If we move from the general to the specific, in our experience all patients with pancreatic cancer fall into the sympathetic dominant category, and therefore, in our model, require a plant-based diet. Though for our practice we prescribe a variety of "vegetarian" diets depending on the patient's particular inherent level of sympathetic activity (there is a continuum of both sympathetic and parasympathetic dominance), most pancreatic patients end up on what we call the "Moderate Vegetarian Diet." This program emphasizes and allows all plant foods, including unlimited vegetables, fruits, nuts, seeds and whole grains. We usually recommend at least a quart of freshly made vegetable juice a day, a good source of concentrated nutrients and enzymes in their raw, undamaged form. This particular diet does include animal protein in limited amounts, specifically eggs and organic whole milk yogurt daily, as well as lean fish such as sole twice a week but no more. We forbid entirely red meat and poultry, which would too strongly stimulate their already hyperactive SNS.

For all our patients, including those on the Moderate Vegetarian Metabolizer Diet, we always believe the cleaner the food the better, and believe that organic generally is best. We do not allow refined or junk food, such as white flour, white bread, white rice, white sugar in all its many incarnations, and synthetic or chemicalized food.

In terms of supplements, for those patients diagnosed with pancreatic cancer we invariably recommend significant amounts of magnesium, up to 1000 mgs a day, some potassium, chromium and manganese, lots of the parasympathetisizing B's such as thiamin, riboflavin and folate—but little of those nutrients such as calcium, zinc and B12 that would stimulate their already overactive SNS. We also recommend large numbers of our pancreatic enzyme product, taken in divided doses away from meals every few hours.

Case Reports: Six Patients with Pancreatic Cancer

Conventional medical journals often publish case reports, that is, descriptions of individual patients whose disease might have taken an unusual course in response to some new treatment. Such "anecdotal" evidence, as it is technically called, differs from a controlled clinical trial, in which different treatments are given to large groups of patients with a particular illness. In such studies, after a period of time, the researchers then tabulate and compare the results observed in each group. Some scientists stubbornly insist that only such rigorous exercises, pursued under the most stringent rules and regulations, can "prove" to everyone's satisfaction that a new treatment for a disease has any value. They often argue that case reports, these histories of individual patients, though perhaps interesting or entertaining, have little scientific merit.

But my mentor Dr. Good, one of the finest scientists of the 20th century and the most published author in the history of medicine, always insisted case reports, if properly written and carefully
documented, can teach us much about the potential of a new approach. In my own situation, when I first began to evaluate Kelley's records, Dr. Good said that if I could find even one patient with appropriately diagnosed, biopsy proven metastatic adenocarcinoma who had lived five years under Kelley's care, he would be impressed, since no one else in medicine anywhere to his knowledge had such a case. Dr. Good's knowledge was indeed extensive, since he was at the time President of Sloan-Kettering and an expert in the disease. A single example might not prove to everyone's satisfaction that the enzyme therapy had value, but it certainly should grab the attention of any fair-minded researcher.

So case histories do have an important, if not definitive role, particularly when considering a deadly disease such as pancreatic cancer for which orthodox medicine can offer little. For example, in one of the major gemcitabine (Gemzar) studies published in 1997 that led to FDA approval, of 126 patients with inoperable or metastatic disease, only 18 percent lived one year and none lived beyond 19 months despite the use of intensive chemotherapy. With sobering data like this, Dr. Good's point should be well taken. Even today, a single patient with appropriately diagnosed inoperable or metastatic adenocarcinoma of the pancreas who lives five years, whatever the treatment and whoever did the treating, represents a rather unusual turn of events.

With these thoughts in mind, I present the following six cases of patients with biopsy proven, carefully documented pancreatic cancer. I have included five from our own private practice experience and one taken from my original Kelley study, all of whom have enjoyed very prolonged and unheard of survival, at times—but not always—accompanying significant disease regression documented by CT scans or other radiographic studies. I include the one "Kelley case" for its historical value, and one taken from my original Kelley study, all of whom have enjoyed very prolonged and unheard of survival, at times—but not always—accompanying significant disease regression documented by CT scans or other radiographic studies. I include the one "Kelley case" for its historical value, and one taken from my original Kelley study, all of whom have enjoyed very prolonged and unheard of survival, at times—but not always—accompanying significant disease regression documented by CT scans or other radiographic studies. I include the one "Kelley case" for its historical value, and one taken from my original Kelley study, all of whom have enjoyed very prolonged and unheard of survival, at times—but not always—accompanying significant disease regression documented by CT scans or other radiographic studies. I include the one "Kelley case" for its historical value, and one taken from my original Kelley study, all of whom have enjoyed very prolonged and unheard of survival, at times—but not always—accompanying significant disease regression documented by CT scans or other radiographic studies. I include the one "Kelley case" for its historical value, and one taken from my original Kelley study, all of whom have enjoyed very prolonged and unheard of survival, at times—but not always—accompanying significant disease regression documented by CT scans or other radiographic studies. I include the one "Kelley case" for its historical value, and one taken from my original Kelley study, all of whom have enjoyed very prolonged and unheard of survival, at times—but not always—accompanying significant disease regression documented by CT scans or other radiographic studies. I include the one "Kelley case" for its historical value, and one taken from my original Kelley study, all of whom have enjoyed very prolonged and unheard of survival, at times—but not always—accompanying significant disease regression documented by CT scans or other radiographic studies. I include the one "Kelley case" for its historical value, and one taken from my original Kelley study, all of whom have enjoyed very prolonged and unheard of survival, at times—but not always—accompanying significant disease regression documented by CT scans or other radiographic studies. I include the one "Kelley case" for its historical value, and one taken from my original Kelley study, all of whom have enjoyed very prolonged and unheard of survival, at times—but not always—accompanying significant disease regression documented by CT scans or other radiographic studies. I include the one "Kelley case" for its historical value, and one taken from my original Kelley study, all of whom have enjoyed very prolonged and unheard of survival, at times—but not always—accompanying significant disease regression documented by CT scans or other radiographic studies. I include the one "Kelley case" for its historical value, and one taken from my original Kelley study, all of whom have enjoyed very prolonged and unheard of survival, at times—but not always—accompanying significant disease regression documented by CT scans or other radiographic studies. I include the one "Kelley case" for its historical value, and one taken from my original Kelley study, all of whom have enjoyed very prolonged and unheard of survival, at times—but not always—accompanying significant disease regression documented by CT scans or other radiographic studies. I include the one "Kelley case" for its historical value, and one taken from my original Kelley study, all of whom have enjoyed very prolonged and unheard of survival, at times—but not always—accomp
liver, and not the other way around. In either case, the prognosis was abysmal, since neither pancreatic nor lung cancer respond to standard therapies such as chemotherapy, and in either case patients face an average survival in the range of several months.

Because of his extensive disease at the time of diagnosis, his doctors told Patient #1 he had no more than two months to live, and that neither chemotherapy nor radiation could help. Instead of giving up and getting his affairs in order as the doctors suggested, he and his wife decided to take the situation into their own hands. They both began reading voraciously about cancer, and nutrition, and alternatives. He began ingesting large numbers of supplements, including vitamin C, vitamin E, even pancreatic enzymes after reading an article discussing our work. He also switched his eating habits to a largely plant-based, raw diet, and began juicing intensively, with his devoted wife’s help.

I first saw Patient #1 in December 1991, fifteen long years ago. Despite his dire situation, he wanted to live, trusted me implicitly, and proved to be a very determined and compliant patient. He seemed to have absolute faith that he could get well on my therapy, and the results, though gradual in coming, were gratifying. Within a year, his general health had improved substantially, and a CT scan of the abdomen done 18 months after his initial diagnosis showed virtually no change in any of the lesions. Technically, the cancer hadn’t improved, but it hadn’t advanced—and he was still alive.

After that set of scans Patient #1 told me he wanted no more testing, period. Since he had already long outlived his doctors’ dismal predictions, he figured he didn’t care what the scans might show and wouldn’t change his treatment anyway. So he happily continued his therapy, feeling grateful for each and every day, and went back to living. He resumed giving tours and lectures at a local art museum and he and his wife enjoyed their retirement for which they had long planned.

In 1997, after he had followed his nutritional protocol for over five years, and with some pleading from me—since I am at heart a scientist and wanted to know what was going on with him—he agreed to undergo radiographic studies. A CT of the abdomen from March 1997 showed two mildly enlarged adrenal glands and a very small, less than 1 cm (less than one half inch) mass in the dome of the liver. However, the other large liver lesions were gone. The radiologist in his report described the pancreas as normal—the previously documented large tumor had simply disappeared.

Then sixteen months later, in July of 1998, nearly seven years after his diagnosis, Patient #1 agreed at my urging once again to “suffer through,” as he said, another series of tests. This time, the radiologist wrote in his summary, “Reading the report from the 1993 study it sounded like the patient had obvious metastatic disease and the largest structure being a large porta hepatis and peripancreatic mass. No such masses are seen today. There is no adenopathy. The adrenals are prominent and there are two very small liver lesions that cannot be characterized because of their small size.”

Patient #1 did well until he drove his car off the side of a road in 2004. At 84 years old, he should not have been driving, but wouldn’t listen to me, or his wife about the issue. Unfortunately, he suffered near fatal injuries and required lengthy rehabilitation, followed by life in an assisted care facility. His wife, three years older, no longer able to care for herself at 87 years old, also entered an assisted care facility, where she and Patient #1 struggled to return to fighting shape. They subsequently moved around a number of times from rehab center to rehab center, and I had lost contact with both, despite repeated messages left, and letters sent. But I recently learned that he is still alive, now 15 years since his terminal diagnosis.

**Patient #2: A Ten-Year Survivor**

In terms of his past medical history, Patient #2 had undergone surgery for localized colon cancer in 1985, but received no radiation or chemotherapy for the disease. He thereafter did very well until he developed a large right neck mass about the size of a golf ball in October 1996, while vacationing out of the country. After returning to his home city in the Midwest, he underwent biopsy in December 1996, which revealed “adenocarcinoma”
ever, Patient #2 had learned of our treatment approach, and decided to proceed with us. I first saw him in our office in January 1997; thereafter, he proved to be a very compliant and determined patient. A follow-up MRI of the abdomen and pelvis in October 1997 revealed no evidence of cancer anywhere.

We usually recommend at least a quart of freshly made vegetable juice a day, a good source of concentrated nutrients and enzymes in their raw, undamaged form.

Today, nearly ten years after he started with us, he appears to be in excellent health, enjoying retirement, and free of his once life threatening cancer.

Patient #3: A Ten-Year Survivor
Patient #3 had been previously very healthy when he first developed chronic heartburn, gradual weight loss and persistent diarrhea throughout the summer of 1992. In August of that year, he became suddenly very weak and short of breath; his local doctor found him to be anemic, enough so that he had to be hospitalized for a transfusion. An endoscopy at the time showed multiple stomach ulcers, which were thought to be the source of the blood loss. Additional testing revealed elevated blood levels of the hormone gastrin, which stimulates hydrochloric acid secretion in the stomach—and which at times can be secreted in great excess by pancreatic tumors. However, despite extensive testing, his doctors could find no such lesion in the pancreas, so after prescribing Prilosec to block acid production, they sent the patient home.

On the medication he actually did fairly well, with no further bouts of severe anemia until October 1994, when his gastrin levels on routine blood testing were again elevated. This time around, a CT scan did show a 6 to 7 cm mass in the retroperitoneal area of the abdomen, the region in back of the stomach where the pancreas sits. After a series of delays, he underwent exploratory abdominal surgery in March of 1995 at a local hospital; unfortunately, his surgeon discovered a very large tumor extending throughout the entire pancreas that because of its size could not be removed. However, a second smaller tumor at the base of the liver was excised: this proved to be metastatic islet cell cancer presumably that had spread from the pancreas.

After recovering from surgery, Patient #3 decided to travel for a second opinion to the Mayo Clinic, where he was seen in March of 1996. He, like Patient #1 and Patient #2 proved to be a very determined, very grateful patient, who followed his nutritional regimen to the letter.

A little over a year later, in June of 1997, his local doctors sent him for a follow-up CT scan to check on his progress. This time, the radiologist reported “no significant change in the appearance of the patient’s pancreatic mass since previous examinations.” The tumor was still there, but no bigger.

For several years, since he felt so well, he avoided any testing until agreeing to another scan in September 2002. The official report stated “Normal CT scan of the abdomen.” The large tumor in his pancreas had simply gone away. A more recent scan was also completely clear, and today, ten years after beginning his nutritional therapy, Patient #3 continues on his program and continues doing well, enjoying a full and productive life.

Patient #4: A Six-Year Survivor
In November of 2000, Patient #4 first reported a gradual 25-pound weight loss to her physician. She was quickly referred for a CT scan of the abdomen, which showed a 3.4 cm mass in the head of the pancreas. A needle biopsy performed in February of 2001 confirmed a “Poorly differentiated adenocarcinoma, ductal type,” the most aggressive form of pancreatic cancer. The slides were also sent to the Mayo Clinic, where the consulting physicians agreed with the diagnosis.

Since the disease seemed localized to the pancreas, her physicians thought the tumor might be operable. She was urged to undergo extensive surgery, but the patient, who had already learned about our approach, decided the risks were too great, the potential benefits too meager, to warrant such an operation. Instead, in March of 2001, she consulted with Dr. Isaacs in our office. A month after she began her nutrition treatment, she underwent repeat CT scan testing, which revealed a 3.2 cm mass in the head of the pancreas, with no evidence of metastatic disease.

A follow-up CT scan performed in January 2002, some ten months after she began treatment with Dr. Isaacs, indicated a 3.0 x 3.0 cm mass in the head of the pancreas, somewhat smaller than noted in April 2001. The next CT scan in July 2003, after Patient #4 had followed her nutritional regimen for more than two years, showed a 3.1 x 2.6 cm mass in the head of the pancreas, and a CT scan not quite a year later revealed a 3 x 2.8 cm mass.

Patient #4, now a five and a half year survivor, is generally in excellent health, enjoying her life. In her case, the CT scans show perhaps some slight shrinkage in her tumor, but no spread. Given the aggressive nature of pancreatic adenocarcinoma, its tendency to metastasize and kill quickly, her course has truly been remarkable. We do find in our practice that though tumors can at times disappear, at times in some patients they seem to stabilize, for years at a time.

Patient #5: A Five and a Half-Year Survivor
Patient #5, with a long history of GERD (gastroesophageal reflux disease) decided in January of 2001 to undergo laparoscopic surgery for correction of what was presumed to be a simple hiatal hernia. However, during the procedure, his doctor, as the records state, discovered “multiple umbilicated, white, firm, and gritty tumors in both the right and left lobes of the liver,
apparently occupying approximately 50 percent of the volume of the liver." This, to say the least, is a lot of cancer.

A biopsy of one of the liver lesions confirmed "poorly differentiated metastatic carcinoma," with, as the pathology report describes, some "neuroendocrine differentiation." After surgery, a CT of the chest, abdomen, and pelvis revealed a large 6.5 x 3.7 cm mass in the tail of the pancreas, with diffuse hepatic metastases.

The patient subsequently met with an oncologist at a major Midwest academic center, who suggested aggressive chemotherapy with cisplatin and etoposide for 4 cycles. The oncologist admitted that even with chemotherapy, the disease would ultimately progress and prove deadly. Before agreeing to the treatment, in February of 2001 the patient traveled to Memorial Sloan-Kettering in New York for a second opinion. The doctors at Memorial reviewed the slides, confirmed a very aggressive pancreatic carcinoma and proposed the same chemotherapy protocol that had been previously recommended. The oncologist at Memorial said that unfortunately, even with aggressive treatment, Patient #5 might live at most two years. Chemotherapy, as he had been told before, might shrink his tumors and prolong his life, but would not be a long-term solution.

At that point, he was not yet aware of our approach, so with no apparent options, he agreed to begin a four-cycle course of chemotherapy in February 2001 administered by his local doctors in the Midwest. After his second cycle of chemotherapy, a CT scan in March 2001 did show response, with marked improvement in the numerous liver metastases and shrinkage in the pancreatic tail mass.

Patient #5 completed the first 3 cycles without much difficulty, but during the 4th cycle he became so ill the regimen had to be discontinued in April of 2001. At that time, after learning about our work, he decided to proceed with our treatment. I first saw him in my office in May 2001, a month after chemotherapy had been halted. He had no scans at that point, but a CT of the abdomen done October 2001, five months after he began his nutritional protocol, revealed a normal appearing pancreas with a single lesion in the liver. By that point, Patient #5, who proved very determined and very compliant, seemed to be improving in terms of his general health.

A CT of the abdomen in February 2002, 10 months after he had first come to our office, indicated multiple small lesions in the liver. I made several adjustments in his regimen, and repeat CT scans in October 2002 confirmed that all the liver tumors were gone. Follow up scans in March 2003 and June 2004 were also completely clear. He has now been following his nutritional regimen for five and a half years, is approaching six years from his original diagnosis of very advanced and very terminal pancreatic adenocarcinoma, and appears disease free.

Patient #6: A Twenty-Four-Year Kelley Survivor
I first learned of Patient #6 while reviewing the records of patients with pancreatic cancer treated by Dr. Kelley. I thought I would include her to illustrate the kind of successes uncovered in Dr. Kelley’s files, as I pursued my five-year study of his therapy.

In early 1980, Patient #6 first experienced occasional bouts of mid-abdominal pain that gradually worsened over a two-year period. Despite the symptoms, Patient #6 did not seek medical assistance until August 1982, when she was admitted to the local emergency room of her Midwest town with excruciating pain. When an ultrasound showed only gallstones, her doctors assumed she might be suffering from gallbladder disease, and proposed cholecystectomy.

Within days, she underwent exploratory surgery and removal of the gallbladder. However, the surgeon also discovered a pancreatic mass that had invaded into the surrounding tissues, as well as a single 1 cm tumor in the liver, which he biopsied. Due to the extent of disease, he made no attempt to excise the pancreatic tumor.

The liver specimen proved consistent with adenocarcinoma that had spread from a pancreatic primary. After recovering from surgery, Patient #6 met with an oncologist, who told her that although chemotherapy might prolong her life slightly, no treatment could cure her disease. He suggested she get her "affairs in order." In the official records, this physician wrote: "The patient’s prognosis is judged to be between 9 and 15 months at most."

After recovering from surgery, Patient #6 decided to seek out a second opinion at the Mayo Clinic in Rochester, Minnesota. When seen at Mayo in mid September, a CT scan revealed an enlarged pancreas, and blood studies indicate abnormal liver function tests. At the conclusion of his evaluation, the consulting oncologist wrote, in the official discharge summary:

"I had a long discussion with her regarding treatment for her cancer. At the present time I would favor simply observation since we know of no known treatment that will necessarily prolong her life. Since she is feeling well at the present time I did not feel justified in making her symptomatic from the side effects of chemotherapy."

Fortunately, Patient #6 learned of Dr. Kelley’s work from a local health food store owner, and shortly thereafter began treatment with him in December of 1982. She responded quickly, and within six months was back to working long days in the family business.

By the time I completed my Kelley study in 1987, Dr. Kelley had closed down his office and disappeared. After I started my own practice, I lost touch with Patient #6 until she referred a patient to me in the mid 1990s. At that time she was in excellent health twenty years out from diagnosis, still following her prescribed diet and still taking pancreatic enzymes. I heard recently that she is still alive, still active, and still enjoying her life, now 24 years from her original Mayo confirmed diagnosis of metastatic adenocarcinoma of the liver.

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