a logical healthy diet, exercise, and consider hormonal intervention such as the use of testosterone, nandrolone, oxandrolone, and other anabolic steroids.

The medical establishment didn’t like our message at first but found such success that they eventually embraced us and our message, because their patients were alive, energetic, happier, and healthier. Dr. Michael Gottlieb, who reported the first cases of HIV+ men in 1981 and practices HIV medicine in Los Angeles, will tell you good things about Nelson and me.

I also had been an HIV denialist in the early ’90s and worked with one of the denialist organizations until it stopped making sense. Afterward, I didn’t speak with anyone from that group until a couple of years ago; I was told that one of the two leaders had died at a young age, refusing to treat his HIV with medications. So goes it.

That all being said, I would condemn the support, promotion, and engagement of the HIV denialists in the natural-health medical community as a distraction from the real goal of helping people with HIV to survive and be healthy. In some cases I know, it is also simply part of a habit pattern within an effort to oppose mainstream medicine, rather than having solid scientific footage that might save lives and real-world experience that confirms their hypothesis by seeing what’s happening with real people who live with HIV. My feeling it that it’s bad for natural health care to be seen as embracing this rubbish. Some of my friends who have HIV and know it well look at this as just another example of how “nutty” natural health-care people can be. And, typically, those natural health-care proponents who embrace this notion do not work in the HIV world. Having little or no direct experience with it, how can they really know what’s going on?

Over the years I have seen maybe a dozen people die, people who listened to the denialists and didn’t address their HIV, when they had had the same chance of survival as others who did use mainstream antiviral medications along with CAM and are still alive and well today in 2009.

Please consider this when reading pro-HIV-denialist information. There are those of us long-term active natural-health proponents who disagree entirely with this notion and feel that it actually has done great harm to people with HIV who believe it and forgo appropriate treatment. Believing in it can be a death sentence.

Sincerely,
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Enhancing Chemotherapy Effectiveness with Simple Vitamin C? My Clinical Experiences

Generally it is not advised by the oncology community for patients with cancer to take any other form of treatment when they are receiving chemotherapy, for fear of a negative interaction. The rationale for this recommendation, particularly with vitamins, largely stems from fears of the antioxidant effect or from the very limited information published. A recent article published October 1, 2008, in the journal Cancer Research cast further doubt on this subject area to a point that even a senior scientist here at the B.C. Cancer Agency [regional public health authority] publicly discouraged patients to use vitamin C together with chemotherapy.

If I were an oncologist and trained only in conventional medicine, I could understand some of their concerns; in addition, one has only so much free time to personally investigate such subjects when dealing with cancer patients – I understand this as well. However, being a naturopathic physician, my training and expertise in the use of natural methods of healing, vitamins, and minerals, etc., is definitely much more involved and extensive than those of an oncologist or most other conventionally trained health-care providers – it’s one of my strengths, and so my understanding of the subject is much more entrenched.

Unfortunately, most people do not realize that the study in this article used a form of vitamin C that is not even used by consumers: dehydroascorbic acid; while for the good old ascorbic acid form of vitamin C that everyone uses with chemotherapy, there has been an overwhelming amount of positive research around the world. It is important to highlight that there already exist two research papers on humans (not in test tubes or mice like the one above) that studied the effects of oral vitamin C either with or without chemotherapy in with cancer patients, none of which show any evidence of interference! In addition, vitamin C by injection (an even stronger method) has also been used in people with cancer (again, not in test tubes or mice) along with select chemotherapy agents, and the preliminary findings demonstrate that the combination works quite well.

Throughout the years of helping patients with cancer, I have observed that some patients who were interested in using vitamin C to help fight their disease, in particular, pharmacological doses via intravenous injection, together with or alongside chemotherapy, often demonstrated very noteworthy responses. In fact, I have seen many cases wherein a patient is about to be removed from receiving a chemotherapy protocol because they showed signs that the tumor was unresponsive or becoming more resistant to treatment. As a consequence, the patient becomes a little more desperate and willing to try
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more unconventional approaches. The patient then begins to incorporate vitamin C into their treatment protocol and, from that point, begins to show impressive signs of tumor response (i.e., shrinking). I have seen this kind of effect in non-Hodgkin’s lymphoma as well. Moreover, I have seen when a patient has suffered serious side effects from a palliative chemotherapy combination cocktail, and so a single agent is used to provide a gentler level of treatment. The patient then decides to incorporate intravenous vitamin C alongside the chemotherapy agent (Adriamycin) and from that point begins to respond and shrink the tumor unlike never before – and to the surprise of the oncologist.

In the medical literature, I was interested to find evidence to support my observations in clinical practice that vitamin C incorporated with chemotherapy can make them synergize and work better (known as chemosensitizing) and/or help to overcome chemotherapy resistance. I found 23 research papers from around the world incorporating a selection of more standard chemotherapy agents used together with vitamin C and demonstrating just that! There was actually more using arsenic trioxide, an experimental chemotherapy medicine; however, this is not a common agent and so I did not include it in this analysis. There was one paper that demonstrated mixed effects (more on the positive side) depending on the cancer cell type used. There are also two papers on experiences using vitamin C by intravenous injection, and some of which together with chemotherapy demonstrated positive outcomes as well. The only negative research paper I found on this subject was the latest article above that has managed to get all the press. There are 2 more human studies, as previously mentioned, that used oral vitamin C either with or without chemotherapy; however, these trials did not demonstrate an effect either way (other than they are safe and help to decrease side effects of treatment); but this is not the basis for this letter.

In general, vitamin C together with chemotherapy medicines has been shown in the scientific journals to:
- reverse chemotherapy-resistant cancer cells
- increase the delivery of chemotherapy into cancer cells (helps overcome drug resistance)
- make the tumor cell membrane more permeable (enhanced drug delivery)
- stabilize p53 genes, increase Bax, decrease Bcl-2 and telomerase activity (decreases drug resistance)
- inhibit translocation of NF-kappaB and AP-1 (decreases drug resistance)
- inhibit Nrf2-mediated gene expression (decreases drug resistance)
- activate the MLH1, c-Abl, and p73 signalling cascade (enhanced drug killing effect).

Note: On its own, vitamin C – in particular by intravenous injection – also has chemotherapeutic effects and supportive properties for the rest of the body (unlike standard chemotherapy agents).
The researched chemotherapy agents used together with vitamin C showing a positive effect have included the following:
- arsenic trioxide
- cisplatinum (platinum-based)
- Cyclophosphamide (Cytoxan)
- Doxorubicin (Adriamycin)
- Dacarbazine (DTIC)
- Gemcitabine (Gemzar)
- Interferon-alpha 2b
- Imatinib (Gleevec)
- Mitomycin C
- Paclitaxel (Taxol)
- Etoposide
- 5-FU (fluorouracil)
- Tamoxifen
- Vincristine (Oncovin).

So you decide: 1 negative, 1 neutral, or 23 positive papers (researched independently around the world).

The above information tends to paint a very different picture of the potential therapeutic properties of vitamin C (ascorbic acid) as a means to improve the benefits of chemotherapy medicines, and vice versa; I have seen this to be true in my clinical experience. It is the classic saying: “is the cup half full or half empty?” Some of the positive data have even shown a lower chemotherapy dosage needed to produce the same effect of regular-strength chemotherapy (i.e., cisplatin) when vitamin C was added; more importantly, in the animal studies, subjects lived longer. Moreover, in cancer cells that were resistant to chemotherapy (Gleevec, Vincristine), the addition of vitamin C reversed that effect. What alarms me is that none of these articles were even mentioned or referenced in the recent negative article — science should be about objective reporting of the total evidence.

The fact that the recent negative trial used dehydroascorbic acid (a "rusted" form of vitamin C), which is not even used in the marketplace, sheds some light in explaining the findings. At the University of Kansas Medical Center, intravenous vitamin C is being studied together with chemotherapy for patients with ovarian cancer, and preliminary published case reports appear quite promising (in humans and not test tubes or mice). Other human clinical reports using vitamin C together with various chemotherapy agents again do not show a negative effect — but rather the exact opposite (and of course there are also my personal experiences). Moreover, some research has shown that patients with cancer have lower levels of vitamin C in their blood even though they consume more than noncancer patients — they appear to need more as well!

While I understand that most oncologists are hesitant about combining vitamins with chemotherapy medicines, the bulk of the evidence shows that there may a certain level of harm in their recommendation. It is everyone’s goal to improve the outcomes and quality of life in our patients; however, when being too restrictive, important tools or approaches can certainly be missed — the patient loses here.

The above information raises some serious questions about the more negative chemotherapy concerns that have been highlighted with respect to vitamin C — it’s a lot more complicated and involved! For example, some chemotherapy medicines also possess antioxidant activity and yet produce cancer-killing effects that do not hit the radar of concern (e.g., Etoposide, Oxaliplatin). Moreover, the majority of the medical community does not even realize that when vitamin C is used in high or pharmacological (intravenous) doses, it operates more like a prooxidative medicine, not an antioxidant, similar to some chemotherapy agents.

It is not my intention in this letter to place the patient in the middle of a medical debate, but rather to simply provide honest information so that they can make good decisions, with no regrets. I regularly see patients who are upset that they were never given this kind of information to begin with or could not discuss it in better detail — a "no" answer is not enough for some, and so this letter is for them.

I have found that while people believe that an either/or approach is the safer course of action in cancer care, a combination of both at some level often works even better if the patient chooses to do so — hence the term *integrative cancer care.*

The current negative article on vitamin C, using the dehydroascorbic acid form, should *not* be held in high regard. There exists an overwhelming amount of positive evidence to the contrary on using simple ascorbic acid — the way nature intended.

Walter Lemmo, ND

American Cancer Society, although others will always disagree. In further fact, an article by Sharon Begley titled “The Myth of Early Detection” appeared in the April 6, 2009, Newsweek, and “What’s Wrong with Cancer Tests” by Shannon Brownlee (and Heather Harris) appeared in the April 2009 Reader’s Digest.

Considerably more on the subject is furnished in A Physician’s Guide to Natural Health Products That Work (2nd ed.), by James A. Howenstine, MD, which was favorably reviewed in the April 2009 Townsend Letter. Thus, in a chapter on malignancies, Dr. Howenstine first notes that inflammation can damage the prostate gland and contribute to the development of prostate cancer (p. 393ff.). It is mentioned, moreover, that a prostate biopsy can cause cancer cells to enter the bloodstream (with the implication of metastasis). It is further mentioned that early in the course of prostate cancer, the patient will have low levels of testosterone and low PSA values. Increasing the testosterone levels will increase the PSA values, but this does not mean that the cancer is growing. A restoration of normal levels of progesterone, testosterone, and estradiol is recommended, as this heals prostate cancer by eliminating the hormone abnormalities.

(The term androgen is used for a class of male sex hormones, with so-called androgen deprivation therapy or ADT used against prostate cancer — but not viewed as a sure-fire, long-term cure. The disadvantages and side effects are reviewed by Alan R. Gaby, MD, in the December 2008 Townsend Letter. These include an “increased risk of fractures, diabetes, coronary heart disease, and myocardial infarction, not to mention the adverse effects of chemical or surgical castration on quality of life.” Proscar, or finasteride, is a low-level version used to reduce the size of the prostate gland.

Dr. Howenstine continues, whereby elevated PSA values occur in patients merely having an enlargement of the prostate gland (benign prostatic hypertrophy, or BPH), as well as in prostatitis and prostate cancer: “A surprisingly high percentage of patients have cancer with very low values of PSA (below 4), supporting the idea that low values of PSA are indicative of poor cellular energy secondary to low testosterone levels.” (Speaking of the inflammation or infection of the urinary system, a routine test used is the quick-and-easy “paper” test, but which is not infallible, indicating also that a culture test be made — which if positive leads to an antibiotic. Thus the patient can insist that a culture test be performed — but which may require a change in doctors. Additionally, the routine blood test used to detect PSA-levels may also indicate a high white blood cell count — also indicative of infection. It was mentioned in Nick Lane’s book Oxygen that inflammation and oxidative stress can lead to cancer [p. 312].)

In the same chapter, Dr. Howenstine cites a number of therapies used against cancer. These include vitamin C or ascorbic acid, cesium, urea, lycopene, Laetrile, nortriptyline, and the Burzynski therapy, Coley’s toxins, and others — for which the reference may be consulted. Of special note is the treatment known as LifeOne Cancer Therapy, with the multiple ingredients specified. (A comment can be made that these are at least anticancer agents, but a complete cure does not necessarily follow.) Dr. Howenstine also offers anticancer diet regimens. Interestingly, he furnishes the following comment about chemotherapy (p. 421): In a survey of oncologists at a medical meeting, they were asked, “In the event you were found to have cancer, would you take chemotherapy?” Most responded no.

As to Coley’s toxins, first developed in the 1890s by prominent physician William Coley, MD, using heat-killed bacterial preparations; his daughter Helen Coley Nauts subsequently founded the Cancer Research Institute; and the successes are described in an article in the June 2004 Townsend Letter. (A notation is that it also acts against such vascular diseases as thromboangiitis