just like cancer — Recent studies on early events in the establishment of mycobacterial infections have reversed long-standing assumptions about the purpose of the granuloma, one of the most ancient host defense strategies by which multicellular organisms wall off infectious agents and prevent their spread through the body. Surprisingly, granulomas form rapidly during infection with virulent mycobacteria and have greater levels of macrophage recruitment, — this is just like a tumor stoma, macrophage recruitment; 50% of the tumor is macrophages in the stoma, okay? — motility and apoptosis — okay, they're all at greater levels than — those that form during infection with non-virulent mycobacteria (which are poorly formed and result in attenuated infections). The result of the accelerated granuloma formation with virulent mycobacteria is early dissemination of the infection, through the release of infected macrophages from*

Surprisingly, granulomas form rapidly during infection with virulent mycobacteria and have greater levels of macrophage recruitment, motility and apoptosis than those that form during infection with non-virulent mycobacteria (which are poorly formed and result in attenuated infections). The result of the accelerated granuloma formation with virulent mycobacteria is early dissemination of the infection, through the release of infected macrophages from the primary granulomas and production of secondary granulomas at distal sites.

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Matzinger PC, Kamala T. Tissue-based class control: the other side of tolerance. *Nature Reviews Immunology* 2011;11:221-230

*H. Schweitzer, cont.*

- 8/9/1932 Recurrence, Pt in "miserable state"

"Therapy which, as always with such recurrences, vigorously returns to initial treatment: raw food, plenty of enemas, rubs, cod liver oil, calcium bromide; Mineralogen followed a week later during the transition to the basic diet. Egg yolks are added after another 3 weeks, liver and brain after the first 3 months of treatment, after the disappearance of the new foci and the cavern in the apex."

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*H. Schweitzer, cont.*

"In the case of fresh processes, relapses, etc., the patient must drink a large volume of juice. He may take as much of the allowed foods as he wants. But if he cannot eat a lot, we may not in turn restrict the juices. We must stand on principle that the juices are of vital importance for him, while it does not matter if he eats one apple or banana more or less."

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Mycobacteria also have immune-subverting effects. Recent studies on early events in the establishment of mycobacterial infections have reversed long-standing assumptions about the purpose of the granuloma, one of the most ancient host defense strategies by which multicellular organisms wall off infectious agents and prevent their spread through the body.

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Matzinger PC, Kamala T. Tissue-based class control: the other side of tolerance. *Nature Reviews Immunology* 2011;11:221-230

Thus, the virulent mycobacterium converts an evolutionarily ancient form of host defense into a convenient and pliant tool that enables its survival and more efficient propagation.

Slide 163

Matzinger PC, Kamala T. Tissue-based class control: the other side of tolerance. *Nature Reviews Immunology* 2011;11:221-230

**Leslie Tell – ovarian carcinoma**

26-year asymptomatic survival of woman with FIGO IIIc papillary serous cystadenocarcinoma and well-differentiated adenocarcinoma

- Bilateral ovaries
  - Uterus
  - Tubes
  - Omentum
  - Peritoneum
  - Perineum
  - Bladder
  - Malignant ascites
  - Right hemi-diaphragm
  - Spleen
  - Cecum
  - Appendix
- Slide 164
- 3/7/1985 - surgically debulked for all lesions >1 cm leaving extensive residual disease. Leslie refused chemotherapy.**

**Note: Prior to dietotherapy, Leslie had 6 weeks IV treatments with vitamin C, laetrile and DMSO.**

Leslie Tell, interviewed in March, 1990:

“I gained weight. I looked and felt like a different person. When I started Gerson, I was strong enough to handle the healing reactions that just really knocked me.”

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**Leslie Tell (cont)**

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**Note: Leslie was admitted for dietotherapy 7/14/1985**

“On the fifth day on the full Gerson treatment, I had a very high fever. We measured it at 103°, but we’re sure it was higher than that. I just ached. I’ve never felt so terrible. It was like the worst case of flu that you can even imagine. Every joint, every part of my body was just aching. Killer headaches. I could hardly move, I was so sick.”

**Leslie Tell (cont)**

**Interviewer: Did you have N/V or diarrhea?**

“Not on the first day (of the reaction). I was taking so many coffee enemas, there was no time for diarrhea. I was just taking one coffee enema after another just to give myself a little relief. It never even touched the fever. The fever stayed right up there.”

Slide 167

*the primary granulomas and production of secondary granulomas at distal sites. Thus, the virulent mycobacterium converts an evolutionarily ancient form of host defense into a convenient and pliant tool that enables its survival and more efficient propagation of the mycobacterium.*

So, in tuberculosis you are seeing very similar cellular recruitment to cancer-stem-cell recruitment of innate immune cells, and it stands to reason that there would be a kind of off-label use for cancer management in the diet therapy.

So, let’s have a look at one of these long-term FIGO stage IIIc survivors, Leslie Tell. We’ll hear some words in her own voice about what the flare-ups were like, because it’s important, if you’re going to do any of this stuff, to know what they might be going through and be able to interpret what they might be going through. Twenty-six-year asymptomatic survival of woman with FIGO IIIc papillary serous cystadenocarcinoma as well as a well-differentiated adenocarcinoma. And these are the metastatic sites: both ovaries, uterus, tubes, omentum, peritoneum, perineum, bladder, malignant ascites, the hemi-diaphragm on the right, spleen, cecum and appendix, all that stuff was infested by tumor. She was debulked for all lesions greater than 1 cm leaving extensive residual disease. She refused chemotherapy.

Prior to dietotherapy, she had 6 weeks IV treatments with vitamin C, laetrile and DMSO. Could not have hurt her, and it didn’t. She gained weight; she ... “*looked and felt like a different person. When I started Gerson, I was strong enough to handle the healing reactions that just really knocked me.*” And this is in a March of 1990 interview.

She says, “*On the fifth day on the full Gerson treatment, I had a very high fever.*” — How many would empirically treat with antibiotics in the presence of 103-degree fever, especially when we were very recently surgical? — “*but we’re sure it was higher than that. I just ached. I’ve never felt so terrible. It was like the worst case of flu that you can even imagine.*” — think about all this being spoken in a nice southern Florida drawl — “*Every joint, every part of my body was just aching. Killer headaches. I could hardly move, I was so sick.*” — That’s the initial exacerbation, right there, in a cancer patient. That’s what it looks like. It’s a difficult experience.

*Did you have N/V or diarrhea? “Not on the first day (of the reaction). I was taking so many coffee enemas, there was no time for diarrhea. I was just taking one coffee enema after another just to give myself a little relief. It never even touched the fever. The fever stayed right up there.”*

*Tell me about day 6.* — That’s the second day of the reaction. She said, well, “*That’s when I started getting the nausea.*” — See, that’s when the GALT tissue kicks in. You know, with all these patients,

you're going to get MALT and GALT. You are going to get all kinds of phlegm and snot, and the stuff coming out of the lungs, and you're going to get the intestine going wacky on you. All that mucosa-associated lymphoid tissue turns

on. She says, *"I couldn't keep anything down. I took the green drink as a retention enema. I couldn't even look at the liver juice. I drank a copious amount of peppermint tea" — this is a good hint — "and a little bit of the oatmeal gruel" — that's one part oats and ten parts water, strained — "and some watermelon juice which really helped settle my stomach. I just stayed in bed and took coffee enemas. I really couldn't eat much. I only vomited one time, when I tried to drink the liver drink."* — No wonder.

*"What was so phenomenal was that the onset of the healing reaction was just like throwing a light switch. It was that sudden. I mean, I felt fine one minute and deathly ill the next. And when it ended, it was just that sudden. I remember, I was taking a coffee break and was still feeling just lousy, and I got up and just sort of blinked my eyes and said, 'Oh, it's over!'"* This is an accurate description; this is not out of the ordinary of what these people go through on nutritional immunotherapy.

She says, *"I had dozens and dozens of healing reactions after that, never that strong, never that high a fever again — they tapered down as time went on. But always, they were like that. I still think I have them, but I'll just get a headache and feel kind of tired."* I just want to point out that her husband is an eminent research psychologist trained in the science of inquiry, so she's a good student of that.

*"The last one that I know I had for sure,"* she said, *"my daughter and I were shopping. We happened to be in Fort Lauderdale, in a mall, and we were walking in Sax Fifth Avenue. Suddenly my knees just buckled, and we had to go sit in a dressing room for an hour. And then, click, the light went back on again, we got up, we left, and I was fine."*

*"And the other real interesting thing about this, is that for the longest time — about every 3 months I would reach another plateau of feeling better. I called these 'clicks'. I would think I was feeling really good, having good energy, and then suddenly, click, I'd move up to another level, another level of feeling even better. I noticed that the clicks were coming in 3-month increments. Now I don't notice any changes, I just go along at a good level. But for a good 3 years it*

Leslie Tell (cont)

Slide 168

Interviewer: Tell me about day 6.

*"That's when I started getting the nausea. I couldn't keep anything down. I took the green drink as a retention enema. I couldn't even look at the liver juice. I drank a copious amount of peppermint tea and a little bit of the oatmeal gruel and some watermelon juice which really helped settle my stomach. I just stayed in bed and took coffee enemas. I really couldn't eat much. I only vomited one time, when I tried to drink the liver drink."*

Leslie Tell (cont)

Slide 169

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Leslie Tell (cont)

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Slide 170

Leslie Tell (cont)

*"The last one that I know I had for sure, my daughter and I were shopping. We happened to be in Fort Lauderdale, in a mall, and we were walking in Sax Fifth Avenue. Suddenly my knees just buckled, and we had to go sit in a dressing room for an hour. And then, click, the light went back on again, we got up, we left, and I was fine."*

Slide 171

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Slide 172

Slide 173

DAVID M.	6/7/2011	6/14/2011	6/21/2011
DX: MELANOMA	CHIPSA	CHIPSA	CHIPSA
Leuk 4.3-10.3	4.5	6	9.1
Bands 2-8	6	15 H	17 H
Segs 40-75	80 H	66	71
Lymph 16-45	11 L	13 L	8 L
Mono 3-9	3	5	4
Sed rate 0-20	16	21 H	45
Absolute differential values 6/21/2011			
Bands (0.086-0.824 x 1000)			1.55 H
Segs (1.720-7.730 x 1000)			6.46
Lymph (0.690 - 4.640 x 1000)			0.73

*was like that. Every 3 months I would reach another level."*

And I think, you know, few people are really that good at journaling their experience, but this is an accurate depiction.

Another thing you want to look at — this is from a patient we've got right now at the CHIPSA facility (see Slide 173) — is what happens when we start moving the patient, because the patient came in, a little bit myelosuppressed with a low WBC and lymphocytes. His treatment was diet and tiny amounts of Coley fluid subcutaneously.

Now, there's an outfit in Canada making Coley fluid, MBVax Bio-science, mbvax.com, they are a great outfit; however, their protocol is IV only and, as you are probably aware, at this point, Dr. Matzinger

and our group are not of the opinion that one route of administration adequately exploits the potential that exists in having different tissues activated at different times. We've found that the subcutaneous and intramuscular routes create slow-burning cytokine generators, where the reactions last a long, long time. And in one case — I'll talk about her later — we had a patient off Coley for at least ten days before a PET scan, which showed her to be in complete remission, but — and the nuclear medicine specialist who — always get your PET/CTs read by a nuclear-medicine-degreed individual rather than a certified radiologist, because radiology is just a few-hour certificate compared to a four-year degree program in nuclear medicine — so, when the specialist read the scan, he said, this woman is in complete remission from pulmonary- and submandibular-metastasized malignant melanoma. But, when I looked at the PET side, I saw FDG avidity in the two stoves at the sites of the subcutaneous injections that hadn't been touched for ten days, and virtually all of the axillary bilateral lymph as well as the intraclavicular lymph, they were all FDG avid, and all of them had an SUV elevated beyond normal tissue.

What happened with David here is that he started out with a bunch of segs, and we see this oftentimes in patients with melanoma; they have a lot of segs, but not much in the way of lymphocytes and leukocytes not doing a whole lot of good. But after a couple of weeks in the hospital, he had gotten bandemia, very significantly, and even though his lymphocytes registered low, because his WBCs had gone up, his absolute lymphocyte count had reached the normal range, and this is the kind of reaction you are after. Whether you achieve it with the diet therapy alone or you add to the diet, GM-CSF, or you do the diet therapy and Coley, or you use an autologous vaccine, or Paspac<sup>®</sup>, which is a Mexican respiratory disease vaccine — it's made of, like, 18 different microbes, pediatric, we use it in adults — whatever you are using as stimulant is going to help to create this shift to the left and normalize a chronically low lymphocyte count as you see down here in the absolute. We just stuck that in there because it was really a nice example.

Resolution of stage IVB melanoma

Resolution of stage IVB melanoma, recurrent skin and mets to the lungs. This is the gal I talked to you about just now with the stoves in the arms and the lymph in both axillae and intraclavicular spaces. She had a forehead malignant

melanoma. It was a Clark level 4, a Breslow depth of 1.45. Her lymph nodes were negative but at Memorial she had interferon treatment, and then within a very short time, by August of 2010 — she went from '07 to '10 — she was recurred. She underwent 3 surgeries. By January 2011, she had an enlarged lymph node lateral to the right-sided submandibular gland; it was big, 2.2 x 1.4. And she had a node in the submental triangle, 1.6 x 1.1. She had bilateral submandibular and internal jugular lymph nodes, a hilar lymph node that was a hunk, pulmonary nodule in the left lung that was approaching a centimeter. That wasn't biopsied; the submandibular was biopsied and was positive for malignant melanoma right here, aspiration biopsy ... oh, and the lytic lesion, a 1.4-cm lytic lesion at T12. So, she was admitted for

**Bailey O.  
Resolution of stage IVB melanoma  
recurrent skin and mets to lung**

- 12/07 S. R forehead: malignant melanoma Civ1.45; LNS(-)
- IFN $\alpha$  MSKCC
- 8/10 recurrence; underwent 3 surgeries
- Jan 2011 CT:
  - Enlarged LN lat to R submandibular gland = 2.2 x 1.4 cm
  - Enlarged LN in submental triangle = 1.6 x 1.1 cm,
  - Sm bilat submandibular and L internal jugular LNS
  - L hilar LN = 2.2 x 1.4 cm
  - Pulmonary nodule L lung = 0.9 x 0.6 cm, susp
  - 1.4 cm lytic lesion T12 bone metastasis poss
- 1/19/11 Asp Bx: soft tissue chin: (+)
- CHIPSA Gtx, Coley, Temodar
- 3/28/11 PET/CT: No susp hypermetabolic pulmonary nodule or bony metastasis seen.

Slide 174

treatment in February and her first PET/CT showed no suspicious hypermetabolic pulmonary nodule or bony metastases. I want to point out that we used Temodar to get some danger signals.

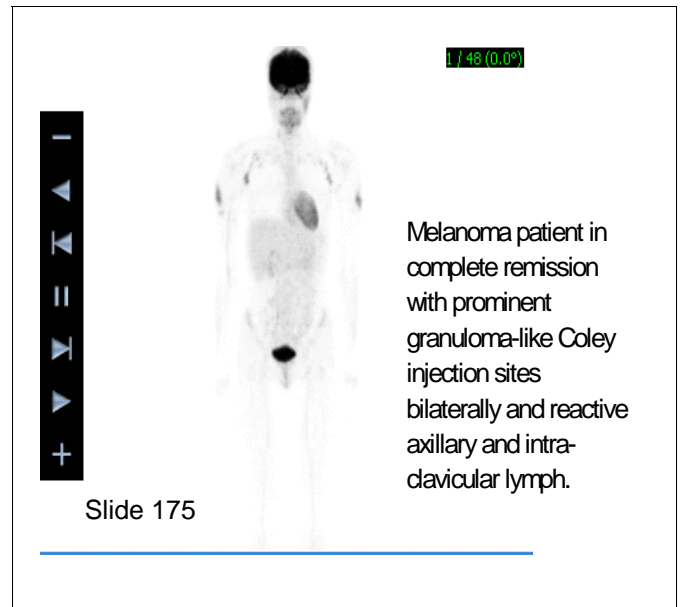
And this is another thing that you to consider. When you search on danger signals in the PubMed or, you know, the journals, what you'll find is that some old war horses like cyclophosphamide or oxaliplatin are capable of really creating messy cell death and are good danger-signal potentiators. Temodar works in melanoma to create danger signals and, if you pulse it — my favorite protocol is three days on, the rest of the month off to do immunotherapy — and you're just doing the Temodar as Sylvia Formenti is using radiation therapy to a single node, to get vaccination *in situ*; that's what we're doing with the Temodar. So, it's a way of thinking of both/and rather than either/or, you know, you're trying to integrate; this fellowship is about integrative cancer management and we're saying, you know, let's put all the tools on the tabletop. The methodology conference is about "what could we put together here that's going to piece together a recovery for the patient?"

So, this young lady remains in complete remission and nobody's more excited about moving forward.

Virginia Golden, oops ... no she was published by that name.

(Christeene Hildenbrand: She went public).

Regression and 53-year disease-free survival — she was one of Max Gerson's patients. She had an excision of a tumor on the left ankle, melanotic sarcoma. She had an inguinal lymph-node dissection that was positive and a tumor in the ankle that was positive. And when she presented to Gerson she had a left inguinal mass the size of a tomato and a lymph node, below the scar from the prior surgery. And by January, 1947, the mass had completely regressed. Virginia was interesting because she was treated by Gerson when he was still at Gotham Hospital in New York and she started the Gerson therapy immediately after the last surgery. During the hospital treatment the tumor mass became red twice and was hot and enlarged, and each time that lasted about two days. And within three months it was hardly palpable and the little node had completely disappeared. By 1948, in October, she carried to term and delivered a baby girl, which is really risky when you've recently regressed a melanoma or any other kind of cancer because, you know, homeostasis is so precarious, and a pregnancy is such a hugely transformative process, with a lot of embryonic activity. I couldn't believe that she made it through. And her last visit with Gerson was in 1956, at which time she complained only that she has, from time to time, a swelling and soreness in the lower left leg and especially in the ankle joint and foot, she limps a little. When that happens, the condition lasts 5 to 10 days. Gerson noted that "the discomfort is limited to this place only, otherwise she is doing all her work; she took, in addition, singing lessons, and was awarded with a prize." She became a vocal teacher and did that the rest of her life. Interestingly, her basal metabolism ran and stayed low for a long, long time. This is one thing that Gerson used to measure, the basal metabolism rate. Her lymphocytes were okay. She passed away at age 81, and she was published in the journal *Experimental Medicine and Surgery* as case 2 and in the *Cancer Therapy* monograph as case 12.



**Virginia G.**  
**Regression and 53-year disease-free survival**  
**of Stage IVA melanoma (melanotic sarcoma)**

- 9/1/45 S. exc tumor L ankle: Melanotic sarcoma
- 7/1/46 S. Ing LN dissection (+),  
Exc rT in ankle scar (+)
- 9/6/46 Presented to Dr. Gerson  
w/ T mass L groin (about size of tomato)  
and LN below scar
- Jan 1947 Mass completely regressed

Slide 176



(Christeene Hildenbrand: you should tell about the coffee.)

When I interviewed her personally, I asked her, "What was your experiences with the coffee enema?" and she said, "Coffee enemas?" She never had them. She had chamomile and caffeine, no coffee enemas, because she was treated in 1946, right? And yet, she was in the *Cancer Therapy* book along with the diet that included the aggressive use of coffee enemas as though she was one of those patients on that. Again, I cut Gerson a lot slack. He was an older man; he'd lost all his support; he slapped together a monograph, desperate to get it done, at a time when his life was falling apart and he was falling apart physically. And no, he was not poisoned. There was no arsenic in his system; that's balderdash. I've read the chart from the hospital; he was a pneumonia patient, and it was a penicillin-resistant staphylococcus

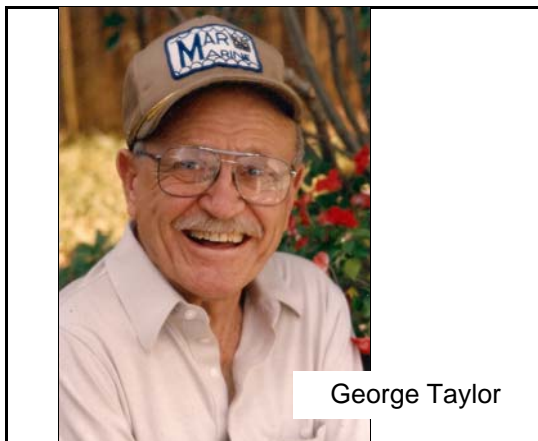
(Question regarding chronic Lyme disease.)

I think it would be entirely appropriate to use it as a treatment for chronic Lyme, because this disease lies latent, and it behaves in a whole lot of ways very similarly to tuberculosis. So, I would say the challenges are roughly the same and, ultimately, you're dealing with a tissue that's incapable of cleaning house. So if you do this extreme sensitization approach that Gerson used, I would advocate in Lyme to *not* use the last cancer-therapy version of the diet therapy, but instead, revert to the earlier tuberculosis form, because you want to go with an approach that's easily shifted according to the response that you're getting in the tissue right now, and there's none of that variability in the protocol as presented in the last text of Gerson, which is, you know,

these same juices, these same enemas every day over and over and over again. But Lyme disease — I would say, treat it with the infectious-disease protocol. And remember always as you look at these different protocols, the cancer therapy was a modified Gerson therapy; it was modified one, two, three, four times in print from 1945 through 1959. So the challenge to the practitioner is to embrace the principles of practice, the basic moves, and then get practical about it. If the patient is in, say, another country, where the food substances are different, where you're using guavas and rare fruits and so on, you can make those adjustments, you know. We've had doctors in the Philippines be in touch with us about, you know, making choices from what's available in the Philippines, in the tropics, and you can still get there, because it's about plants and its about avoidance of complex antigenic animal proteins to initiate the treatment. There might even be a substitute for the potatoes for the apple-potato days, where you can drive the carbohydrate component enough to get to the leukocytosis.

(Question: So, would this particular patient, for her to be disease free as long as she was, did she need to follow that diet for the rest of her life?)

She did not. She did not, and the point is — and Gerson said this over and over again — he didn't consider his patients well until they could eat foods from normal nutrition — not all the time — you don't want to lose the edge. So you keep it heavily weighted towards plant foods, heavily weighted. But, you should be able to tolerate it, otherwise you would be too hypersensitive to walk into a department store, you know, the carpet centers would knock you out, because that's how allergic these people get.



George Taylor

Okay. George was a former Navy Chief and his case is just full of fun stuff. It starts with an upper left chest malignant melanoma, Clark level 4. And then, ten years later, he's got one on the back, and back lesions are a horrible prognosis in melanoma anyway. And he's operated two times, and then he presents with a 5 cm left axillary mass in '92. He starts, almost immediately, he starts the diet therapy, and that mass encapsulates and eventually — you know, and the CT demonstrates the margins are strandy & indistinct, okay, so that means it's got crab grass, it's moving out, and you don't like to see that. There are lobular densities adjacent to mass. So this thing is going to gallop. He returned to CHIPSA because he didn't think he was doing enough, and he got real strict, but let me explain



strict. He did eventually have conservative lumpectomy, and the surgeon was a naval officer who wrote a very nice letter telling us that what we had predicted was exactly true. And that the tumor had been encapsulated by a quarter to 3/8 of an inch of scar tissue, which is a lovely thing to see happen. So that conservative lumpectomy was it for him. And he was an old guy already, so the fourteen years after the surgery was great.

Let me tell you what he did at home. He knew, right away, that he would never do this diet therapy if he had to do it the way he learned it, which was to make a juice every hour, clean the juicer every hour, take the coffee enemas; he would not do it. And so he hired a couple of girls to come in the morning for just a couple of hours and make the juices for the entire day. He kept them refrigerated. He drank them on schedule, because he was that disciplined. Do you know why Gerson says in his book, do not refrigerate? In the letters that we read from the charts that were in his office at the time of his death — it was a German control thing — he came clean with a patient; he said, “Look, the reason I said do not refrigerate the juice is the patients put it in the refrigerator and forget to drink it.” Right? Well, I’d rather tell people the truth. Of course you want to refrigerate it; it doesn’t break down as fast. But carry it with you; put it in a thermos and drink it — set a timer if you have to — just remember to drink it.

And he had them make the juices for the weekends, because he didn’t have quite the budget to hire them for the weekends. And one time he went on a vacation in his RV, and he had them make a week’s worth of juices that he froze. And still, he ended up with this 1/4-to-3/8-inch scar-tissue encapsulation of the tumor with a single pedicle to be amputated for the surgical extirpation of the tumor that was so ready to blow up on him that nobody would have thought he could possibly make it.

(Christeene Hildenbrand: Hildy, he was also a Navy Seal and a deep sea diver, a professional deep sea diver.)

Yes, we should have told him to go diving; he would have gotten a hyperbaric treatment out of it.

Okay, our dear friend, John, from Great Britain (Slides 178-188): Complete regression and 19-year disease free survival of stage IIIB nodular melanoma of a right shoulder lesion, Clark 3, the Breslow was 2 mm; it was a T2. That was in May of ‘91. By March of ‘92, he had a right axillary lymph node that was biopsied metastatic melanoma. That node was apple-sized when he arrived at CHIPSA, which is Centro Hospitalario Internacional Pacifico, S.A. de C.V. His right-axillary mass was gone after 11 weeks.

John gave an interview and I wanted to do this in his words, because he’s so great at communicating. He says, *“After a few days at the hospital I started to feel my energy draining from me to the point where just getting around became difficult, I had to use the lift to go up one short flight of stairs, and I thought it was a good job I hadn’t gone to Mexico to sight-see; I was exhausted all the time. The food became a lot less appetizing particularly on the mornings of every other day after getting up at 5am for 2 dessert spoons of castor oil. In spite of it being cold pressed and free from additives, I find castor oil to be one of the nastiest experiences of my life although its cleansing effects are something to be experienced. It is repulsive, similar, I would imagine, to drinking*

**George T.  
14-year disease free survival  
of Stage III malignant melanoma**

- 1979 S. Up L chest: malignant melanoma, Civ
- 1989 S. L low back: malignant melanoma (+)
- 12/92 Presented with 5 cm L AX mass
- 12/21/92-1/9/93 CHIPSA Gtx
- 12/16/93 CT: L AX mass = 7 x 4 x 7 cm  
margins strandy & indistinct, ext: adj soft tissue,  
2 lobular densities adj to mass.
- 12/127/93-12/29/93 Return to CHIPSA strict Gtx
- 12/19/94 S. Conservative lumpectomy L AX LN:  
Encapsulated 9 x 8 x 4.5 cm

Slide 177

**John H.  
Complete regression and 19-year disease free survival  
of Stage IIIB Nodular Melanoma**

- 5/3/91 S. R shoulder: Nodular Melanoma
- Ciii/2mm T2N0M0
- 3/9/92 Bx R AX LN (+) Metastatic Melanoma
- 3/2/92-4/16/92 CHIPSA Gtx (Ax apple-size tumor)
- R AX mass gone after 11 weeks

Slide 178

(John H., cont)

After a few days at the hospital I started to feel my energy draining from me to the point where just getting around became difficult, I had to use the lift to go up one short flight of stairs, and I thought it was a good job I hadn’t gone to Mexico to sight-see; I was exhausted all the time.

Slide 179

(John H., cont)

The food became a lot less appetizing particularly on the mornings of every other day after getting up at 5am for 2 dessert spoons of castor oil. In spite of it being cold pressed and free from additives, I find castor oil to be one of the nastiest experiences of my life although its cleansing effects are something to be experienced. It is repulsive, similar, I would imagine, to drinking engine oil. Once swallowed (its best warmed, not quite so "claggy"), it takes between four and five hours to pass through the body during which time it's safer to stay horizontal!

Slide 180

(John H., cont)

Unlike other organic matter, the body does not absorb the oil and seems to want to be rid of it as soon as possible. A castor oil and coffee enema is taken after five hours and then the whole lot is eliminated. This is gruesome but it is quickly followed by a wonderful experience of mental clarity, and physical cleanliness.

Slide 181

*engine oil. Once swallowed (its best warmed, not quite so "claggy"), it takes between four and five hours to pass through the body during which time it's safer to stay horizontal!"*

*"Unlike other organic matter, the body*

*does not absorb the oil and seems to want to be rid of it as soon as possible. A castor oil and coffee enema is taken after five hours and then the whole lot is eliminated. This is gruesome but it is quickly followed by a wonderful experience of mental clarity, and physical cleanliness"*

*"I was into the second week when I became aware that far from shrinking and disappearing, — and think about this, it happens all the time — as I was led to expect, my malignant lymph node was getting progressively bigger." This is the head-up to the initial exacerbation; this is induration, this is the capillaries opening. This is blood flowing in, and immune cells swarming, chemotaxis, big chemotaxis events. — The bigger it got the more worried I became until it grew to the size of a small apple. 17 days after I arrived at the hospital it was so painful, so hot and swollen, that I didn't know how to relax or get comfortable. The clay packs which the doctor recommended for drawing out toxins and easing the pain were no longer effective. I was depressed even though Dr Bravo seemed to be taking it in her stride, I didn't believe that this was a sign that the treatment was effective, from where I was sitting it seemed very much like this was a typical progression of the disease. Then suddenly in the middle of the night it changed. It was still painful but in a different way, almost like a bruised pain and the heat started to subside. It felt like the pressure had been released and then I experienced a tremendous feeling of euphoria. I had to get up and walk about. I*

*couldn't possibly sleep, I had this joyful feeling welling up inside me that made me want to laugh. I went up on the roof and watched the stars in the warm night and then looked down into*

(John H. Healing Reaction, cont)

I was into the second week when I became aware that far from shrinking and disappearing, as I was led to expect, my malignant lymph node was getting progressively bigger. The bigger it got the more worried I became until it grew to the size of a small apple. 17 days after I arrived at the hospital it was so painful, so hot and swollen, that I didn't know how to relax or get comfortable...

Slide 182

(John H. Healing Reaction, cont)

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Slide 183

(John H. Healing Reaction, cont)

Then suddenly in the middle of the night it changed. It was still painful but in a different way, almost like a bruised pain and the heat started to subside. It felt like the pressure had been released and then I experienced a tremendous feeling of euphoria. I had to get up and walk about. I couldn't possibly sleep, I had this joyful feeling welling up inside me that made me want to laugh...

Slide 184

(John H. Healing Reaction, cont)

...I went up on the roof and watched the stars in the warm night and then looked down into the dusty Mexican streets and watched the town close down for the night the last few pedestrians walking home alone, hands in pockets, heads down, I loved them all.

Slide 185

*the dusty Mexican streets and watched the town close down for the night the last few pedestrians walking home alone, hands in pockets, heads down, I loved them all.*

[Tears]. Well, that was a surprise.

*"I woke up the next morning and still felt bruised and saw that all round the area of my armpit was black and blue,— he was bruised down to his elbow and the ribcage — the pain had spread down my side, round my back and along my arm. I knew I had just experienced some of that healing power that I so desperately needed. I phoned home immediately, joyfully telling my anxious family and friends that the therapy was working."*

This is what his differential was doing (Slide 187). His triglycerides were enormously elevated at the beginning of management. Sometimes you see this in malignant disease. You'll see really mobilized lipids. He was also making tons of monos, this is presumably because the tumor was recruiting his monocytes to become preferentially morphed into tumor-associated macrophages to bolster the stroma. All right? At a point several weeks into treatment, you see the triglycerides have been cut almost in half and we get the bandemia, finally. Right? And he has ample lymphocytes, and you see the sed rate started low and went high and stayed high, because he was inflamed.

And this is what John looks like (Slide 188).

Sharon Brockman

Now, Sharon. Sharon was cut on nine times, I think, and she went from 1987 with a mole on the lower leg. Then she had a groin dissection in 1988. In 1994 she had a recurrence that was operated on the lower leg. In 1995 she started the Gerson therapy at home. She went to John Wayne in Santa Monica — for a melanoma vaccine that Don Morton developed — in the spring of 1995. In March of 1995, we saw her at CHIPSA and started her with the Gerson management. We didn't have the Coley yet. Coley didn't come in until the next year. Surgery, recurs right lower leg. Surgery for nodules of the thigh. Lung metastases of the left upper lobe. She started BCG, which is a cool thing.

Did you see the article in the LA Times about BCG? Very cool. This morning? Very cool stuff. BCG actually causing pancreatic re-

**Sharon Brockman**  
**Resolution and 14 year disease free survival**  
**of melanoma with mets to lung and abdomen**

- 4/87 S. Mole lower leg: Civ
- 3/88 S. R groin dissection (-)
- 12/94 S. recur R low leg (+)
- 2/95 Started Gtx at home
- Spring 95 John Wayne Mel-vaccine
- 3/3/95-3/12/95 CHIPSA Gtx, B17
- 6/95 S. recurs R low leg
- 12/95 S. nodules thigh, groin
- 3/96 Lung metastases L Up Lobe
- 3/96 BCG

(con't)

Slide 189


(John H. Healing Reaction, cont)

...I woke up the next morning and still felt bruised and saw that all round the area of my armpit was black and blue, the pain had spread down my side, round my back and along my arm. I knew I had just experienced some of that healing power that I so desperately needed. I phoned home immediately, joyfully telling my anxious family and friends that the therapy was working.

Slide 186

	3/27/1992	4/7/1992	4/14/1992
JOHN H.			
Dx: Melanoma	CHIPSA	CHIPSA	CHIPSA
Trig 30-135	306.0 H	150.0 H	159.0 H
Leuk 4.8-10.8	6.4	6.2	5.2
Bands 0-3%	1.0	2.0	9.0 H
Segs 50-70	52.0	57.0	56.0
Lymph 20-40%	39.0	31.0	28.0
Mono 3-6	7.0 H	7.0 H	1.0 L
Sed rate 0-10 Males	10.0	18.0 H	18.0 H

Slide 187



Slide 188

Brochman, con't

- 3/17/96-4/13/96 CHIPSA Gtx, HBO
- 6/96 Lung metastasis stable
- 9/5/96-9/16/96 CHIPSA Gtx,
- Coley, Urea/Creatin
- 12/96 S. L exc of LUL lung nodule
- 1/27/97 CT: Lg pelvic mass, new
- 2/5/97-2/22/97 CHIPSA Gtx,
- Coley & Urea intra-abdom, S. ovary (+)
- 5/97 S. Takedown of colostomy, adhesions, no ca
- Continued with diet and vaccines
- No cancer recurrence for 14 years
- Still cancer free 2011

Slide 190

generation in mice after Type I diabetes. It was mice in the prototype, and two studies published in the mice, and this study was, in fact, a human preliminary study which was looking at C-protein which is a precursor of insulin in type I adult diabetes with an indication there might be regenerative capability of the pancreas using general immune stimulation by BCG. I just thought it was very cool and it is very much along the lines of what we've been working with, with general inflammatory states, trying to get the regenerative capabilities of the body to kick back in, because, you know, the body — all the tissues retain — every cell retains an embryonic capacity, if you can turn it on.

Sharon; you know, just the number of times she had trouble ...

She did some hyperbaric oxygen with us and then, because the lung metastasis was stable, we saw her again at CHIPSA and treated her with urea and creatine, and Coley. I don't think we noted ... yeah, yeah, subsequent to that, she had a wedge resection for the left-upper-lobe lung nodule. And then she developed a large pelvic mass and she returned to CHIPSA again, and then we went intra-abdominal with Coley and urea. You want to talk about cowboy

medicine. She wouldn't talk to any of us for three days. It was an unpleasant experience, but our surgeon went in and he spent the first hour cleaning up adhesions and then he lifted the pedunculated mass and easily removed it. That was her last tumor. She did continue Coley at home. She almost died because adhesions caused her bowel to twist; and she nearly died because she was not being managed correctly. Her father bailed her out of the wrong hospital, brought her to a hospital where they did a take-down of the colostomy and the adhesions were removed, and she was found to have absolutely no cancer in the abdominal cavity at that time. She continued with the diet and vaccines, and no recurrence for fourteen years — and she wrote about it.

**"Coley's Torture Treatment"  
Sharon to her CHIPSA attending physician, Oct, 1996**

"I'd like to write you and give you an update on how my Coley's Torture treatment is going. As you know I did not react very much to the IM injection on Friday. You then requested that I inject myself on Saturday, which I did. This day also proved to be a breeze in regards to symptoms. I thought I had it made. Boy was I wrong..."

Slide 191

*"Torture treatment" cont.*

Monday, I injected this wonderful substance as instructed. I had a very full day, trying to catch up in school, and all the other law suits, divorce issues, IRS issues, credit card accounts etc. etc. etc. that seem to pile up on me. I was extremely tired Monday night. I know, I over do it. Tuesday, it hit; I felt extremely bad, barely dragging myself through school. At 10:15 it hit me strong and hard. Within minutes I wondered if I could get home.

Slide 192

*"I'd like to write you and give you an update on how my Coley's Torture treatment is going. As you know I did not react very much to the IM injection on Friday. You then requested that I inject myself on Saturday, which I did. This day also proved to be a breeze in regards to symptoms. I thought I had it made. Boy was I wrong."*

*"Monday, I injected this wonderful substance as instructed. I had a very full day, trying to catch up in school, and all the other lawsuits, divorce issues, IRS issues, credit card accounts etc. etc. etc. that seem to pile up on me. I was extremely tired Monday night. I know, I overdo it. Tuesday, it hit; I felt — this can happen, no new injection, but a cumulative effect, a sort of building head of steam, and she*

*says, "I felt extremely bad, barely dragging myself through school. At 10:15 it hit me strong and hard. Within minutes I wondered if I could get home. I was also scared if I had to go through this reaction at school they probably*

*"Torture treatment" cont.*

I was also scared if I had to go through this reaction at school they probably would think I was having a drug overdose or withdrawal systems (sic). I don't really know how I drove home, but I did. At home it was like I had had Coley's Torture Treatment from the Drip (IV). The shakes, headache, pain, pain, pain, hands burning, my temp topped out at 101 degrees. It lasted a looong time. Has anyone else had this happen at home?

Slide 193

*"Torture treatment" 2 weeks later*

"I have continued to give myself injections of "Torture" at 1/10th of 1 cc. As we discussed on the phone, my reactions were reducing with every injection to the point of almost not feeling anything. As you instructed, I doubled the dosage of "Torture" and feel oh so horrible again. Thanks! I have given myself two injections since we talked. You said you want a reaction with every injection. I am feeling lots of pains, complete exhaustion, but no temperature. My temperature is in fact low, 96.9 orally, and 96.4 taken maxilla (sic)."

Slide 194

would think I was having a drug overdose or withdrawal symptoms. I don't really know how I drove home, but I did. At home it was like I had had Coley's Torture Treatment from the Drip (IV). — which she'd had at CHIPSA — The shakes, headache, pain, pain, pain, hands burning, my temp topped out at 101 degrees. It lasted a looong time. Has anyone else had this happen at home? — Oh, yeah. Yeah.

"I have continued to give myself injections of "Torture" at 1/10th of 1 cc. As we discussed on the phone, my reactions were reducing with every injection to the point of almost not feeling anything. As you instructed, I doubled the dosage of this "Torture" and feel oh so horrible again. Thanks! I have given myself two injections since we talked. You said you want a reaction with every injection. I am feeling lots of pains, complete exhaustion, but no temperature. — There are people who don't have "temperatures" for a long time and still get well. This is just something you need to know, that those are the exceptions that Gerson was talking about when he was talking about flare-ups, patients who go ahead and get objective and radiological evidence of disappearance of disease, but who don't run a fever, but they still feel like hell — *My temperature is in fact low, 96.9 orally, and 96.4 taken maxilla (sic).*"

And this is just for amusement. We made a little documentary for our friend Senator Tom Harkin who's, you know, the alternative medicine guy in the Senate. And this is Sharon, we went to (Ft. Myers) from New York. We did this in 2009.

[See the interview with Sharon in "Cancer Survivors USA: a road trip and an open letter to Senator Harkin" at: <http://www.vimeo.com/15289257>].

Patricia C. (See Slide 197). This is a woman who started with a back lesion, melanoma, Clark's level 4, Breslow, 1.8 mm. She had surgery of the lymph nodes of the right axilla. She had zero positive. But she had a nodule in the scar and the finding of the aspiration was positive. By April of 2000, that would have been nine or ten months later, she had a CT of the chest and she had lung nodules, left upper lobe and right lower lobe, both of which nodules abutted her heart. She used the Coley and the Gerson (which is "Gtx", Gerson therapy) and hyperbaric oxygen (HBO). The chest wall nodules reduced, and she went back to New York. New York is kind of a difficult place because you have a lot of attractive smells from the thousands and thousands and thousands of restaurants there. And she kind of fell off the wagon a little bit, and developed huge abdominal pain. They were very small metastases, but she had to be operated to have the metastases removed. She went back on the strict diet therapy, but you know the luck of the Irish, Patricia Curry, by September 11<sup>th</sup>, just a few days before 911, in Manhattan, she had a motor vehicle accident, a rollover, and she was in an induced coma for well more than a month, during which time the scans revealed no cancer at all.

Now here again, what you're looking for is the bandemia is evident, leukocytosis is evident, sed rate monstrously elevated here, and she did a very, very good job of clearing the tumors. The lungs were not operated so this was just, there were some micrometastases left in the abdomen that she would have cleared if she had not fallen off the wagon. She fell off the wagon, and got back on it, and was cleared, and even the hypoxia of the trauma of this motor



See interview with Sharon in "Cancer Survivors USA: a road trip and an open letter to Senator Harkin" at <http://www.vimeo.com/15289257>

Slide 195

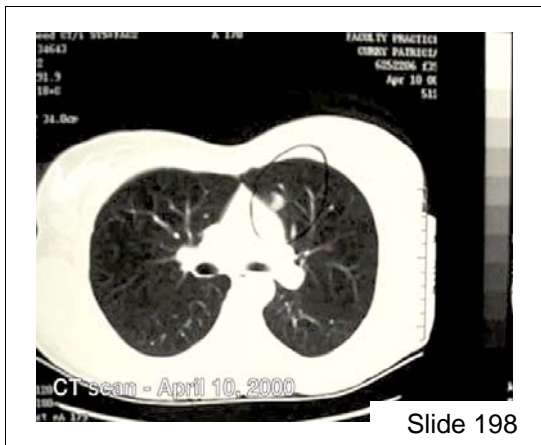
**Patricia C.  
Regression and 11-year disease free survival  
of Stage IVB nodular melanoma**

- 7/99 S. Skin back:nodular mal melanoma Civ/1.8 mm
- 7/99 S. LN R AX exc: 0+/5 LNS (-)
- 3/2000 FNA of sm subcutaneous nodule in scar/ Up back (+)
- 4/2000 CT chest: 2 nodules lungs: LUL (1.3 cm) & RLL (9 mm)
- 5/8/2000-6/28/2000 CHIPSA Gtx, Coley, HBO
- 5/26/00 CT Chest: Nodules reduced: 6x5 & 5x3 mm.
- 1/11/01 S. 3 sm abd metastases removed (+)
- 9/3/01 MVA rollover, in coma, scans reveal no cancer

Slide 196

Patricia C.	Coley 5/16/2000								Slide 197
Dx: Melanoma	5/9/00	5/15/00	5/18/00	5/22/00	6/5/00	6/12/00	6/19/00	6/26/00	
Iron 60-170	16	37	10	97	55	25	71	59	
TIBC 250-450	265	113	82	155	115			174	
WBC 4.3-10.3	6	5.6	14.9	8.2	5.1	7.3	8.2	7.1	
Bands 2-8	10	3	16	11	7	8	7	5	
Lymphs 16-45	25	31	8	29	33	28	22	21	
RBC 4.2-5.4	4.49	4.41	3.96	4.43	4.07	4.03	4.53	4.11	
Hgb 11.7-16	13.2	13	11.5	12.3	11.9	11.5	12.4	11.5	
Hct 36-47	40	38.4	34.5	39	35.8	34.3	37.6	34.9	
Sed rate 0-20	32	38	65	36	43	40	32	42	

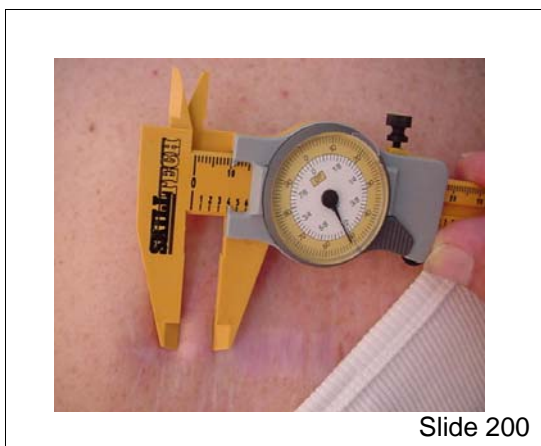




Slide 198



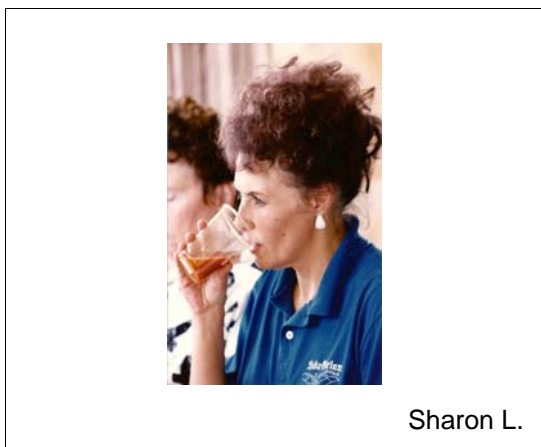
Slide 199



Slide 200



Patricia



Sharon L.

vehicle accident, with all of the contusions and the ecchymoses, and all the crap that happens when you get that closed-head injury. She had to learn to walk and talk all over again with closed head injuries; she did not recur which was really quite wonderful.

This is what the tumors looked like (Slides 198-199), the left upper lobe — I'm sorry it's so blurry but I snapped it on a screen shot from the film — and there's the right lower lobe tumor. And there's the tumor on her back being measured by caliper. It started out the size of a garbanzo bean in the hospital and, within the context of her first reaction, shrank to lentil-size, then we called it the lentita, because we're Spanish down there, and then we called it the lentita chiquitita, because it was shrinking and shrinking and shrinking.

And this is what she looks like. The Irish don't make them any cuter than that.

I think ... Is that enough cases? That's enough cases. Let me just. Oh, Mary tells a great story too about how the reactions ... and again the same blood findings, but let me get down to the bottom.

*[Note: Time constraints made it necessary to cut the presentation of slides 202-216. We have included these cases in the addendum. -Ed.]*

That's a lymphoma patient (Sharon L.) who completely absorbed the disease with nothing but diet therapy, and she had such profound abdominal lymphoma, she had stove-pipe lymphedema. She lost 21 pounds of water weight in a couple of weeks, the first couple of weeks of the treatment, and she regressed the disease completely, and had a long-term disease free remission. She passed away only recently.

**Reversal of inflammatory lobular carcinoma of the breast**

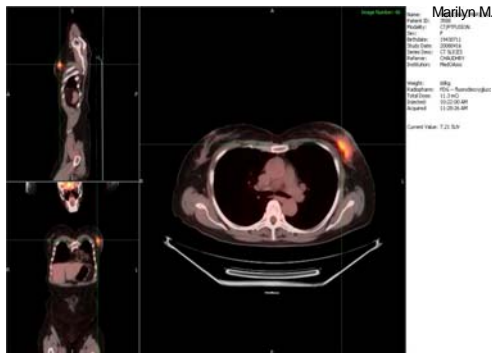
- 1/7/2008 Mam: L Br: 2:30 - 4cm x 4cm firm, tender, non-moveable lump, peau d'orange. L nipple retracted, pulling to 3:00 position.
  - 1/8/08 US: Lg hypoechoic, poorly defined mass 2:00, lump = 3.0 x 2.5 x 3.0 cm. T. lies on top of the chest wall. Overlying skin thickened. Abnormal LN 2.3 x 1.2 x 1.8 cm in L AX...
- "Findings most compatible with inflammatory breast carcinoma in this patient with nipple inversion. Enlarged axillary lymph node most compatible with metastatic adenopathy (MRI confirmed findings)
- 1/10/08-2/29/08 CHIPSA Gtx, Bx, Coley, PUVA photopheresis and DCV
  - 1/14/08 Tru-cut needle Bx: Infiltrating lobular carcinoma, nuclear grade II, ER(+ 100%), PR (- 10%), P53 (+ 95%).

Oh. Marilyn. Marilyn is a great one. This is, I'll just show you, this is the "angry boob," with peau d'orange. This is an inflammatory breast cancer. You can see some Coley injection sites starting to be treated, and you can see that it is beginning to change, the skin's beginning to peel off of it. By the time we're done with the treatment, where she had the same changes, we got a PET/CT and all we've got is vestigial lobular carcinoma underneath there, and sent her home for continued treatment. Unfortunately, she got into a marriage and a bankruptcy and some tension and she dropped out of therapy and developed liver metastases, which is a terrible outcome. There's complete resolution of the inflammatory breast cancer and, that's a hard one, inflammatory. And that's Marilyn.



Slide 219

1/31/08



Slide 222



Slide 220

2/7/08

Marilyn M.	1/11/2008	1/24/2008	2/11/2008	3/1/2008
Dx: Breast Cancer	CHIPSA	CHIPSA	CHIPSA	CHIPSA
Leuk 4.3-10.3	4.7	8.1	9.6	29.8 H
Bands 2-8	6.0	6.0	6.0	36.0 H
Segmts 40-75	55.0	55.0	67.0	
Lymph 16-45	33.0	35.0	25.0	6.0 L
Mono 3-9	6.0	4.0	2.0 L	
Sed rate 0-20	22.0 H	25.0 H	30.0 H	35.0 H

Slide 221



Slide 223

2/9/09

Jean M.  
 Complete regression and 4.5-year disease free survival of Stage IIIB breast cancer

6/89 Sx: Lumpectomy R BR 1.0 cm: lobular adenocarcinoma

8/89 50000 cGy to R BR & electron boost

1/93 S. L BR: 1.6 x 1.4 cm: Well diff ductal ca; LN dissection (-)

Raw food diet

Cont

Slide 225

Jean M, cont.

? 1997-2004 4 surgeries to remove total of 6 sm tumors

6/97	R Br	14mm	Mxd lobular & ductal
12/03	L Br (2)	1.8cm	Mxd lobular & ductal g1, & skin lesion (+)
12/03	R Br	1 cm	Well diff inv ductal, g1, margins not clear
7/04	L Br (2)	0.4 cm & 0.3cm	Invasive ductal g1 Cont.

? 2005-12/2006 sm skin lesions and Ts grew, disappeared, regrew – Refused Sx

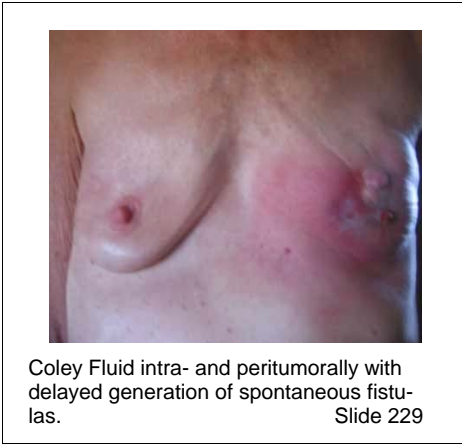
Cont.

Slide 226

Jean M. cont.

12/2006 Began coley treatment, presented with at least six sm tumors and skin lesions. Treatment was by intratumoral injections over a course of many months. Spontaneous fistulas and drainage occurred a number of times. These lesions resolved without specific treatment.

Slide 228



US reports			2/05	6/05	7/05	9/05	6/06
2/05	L Br	12:00	9x7x4	10x8x7			
	4	6:00	3.9			2 Ts	
		skin	8.0		mass:6		
		9:00	10x5.8			10x8.3	
6/05	L Br	2:00		10x10		10x9.5	12.x11
3 new	7	8:00		5x6			
		1:00		9x7x6			
7/05	L Br	3:00			14x6x5		
		3:00B			7x7x6		
9/05	L Br	skin				3.6	
6/0606	L Br	3:00					7.2x5.3
		5:00					5.1x3.5
		skin					12x8
		12:00					10x6.9
	R Br	10:00					6.2x2.5

This last one, I wanted to show you. Jean had had just too many surgeries, so many you can't even chart them out. Just one after another after another after another. She comes from a family full of doctors. This is a breast cancer that eventually was giving skin metastases. I wanted to show this because this is ... She started treatment with six small tumors and she

Cases

Spontaneous fistulas and drainage of ropey pus several weeks after the most recent CF injection.

Slide 230

had metastatic skin lesions at this time. Intratumoral injections over a course of many months. I wanted to show you the spontaneous fistulas that ended her treatment, because when this happened we knew that she was done. She's got a red, almost disappeared breast, but she was small breasted in the first place. And this is a spontaneous fistula and drainage of ropey puss, several weeks after the most recent Coley fluid injection. This is exactly the kind of fistula Gerson was talking about in his tuberculosis treatment. When she called and she sent these photos, we looked at them and we said, you can stop the Coley. Just keep up the diet. And she is... that's how its resolving. She used a little green clay to help adsorb toxins. It cleaned up real nice, resolved with a lot of dry cracking of the skin. But there she was; she escaped the United States to Costa Rica.






And we'll skip ... That's a small cell lung cancer (Slide 234, right).

Oh, I can't help but show this (Slides 235-238). That's lymphoma. We used urea and Coley and diet therapy. It's the face, you know, the fear transforms when the body gets well. You see this complete change in aspect and kind of a little pride, a little pride in ownership of the healing.

**John H.**  
**Urea and Coley's toxin induced remission of NHL lymphoma refractory to diet therapy**

- John H., 61 years old.
- 1990 R eye: interned grade non-Hodgkin's lymphoma.
- Refused Ctx used AltMed
- Dec 1995 CHIPSA w/ massive tumor load.
- Diet therapy response good but not durable.
- May 96 Added urea inj and Coley
- Last treatment, minor surgery for scarring and residual axillary disease, no cancer Dec. 1997.

Slide 235

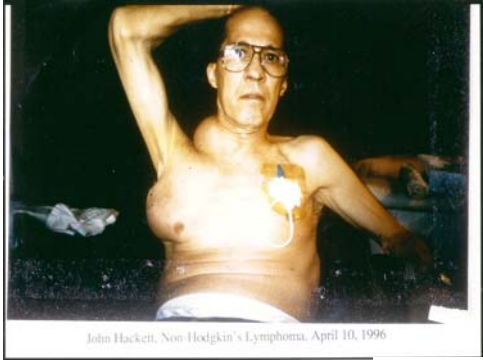


Slide 237

**William H.**  
**Complete Response of Small Cell Lung Cancer with 17-year disease free survival**

- Jan 1993 (age 54) hospitalized L-sided pneumonia
- 2/5/93 CT: LLL mass
- 3/8/93 Bx: small cell anaplastic carcinoma
- Patient refused Ctx
- 3/29/93-4/18/93 CHIPSA Gtx
- 2/94 Added shark cartilage and B17
- 5/94 switched to bovine cartilage
- 1997 S. LLL mass: carcinoid tumor -- no small cell
- 2010 Doing well

Slide 234



Slide 236



Slide 238

This one is the last one on the list. Eddy Braun was Max Gerson's patient. He had an orchiectomy. He had deep x-ray treatments — this is the Danger Model — deep x-ray treatments for the lungs, you know, because it was bilateral. Oh I'm sorry, this is pelvic x-ray treatments. The metastases in the lungs developed in 1956 and he went to see Gerson in April of 1956 and he had a large tumor mass in the right inguinal area. I want to skip all that stuff; I just want to show you what the lungs looked like.

(Christeene Hildenbrand: Hildy, he was exposed to radiation at Los Alamos).

**Edward B.**  
**Regression and 48-year disease-free survival of Stage IV testicular cancer metastasized to lungs**

- 8/11/1955 S. R Orchiectomy: Endometrial cell carcinoma (teratoma). All aortic LNS (+)
- Rx: 82 "deep X-ray treatments"
- 3/1956 Chest XR: Metastases in both lungs
- 4/13/56-5/27/56 Oakland Manor clinic in Nanuet, NY with Dr. Gerson

Cont.  
Slide 239

Ed B, cont.

There was a large tumor mass in right inguinal area, the pubic hairs at the right half of the abdomen were vacant, caused most probably by X-ray therapy. The abdomen was distended and resistant to pressure. It was therefore difficult to examine for mesenteric glands, spleen and liver. The chest did not show any dullness nor remarkable changes in breathing. Patient looked pale and was nervous. Slide 240

Ed B, cont.

Hemoglobin 75%, 4,500,000 RBC, leucocytes 4,200, some cells showed toxic granules.

From the chemical examinations it was remarkable that his basal metabolism was low, 17, and remained in ups and downs for a long time on the lower side, 9/18/56-21; 1/24/57-16, and 7/9/57-4, despite an intensive treatment of larger doses of thyroid and Lugol solution.

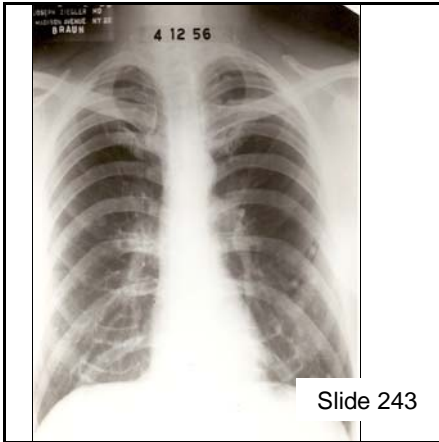
Slide 241

Ed B, cont.

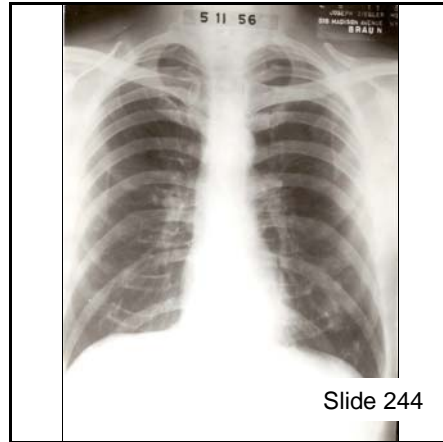
Slide 242

The tumor masses in the right groin disappeared in about 4 weeks. The lung metastases responded relatively quick; however, a much longer time is required to absorb the older settlements after the first disappearance of the fresh metastases.

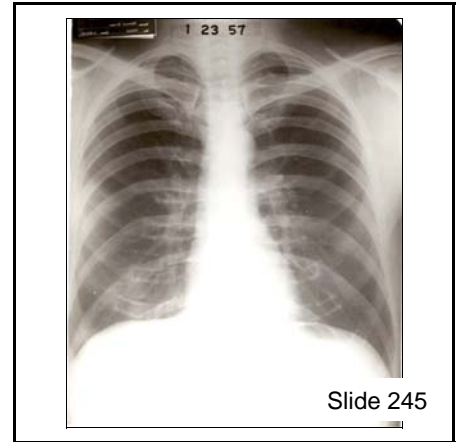
Ed continued his program at home. He returned to work in October, 1957. His wife delivered his fifth child in February of 1959. He never recurred. He passed away in 2005 at the age of 79.



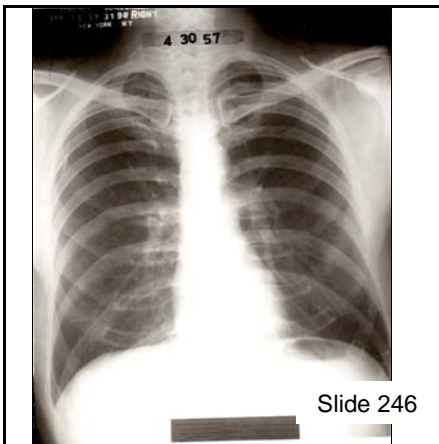
Slide 243



Slide 244



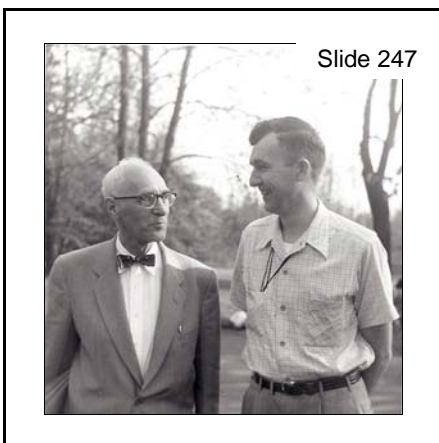
Slide 245



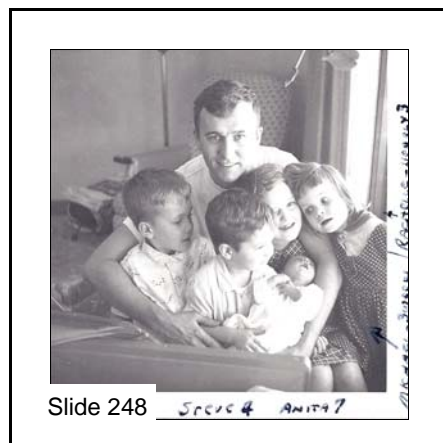
Slide 246

Right, right, he was a Los Alamos victim, so he was in complete remission. There he is with old man Gerson (slide 247), you know, sort of a father-son pride there. And he made one more baby on one testicle after that treatment, which is quite lovely.

And now, all of that, having been said, I want to remind you what the environment was when Gerson was doing this treatment. Here is a little propaganda movie we extracted from our friend Kenny Ausubel's film about Hoxsey. It's an excellent archival snippet to remind you of how hard it was in that day and age (Slide 249). Okay, that's it, that's what you're facing. If you want to be in touch with us at the Gerson Research Organization, there's my email: [ghildenbrand@earthlink.net](mailto:ghildenbrand@earthlink.net)



Slide 247



Slide 248



Film clip from "Hoxsey: How healing Becomes a Crime" produced by Kenny Ausubel and Catherine Salvesson.

## Comments, Question and Answer Session

(Participant: Yes, what about prostate cancer with the Gerson therapy protocol?)

Well, there are a number of satisfactory outcomes of prostate cancer once you get into the combination of integrative managements. I wouldn't take an advanced prostate patient on the diet therapy alone for a bet. But if you take advantage of the myriad treatments there are for prostate cancer, you can pretty much count on getting your patient into better shape and keeping them that way for quite a while. Yes?

(Participant: So if patients are really interested in doing this, could they begin with your facility, I'm in California, in Southern California, so you guys are not very far. Could they begin with you and they transition to...How does that work?)

Our policy is that if you send somebody to CHIPSA, CHIPSA then becomes tertiary care; you are still the attending. So the protocols for what CHIPSA can provide, just like sending someone to an interventional radiologist, or some other specialist, a hyperthermia guy, for treatment, they are going to send them back to you because you are the center of the treatment. So yes. Yes sir?

(Participant: Are you totally doing the Coley vaccine by injection, or are you doing it orally as well?)

Say it again?

(Participant: The Coley treatment; are you totally doing that by injection, or is that also oral?)

We have never done it orally or rectally. We've done it intra-abdominally and intravenously, intralymphatically, intratumorally, peritumorally, intramuscularly and subcutaneously, but never done it oral, because, you see, it's a lysate of two killed microbes, *Serratia marcescens* and *Streptococcus pyogenes*. I think it probably would upset your stomach.

(Participant: And you don't necessarily just inject it into the tumor? You can inject it anywhere in the body?)

We oftentimes will ... We'll go into a tumor if we can, but we almost always use general stimulation. We like to work the afferent lymphatics at the axillae because, you know, they take up the toxin and they get to chattering, and they activate the rest of the lymphatics. Yes, sir.

(Participant: Where are you getting it? Because I tried to get it, and they don't ship to the US.)

On a scrip you can get them to send it to you from MB-Vax. Have you been in touch with them?

(Participant: No, we didn't.)

It's "M", "B" as in "mixed bacterial vaccine", that's what Coley used to call it, "M", "B", "V", "a", "x".

(Mark Rosenberg: But, Gar, they won't ship it in the states.)

They won't ship it into the states?

(Mark Rosenberg: No.)

Do you write a scrip and the patient has to go get it?

(Mark Rosenberg: Yeah, well, I will tell you, in another module we're going to talk all about how to do Coley's. I have done it, as Gar knows, but they won't ship it in here. Just recently, 2 weeks ago, I had a patient go to Canada, and it got confiscated at the border.)

She had trouble coming back with it?

(Mark Rosenberg: It got confiscated. It got confiscated at the border. It happened 2 weeks ago; it got confiscated at the border.)

The legalities are, as I interpret them, the patient is protected if the patient has been treated at a foreign facility.

(Mark Rosenberg: So let me tell you how we do this and, certainly, if Gar is comfortable with doing that ... you know, I have a clinic in Bogotá, Columbia, as well. And so what we've been doing is people who want Coley's, my colleague in Bogota, Columbia, is waiting on the patient. The patient goes down there. Now he orders it from MB-Vax. They send it to him in Bogota, Columbia. He treats them, and then he sends them back with a prescription and the rest of the Coley's for indefinite. And you can either do it with the patient, and I'll explain, and I apologize for stepping on your time ... )

That's fine.

(Mark Rosenberg: But there is a clause, if you go to [fda.gov](http://fda.gov) online, you'll see it specifically addresses people using drugs that are not FDA approved, and what it says is if you've been treated in another country with a non-FDA-approved drug and you want to continue using it in this country, you have a right to bring it for your own personal use, not for resale. And they recommend — it says that we recommend that you bring no more than a 3-month supply, although you can bring more as long as you have a doctor in the United States that will continue

to follow you. That's what it says. If you go to [fda.gov](http://fda.gov) and you look at imported drugs, you'll see it. So that's what we have done is we would order it to Bogota, Columbia, and the patient goes there [for treatment] and brings the rest back. Now Gar, are you comfortable if they have a patient that, you know, wants to be treated, for them to come to you in Mexico, because you can obviously get it shipped to Mexico, no problem, and treat for however long you want to do, and if the doctor wants to continue it here, you send them back with a prescription?)

I'm sure we're comfortable with that because, ultimately, what I want to see happen is I want to see this material get some traction in the States, and I'd like for our friends in the Senate to help us to work out a workaround, a fix. You know, the FDA clause that you read is the result of the Bohanon decision in 1977 around laetrile, which was rather innocuous compared to Coley. Right? It still stands, and I'm glad that it does. And I think the way that you got built, that's a great way to do it.

(Christeene Hildenbrand: That's how Jean Mayes did it. Jean was an outpatient and she came into the — she didn't even stay in CHIPSA — but she was already on a raw-food diet and then she came in and — at that time it was Dr Lopez — but Dr Lopez saw her and he determined ... he got her started on it, watched her and said "Yes, she can handle this." Now, there are some patients, particularly far-advanced patients, where our doctor would not say that; he would say, "I think you need to stay here for a little while and make sure you're going to be able to handle this, and we're not going to have any issues." So, there's going to be a balancing act.)

There's going to be a spectrum, yeah. We've got a very talented attending who has cut his teeth on immunotherapy in cancer management and I defer to his judgment oftentimes because he's like a walking scanner. He comes in and it's "10-finger medicine", which I love when you go to the Latin American countries; nobody's treating the test, they're treating flesh and blood, you know, it's all clinical. And, yeah, he would make the judgment call and he would talk to you personally about what he thinks the patient needs. So, if anyone wants to be in communication, send me an email and I'll hook you up with Dr Mora.

(Participant: What they told me is that if you have a

physical address in Canada, they can ship to that place.)

They can't do it in Canada. They're restricted; they don't have GMP yet.

(Participant: They make it there but are not able to prescribe it?)

(Mark Rosenberg: That's correct.)

That's absolutely correct. But, he has had several compassionate use approvals. Switzerland is one of them; there was one in the US, a compassionate use. Now, those are a pain in the ass.

(Participant: Was there one in Africa? Was it South Africa?)

That's right, South Africa compassionate use. Essex, I think. So, this is not for the faint of heart, certainly, and Mark can tell you a little bit more about that, but it is something that you can consider.

(Participant: So in that scenario that you were talking about, they go outside the country and they come back with their own supplies. You said "as long as a doctor is willing to follow them", you mean the doctor in that country?)

No, in the States.

(Mark Rosenberg: No, no, no ... you.)

(Participant: What kind of repercussions is that with the FDA?)

(Mark Rosenberg: Okay, once again, we'll get into more of this in another module. I don't want to really hit Coley's completely, but here's the deal. You are following the law if you continue to follow the patient, someone else sent a prescription with the Coley Fluid, and you agree to follow the patient, that's completely — you go to [fda.gov](http://fda.gov) and you read it — you're completely within your right. The thing you have to realize is you can have complications. If you have a complication — if you give someone chemotherapy and they die, well, hey, you followed the standard of care and they died. But if you give Coley's Fluid and they die, even though, you know, you followed the rules, it's not that — I mean, you're not going to jail, but I just want you to understand the possible repercussions. One of the family members calls the California Board of Medicine and says, "You know this doctor is doing something here that's not the standard of

care”, you’re not going to jail, but they can review you. You can raise red flags and they can say, “Yeah, I know this was legal, but you’re not practicing standard of care.” So, the big thing that I just want everybody to be aware of is when you’re doing things that are not standard of care, you know, you’re on the edge. Many of us ... I’ve accepted that’s my role ... that’s my role in this life is to be on the edge all the time, and I accept that. And I also accept that some day they may take my license away and, when that happens, or if that happens, I’m going to continue to practice medicine in another country. But, so, yes you are following the law, but yes there is a possibility – and we all will have bad outcomes – there’s a possibility that you’ll be under scrutiny. And the best way – I’m not telling you anything you don’t know – have a great rapport with all your patients – as I know you do – and the family, and you’re not likely to run into a problem. And I’ll tell you very quickly – I told everybody before – I had a patient who was bipolar, and the family was wonderful, and he had a tremendous response, but he almost caused me a lot of problems, and that’s the issue you run into... So, one of the protective things for you is, you know, “I’m following the law; this patient got treated in Mexico, or got treated in Columbia. He gave a prescription and gave the medicines, and I agreed, I’ll continue the treatment they’re doing there. And that’s your protection along with good patient rapport and all that. But, you’re not doing anything illegal. You’re not doing anything illegal.)

Amen to that. And it’s even okay on the morality and ethics side.

(Mark Rosenberg: That’s where it’s definitely okay. You’re doing everything you can for the patient.)

(Question inaudible)

At this point, what Liz is going to send you is this Power Point presentation. When you look over that, a bunch of the stuff that I said, you can look at that later, is exactly the stages of diet for both the infectious diseases and the malignant application, the off-label use. And it breaks down into: What foodstuffs yes? What foodstuffs no? What are the time intervals at the various stages? What are the gram weights of the foods that are supplied? And, you know, it’s pretty much in here. And this is because I have been translating the pulmonary tuberculosis text. My idea is to make this information available in the public domain where it belongs so that physi-

cians who want to use it can use it. You’re just the first guys to get it.

(Christeene Hildenbrand: If anybody wants the handbook that we use at CHIPSA, which goes into detail about the coffee enemas and – it’s just stuff we put together for the patients – send us an email and I’ll send it to you.)

Yeah, we’ll send you a pdf.

(Christeene Hildenbrand: Yeah, it’s a pdf and it’s like 100 pages or something.)

(Participant: That’d be awesome.)

(Christeene Hildenbrand: It has recipes, too.)

That way you can use it for review yourself, and you can always pass it on to your patients and say, “look, read this and become expert in your own coffee enema preparation ... and so on.

(Christeene Hildenbrand: It’s not something we sell. It’s something we put together for patients to use. As a matter of fact, do you remember when we went to ...)

Scottsdale?

(Christeene Hildenbrand: No, it was Utah, I think.)

Utah, that’s right.

(Christeene Hildenbrand: Yeah, Salt Lake City, and we went to this little clinic. We were in the waiting room to wait to talk to the doctor, and I glanced over – I’m always snoopy about what people are reading – so, I looked over and I went, “What?! Where did you get that?” And he said, “Oh, this doctor gave it to me.” And I said, “I wrote it.” He said, “Oh, really?” and he had me sign it.)

(Laughter)

There are a number of vendors selling them ...

(Christeene Hildenbrand: But I just want it out there.)

But that’s silly, because it’s stuff created by a nonprofit for the public benefit. So the more we spread around the pdf, the less chance there is of somebody trying to make money. Yes?

(Participant: Is it possible – I’m just going back to the problem of getting it into the US – is it possible to use some other adjuvant other than the Coley Fluid?)

There are a number of possibilities, apple ... mistletoe

lectins of the apple variety have been used by a colleague of mine, Jeanne Achterberg, to successfully put into remission her ocular melanoma. Jeanne's a sort of an alternative medicine goddess, the shaman lifestyles, and so on. Yes?

(Participant: Have you heard anything about hypochlorous acid?)

Hypochlorous acid? No experience with it. Yes, I've heard of it, but I've had no experience with it.

But, again, you know my bias is – and it's a bit politically motivated because I would like to see reform – is that the larger the group of physicians is that's employing this, the greater critical mass we have and the greater likelihood there will be that we can actually change some policies and correct the wrong, because this material, Coley Fluid, was on the market, and Parke Davis made it for 50 years or more. It was available, in use; it's never been out of publication. There have been articles about it since the 1890s, and it should be in use as one tool in the toolbox.

(Participant: *unintelligible* ... could it be grandfathered?)

Well, it doesn't seem as though, with our Food and Drug Administration, grandfathering is possible with anything, unless you are a corporation.

(Christeene Hildenbrand: No, they put a regulation out and – I think it was 1979, I'd have to look it up – that they will not grandfather anything in after that series of Kefauver thingies.)

Nobody was aware of what was happening when Parke Davis requested revocation of its licensure to manufacture Coley, which we think the historical record suggests that it was C.P. "Dusty" Rhoads from Memorial who suggested that, and encouraged them to do so, by saying, "We're going to make it and conduct clinical trials," which never happened. It just sort of disappeared like a little trace of smoke.

(Christeene Hildenbrand: And the FDA outlawed the use of strep, at all).

That's a good point; that's a good point. Christeene started a FOIA request and, after Bush left office, we finally got an answer, after years of being told we were in the queue. Two weeks after the Obama administration came in we got an answer, because they lifted the blockade on FOIA requests. And some really neat peo-

ple at FDA Division of Biologics helped us out; they sent us the entire working three-ring binder with all the updates, all the Federal Register reports, and what we found was a shocking decision made by FDA. What was the year that Donald Kennedy...

(Christeene Hildenbrand: I think that was 1971; but it was 1979 that they actually...)

Yeah, FDA got a hold of biologicals in 1972 because NIH had a conflict-of-interest scandal over an influenza vaccine and a pharmaceutical manufacturer and lack of appropriate testing, so Congress yanked biologicals from NIH and gave them to FDA, and be careful what you wish for. FDA froze all but the preventive vaccines; all the therapeutic vaccines were blocked. They took an intravenous streptococcus vaccine from Lilly and said, "forget about it for rheumatoid arthritis." A whole bunch of patients and doctors petitioned Commissioner Donald Kennedy for a chance to appeal and Kennedy said to them according to FDA policy people do not have a standing to appeal, only corporations can appeal an FDA decision. And you can take that home with you. They banned streptococcus pyogenes on vague concerns about multiple administrations leading to late-blooming delayed effects, negative adverse effects. It was banned from interstate commerce in any part, in any preparation, in 1979, and that was not lifted until 2006, July of 2006. So the entire end of Helen Coley Nauts' life and the Cancer Research Institute and Lloyd Old even, from Ludwig, trying to convince people that this was a good thing, failed because you couldn't get a corporate sponsor for a material that was not going to be able to go into interstate commerce. So it all fell flat. And that is why we went to Senator Harkin and said this needs a legislative remedy, this is really - this is bordering on criminal, what's been done here, you know. Some sort of hearings into FDA need to be held, and at this point, we're trying. We're trying really hard. We have a commitment from Polly Matzinger to be the leader of the gang, and Steve Groft, the director of the Office of Rare Diseases Research – which is where all the orphan-disease and orphan-drug issues end up – he is familiar with ways to do workarounds. We're trying to make this happen, and the senator is giving tacit support. We copy emails of Polly and Steve over to the senator's office and the senator answers all of us and says, "We're rooting for you; let us know how it's developing." I don't know ... we could be backdoored any minute. I'm



not naïve. Doing 12 years in Washington was quite an eye opener, but we're trying – because there are legitimate grounds, and they are recognized, at least by one good guy – to make this right, because it never should have been allowed, it never should have happened.

There was never any evidence of any type that *Streptococcus pyogenes*, dead or alive, was going to create – certainly not a lysate, a killed lysate – was not going to create any kind of down-line adverse event. In fact, the historical literature says quite the opposite.

Anybody else? You've been fascinating.

(Participant: I have a question. If you have a patient who has a history, like a stage III, either A or B, of melanoma, but currently doing fine – everything seems to be in remission – but they want to proactive about it never coming back, would that be a good candidate for something like this? Because, obviously these people had active disease that you put up on the screen.)

Absolutely, because the prognosis is kind of in the crap category, you know, the chance of recur is high when you are stage IIIA or B; it's a high recur. So the proactive insurance against it would be a combination of nutritional management and probably just by using the Coley maybe weekly initially, and then moving it to biweekly and then monthly, and all sub-cu, just to see what happens to the counts and the differential, and the clinical. You know, you don't have any objective findings to worry about, but you can change the patient substantially by doing this. It would really greatly enhance the resistance to recurs.

(Dr. Rosenberg: Gar, at CHIPSA are you following CD4 to CD8 ratios, Tregs, natural killer cells, anything like that:?)

We've done it; it doesn't particularly avail, and Polly's latest paper suggests that we may be kidding ourselves, because when we look at Tregs, we tend to be looking at only one or another type of assay, and we're not looking at the tissue. So we're missing the tissue response, and we may be missing the helper functions of T-regulatory cells; under certain circumstances we could be miscategorizing cells. So it's a little premature to be able to make good use of that because, as Polly points out, the science of immunology is still birthing when it comes to the adaptive side of the immune system.

(Dr. Rosenberg: Sure. The reason I bring this up is I

have a patient I'm following who's had multiple recurrences of melanoma; complete remission each time; low Clark stages, I don't remember all the details. The bottom line is the guy comes to me and says, "I just want to stop getting these recurrences." He's never had anything bad, so just for grins and giggles, I said – "I hadn't been doing it – but, I'm going to check everything." I did a really thorough immune workup, and he's low on everything. It's just interesting. He's very low on everything, including actually lymphocytes, although his total white count is normal. So I actually put him on a whole bunch of things to include astragalus and selenium and glutamine – a whole bunch of things – to see if I can improve all these numbers, but this is kind of new to me because I really haven't been following it with the patients. I just wondered if you had any experience doing it and, really, how much does it matter because you won't find a lot of people that have been doing this.)

There's no consistent predictive value in the CD4:CD8 ratio and counts, *per se*. If you rely on the older method of looking at bandemia and, you know, as you move a patient forward with these general stimuli, you will get into periods of time where they become, if not febrile, at least somewhat symptomatic, and you know you're making progress that way. And that is reflected in the differential and in the sed rate and C-reactive protein; you're going to see changes there. That's what we do. We were just charging the patients more money when we were doing the immune profiles, and we weren't getting anywhere.

(Participant: Will you be providing us some of your typical lab evaluations that you do when you send us your ...)

Well, that's a part of the PowerPoint.

(Dr. Rosenberg: Okay, you're getting the entire PowerPoint that was here. You're getting it.)

(Participant: Right, but I didn't see a slide of – I mean, you showed parts of labs, but...).

We extracted the labs that moved. We just sort of left everything else out because all it is is noise to the eyes and we were pointing out, "This is what we were looking for."

(Participant: But you'll show us a typical panel that you run? That you typically order?)

Send me an email. Yes?



**Elizabeth C.**  
**Regression and 21-year disease free survival of Stage IA cervical cancer**

- 1/4/83 PAP: class IV
- 2/23/83 Cold conization and D&C:  
 Squamous cell carcinoma,  
 mod diff grade II-III, superficially invasive,  
 not extending to endocervical or  
 ectocervical margins T1aNOM0
- 3/12/83-3/18/83 LA GLORIA Gtx, GKI
- No recurrence. Last contact 2004.

Slide 202

(Participant: *unintelligible* comment regarding Chinese traditional botanical medicine.)

That's an excellent point. I think that the in Chinese system there is much more of an awareness of what's happening in the different tissues and structures of the body, and you're asking, "How well is this functioning," not, "Is it diseased?"

(Dr Rosenberg: Gar, we should take 10 minutes; we'd like to take 10 minutes and I'm going finish up. Gar, thank you very much)

(Participants: Thank you. Great. Thank you, *etc. Applause.*)

**Mary H.**  
**26-year asymptomatic survival of FIGO IIIc invasive serous ovarian carcinoma**

- 10/5/85 S. bilateral ovarian masses,  
 L periaortic lymph node (+) grade 1 serous carcinoma
- Refused chemotherapy
- 10/30/85 Gerson therapy at La Gloria facility in Mexico.  
 She stayed in Mexico for 9 months
- 5/86 Abnormal mass anterior mediastinum (MRI)
- Added thymus extract
- Continued diet for 2 years
- Thymus mass resolved.
- Alive and well, no recurrence 26 years (2011)

Slide 203

*From interview of Mary H. by John H.  
 The Wellness Newsletter (TWN)*

"When I first went to Mexico, I had just recently had the surgery. Physically, I wasn't feeling all that great, and then I started the treatment and after 2 or 3 weeks, I went into a healing crisis which I didn't particularly enjoy.

At that point, I almost left Gerson - I really had to struggle and fight with myself, with the support of my husband and the staff at the Hospital, because I just didn't think I could get over the sickness from the juices and the demanding treatment. I went through a week of wanting to literally run away."

Slide 204

**Addendum**

These slides were cut from the presentation due to time constraints.

*(Interview, cont)*

TWN: At what point in the treatment did that crisis happen?

Mary: It happened at about the 3rd week. I remember there was a phone in the cleaning closet and I would go in there to call someone up in the US and beg them to come get me - literally - take me away from this! It was really a struggle, but finally that passed and I became more comfortable with the treatment.

Slide 205

*(Interview, cont)*

TWN: How long did that crisis last?

Mary: It was a good week - a good week of not wanting to go down to the dining room, not wanting to talk to anybody, of being very angry, resentful and frightened, but with the support of everybody at the hospital I was able to get through that. After that occurred, and after I passed through that initial phase, what was most amazing to me and to my family members when they finally visited was that I looked and felt very well...

Slide 206

Slide 207

*(Interview, cont)*

...When I went to Gerson, it was against everybody's advice to the point where the pressure from friends and family was almost unbearable. They were prepared to disown me if I chose to do this alternative treatment as opposed to the chemotherapy. Because of this, my family didn't visit right away - but when they did they were shocked to see how healthy I looked. Everything, after a while, started physically to find a balance; my weight became consistent, the color of my eyes became very bright, the whites were very clear, my hair was healthy, nails were growing for the first time, it was truly amazing.

MARY H.	10/31/85	11/4/85	11/25/85	12/17/85	5/6/86
Dx: Ovarian Ca	DEL SOL	DEL SOL	DEL SOL	DEL SOL	DEL SOL
Leuk	4.3-8	4.9	7.5	4.4	5.7
Bands	0-9	5.0	13.0 H	7.0	2.0
Segs	50-70	71.0 H	68.0	59.0	46.0 L
Lymph	20-40	20.0	10.0 L	21.0	41.0 H
Mono	1-6	3.0	5.0	8.0 H	8.0 H

Slide 208

Slide 92

- **Whole bowel irrigation as a gastrointestinal decontamination procedure after acute poisoning.** Tenenbein M, *Med Toxicol.* 1988;3(2):77-84
- **Whole bowel irrigation as a decontamination procedure after acute drug overdose.** Tenenbein M, *Arch Intern Med.* 1987;147(5):905-907.
- **The effect of whole-gut lavage on colon motility and gastrocolic response in a monkey.** Condon RE, *Surgery.* May 1986;99(5):531-536.
- **Endotoxaemia in active Crohn's disease. Treatment with whole gut irrigation and 5-aminosalicylic acid.** Wellmann W, *Gut.* 1986;27(7):814-820.
- **Whole-gut irrigation as antiendotoxaemic therapy in inflammatory bowel disease.** Wellmann W, *Hepato-gastroenterol.* 1984;31:91-93.
- **Effect of gut lavage on phenobarbital elimination in rats.** Lenz K. *J Toxicol.* 1983;20(2):147-157.