Cancer, Pancreatic Enzymes, and Politics: An Interview with Nicholas Gonzalez, MD
Nutritional Medicine Update with Robert Crayhon, MS
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Dr. Nicholas Gonzalez

Robert Crayhon, MS, CN is a nutritionist and educator with 20 years of clinical experience and author of four books. With Mark Schauss, he interviews top clinicians and researchers from around the country to share cutting-edge, clinical information in the world of nutrition and health. Free downloads of his Nutritional Medicine Update shows are available at www.CrayhonResearch.com. In this interview, Crayhon meets with noted cancer specialist, Nicholas Gonzalez, MD.

Nicholas Gonzalez, MD, graduated from Brown University, Phi Beta Kappa, magna cum laude, then worked as a journalist, first at Time Inc., before pursuing premedical studies at Columbia. He subsequently received his medical degree from Cornell University Medical College in 1983. During a postgraduate immunology fellowship under Dr. Robert A. Good, considered the father of modern immunology, he completed a research study evaluating nutritional therapy in the treatment of advanced cancer. Since 1987, Dr. Gonzalez has been in private practice. His nutritional research has received substantial financial support from Procter & Gamble, Nestlé, and the National Cancer Institute. Results from a pilot study published in 1999 described the most positive data in the medical literature for pancreatic cancer.

Robert Crayhon (RC): Joining me now is Dr. Nicholas Gonzalez, who has maintained a very busy practice treating the treatment of cancer with nutrition and a lot of other modalities in New York City for many years. Dr. Nicholas Gonzalez, welcome.

Dr. Nicholas Gonzalez (NG): Thank you for having me.

RC: Dr. Gonzalez, can you tell me the origins of your interest in looking at cancer from something other than the chemotherapy/radiation perspective?

NG: My personal journey began when I was a second-year medical student and I had the opportunity to meet William Kelly, the eccentric dentist who during the 1960s and 70s developed a very intensive program for treating advanced cancer with some great success. I was actually a very orthodox medical student, and after my first meeting with Kelly, I began to suspect he may be very eccentric, as has been claimed correctly, but that he also probably was onto something. My research mentor at the time, Robert Good, who then was president at Sloane-Kettering, really encouraged me to start looking into Kelly's patient charts, thinking even if Kelly turned out to be a fraud, I would learn a lot of medicine just going through the charts. So what began as a simple student project eventually developed into a major investigation under Dr. Good's direction.

I finished my immunology training under Dr. Good. By that point, he had left Sloane-Kettering and gone down to Florida, and I followed him to a children's hospital where I finished my investigation of Kelly, which ultimately took five years and 2000 of his records. That's how I myself got interested. It really was kind of a quirky thing, I just had this opportunity to meet Kelly.

RC: What did you find?

NG: I went down to his office. At that time, he was in Dallas. Under Dr Good's direction, I spent a couple initial weeks going through Dr. Kelly's charts. The first thing I noticed [was that] he kept very good records. He had his successes, his failures, anyone who'd ever come to his office. He wasn't hiding anything. And what I found, even though I was just a second-year medical student, was that Kelly had patient after patient with appropriately diagnosed advanced cancer, who, five, ten, and 15 years later, appeared to be in good health. I actually began calling some of these patients and talking to them about their histories and putting together some of the records. I went back to New York after two weeks, showed them to Dr. Good, and that's when he thought we should really start pursuing this as a more formal investigation.

But there was no question that something serious was going on in Kelly's office, that it wasn't just some crazy alternative nonsense, that something really profound might be happening there.

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RC: What was Kelly doing?

NG: Kelly's program had three basic components. First, for each patient, he designed a diet. Kelly differed from a lot of alternative practitioners in that he didn't believe all patients should be on one diet. He had actually developed ten different diets that ranged from pure vegetarian (nuts and seeds) to an Atkins-type red-meat diet, and about 90 variations of the ten basic diets. And for each patient, he would individualize the diet. So the diet component was very important, and it was very individualized.

Secondly, he used large doses of supplements. Kelly, in his day, and, of course, we, today, are notorious or famous as doctors who prescribe lots of supplements, and indeed we do. He also would prescribe very individualized supplement programs. The main emphasis in terms of cancer treatment wasn't the vitamins and minerals and trace elements, which he did use for supportive care; the main anti-cancer elements were large doses of the proteolytic pancreatic enzymes derived from a pig source. Kelly had picked up on the work of Dr. Beard from the turn of the twentieth century. [Beard] first proposed that pancreatic proteolytic enzymes, in addition to their digestive function, represent the body's main defense against cancer and would be useful as a cancer therapy. Kelly had really refined Beard's early work and used large doses of enzymes in the treatment of cancer.

The third component [was] detoxification, which involved things like the coffee enemas, liver flushes, and juice fasts, which Kelly proposed helped the body mobilize and neutralize all the toxic debris that we're all loaded with due to the environment we live in. Also, particularly with cancer patients, as tumors die, lots of toxic waste is released from the dead tumor, and the body has to mobilize that. Things like coffee enemas and these fasts help the body mobilize and neutralize toxic debris, help excrete it efficiently, so patients can tolerate getting well on the program.

So the program essentially involved and involves today individualized diet, individualized supplement programs with large doses of pancreatic enzymes for cancer patients, and detoxification routines such as the coffee enemas.

RC: How many years have you been working with this program with patients?

NG: I met Kelly in 1981, and I finished my fellowship in 1986 and came back to New York and opened my practice late 1987, so actually this late fall it will be 20 years that I've been seeing patients myself in a private practice.

RC: And how have you refined or changed the therapy over those years?

NG: In Kelly's day, going back to the 60s and 70s when he was really very, very active — in those days, alternative medicine wasn't as popular as it is today, and he was really considered almost a criminal for trying to treat cancer with nutrition. Things have changed, of course, in some respect. As a result, Kelly really didn't have access to top-quality supplements. He took what was available. We've been able to really get good manufacturers to make supplements according to our needs for our particular program. We have what we think are the best pancreatic enzymes on earth. Dr. Isaac, my colleague, and I actually developed a method for processing enzymes that meet our specifications for their anti-cancer effect. So we've been blessed in that we've been able to get top-quality supplements, which makes the program work better. One of the things that really drove Kelly crazy was the fact that he claims he had to change supplement companies 14 times. Again, this is going back to the 60s and 70s when things like quality control were just not as sophisticated as they are now. People weren't using supplements to treat cancer. Kelly had a lot of trouble, and it created a lot of frustration trying to find really good supplements. We've been able to do that, so that's one thing. We also update the program. Supplements like CoQ10 weren't really around back in the 1970s. As new supplements are discovered or made available, we always evaluate them and try and incorporate them as we think appropriate. So we're always trying to keep up with the literature and refine the program as needed, but we still use the same basic Kelly/Beard-type model. We just refine it as new information becomes available.

RC: Do you still use ten separate diets or have you increased that number?

NG: We have ten basic diets and about 90 variations, but it's still basically the ten diets that Kelly used going 30 years ago.

RC: How did Kelly determine which diets to use and how do you do it?

NG: Kelly first did it by trial and error. When he first started out, he didn't come out of the Gerson mode; he thought everyone should be a vegetarian. His wife at the time got really sick on that diet and almost died. Turned out she was a genetic meat-eater. He put her on red meat three times a day, and she really turned her health around. Over time, he gradually developed his ten diets, and he basically was a very astute clinician. Actually, over a period of five years while I studied his work, I spent two years in his house at various times, and I used to watch him work with patients. He was a very astute clinician, very smart. He knew how to concentrate on patients. He could do a lot just from evaluating the patient in his office, but he had developed a very sophisticated 3,300-question questionnaire, the famous old Kelly questionnaire that had been available for 20 years, based on the patient's answers to those questions — and he would ask questions like, "Do you crave salt?"; "Do you like fat?"; "How many hours of sleep do you need each night?" — all of which can relate to the innate physiology and the diet a patient needs. We have a test that we use — we can do it from blood work...
and we have a hair test we use that's specifically altered for our specific needs and basically tells us immediately, based on the biochemical profile, whether the patient's vegetarian, a meat-eater, balanced, or somewhere in-between. So, we get it from the objective tests. Again, having done it for 20 years, you pretty well know what the patient needs. For example, breast cancer patients are always moderate vegetarians. Basically, it's a vegetarian diet with some limited animal protein (fish, eggs, and yogurt). Melanoma patients, myeloma patients, leukemia and lymphoma patients are always on the meat-eating side. You just know from clinical experience after awhile what diet a patient needs. But the hair test we run basically tells us with great specificity and precision which diet a patient needs.

RC: And this is a test you’ve developed and only your office runs.

NG: Right, and I don’t say that with any pride. We’ve been accused of being secretive. We’re not trying to be secretive. We just don’t have the finances and the facilities to develop it. Our hope was to get our work properly tested and proven and demonstrated, and then it would be available to anyone who wants it. It’s taken about ten years longer than I hoped it would. At some point, we want the test available to anybody, but right now, yes, it’s available only through our office. The lab that does it for us doesn’t have the facilities to enlarge it anymore right now.

RC: How is the research on your work going?

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NG: In some respects, very good; in [other] respects, catastrophic, in terms of some of the project. We’ve had a lot of industry funding over the years as you may know. Proctor and Gamble put a lot of money during the mid-90s to help us develop the enzyme-processing technique. They were very gracious and gave us a lot of research support. Nestle has been a supporter on and off for years, and they funded our first clinical trial, which was published in 1999. That was our pilot study with pancreatic cancer, which was very successful and gave very positive results. As a result of that pilot study, the National Cancer Institute (NCI) awarded us $1.4 million to do this big control clinical study, again with pancreatic cancer, comparing our treatment to chemotherapy, and that actually began around 1999. It’s hard to believe: it’s as if it were a thousand years ago, and it’s been a total catastrophic disaster, and the one thing I learned from that is the idea that the academic establishment is ready to welcome well-meaning, well-intentioned, serious alternative practitioners who are doing serious research just isn’t happening. They’re so tied in to chemo and radiation that it’s going to take a major nuclear explosion to change the way they think. We worked on this for eight years. We’ve worked right up to the heads of the NCI and the National Institutes of Health (NIH), and it’s just been an absolute boondoggle trying to get the missions to do a study with alternative therapy in the properly managed way. After eight years, we’re still not at an end. It’s just a quagmire.

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RC: So when you say “catastrophic,” you mean from the bureaucratic standpoint.

NG: From the bureaucratic standpoint, not in terms of the data. That’s exactly what I meant. Trying to deal with these bureaucracies...it’s like taking the IRS, multiplying it by about a million, and that’s about how efficiently these organizations work. They have huge budgets, and a lot of it just goes into bureaucratic twiddling of thumbs. It’s a very, very difficult experience. In fact, right now, the study, at our urging, is currently being evaluated because of concerns that it hasn’t been managed properly at the higher academic levels. We’ve made that charge, and at this point, I’m not going to hide that issue. We were so concerned about the way it was being managed, we’ve actually raised complaints about it, which are being taken very seriously.

RC: What’s the data from the results?

NG: The data is a mess. I’m trying to find a way to explain it in a way that I can. There are currently two investigations into the trial in terms of the way it was managed at Columbia and at the NCI. Our feeling is that there was intent, either through carelessness or maybe deliberate [efforts], to make the chemo look better than our treatment. That’s being investigated now, so I can’t say with certitude that that’s going to be the conclusion, but that’s basically what we felt. So with two investigations on, the data really has no meaning.

The biggest problem we ran into is that there were very clear criteria for the entry of patients, and of course this is a nutritional therapy, so, for example, patients have to eat. We had nothing to do with the entry of patients. It was all done through Columbia. They were the site, and they didn’t want us involved with anything to do with the evaluation of patients because they thought we would somehow bring bias into the studies of pancreatic cancer. I don’t know how you can bring bias, but they were in charge of entering patients, and what we found is, they were repeatedly sending us patients [who] were so sick in advance that they couldn’t do the treatment. We had one patient [who] died a week after he saw us, never even got a supplement order. They considered him a Gonzalez treatment failure. They said any patient who walks into your office, even if he doesn’t do it or if he dies the next day, is a Gonzalez treatment failure. When there was patient after patient entered like that, it started raising red flags and warning signs. Indeed, when we went to our congressional supporters, it raised warning signs with them, and then, when we went to the investigator groups, who oversee all federally funded studies, it raised warning signs with them, and that led to the two investigations.

I can’t comment on what the outcome’s going to be until they finish their investigation, but I can give you the preliminary issues. People have a right to know; the study’s been around for eight years, and people wonder what happened. So that’s basically what’s going on. There’s an investigation as to the way it was managed, not by us because we weren’t involved with the management. We were the ones who protested the way it was managed.

RC: In your clinical practice, how well does the therapy work? There’s a very unscientific question, but it’s an important one.

NG: No, it’s not an unscientific question at all. There’s this mythology in academic medicine that anecdotes really don’t teach anything. In fact, anecdotes teach you everything. One of the reasons I really respected Dr. Good is that he said medical advances don’t begin with controlled clinical trials; they begin with observations in nature. That’s what he used to call them: observations in nature. That’s the way science moves. Mendel made observations with his pea plants; Darwin made observations with finches. You don’t start with controlled clinical studies or laboratory work. You start with observations in nature, and they’re very valid. Anecdotal reports are very valid. In fact, orthodox physicians and scientists often criticize alternative medicine as being anecdotal. Of course, a lot of orthodox medicine is anecdotal. Orthodox therapies have become accepted standard-of-care medicine based on anecdotal evidence. Interleukin-2, the most famous in cancer medicine, was approved by the FDA in 1990, just based on anecdotal evidence. They hadn’t done a controlled clinical study. It became standard-of-care medicine. In 1998, a controlled clinical study was finally done, and to everyone’s horror, it turned out it didn’t work any better than placebo for kidney cancer, which was one of its main indications. That was an example where the jump by orthodox physicians to accept something as real because it agreed with their philosophy turned out to be a boondoggle, because eight years later, it was proven not to work very efficaciously.

So my point is that anecdotal evidence is used by the orthodox physician, sometimes wrongly and incorrectly, but if used wisely, it can teach you a lot. And indeed our private practice is a collection of anecdotal results, but when you have patients with pancreatic cancer, as we do, who are alive 14 and 15 years later, with appropriate biopsies and appropriate CAT scans and tumor regression on sequential CAT scans, that’s an important observation. No one else in medicine, to my knowledge, has cases like that, for example, with pancreatic cancer. In fact, when I first began reviewing Kelly’s records, [I could see that] Kelly’s practice was an uncontrolled environment, not a controlled clinical study. These are private-practice patients that he saw over a 20-year period, and you may not be able to prove to everyone’s satisfaction that he cures cancer or not. But if he has patients with pancreatic cancer, acute leukemia, or metastatic breast cancer alive five or ten or 15 years later, any well-meaning honest oncologist or researcher is going to have to take that seriously as he did and as I did.

And the same is true with our practice. You either have patients like that or you don’t, and we do. Now that this NCI study, to be blunt, has fallen apart, we realize we can’t rely on the academic establishment to bless this and bring everyone together for the benefit of mankind, scientific truth, and sick patients. That’s not going to happen. We have to do it ourselves, as usual. So we’re putting together a book of a 100 cases, entirely composed of patients with appropriately diagnosed advanced cancer who, by the orthodox standards of oncology, were terminal, had poor prognosis, and are alive five, ten, 15 years later. We actually put the first 36 on our website. I have a patient with metastatic breast cancer of the brain and bone and liver, who’s alive 17 years later with no evidence of disease. Those are the kind of cases that we’ve been able to find anywhere in the orthodox literature. So even though they may be anecdotal, or as you said, unscientific, they still have meaning in terms of what is
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...after 35 years of war on cancer and billions of dollars a year spent on research, this is what they can get: a 60-day improvement in survival at an enormous expense and of course with terrible side effects. Where's the victory in that? ... If that's the best I could do, I'd have shut my office down a long time ago...

RC: In the case of pancreatic cancer, there isn't a lot that orthodox medicine has, is there?

NG: No. The last drug that was approved specifically for the treatment of pancreatic cancer was gemcitabine (Gemzar), which was approved around 1998. Eli Lilly patented the drug and developed it. They did a major clinical study. They had 126 patients, half of whom got Gemzar and half who got the old standard treatment, which was 5-FU. There was a one-month average improvement in survival. Out of 126 patients, 18% lived one year. The longest survivor, and there was only one of those, lived 19 months, and that was it. But based on the fact that there was an improvement in average survival from 4.5 months to 5.5 months, the FDA approved Gemzar for the treatment of pancreatic cancer. It's now a billion dollar-a-year industry that's used all over the world, even though it didn't do much. [Twenty-nine percent] of patients had a somewhat improved quality of life - they needed less pain medicine - but no one lived longer than 19 months out of 126 patients. To me, that's not a major advance and certainly, to me, is not indicative of a drug that warrants a billion dollar-a-year industry. But it got approved; it's very successful. It's used everywhere, from Singapore to Los Angeles, for the treatment of pancreatic cancer.

RC: When you say a billion dollar-a-year industry, you mean just that drug?

NG: Just that drug. Yes, sure. Some of these cancer drugs bring in two, three billion dollars a year. Just a single drug.

RC: I think when you said academic establishment, I was thinking really economic establishment. That's the problem, and when there are trillions (I don't know the number, maybe you do) of dollars made on chemotherapy, what incentive could there ever be economically on the large scale to investigate a therapy such as yours?

NG: That's what we ran into. There's no incentive at all. To give the NCI credit, the former head of the NCI, actually it's two former heads ago - Richard Klausner, back in 1996, 1999 - met with me in Congressman Burton's office and actually approved this clinical study. And I thought he was absolutely sincere about wanting to do a fair, honest study. Trouble is, he went off to work for the Bill Gates Foundation, and the new groups that were assigned to my study did not have his enthusiasm or scientific objectivity. They felt they had inherited this boondoggle and had to work with crazy Gonzalez who does the ugly coffee enemas. That kind of stuff. They kind of felt forced into doing it. There are scientists there who really are out for the benefit of mankind, but my experience is they're few and far between. A lot of it is ego-driven. A lot of it is arrogance. Dr. Isaacs, my colleague - I wish I could clam this as my own - she came up with a junior high school" syndrome. Suddenly, they're adults at age 50, and the fact that they were the smartest kids in junior high 40 years ago just doesn't mean very much anymore.

RC: Neither does the fact that their arrogance is costing tens if not hundreds of thousands of lives every year.

NG: The saddest thing I saw in my clinical trial was the absolute indifference to the fact that this might be useful therapy that could help people for a cancer - pancreatic cancer - for which there is no useful therapy. It's not as if we're trying to take something away from somebody or destroy an industry. We're just providing a treatment for an illness for which there is no treatment. There's nothing - not with the previous group of people but with the new group. And I'll tell you how bad things got. There was one NIH person who really supported this clinical study and really believed what I was doing and believed and believed the pilot study data was legitimate and this warranted serious testing. She was taken off my study, and the longest survivor, and there was only one NIH person who really supported this clinical study and really believed what I was doing and believed and believed the pilot study data was legitimate and this warranted serious testing. She was taken off my study, and the longest survivor, and there was only one NIH person who really supported this clinical study and really believed what I was doing and believed and believed the pilot study data was legitimate and this warranted serious testing. She was taken off my study, and she was even told she couldn't talk to me. If she talked to me, she'd be fired. She quit and went off to work for a foundation; she was so disgusted.

That's the level of the kind of politics that go on down there. It's absolutely appalling, because how can legitimate creative scientific work thrive in that kind of oppressive environment? It's like the Soviet Union, where you had to believe in Lysenkoism, the inheritance of acquired traits. You know, you cut off your finger, then your kid's not going to have a finger. It was like the Soviet Union, where you had to believe in Lysenkoism, the inheritance of acquired traits. You know, you cut off your finger, then your kid's not going to have a finger. It was politically determined that that's what you had to believe. It's politically determined that Gonzalez can't possibly be right, and therefore anyone who agrees with him has got to be an idiot and has got to be stopped. So, I wasn't very impressed with the way they handled themselves at all.

RC: I have this theory that we need to develop something I call the people's government, which is a government that's actually
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about the people and that actually addresses the concerns of the people, and maybe one day, we might even have that, who knows, considering all the dollars that go into the government. But cancer is a tremendously profitable business. What’s the average amount of money that a course of chemotherapy for a cancer patient will cost?

NG: It depends on the drug, of course, but there are drugs that cost $10,000 a month, and patients have to be on these things for months. A bone marrow transplant can cost $250,000 on average. I used to do bone marrow transplants when I worked with Dr. Good. A course of aggressive chemo can run you about $50-100,000. It’s very lucrative. There’s a big write-up, a big profit-margin for everyone involved. What’s not generally appreciated is – you know, they criticize orthodox doctors for, God forbid, getting profits from supplements [but] because we’re so watched so closely, we don’t do that, even though we developed a lot of our supplements. I don’t have any problem with anybody who gets money from supplement sales. They should, of course.

Oncologists are legally allowed to charge patients for the chemo they give in the office and not tell the patient they’re making a profit on it. They have such a strong lobby in Washington, so they’re able to do that. The Wall Street Journal estimated the average oncologist himself personally, not through his office, just his own pocket, is making over $100,000 per year just on the write-up of chemo. Most oncologists now give chemo in their office. They have chemo rooms. They’ll be giving chemo to ten to 15 people at a time. The nurse does it. The doctor doesn’t even see the patient, and actually charges the patient for the drug. These doctors buy the drugs from the company, then charge the patient. They’re able to mark it up, the patient for the drug. These doctors buy the drugs from the company, then charge the patient. They’re able to mark it up, and that’s legal. It’s considered ethical, and they don’t have to tell the patient. There’s no full disclosure required, because the oncology lobby is so strong. It really adds to the incentive to treat. Even if the drug doesn’t work, these doctors will use it because they make money off of it. They often accuse the alternative guys of being in it for the money. You know, Atkins made money from supplements. Well, so what? The oncologists make money from chemo. Every oncologist in America’s making money from chemo.

RC: And, of course, one of the differences is that chemo has quite a negative effect on immune function and quality of life, whereas supplements, at their worst, will not do that.

NG: If chemotherapy worked well, you’d have to say, well, you put up with the bad with the good. If you have appendicitis, you get surgery done. There’s the downsides – you’ve got to have surgery, you’ve got to have anesthesia. The trouble with chemo is it doesn’t work for most cancers, despite the laudatory press releases that go out every April when the budget for the NCI is up for renewal down in Washington. There’s always press releases lauding the latest new development every year. It’s kind of tiresome after awhile. But, for most cancers, chemotherapy doesn’t work.

When I was in medical school in the early 80s, we were taught that the cancers that respond to chemotherapy are testicular cancer, acute lymphocytic leukemia of childhood, choriocarcinoma – which is a particular cancer of pregnancy – and about two or three other cancers, and that was it. Hodgkin’s disease – that was the great success. Twenty-five years later, medical schools still teach that the cancers that respond to chemo are testicular cancer, acute lymphocytic leukemia of childhood, certain lymphomas, Hodgkin’s disease, and choriocarcinoma, and that’s about it. Despite all the hoopla, there really hasn’t been much change in the last 25 years for most of the major cancers – metastatic lung cancer, metastatic colon cancer, metastatic breast cancer. They’re very incurable with chemotherapy. Even with all the targeted therapies, they’re absolutely completely incurable. There might be little advances. I read the oncology journals. [Studies are published as] major articles because [they show] a two-month average improvement in survival. Makes you want to vomit. This is something to be happy about? That’s a sign of failure, that after 35 years of war on cancer and billions of dollars a year spent on research, this is what they can get: a 60-day improvement in survival at an enormous expense and of course with terrible side effects. Where’s the victory in that? I don’t see a victory in that. If that’s the best I could do, I’d have shut my office down a long time ago and done something honest like sell shoes or repair shoes. I wouldn’t be doing this. But they consider that a major victory. There’s an extraordinary incentive. Ralph Moss is the real expert on the cost of chemo. I think in the US last year, it was something like $43 billion just for the drugs. Total cancer care was over $100 billion. It’s a major industry, a lot of profit involved.

RC: I’ll never forget the oncologist at a very major cancer center who described in his book Questioning Chemotherapy how he spent his life dispensing chemo and when he was diagnosed with colon cancer, said, “Do what you want, just don’t give me chemo.”

NG: Yes, that’s right. These are not stupid people. They get through pre-med, they got through medical school, they got through residency, they got through their three-year post-graduate fellowship in oncology. They’re not dumb. They know that it’s not working. It’s just, they make a living doing it. What else are they going to do?

RC: The media today seems more than ever so homogenized by corporate control that I don’t expect Terry Gross or Paula Zahn or someone to call you up and say, “Come on in. Let’s really have the whole story of cancer, economics and everything, out there.”

NG: What’s funny, having been a journalist before I went to medical school, is seeing the absolute lack of intelligence among journalists when it comes to medicine or cancer care. Journalists have this reverent awe toward anyone who got through medical school. Anyone in medicine must be this Arrowsmith-type scientist, seriously looking for the answers to terrible diseases, working late on Friday nights, sacrificing their personal life, their home life, their hobbies, their joys, just for the sake of cancer patients or whatever patient, whatever the disease. It’s a lot of hokum. That’s not what medicine is. It’s an ego-driven, arrogance-driven, territorial-driven, money-driven, profit-driven profession with a lot of smart people with a lot of ambition. The people who end up in medicine have a lot of ambition. It’s the worst combination: terrible ambition with a lot of intelligence, so they can figure out ways to be ambitious in a lot of creative ways. But in terms of getting people well, that’s a different story. Ralph Moss has documented that really, really carefully.
I use this analogy: I don't own a car in Manhattan. I walk to work. But I did have a car at one point, and one time, it broke down. You bring your car to a service shop, and you say, what are the chances of getting this fixed? Oh, 90%. You go to an oncologist, let's say, with metastatic pancreatic cancer. What's the chance of getting it fixed? Well, zero. You're going to die. Who would bring their car to a mechanic who gets zero percent of the cars well? You'd have to be an idiot. Yet patients continually bring their bodies to oncologists who have zero success with certain cancers. And the media, getting back to your question – I'm off on a tangent – why doesn't the media look into this? The media just has this reverential awe. They look at science as this kind of mysterious profession with all these brilliant people – you know, the valedictorians from high school – and they're all working together for the benefit of mankind. The smartest journalists in the world, when it comes to cancer, just repeat the press releases from the NCI.

Recently, Iressa was the great drug; this was the great answer to lung cancer. They used it up at Dana Färber and had one patient whose liver metastasis got smaller, and those guys were parading her around on all the talk shows. Iressa had gotten approved without an appropriate clinical trial. They finally did a controlled clinical trial, and it didn't work any better than the previous drug. There was no advantage to it. Only ten percent of patients respond. None of them were cured despite the dog-and-pony show on all the major TV networks. And yet because the doctors came out of Harvard, they got on the Today show and all these major networks. If an alternative person had done that, they'd have been in jail for promoting an unproven therapy.

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And Iressa, despite all this promotion – the Wall Street Journal actually had an article on it – made hundreds of millions of dollars and then was proven not to work. The FDA almost pulled it. To their credit, the FDA finally reacted after having approved it without proper evidence, then was going to disallow it. I think it's still available. Here's a drug that had virtually no benefit, and all the media outlets, the major TV shows – we're not talking about the local weekly newsletter somewhere in the middle of nowhere – we're talking about major places: Today Show, Good Morning America – paraded this single patient. It was pathetic for the patient to have to do that, but it just turned out, that was it – that was the single patient that led to $100 million-a-year industry. It's terrible, and the media did nothing about it. And when the FDA decided they were going to pull it, only the Wall Street Journal covered it. All the others, including The New York Times, which had had positive articles, they didn't say anything about it. But the news made it into the Wall Street Journal to that paper's credit.

RC: I think I have an even more insidious thought pattern in my head, which is that, first of all, the media doesn't question anything. Investigative journalism doesn't exist anymore. We lost the great David Halberstam, and there aren't people who really dig into a story and want to know what's going on. Occasionally, there'll be a book, but a book is not something that holds weight in our culture. In our society, that it may have

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at one point. Now and then, the LA Times or The New York Times will have a sort of token article about something, about Katrina maybe, but really the big issues that face this country – like cancer and, I don't know how much you ascribe to Samuel Epstein's suggestion that most of cancer has at least as one of its major factors, pollution – are not really discussed.

But let's get back to your therapy. You mentioned pancreatic cancer. What cancers in particular do you see it working best for?

NG: We've used it for all cancers, from brain cancer to leukemia. Beard, 105 years ago, suggested every cancer will be susceptible to the enzymes. We believe he was right. This isn't my idea; I'm not giving myself credit. He developed the idea, and I think he was right. Kelly thought the same; I think Kelly was right. We find that the enzymes seem to work against any cancer. Of course, there're certain limitations. If a patient is two days from death, nothing's going to get them well. They're going to die. We've had patients who have had so much chemotherapy and radiation to make the tumors go away, they still die from toxemia from the previous therapy. That could be an issue, although most of the patients we've treated have had some previous orthodox therapy. But in terms of cancer types, we treat all types, even rare cancers. I have several male patients with breast cancer, maybe 300 cases a year. Women with breast cancer, there's 200,000 cases a year; breast cancer in males is very rare. We see some very rare cancers, because people come to us thinking and hoping we can help. The enzymes seem to work against any cancer. The reason we've emphasized pancreatic cancer in our paper is because that's the worst cancer there is, and we thought if we could make a point with that. People would have to take the treatment more seriously. That was always my intention. But enzymes seem to work for any cancer.

RC: Whether there's a solid tumor or not.

NG: Yes, they work for both: the immunological tumors, the blood tumors, as well as solid tumors.

RC: How many supplements on average are your patients taking per day?

NG: My average patient takes about 200 pills a day. Probably about 100-110 of them would be pancreatic enzymes, but they also take vitamins, minerals, trace elements, antioxidants, some herbs, sometimes, depending on the patient's needs and metabolic profile.

RC: What's your opinion of soy?

NG: In this conversation, I've gotten in trouble with the NCI, the FDA, the drug industry, and now I'm going to take on Arthur Daniels, the soy industry. Kelly, my mentor, was adamantly against soy 35 years ago, and people thought he was crazy. But he had very good thinking about it. Even then, this is how smart Kelly was. He knew that soy had phytoestrogens. He said those phytoestrogens are not protective; they're stimulating. It's very interesting. I have on my desk two feet away from where I'm talking to you now an article from the new South Wales Cancer Institute in Australia, where in January 2007, they came out with an edict that soy is not safe for cancer patients, that it can actually stimulate cancer growth.

There are three problems with soy. First, soy has the most powerful trypsin inhibitors of any food on earth, and trypsin is the main pancreatic enzyme that we believe has the major anti-cancer effect, along with chymotrypsin, and soy completely neutralizes it. This has been known for 35 years. It's got that Bowman-Birk inhibitor, which blocks trypsin. Period. The Department of Agriculture did a study about ten years ago in which they were going to raise calves on 40% soy, because they figured it would be a cheap way to raise cows, and the cows all died. The cows all died in infancy, and the researchers did autopsies. The cows all had pancreatic failure because of this trypsin inhibitor. Of course, 40-50% soy is a lot of soy to eat.

Second problem, it's got thyroid blockers, which you probably know, and it can block thyroid. We believe even fermented soy will block thyroid function. The third problem is the phytoestrogens, which we don't think are really safe in large amounts. We think they can stimulate cancer growth. New molecular biology as well as clinical evidence seems to indicate that. So the idea that phytoestrogens are somehow good and block the hormone-sensitive cancers may not be correct. I think there was a big rush to embrace it as a health food prematurely. Kaayla Daniel wrote a good book, The Whole Soy Story, which is around 400 pages and really dense, referenced completely, beautifully, totally referenced. She really raises a lot of these issues, and she isn't even discussing my kind of work where we rely on pancreatic enzymes, and soy just knocks our enzymes right out.

RC: Well, that's an angle I don't think a lot of people have thought about, the suppression of pancreatic enzymes, which you feel you have seen help cancer patients. So, here's a whole other vector by which soy might be interrupting the normal physiology.

NG: The thyroid issue has been documented. The phytoestrogens as possibly pro-carcinogenic have also been studied now more extensively, to the point where official government agencies are starting to come out with edicts warning people who have cancer about soy. But the fact that soy blocks trypsin and pancreatic enzymes is, to me, the biggest danger, because those are not only the digestive enzymes, they are the main enzymes that protect us against cancer – more than the immune system or anything else. You knock those things out, and you're pleading for cancer to come in and attack you. We believe, in our theory and our world, you knock out those enzymes, and you're headed for trouble. So, we think that's the biggest danger with soy, and some studies have now shown that people who eat a lot of soy may not have lower cancer rates. They may have increased cancer rates. So, there's starting to be a turnaround in the way people approach that food.

RC: So zero soy for your patients.

NG: Less than zero if possible. We tell patients if they see a soy plant walking down the street to cross over and avoid it or take another route. Just avoid it. Don't eat it, don't take it. I know the people go ballistic about it, the vegetarian people particularly because they like their soy. If you want to knock out your
thyroid, knock out your pancreatic enzymes; if you're a boy and want to turn into a girl, take lots of soy. Those phytoestrogens will help do it.

RC: How important are organic foods?

NG: Absolutely critical. Who wants to take neurotoxins? Pesticides kill insects, because they poison their nervous system. How much intelligence does it take? Do you want to fill your body over a 50-, 60-, 70-, 80-year period with neurotoxins that kill insects? I don't want to do that. I want to take things into my body that would help insects grow: organic food. Insects love organic food. There are ways of protecting the plant from insects, of course, but I'm saying there are all the nutrients in there. There's nothing poisoning us. You don't want these neurotoxins coming in. New studies show this—the orthodox scientists tended to laugh at it. The Internet's a wonderful thing in that regard. I pulled out a very legitimate study that found laboratory animals raised on organic food live longer, are healthy, even get along with each other better than animals raised on the same types of food grown non-organically. Guess what? These little animals, their brains were getting poisoned with the pesticides. Maybe the neurotoxins are not that much in a single piece of broccoli, but when you eat broccoli over 50 years, toxicity starts adding up if it's not organic. We insist that all our patients eat as much organic food as they can. I live that way. I've lived on organic food for 26 years, and I tell you, it makes a difference. When I don't eat organically, I don't feel as well.

RC: There was a paper in The Lancet recently that showed that the more produce people eat, the greater their risk for a neurodegenerative condition, which has to point to pesticides. I don't know what else it could be.

NG: Of course, yes. It's not the food itself. It's obviously the pesticides in the food. Pretty soon, you won't be able to eat anything. You look at some of the studies with animal fat that says animal fat causes cancer. Well, what kind of animal fat are they talking about? Are they talking about organic caribou from the Arctic? Are they talking about feedlot-raised animals that have hormones and pesticides and fungicides and insecticides, etc.? A lot of these chemicals are fat-soluble so they get stored in the fat cells. You don't pee them out quickly. You eat a hamburger, and you get all that chemical stuff from the fat. So, yes, that's exactly right. It's getting to be the point where scientists are going to realize that people can't eat anything. They'll just have to stand on the street and starve to death. It's a real problem. We think organic is absolutely, critically important. We started doing this 15, 20 years ago. It was hard to get organic produce. Even in New York City, it wasn't that easy. Now, of course, it's easier to get, although they're trying to dilute the definition of organic. More people are demanding organic foods, correctly and rightfully. They should demand it.

RC: How many patients have walked through your door since you opened your clinic 20 years ago?

NG: In the level of thousands. We don't have an assembly-line operation. I'll spend four or five hours with each new patient over two days. We don't want to rush patients. The people we see have complicated medical problems. They are very sick. Often, a patient has seen 30 doctors before they see me. So, we spend a lot of time with each new patient. We deliberately will not run an assembly line. We don't have 100,000 patients, as some clinics boast. We have in the thousands.

RC: Does your office accept insurance?

NG: Insurance doesn't accept us. Not only are we alternative, but we're also very well-known. All the insurance companies know me, and they don't, by regulation, have to pay for alternative therapy, so the answer is that, generally, patients get nothing back. We're not an insurance-based practice at all. We tell patients up front, you're just going to have to pay for it, and if insurance gives you something, fine. Most of the time, it gives very little; often, it gives nothing. Sometimes, rarely, you have a kind insurance company, and they'll pay quite a bit, but that's rare.

RC: Patients taking 200 supplements a day—is this something also determined by your testing or is this mainly a standard protocol? It sounds like everyone gets the pancreatic enzymes.

NG: Most of the patients we see have advanced cancer, and those patients have got to be on about 100 enzymes a day. We would adjust the dose accordingly, but it's in that range. The protocols are all individualized, but a patient will be on a lot of supplements and a lot of enzymes. The enzymes are key, and they're pretty standard.

RC: If some practitioners are enticed—obviously, I am—by the quality of your enzymes and the work you've put into developing them and want them in their practice, is there any way that can happen?

NG: We're starting to think there should be. Again, I know all the things that have been said about me: I'm secretive, I'm paranoid, and all that stuff, keeping it a secret. The reason is that we were working with the NCI and the FDA and the NIH, trying to get this stuff accepted, so it would be available everywhere. And they did not want me commercializing my work, because we were going through this noble process of getting my work properly tested in a controlled clinical trial. Now that I realize it's just a lot of nonsense, we've realized those agencies are not my friends, and the alternative people are, and we are in the process of finding a way to make the enzymes available so it's not our little secret anymore. And we think it should be because we did it the right way: we went through the major grant; we did the NCI/Columbia/NIH clinical study that led nowhere; and now, they're not going to help us and we're not going to let them get away with it. And, in terms of my practice, we're going to start making the supplements available, making the enzymes available. We're in the process of doing that right now.

RC: That's very exciting. I know that'll help a lot of patients. Do you take pancreatic enzymes as a preventive?

NG: I sure do. I've taken them since I met Kelly 26 years ago. I don't take a huge amount, but as I've gotten older, I take more. I probably take about 30 a day, maybe 25 a day. The reason it varies is that if I have a big meal, I'll take some extra enzymes, so it ranges between about 25-30 a day.
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RC: Do you take them with or away from meals?

NG: I take them with meals, generally. Now, when we treat cancer, we have patients take them away from meals, because then they're absorbed and they're not wasted digesting the food. In my case, I'm not a cancer patient. I take them with meals, and that will have a preventative effect. When you're trying to treat somebody aggressively, the enzymes should be taken away from meals.

RC: We've said not-nice things about soy. Are there any particular foods that you do like for everyone?

NG: First, a food should be organic. No one should eat white sugar, white flour, white bread, etc. We have different diets, so for a meat-eater, they've got to eat fatty red meat, organic. For vegetarians: fruits, vegetables, nuts, seeds, and grains. Is there a universal food? No. The Eskimos up in the Arctic circle, the traditional Eskimos, never ate fruits and vegetables or grains. In the Arctic circle, there's no growing season. All they had was fatty meat, and they lived on an 80% fat diet and were among the healthiest people ever to be documented. When they went into the towns and cities and ate less fat, they all collapsed and had epidemic diabetes, heart disease, and cancer. So it depends on the type. The traditional Maasai lived on 70% raw milk. The average Maasai guy would drink two gallons of raw milk a day, and again, they were among the healthiest people on earth. I wouldn't want to drink two gallons a day of milk, but they did. They lived on blood and milk. And there were vegetarian groups that really thrived on that kind of diet. So really, people are different. So I would never give an Eskimo a piece of fruit, and I wouldn't give a Maasai a sandwich, and I wouldn't give a vegetarian hunter-gatherer a big fat piece of meat. They'd get sick on it. Everybody's different. What's the ideal food for an Eskimo is completely different than the ideal food for a Maasai, is a completely different food than the ideal food for a hunter-gatherer. You have to address people's anthropological cultural origins before you can figure out what would be the ideal food.

RC: If a practitioner wanted to intern with you, an MD or some other practitioner, would that ever be possible?

NG: While we were doing our lauded clinical trials, we were so good at it (it's really disgusting, eight years of my life I spent on this stuff), we just didn't have the time. We were so busy trying to figure out why this study was not going the way it should - why it wasn't being managed the way it should be. We just didn't have the time. Taking on somebody in the office is a lot of work, but, on the other hand, we realize that the only way this work is going to continue is if we get people interested who are really well-motivated. We did all the right things, and that didn't work. By right things - I mean that sarcastically - with the government authorities, etc.

Now, we know we have to start training people, along with making our supplements available, the enzymes, in particular. We want to start doing that, and we're open to any kind of legitimate suggestion from well-intentioned people, always with the caveat that we also run into people who think it would be great to spend an afternoon in Gonzalez's office on a Friday and, on Monday, start curing cancer and become a hero, write a book, and end up on Oprah. That kind of attitude we don't like. We want people who really want to spend their life helping patients, because dealing with cancer patients is hard work. These patients are sick; they're medically unstable. Friday nights, you've got to be available for them, because that can be the difference between life and death. These are really difficult management problems, and you have to be willing to put in that kind of time and effort. It's not for the weak of heart, that's for sure. But, in terms of interning, to answer your specific question, yes, we're open to that. The right people and the right circumstance. We're not trying to keep it our secret.

RC: Is there a book in the works?

NG: We are actually writing a series of books. That sounds megalomaniacal, but it started out as one book and evolved into seven different books. People are going to gag when they hear that. Well, there are reasons why there are different volumes. One is going to be a series of case reports, just a hundred case histories of appropriately diagnosed cancer with their case histories and their medical records redacted for privacy reasons, of course.

Another book is going to be, having been trained as an investigative reporter, the story of this clinical trial, and that's just about finished. We're just going to wait for the final report from the government, but that's an extraordinary story. To me, it's the purest example of how a scientific study can go wrong. Until the final report comes out, I can't use words like fraud. That would be inappropriate, and I'll end up getting sued, so I won't use the word fraud. What I can say is that it's going to be an extraordinary book. It's a book I never wanted to write, but it had to be written, so that's just about finished.

Then we're doing one that's just about finished, a technical book on how we use nutrients differently from anybody else, how we use them to manipulate the autonomic nervous system, why vegetarian patients need a completely different set of vitamins and minerals than the meat-eaters and the balanced people somewhere in between. We're doing all that, and that's going to be detailed. That's very technical, all referenced - i.e., the justification for using different diets, different supplements.

One other book is kind of the history of how I got involved, because people always ask how I met Kelly, just the way you started the conversation. How did you get interested in this? I was headed on a very research-oriented career. I expected to spend the rest of my life working at Sloan-Kettering under Dr. Good, the lauded president of Sloan-Kettering, etc. My whole life took a change. Sloan-Kettering, if they saw me, they'd probably call security and have me arrested. We talk about the story of how I met Kelly, some of Kelly's history - an interesting story of how he fought to keep this therapy alive.

One of the books has a whole section on Dr. Beard, who was an extraordinary, brilliant scientist, totally forgotten, who first suggested pancreatic enzymes have an anti-cancer effect. I talk about how he was absolutely correct in his thinking, biochemically and physiologically, a hundred years ago.

So, it ends up being seven volumes. One of them is my monograph of my investigation of Kelly which, 20 years ago, I couldn't get published. No one believed that nutrition could be useful to treat cancer. We just couldn't get it published, and now, of course, there's so much interest in our work, we'll be
able to do that. So most of these volumes are actually finished or in the process of being finished. It'll be a series. It's not like Winston Churchill with a 14-volume history of World War II. But it's a lot to tell, with the case history book and the history of Kelly and then the history of Beard and the science behind what we do, and we wanted to get it all out there, so if I get hit by a truck when I walk out of my office, it'll all be down there for good.

RC: Well, hopefully, that'll never happen. I'm also looking forward very much discussing [in the future], as I'm sure you will, the whole manipulation of the autonomic nervous system with nutrition.

NG: Yes, that's what I really enjoy doing, and one of the volumes I've written and that's really finished discusses that in detail. There's so much evidence from the scientific literature on how to use nutrients to manipulate the autonomic nervous system, so it really kind of confirms what Kelly did. We didn't get into that today in our conversation, but, as you know, that's an important part of our therapy and the real neurophysiological foundation of what we do.

RC: I think it's almost as though we've been hijacked by the electron microscope to just think about the mitochondria and the cellular machinery, which is all wonderful, but we've forgotten the big picture.

NG: Physiology is the big picture. You're right. Even the alternative world is so entranced by gene technology. Again, they're looking at the microscope, and we tend to look at the telescope where you consider the ecology and the anthropology and the cultural history and physiology and how physiology interacts with food. The physiology of an Eskimo is completely different than that of a hunter-gatherer. Eskimos cannot use carbohydrates efficiently. They don't have the enzymes, whereas hunter-gatherers do real well with carbohydrates. They have a completely different physiology, and you don't have to look at the gene to figure that out. You can really sort it out just by looking at the physiology. Actually, artistically it's more attractive, it's more interesting, and there's a real truth to it that's very profound.

RC: Dr. Gonzalez, thanks for taking time out today from your busy practice.

NG: Great. Thanks for having me again. It's been great talking. I probably said a lot more than I should have, but that's okay.

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