Complete Reversal of Stage IV Squamous Cell Carcinoma

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Alan Loader BHSc (Nat)

Helen Tyrrell B Physio

[redacted] Radiology

#1. 1/2

[redacted]

Patient : [redacted]

[redacted] 12 Aug 2009

CT NECK, CHEST, ABDOMEN AND PELVIS

Clinical notes:
Large mass floor of mouth, ? SCC.

Technique:
Oral and intravenous contrast enhanced examination.

Findings:
There is a large ill–defined heterogenous lobulated soft tissue mass seen in the floor of the mouth which appears to be arising from the left side. It measures up to 5cm in maximal sagittal diameter. It is not possible to obtain an accurate axial diameter as it is ill–defined. It involves the deep tissues of the floor of the mouth extending up to and possibly invading the platysma. Given it's location and appearance it may be a mass arising from the left sublingual gland and may represent a SCC though histological diagnosis is beyond the scope of CT.

There are no definite enlarged lymph nodes seen in the neck. No other soft tissue mass.

In the chest, there is no mediastinal or hilar lymph node enlargement. No pleural or pericardial effusion.
An 11mm sub pleural soft tissue nodule is seen in the right middle lobe anteriorly. A similar sized sub pleural soft tissue nodule is seen posterolaterally in the sub pleural space of the left lower lobe. A 6mm nodule is seen in the right lower lobe.

#1. 2/2

In the abdomen and pelvis, a 12mm hypodense area is seen in segment 2 of the liver. This is likely to be a cyst but this should be confirmed with ultrasound. The liver has an otherwise normal appearance. The kidneys, adrenal glands, pancreas and spleen have a normal appearance. No para-aortic or pelvic lymph node enlargement. No ascites. The bowel has a grossly normal CT appearances.

There is a 1.8cm sclerotic area in the left ilium adjacent to the left sacroiliac joint. No other focal bony lesion demonstrated.

Conclusion:

Large mass in the floor of the mouth which appears to be left sided and may be centered upon the left sublingual salivary gland. It's appearance are in keeping with an SCC. No

continued ...

[redacted]

Collected: 12/08/2009 12:00 AM **Notified by:** on 00/00/00
Reported: 12/08/2009 **Message:**

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[redacted]

HISTOPATHOLOGY REPORT

#2. 1/1

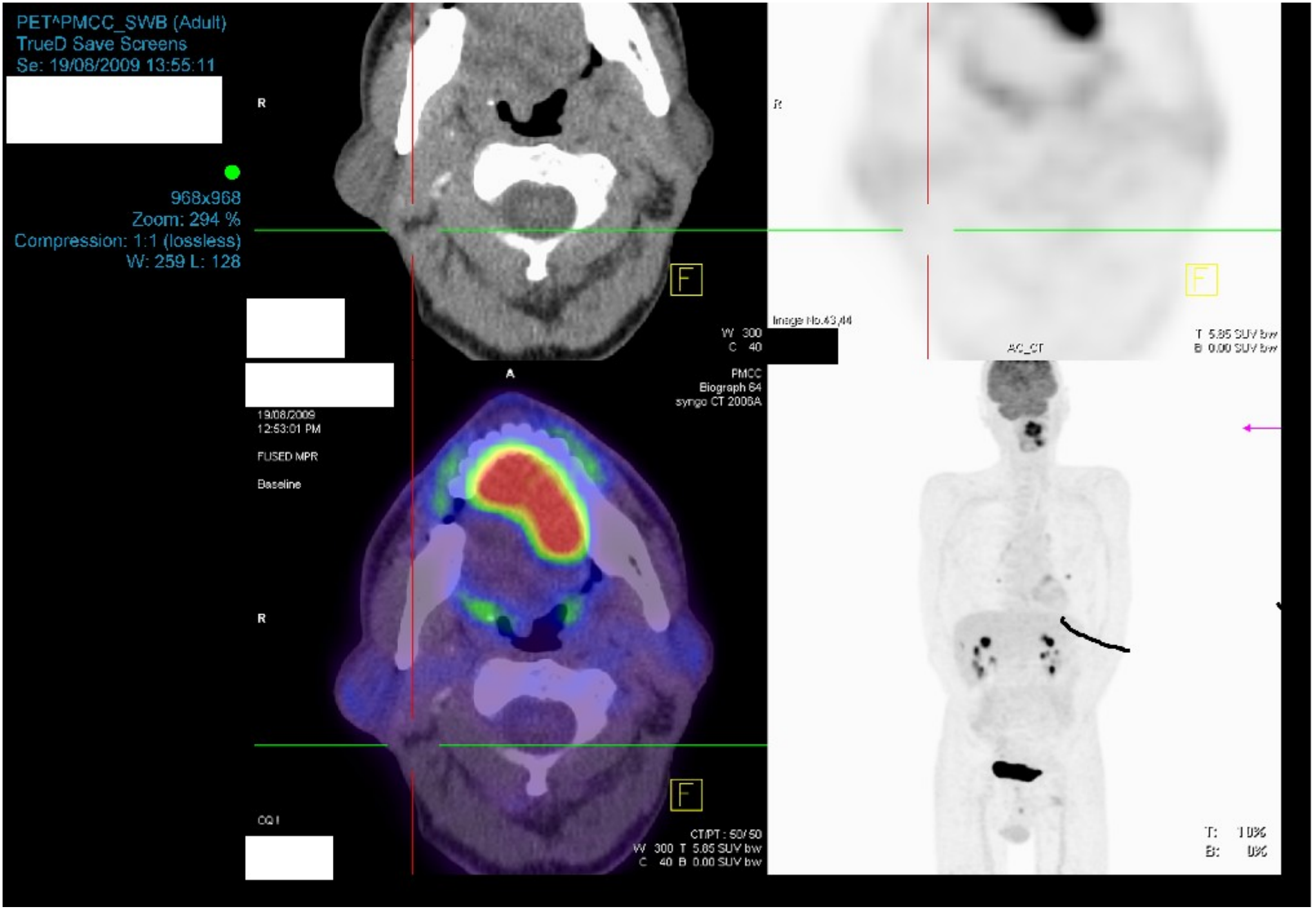
CLINICAL NOTES:
Fungating tumour floor of mouth - punch biopsy.

SPECIMEN:
Floor of mouth: A punch biopsy 2mm in diameter and 3mm in length. All processed. One block. (SNM/rs/

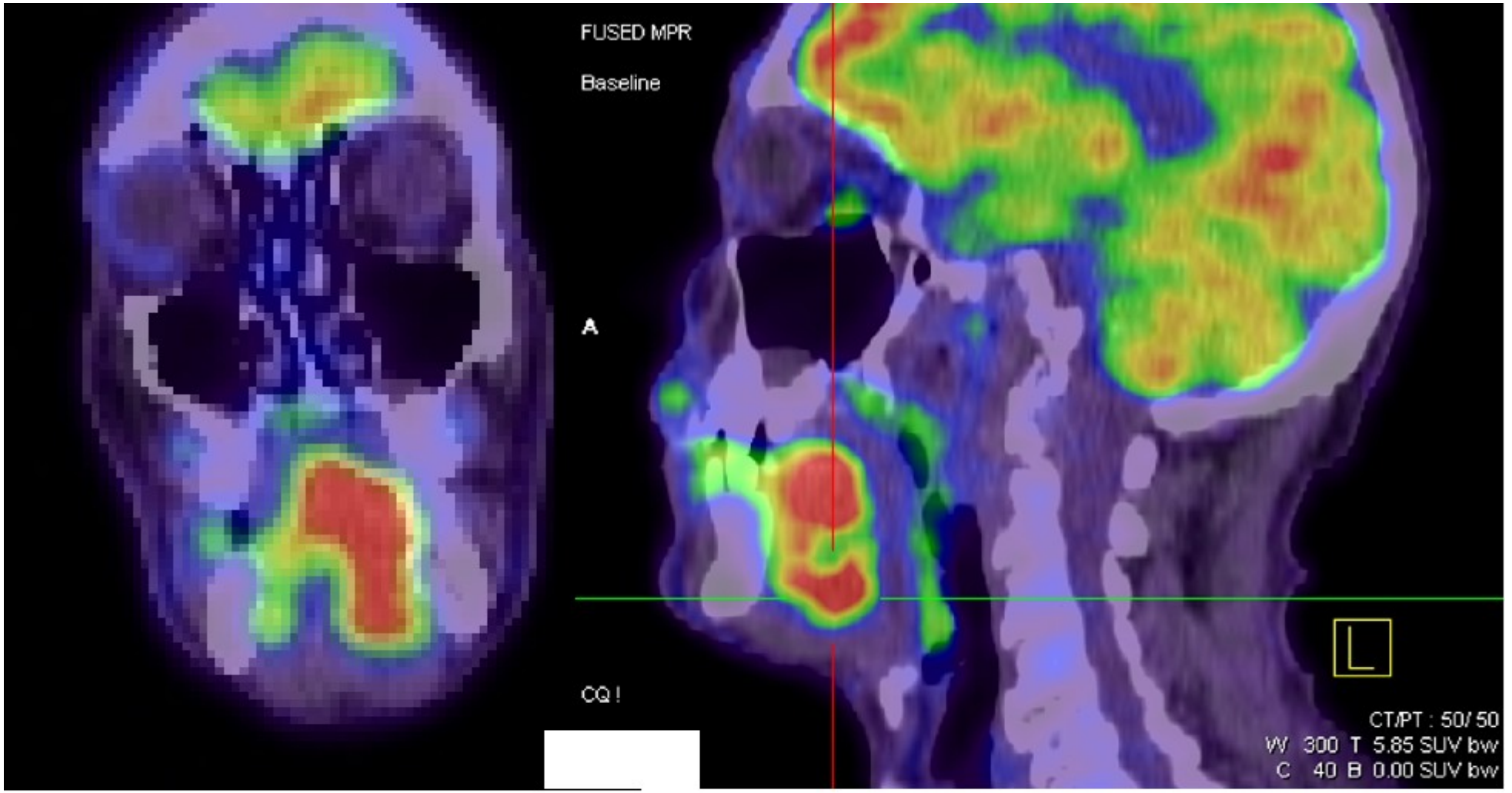
MICROSCOPY: Section shows squamous mucosa with invasive islands of moderately atypical squamous epithelium which infiltrate into the underlying connective tissue. The lesion extends to the base of the specimen.

CONCLUSION: Floor of mouth: Moderately differentiated squamous cell carcinoma.

[redacted]



AUGUST 19 2009



AUGUST 19 2009

[redacted]

#3. 1/1

Collected: 12/08/2009 - 10:00 AM **Notified by:** on 00/00/00
Reported: 12/08/2009 **Message:**

SERUM BIOCHEMISTRY

			Ref.Range	
Sodium :	138	mmol/L	(136-146)	
Potassium :	4.6	mmol/L	(3.5-5.0)	
Chloride :	100	mmol/L	(95-110)	
Bicarbonate :	28	mmol/L	(22-31)	
Urea :	2.3	mmol/L	(3.0-10.0)	**
Estimated GFR :	> 90	mL/min	(> 60)	
Creatinine :	58	umol/L	(60-110)	*
Total Bilirubin :	7	umol/L	(< 20)	
Ala. Aminotransferase (ALT) :	18	U/L	(< 35)	
Asp. Aminotransferase (AST) :	20	U/L	(< 35)	
Alkaline Phosphatase (ALP) :	54	U/L	(35-110)	
Gamma Glutamyl Trans. (GGT) :	13	U/L	(< 50)	
Total Protein :	83	g/L	(60-85)	
Albumin :	44	g/L	(36-48)	
Globulin :	39	g/L	(22-38)	*
Calcium :	2.51	mmol/L	(2.15-2.65)	
Cor. Calcium :	2.43	mmol/L	(2.15-2.65)	
Phosphate :	1.0	mmol/L	(0.8-1.4)	

Liver Function Test normal

[redacted]

Collected: 12/08/2009 - 12:08 PM **Notified by:** on 00/00/00
Reported: 12/08/2009 **Message:**

#4. 1/2

[redacted]

[redacted]

08/09/2009 (typed: 09/09/2009) [redacted]

Re: [redacted]

[redacted] was reviewed in the Head & Neck clinic today. He is [redacted] year old gentleman with a T4N0M1 moderately differentiated squamous cell carcinoma of the floor of mouth with lung metastases. He initially presented with a self detected lump and some associated discomfort under his tongue. He was investigated for this with a biopsy which revealed squamous cell carcinoma. Further investigations revealed a 5cm tumour in the floor of mouth. Staging investigations revealed bilateral pulmonary lesions. A subsequent PET scan demonstrated FDG uptake within the left side of the floor of mouth consistent with his known primary as well as two subpleural nodules; one in the left lobe and a second in the right middle lobe with increased FDG uptake as well as a further smaller 5mm nodule in the right lower lobe posteriorly consistent with multifocal pulmonary metastases.

He has lost approximately 5-6 kilograms in weight and has some dysarthria and a little bit of bleeding from the lesion in the floor of mouth. He does not have any pulmonary symptoms. His ECOG performance status is 1.

He has no significant past medical history of note. He is not on any medications. He [redacted]

#4. 2/2

Physical examination revealed a large tumour in the floor of mouth. There is no palpable cervical lymphadenopathy. Cardiovascular and respiratory examinations were within normal limits.

[redacted] case was discussed at the multidisciplinary meeting. Although VATS biopsy of one of his lung lesions had initially been concerned, the presence of multiple lesions with FDG uptake was indicative for metastatic and thus a VATS biopsy has been cancelled. [redacted] are relieved that this is the case. The options for subsequent treatment were discussed with him in particular the option of systemic treatment with Carboplatin and 5FU, given his metastatic disease. The specific side

[redacted]

#5. 1/2

[redacted]

[redacted]

[redacted]

10/02/2010 (typed: 11/02/2010)

[redacted]

RE: [redacted]

DIAGNOSIS: Stage IV squamous cell carcinoma of the floor of mouth with known lung metastases which has proved chemo-resistant to the Carboplatin and 5FU.

Thank you very much for your referral of [redacted] to our radiation oncology clinic. I had the pleasure of reviewing him today. As you know, [redacted] has an extensive SCC of the floor of his mouth which I understand initially had good response to chemotherapy but has now proved to be chemo-resistant.

His repeat staging CT scan performed on 4/2/10 showed progression of one of his lung nodules but no other metastatic disease.

I reviewed him with Dr [redacted] and we believe that palliative radiotherapy would be a reasonable next step for [redacted] in consideration of his progressive symptomatology. We intend to treat him with a regime of 36/12/5 to the floor of his mouth. We discussed this treatment in detail with [redacted] today explaining the purpose of the treatment as for symptomatic relief rather than cure and he understood this. We also discussed the possible side effects of the treatment in detail and we were able to allay some of his concerns regarding this. He agreed to have his simulation today and I understand he is seeing you later this afternoon for further discussion regarding his ongoing treatment.

Naturally, we will keep you informed of his progress throughout treatment.

Many thanks.

#5. 2/2

Yours sincerely,

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

31/03/2010

[redacted]

Dear [redacted]

Diagnosis: *Stage IV SCC of the floor of mouth (T4 N0 M1) with lung metastases, progressive disease after 5 cycles of Carboplatin/5FU*
Patient declined palliative radiotherapy

Management: *Review in 2 months*

#6. 1/2

Management: *Review in 2 months*

[redacted] was reviewed in our Medical Oncology Clinic on the 31st of March. As you know, he declined radiotherapy in the end and decided to go onto a cleansing diet and then high dose Vitamin C tablets. [redacted] tells me he would like to increase the dose of Vitamin C but is unable to take this orally and he has therefore been in touch with you about some Vitamin D injections. At this point in time he is not interested in trying any chemotherapy nor radiotherapy, and I have to say treatment options are limited and mainly for symptom benefit.

Physical examination revealed no peripheral lymphadenopathy, the tumour underneath the tongue is now filling the whole area along the teeth, it is quite irregular and dark, the remaining examination was unremarkable apart from [redacted] having lost further weight.

We will see [redacted] again in 2 months.

#6. 2/2

Yours sincerely

[redacted]

[redacted]

[redacted]

21/04/2010

[redacted]

#7. 1/2

[redacted]

Diagnosis: *Stage 4 SCC of floor of mouth with lung metastases, progressive disease of the primary after 5 cycles of Carboplatin/5FU*

Patient declined palliative radiotherapy in February 2010

Thank you for seeing [redacted] as discussed earlier on the phone today with regards to radiotherapy. As you know, he cancelled very last minute when everything was lined up for him in February of this year but since then the tumour has progressed quite rapidly and [redacted] can see the need for local treatment. As explained to him, I would like to keep chemotherapy for later on if we have to treat either a local recurrence once more or if his metastatic disease becomes bothersome. [redacted] now has increasing problems with eating and speaking. He is very well aware of his limited options and will need just a bit of gentle encouragement to overcome his fear of radiotherapy and the side effects, which have been painted in dramatic ways in the past to him.

Thank you again for seeing him, a tentative review appointment with me has been booked for the end of May.

Yours sincerely

[redacted]

[redacted]

[redacted]

dorevitch Pathology

Pathology Report

[redacted]

[redacted]

UR No: NA Dr Ref:

Patient: [redacted]

Address:

Postcode:

DoB: [redacted] Gender: M Age: [redacted] Years

Tests Requested: FBE,CRP

* = Tests Outstanding

Receipt date: 19/05/10

Collected: 19/05/10 @ 09:00

Printed: 20/05/10 @ 10:00

Doctor: [redacted]

[redacted]

HAEM

	Coll.Date: 12/08/09	19/05/10			Units	Ref.Range
	Coll.Time: 10:00	09:00				
Haemoglobin:	14.7	9.3	--	--	g/dL	(13.0-18.0)
WCC:	7.7	8.8	--	--	$x10^9/L$	(4.0-11.0)
Platelets:	307	611	--	--	$x10^9/L$	(150-450)
PCV:	43.6	29.9	--	--	%	(40.0-54.0)
RCC:	4.58	3.00	--	--	$x10^{12}/L$	(4.50-6.50)
MCV:	95	100	--	--	fL	(80-96)
MCH:	32.1	31.0	--	--	pg	(27.0-32.0)
MCHC:	33.7	31.1	--	--	g/dL	(32.0-36.0)
Neutrophils:	5.5	5.8	--	--	$x10^9/L$	(2.0-8.0)
Lymphocytes:	1.3	1.5	--	--	$x10^9/L$	(1.0-4.0)
Monocytes:	0.7	1.1	--	--	$x10^9/L$	(0.0-1.0)
Eosinophils:	0.2	0.4	--	--	$x10^9/L$	(0.0-0.5)
Basophils:	0.1	0.1	--	--	$x10^9/L$	(0.0-0.2)
ESR:	17	76	--	--	mm/hr	(0-15)

12/08/09 7556661 The ESR is mildly elevated.

19/05/10 1674179 Red cells: macrocytes+, rouleaux2+, White cells: show normal morphology Platelets: appear mildly increased. Progress report - patient with known Ca mouth. The ESR is moderately elevated.

Materials and Methods

Ca markers found by BDORT research

Quick and Non-Invasive Screening and Diagnosis of Cancer by Measuring Telomere, 8-OH-dG, Integrin a5b1, Acetylcholine, Hg etc and Safe & Effective Treatment of Cancer: Marked Decrease of the Telomere of Cancer Cell & Increase of the Normal Cell Telomere by Stimulating the Press Needle Inserted at 'True ST 36' and Effective Treatment & Longevity Effect of Selective Drug uptake enhancement method.
Omura Y.
6th Biennial International Symposium on the Bi-Digital O-Ring Test, Japan, 2004.

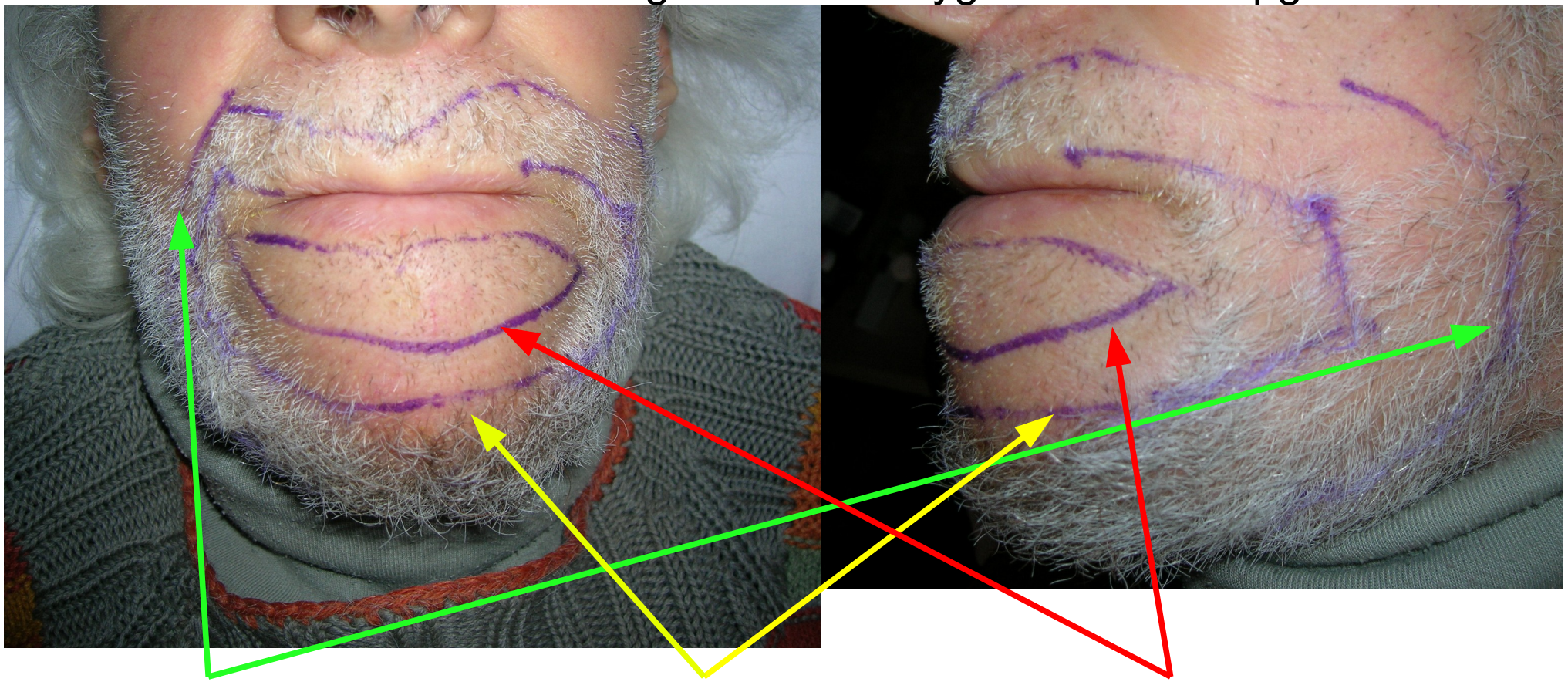
Research of Reference Control Substances Related to Increase or Decrease of Tumor Markers.
Ohki M, Nishimura M, Kawabata R, Shimotsuura Y.
13th Annual Meeting of Japan Bi-Digital O-Ring Test Medical Society, Japan 2003.

Ca markers found by BDORT research

[periodically expanded]

1) increase in Oncogene C-fos Ab2
2) increase in Integrin alpha5beta1
3) increase in mercury
4) decrease in Acetylcholine
5) increase in viral infection
6) decrease in Nitric Oxide
7) increase in Glucose (except some lung Ca)
8) increase in Telomere
9) increase in Cycline E
10) increase in KI 67
11) increase in 8-OH-dG
12) decrease in Folic Acid
13) increase in asbestos

Normal cell telomeres: <<10ng TTAGGG. 1yg <CCCTAA<1pg

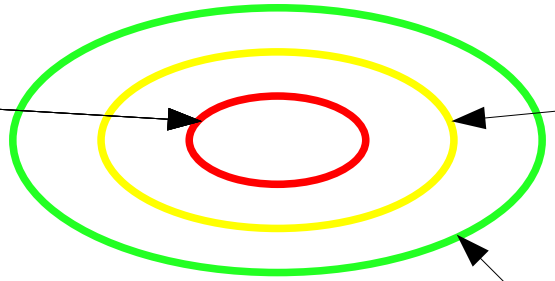


Border 'A'
Oncogene c-fosAb2: 600ng
Hg: 50mgU

Border 'B'
Integrin a5b1: 655ng
Hg: 210mgU
ACh: 1pg

Border 'C'
CCCTAA: 1700ng
TTTAGG: 1700ng
✱ HBVe: 1100ng
Asbestos: 15mg

Border 'C' contains parameters of borders 'B' and 'A'



Border 'B' contains parameters of border 'A'

'A'

Other GNOP normal

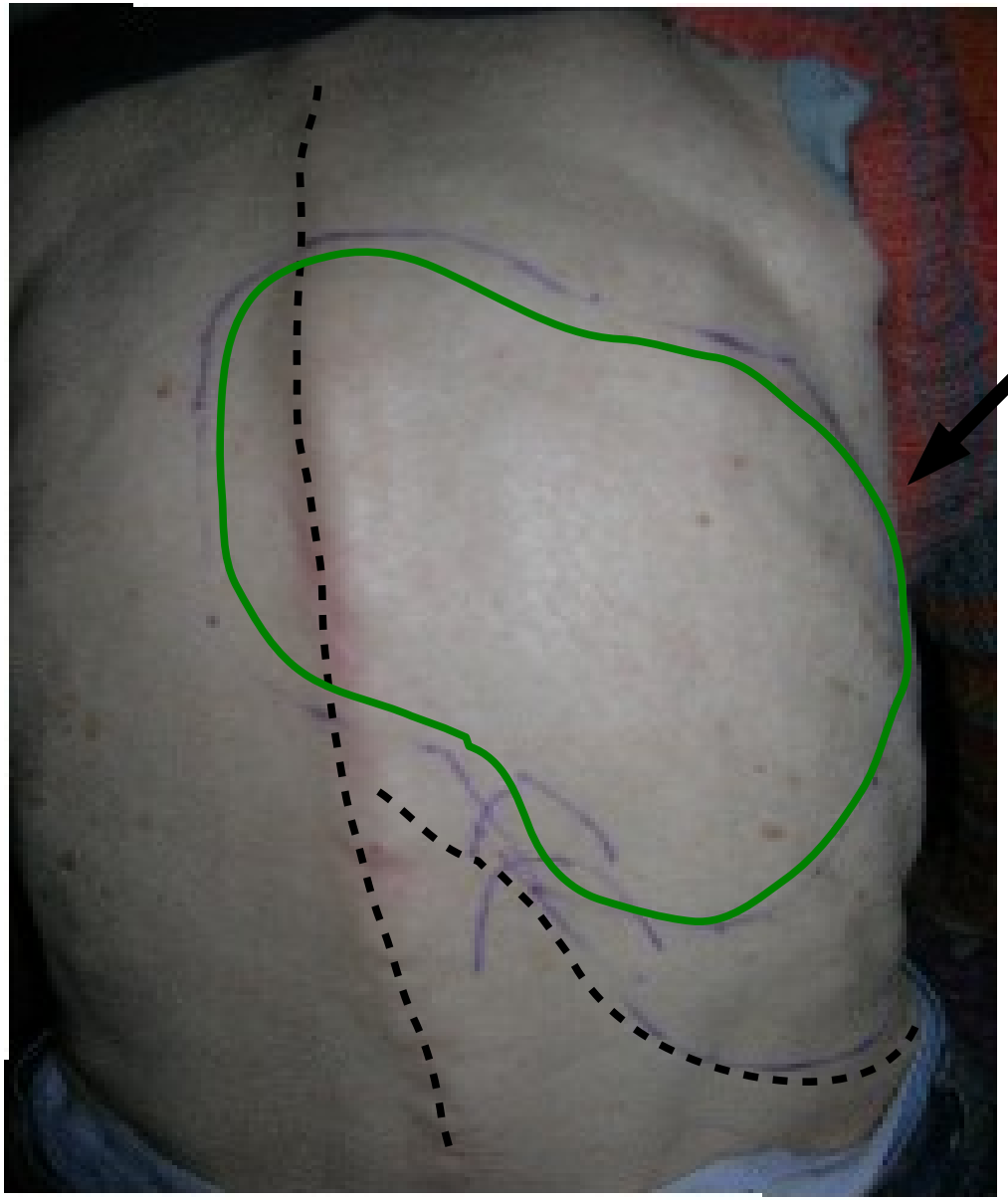
Date	MAY 25 2010	JUNE 08 2010	JUNE 22 2010	JULY 06 2010	AUG 10 2010
Liver (visceral)	**Liver (visceral)**	**Liver (visceral)**	**Liver (visceral)**	**Liver (visceral)**	**Liver (visceral)**
CCCTAA / TTTAGG	1600Ng / 1600ng	440ng / 440ng	680ng /690ng	840ng 850ng	950ng / 950ng
TXB2	>>1010ng	<1ng	<1ng	<1ng	<1ng
L-Homocysteine	??	7mg	0.1mg	0.1mg	0.1mg
Amyloid 'AA'	1000ng	1ng	1ng	1ng	1ng
TNF	1ng	1ng	1ng	700ng	1ng
HBVe/s	1000ng	400ng	200ng	<1ng	<<1ng
Anti-Prion	<<1ng	<<1ng	<<1ng	110ng. Bloodstream: 80ng	<1ng
Liver (anterior)	**Liver (anterior)**	**Liver (anterior)**	**Liver (anterior)**	**Liver (anterior)**	**Liver (anterior)**
TTAGGG	=normal cell TTAGGG	440ng	680ng	850ng	950ng
CCCTAA	=normal cell CCCTAA	440ng	690ng	840ng	950ng
	other GNOP normal	other GNOP normal	other GNOP normal	other GNOP normal	other GNOP normal
SCC (central border)	**SCC (central border)**	**SCC (central border)**	**SCC (central border)**	**SCC (central border)**	**SCC (central border)**
Asbestos	15mg	<0.05mg	<0.05mg	<0.05mg	<0.05mg
Hg	Hg 210mg	0.5mg	0.5mg	0.5mg	0.5mg
ACh	<1pg	1mg	1mg	1mg	1mg
Oncogene c-fos Ab2	600ng	1ng	1ng	3ng	<1ng
TXB2 / PLGF	↑↑↑ / ↑↑↑	1ng / 1ng	1ng / 1ng	1ng / 1ng	1ng / 1ng
Integrin a5b1	655ng	9ng	2ng	1ng	<1ng
HBVs/e	**1100ng**	<<1ng	<<1ng	<<1ng	<<1ng
CCCTAA	1700ng	440ng	680ng	840ng	950ng
TTAGGG	1700ng	440ng	690ng	850ng	950ng
p53	900ng	??	2ng	1ng	1ng
Glucose	GI ??	??	40mg	30mg	30mg
Size of original mass	100% (5cm)	50%	20-25%	10-15%	0%
Flaxseed dose	36 x 1000mg	36 x 1000mg	27 x 1000mg	Blood electrifier	none
Normal Cell TTTAGG	<<10ng	420ng	680ng	850ng	950ng
Normal Cell CCCTAA	1yg <CCCTAA<1pg	420ng	690ng	840ng	950ng

- **HBV detected in tumour - - - > liver examined and treated**

- **Tumour not treated directly**

Group of Normal Organ Parameters (GNOP)

BDORT Reference Control Substance (RCS) kit/parameter	Normal amounts
Oncogene c-fos Ab2	≤1ng
Integrin alpha5beta1	≤1ng
p53	≤1ng
ThromboxaneB2 (TXB2)	≤1ng
Placental growth factor (PLGF)	≤1ng
L-Homocysteine	≤100µg
Acetylcholine (ACh)	≥1mg
8-hydroxy-2'-deoxyguanosine (8OHdG)	≤1pg
Telomere '1' [TTAGGG]	= normal cell Telomere1: 400+ng
Telomere '2' [CCCTAA]	= normal cell Telomere2: 400+ng
Tumour necrosis factor (TNF)	≤1ng
Amyloid-'AA': **800G non-coated magnet bionorth(S) side to 1ng ß-Amyloid slide, held with other ß-Amyloid slide(s)** [only measured in liver]	≤1ng
Dehydroepiandrosterone (DHEA)	130ng
Noradrenaline	≤1µg
BDORT Function Test	+5/6
BDORT imaging: **size and complete outline of anterior, posterior, & right side**	normal imaging
Angiotensin 2	70ng [adult]
Angiotensin 1	40ng [adult]
B-type natriuretic peptide (BNP) [only measured in liver]	≤1ng
Lipoprotein(a) [only measured in liver]	≤1ng



BDORT liver imaging: 'enlarged' BDORT visceral surface

CCCTAA / TTTAGG	1600ng / 1600ng
TXB2	>>1010ng
Amyloid 'AA'	1000ng
TNF	1ng
HBVe/s	1000ng

- **Cilantro tincture**

Biodynamically grown and prepared. Preserved in ethanol. Alcohol evaporated in water before ingestion. BDORT pre-tested preparation as not all individually prepared batches are effective.

- **Chlorella 500mg tablets**

Non-organic toxin removal

- **Organic flaxseed oil**

1000mg in vegan capsules, or liquid.

Viral infection(s)

Selective Drug Uptake Enhancement Method (SDUEM)

US Patent: 609530. Omura Y. 1998

Used when ThromboxaneB2 (TXB2) is elevated in target area

Alternating Current Supplied Electrically Conductive Method and System for Treatment of Blood and/or Other Body Fluids and/or Synthetic Fluids with Electric Forces

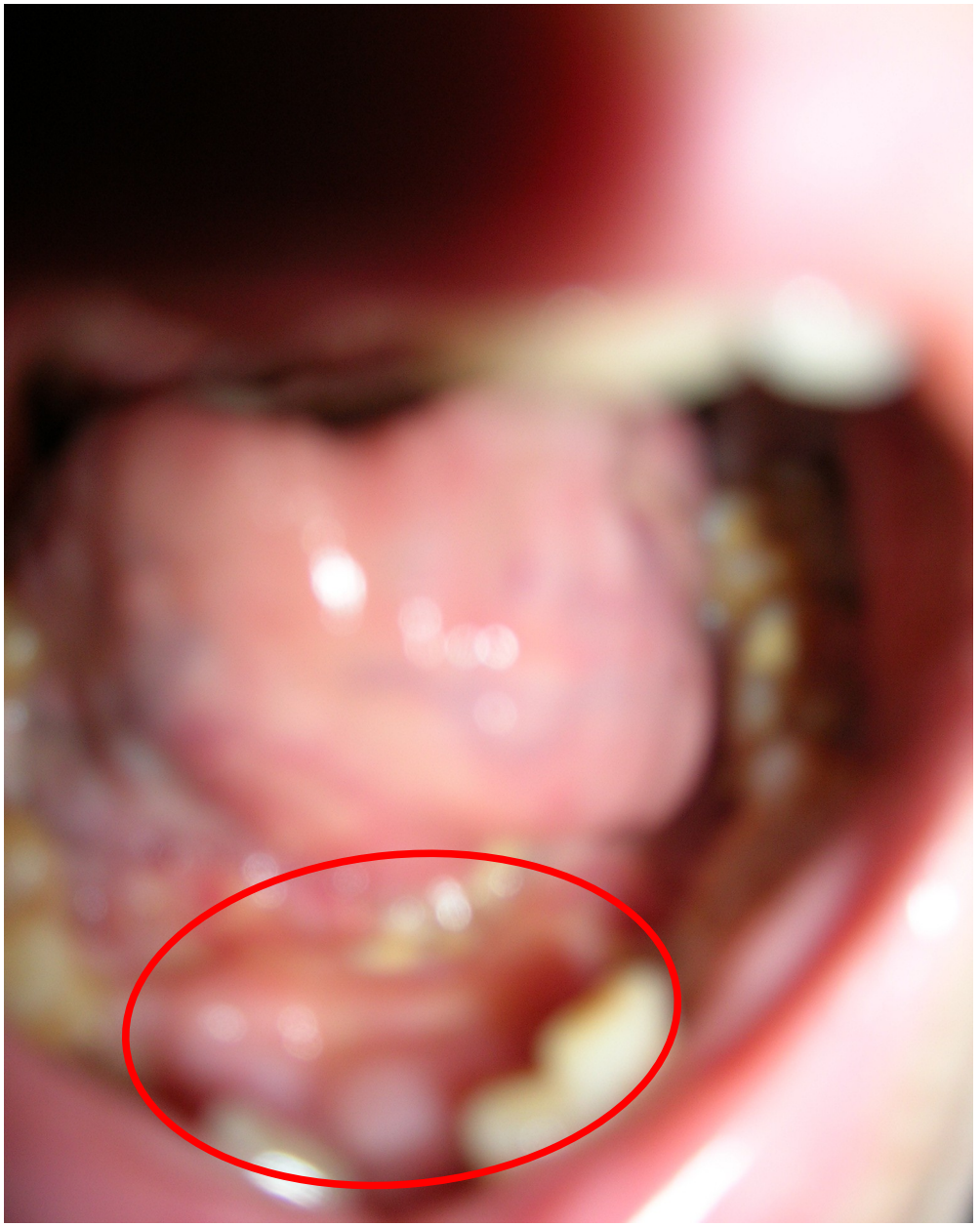
United States Patent 5188738. Publication date: 1993

Kaali S, Schwolsky PM. Albert Einstein College of Medicine, NY, USA.

- **Claims & Description:** To attenuate any bacteria, virus, parasites and/or fungus contained in the blood [] by the action of the electric current flow [] to render the bacteria, virus (including the AIDS HIV virus) [] ineffective for infecting a normally healthy human cell while not impairing and maintaining the biological usefulness of the fluids.

- **Experiment** performed: 50-100μA Direct Current applied to HIV-1 infected blood in vitro via platinum electrodes.

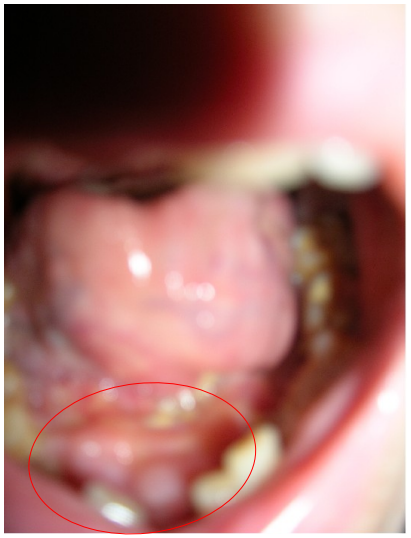
- **Results**: ability of HIV-1 to infect human T lymphoblastoid cells attenuated (amount of reverse transcriptase produced) inversely proportional to, **1**) increased current, or **2**) *lower current and increased duration of exposure time.*



After 2 weeks liver treatment

Patient report:
Able to talk freely again.
Able to eat freely again.
Appetite very good and gaining weight.

<u>JUNE 08 2010</u>: 50% reduction in size



JUNE 08 2010

Tumour:
X-Y laser scan border:
Integrin a5b1: 9ng
Oncogene c-fos AB2: 1ng
ACh: 1mg
Hg: 0.5mg
Asbestos: <0.05mg
BDORT -5
TXB2: 1ng
PLGF: 1ng
TTAGGG: 440ng
CCCTAA: 440ng
HBV(e): <<1ng
Pelvic area:
p53: 1ng
Integrin a5b1: 1ng
Oncogene c-fos AB2: 1ng

Normal cell telomeres:
TTAGGG: 440ng
CCCTAA: 440ng

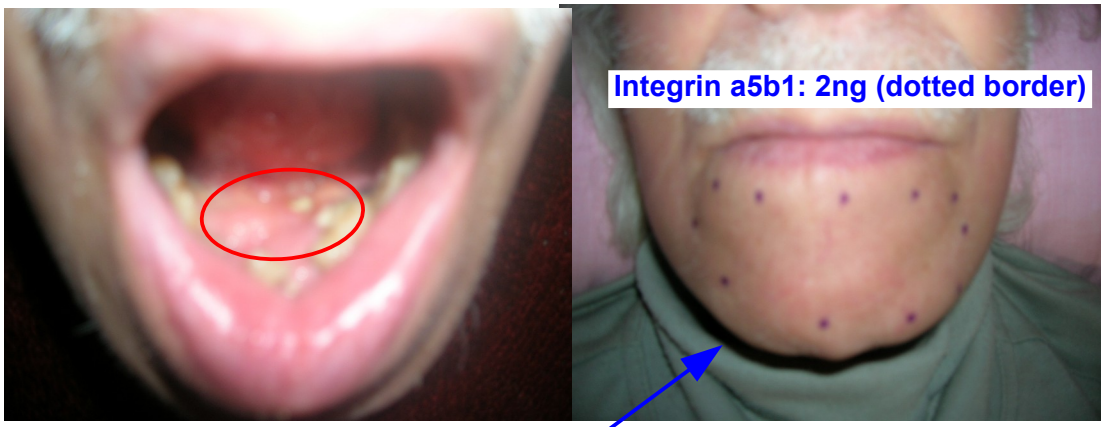
Liver
Amyloid-'AA': 1ng
TXB2: 1ng
Hg: 0.5mg
Asbestos: <0.05mg
L-homocysteine: 7mg
HBV: 400ng
HBVe: 400ng

After 4 weeks liver treatment

Patient report:

Talking freely. Eating solid foods normally.
Appetite very good.
Weight increasing.
Normal bowel movements.
Normal feeling inside mouth returning.
Energy good and increasing.
Very cheerful.

<u>JUNE 22 2010</u>: 75-80% reduction in size



JUNE 22 2010

Tumour:
Integrin a5b1: 2ng
Oncogene c-fos AB2: 1ng
p53: 2ng
ACh: 1mg
Hg: 0.5mg
Asbestos: <0.05mg
BDORT -5
TXB2: 1ng
PLGF: 1ng
ACh: 1mg
DHEA: 130ng
Glucose: 40mg
8OHdG: 1pg
TTAGGG: 690ng
CCCTAA: 680ng
HBV(e): <<1ng

Normal cell telomeres:
TTAGGG: 690ng
CCCTAA: 680ng
Normal cell glucose: 30mg

Liver
DHEA: 1pg
HBV: 200ng
HBVe: 200ng

BDORT measurements together indicate a cancer negative condition

After 6 weeks liver treatment

Patient report:
Feeling very well.
Functioning normally.
Weight increasing.
Very cheerful.

<u>JULY 06 2010</u>: 85-90% reduction in size

JULY 06 2010

Tumour:
Asbestos: <0.05mg
Hg: 0.5mg
ACh: 1mg
Oncogene c-fos AB2: 3ng
TXB2 / PLGF: 1ng / 1ng
Integrin a5b: 1ng
HBVe: <<1ng
HBVs: <<1ng
CCCTAA: 840ng
TTAGGG: 850ng
P53: 1ng
Glucose: 30mg

Normal cell telomeres:
CCCTAA: 840ng
TTAGGG: 850ng

Liver
CCCTAA: 840ng
TTAGGG: 850ng
TXB2: <1ng
L-Homocysteine: 0.1mg
Amyloid 'AA': 1ng
TNF: 700ng
HBVe/s: <1ng
PrP: 110ng (bloodstream: PrP: 80ng)
Other GNOP: normal amounts

SEPT 21 2010: NO TUMOUR

Date	MAY 25 2010	JUNE 08 2010	JUNE 22 2010	JULY 06 2010	AUG 10 2010
Liver (visceral)	**Liver (visceral)**	**Liver (visceral)**	**Liver (visceral)**	**Liver (visceral)**	**Liver (visceral)**
CCCTAA / TTTAGG	1600Ng / 1600ng	440ng / 440ng	680ng /690ng	840ng 850ng	950ng / 950ng
TXB2	>>1010ng	<1ng	<1ng	<1ng	<1ng
L-Homocysteine	??	7mg	0.1mg	0.1mg	0.1mg
Amyloid 'AA'	1000ng	1ng	1ng	1ng	1ng
TNF	1ng	1ng	1ng	700ng	1ng
HBVe/s	1000ng	400ng	200ng	<1ng	<<1ng
Anti-Prion	<<1ng	<<1ng	<<1ng	110ng. Bloodstream: 80ng	<1ng
Liver (anterior)	**Liver (anterior)**	**Liver (anterior)**	**Liver (anterior)**	**Liver (anterior)**	**Liver (anterior)**
TTAGGG	=normal cell TTAGGG	440ng	680ng	850ng	950ng
CCCTAA	=normal cell CCCTAA	440ng	690ng	840ng	950ng
	other GNOP normal	other GNOP normal	other GNOP normal	other GNOP normal	other GNOP normal
SCC (central border)	**SCC (central border)**	**SCC (central border)**	**SCC (central border)**	**SCC (central border)**	**SCC (central border)**
Asbestos	15mg	<0.05mg	<0.05mg	<0.05mg	<0.05mg
Hg	Hg 210mg	0.5mg	0.5mg	0.5mg	0.5mg
ACh	<1pg	1mg	1mg	1mg	1mg
Oncogene c-fos Ab2	600ng	1ng	1ng	3ng	<1ng
TXB2 / PLGF	↑↑↑ / ↑↑↑	1ng / 1ng	1ng / 1ng	1ng / 1ng	1ng / 1ng
Integrin a5b1	655ng	9ng	2ng	1ng	<1ng
HBVs/e	**1100ng**	<<1ng	<<1ng	<<1ng	<<1ng
CCCTAA	1700ng	440ng	680ng	840ng	950ng
TTAGGG	1700ng	440ng	690ng	850ng	950ng
p53	900ng	??	2ng	1ng	1ng
Glucose	GI ??	??	40mg	30mg	30mg
Size of original mass	100% (5cm)	50%	20-25%	10-15%	0%
Flaxseed dose	36 x 1000mg	36 x 1000mg	27 x 1000mg	Blood electrifier	none
Normal Cell TTTAGG	<<10ng	420ng	680ng	850ng	950ng
Normal Cell CCCTAA	1yg <CCCTAA<1pg	420ng	690ng	840ng	950ng

Patient: [redacted]
Subject: Ct Neck To Pelvis With Contras

DOB: [redacted]
Date: 08 Sep 2010

[redacted]

FINAL CT SCAN REPORT

SURGERY PATIENT ID NUMBER -

CT NECK, CHEST, ABDOMEN PELVIS

Clinical notes: metastatic carcinoma floor of mouth post chemoradiotherapy surveillance

#8. 1/2

Technique: Arterial phase chest, portal venous phase abdomen and pelvis with multiplanar reformats. Oral contrast was given.

Findings:
NECK:
Primary site: no definite mass seen. There is asymmetry of the oropharynx with the right lingual tonsil larger with focal calcification probably benign
Nodes: No lymphadenopathy seen.
Metastases: Destructive expansile mass of the anterior symphyseal mandible measures 19 x 27 mm (AP x TR).

Incidental findings: both carotid bulbs show calcified plaque causing 50% plus stenoses; both internal carotid arteries are patent

CHEST:
Nodes: No lymphadenopathy.
Metastases: innumerable pulmonary nodules have increased in size and number: for example, target lesion in the superior segment left lower lobe now 30 x 35 mm compared to 8 x 9 mm previously.

Pleural and pericardial spaces clear.

FINAL CT SCAN REPORT

ABDOMEN PELVIS:
Nodes: no lymphadenopathy seen
Metastases: no liver metastases seen. No significant ascites.
There is a sclerotic lesion in the left ilium which could either be a chondroid lesion or possibly metastasis. This is unchanged.

Incidental findings:
Bulky seminal vesicles. Extensive atherosclerotic calcification of the aorta without focal aneurysm patient. Renal calcifications are probably vascular

CONCLUSION:
Progressive pulmonary metastatic disease
Destructive mandibular lesion? Metastasis or direct extension from primary site

[redacted]

Copy to:
Ordered by:

[redacted]

#8. 2/2

#9. 1/1

Dorevitch PATHOLOGY

Pathology Report

RCPA

This document is issued in accordance with the NATA/RCPA

[redacted]

LAB NUMBER [redacted]

PATIENT: [redacted]

ADDRESS: [redacted]

DOB [redacted] M [redacted] Years Ph:

DOCTOR: [redacted]

BIOCHEMISTRY

SERUM BIOCHEMISTRY

			Ref. Range
Sodium	:	136	mmol/L (136-146)
Potassium	:	4.7	mmol/L (3.5-5.0)
Chloride	:	98	mmol/L (95-110)
Bicarbonate	:	30	mmol/L (22-31)
Urea	:	3.5	mmol/L (3.0-10.0)
Estimated GFR	:	> 90	mL/min (> 60)
Creatinine	:	58	umol/L (60-110)
Total Bilirubin	:	6	umol/L (< 20)
Ala. Aminotransferase (ALT)	:	15	U/L (< 35)
Asp. Aminotransferase (AST)	:	19	U/L (< 35)
Alkaline Phosphatase (ALP)	:	79	U/L (35-110)
Gamma Glutamyl Trans. (GGT)	:	9	U/L (< 50)
Total Protein	:	73	g/L (60-85)
Albumin	:	40	g/L (36-48)
Globulin	:	33	g/L (22-38)
Calcium	:	2.45	mmol/L (2.15-2.65)
Cor. Calcium	:	2.45	mmol/L (2.15-2.65)

NORMAL FILE

NOTES REQUIRED

RECALL PATIENT ☐ URGENT ☐ NON URGENT

Tests Requested: MBI,FBE

MBI

Collected: 13/10/10 00:00

Reported: 14/10/10 09:00

Authorised: [redacted]

Dorevitch PATHOLOGY

Pathology Report

RCPA

This document is issued in accordance with the NATA/RCPA

[redacted]

LAB NUMBER [redacted]

PATIENT: [redacted]

ADDRESS: [redacted]

DOB [redacted] M [redacted] Years Ph:

DOCTOR: [redacted]

HAEMATOLOGY

FULL BLOOD EXAMINATION

					(x10^9/L)
HB	:	13.7 g/dL	(13.0-18.0)	WHITE CELL COUNT	6.3 (4.0-11.0)
PCV	:	41.5 %	(40.0-54.0)	Neutrophils	61% 3.8 (2.0-8.0)
RCC	:	4.50 x10^{12}/L	(4.50-6.50)	Lymphocytes	20% 1.3 (1.0-4.0)
MCV	:	92 fL	(80-96)	Monocytes	12% 0.8 (0.0-1.0)
MCH	:	30.4 pg	(27.0-32.0)	Eosinophils	6% 0.4 (0.0-0.5)
MCHC	:	33.0 g/dL	(32.0-36.0)	Basophils	1% 0.1 (0.0-0.2)
				PLATELETS	349 (150-450)

COMMENT: Red cells, white cells and platelets are within normal limits.

NORMAL FILE

NOTES REQUIRED

RECALL PATIENT ☐ URGENT ☐ NON URGENT

Tests Requested: MBI,FBE

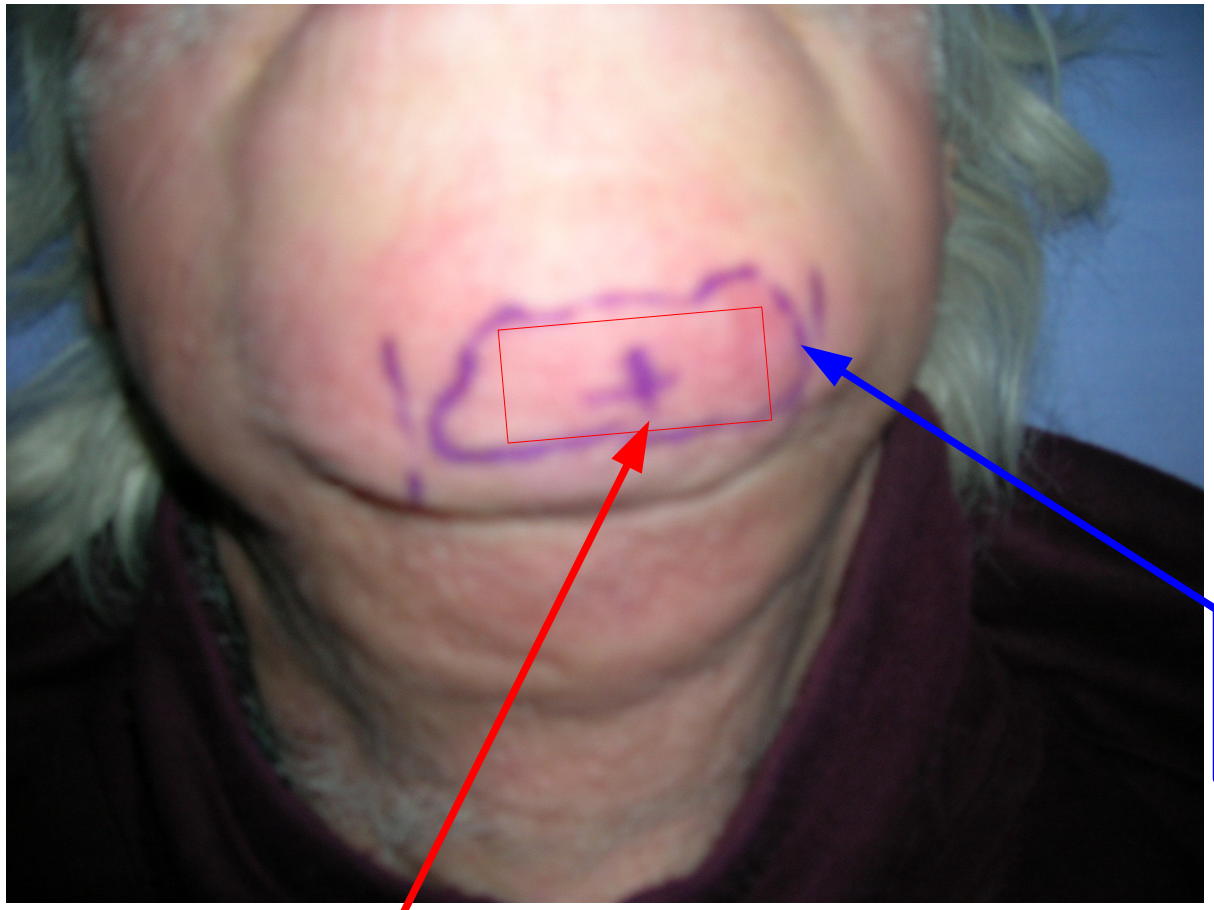
FBE

Collected: 13/10/10 00:00

Reported: 14/10/10 09:00

[redacted]

Secondary mandibular lesion found on CT scan examined by BDORT



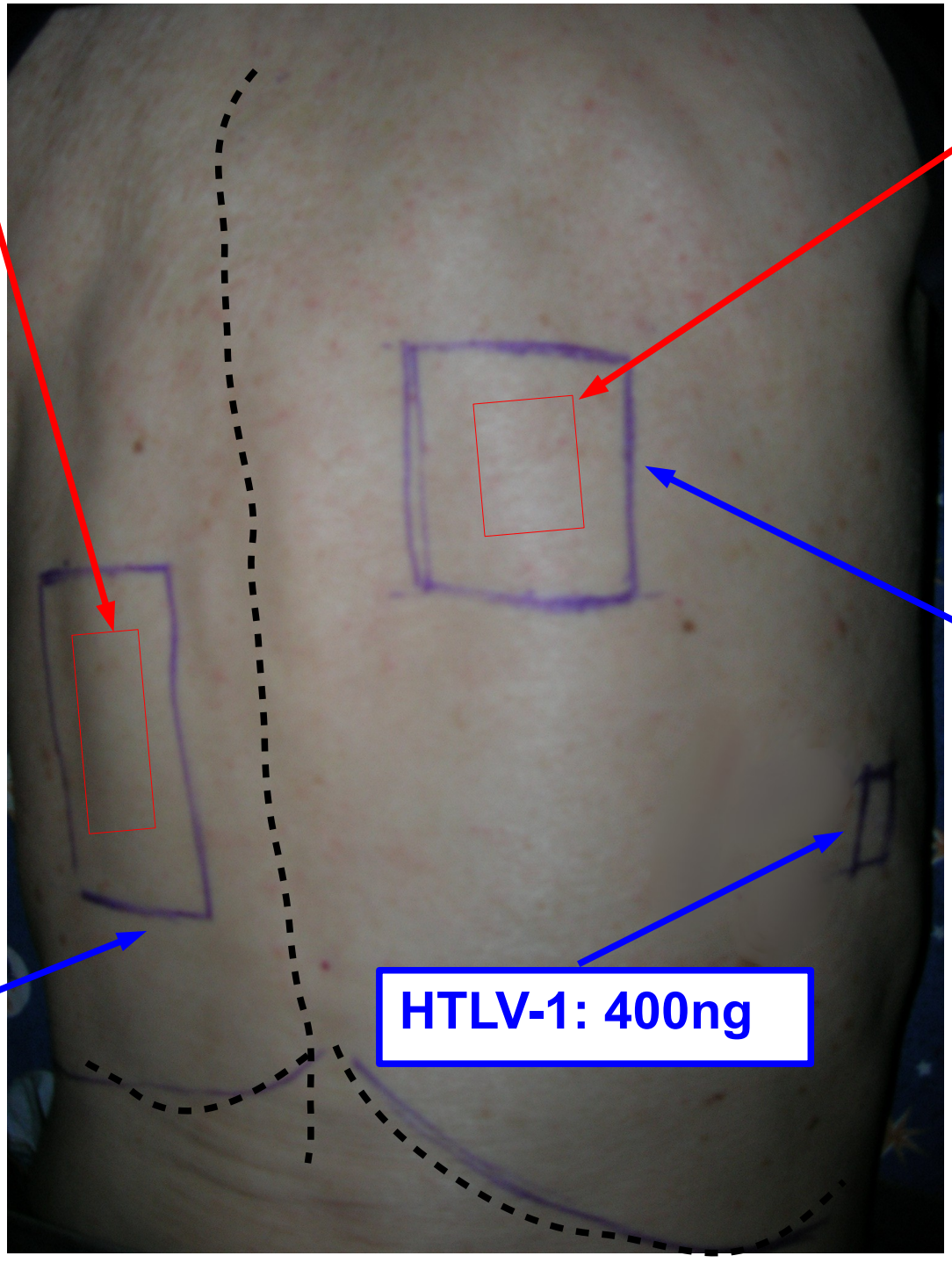
CT SCAN: *19mm x 27mm*

BDORT: border TXB2 1ng—›900ng
25mm x 35mm

HBV'e': 1000ng
HHV-8: 440ng

All other BDORT cancer parameters normal

Secondary pulmonary lesions found on CT scan examined by BDORT



CT SCAN:
30mm x 35mm

CT SCAN:
11mm nodule

HBV'e':
400ng

Border TXB2 1ng—›200ng
50mm x 45mm

HSV-11: 1000ng

Border TXB2:
1ng—›400ng
90mm x 50mm

HTLV-1: 400ng

All other BDORT cancer parameters normal

Viral infections diagnosed as 'malignancies'

Maeda K. “Diagnostic Dissociation between Modern Medical Technologies and BDORT Technique”. Acupuncture & Electro-Therapeutics Research, The International Journal, November 2006, VOL 31/3-4(301-301).

Maeda K. “Infectious Diseases Likely to be Diagnosed as Cancer Recurrence and their Treatment”. 13th Annual Meeting of Japan Bi-Digital O-Ring Test Medical Society, Tokyo, Japan 2003.

Madhusudhan K S, Gamanagatti S, Seith A, Hari S. “Pulmonary infections mimicking cancer: report of four cases ”. Singapore Medical Journal, 2007; 48(12).

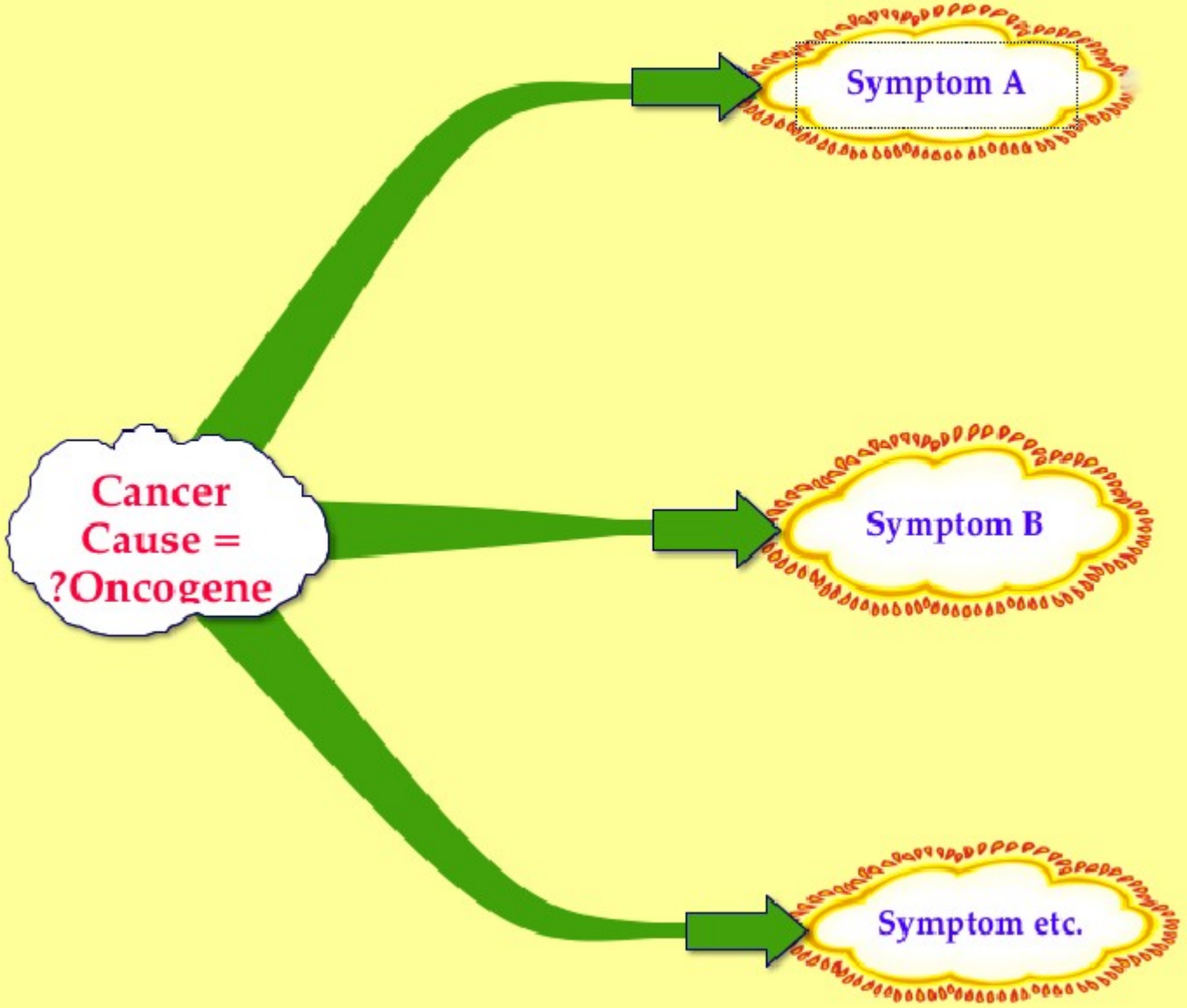
Florian H. Pilsczek. “Helminthic infections mimicking malignancy: a review of published case reports”. Journal of Infection in Developing Countries, 2010; 4(7):425-429.

David K. McGregor DK, Citron D, Shahab I. “Cryptococcal Infection of the Larynx Simulating Laryngeal Carcinoma ”. Southern Medical Journal, Jan 2003; Vol. 96(1):pp74-77.

Jack CM, Adwani A, Krishnan H. “Tattoo pigment in an axillary lymph node simulating metastatic malignant melanoma ”. International Seminars in Surgical Oncology 2005, 2:28. Creative Commons Open Access article.

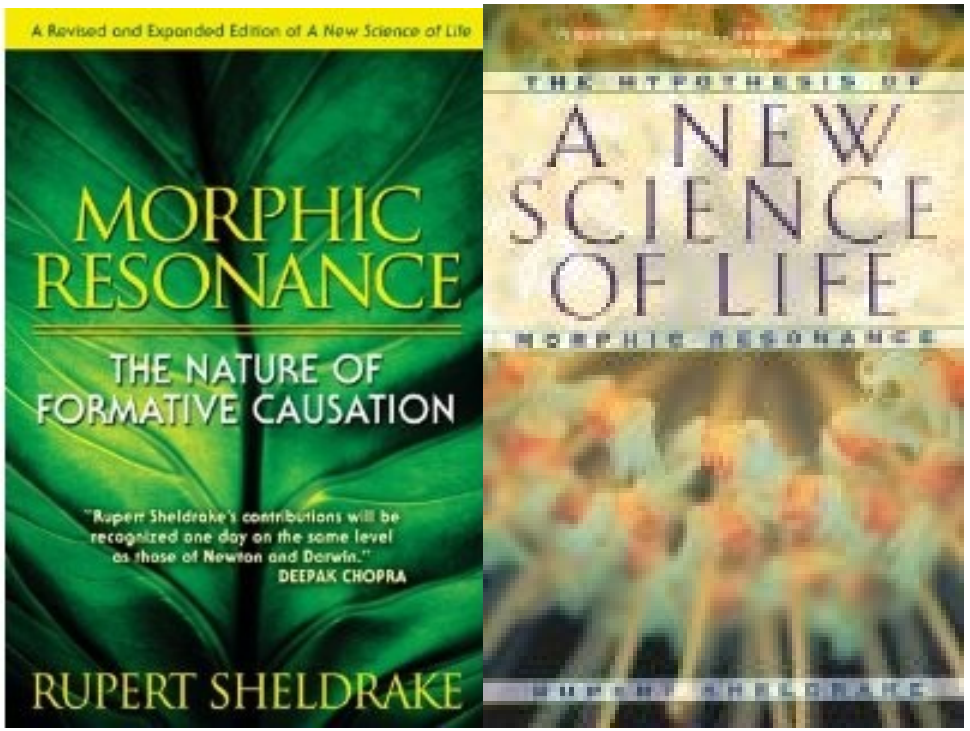
Mainstream Approach to Cancer Causation

(Focused on the symptoms and killing the cancer cells)



Understood BDORT Approach to Disease Causation

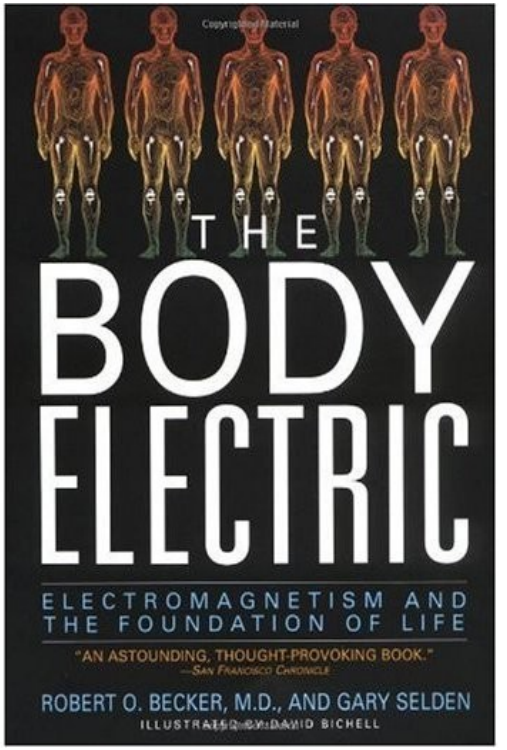
De-differentiation--->re-differentiation phenomena can be explained by a nested set of morphogenetic fields?



Rupert Sheldrake

Hypothesis of 'Formative Causation'

Proposed that biological organization depends on non-local morphogenetic fields: work by imposing patterns on otherwise random or indeterminate patterns of activity.



Robert O Becker

Seilern-Aspang F, Kratochwil K. “Induction and differentiation of an epithelial tumour in the newt (Triturus cristatus)”. Journal of Embryology & Experimental Morphology. 1962;10:337-356. PMID: 13992628.

Rose SM, wallingford HM. “Transformation of renal tumors of frogs to normal tissues in regenerating limbs of salamanders”. Science. 1948 May 7;107(2784):457, 1948. PMID: 18938459.

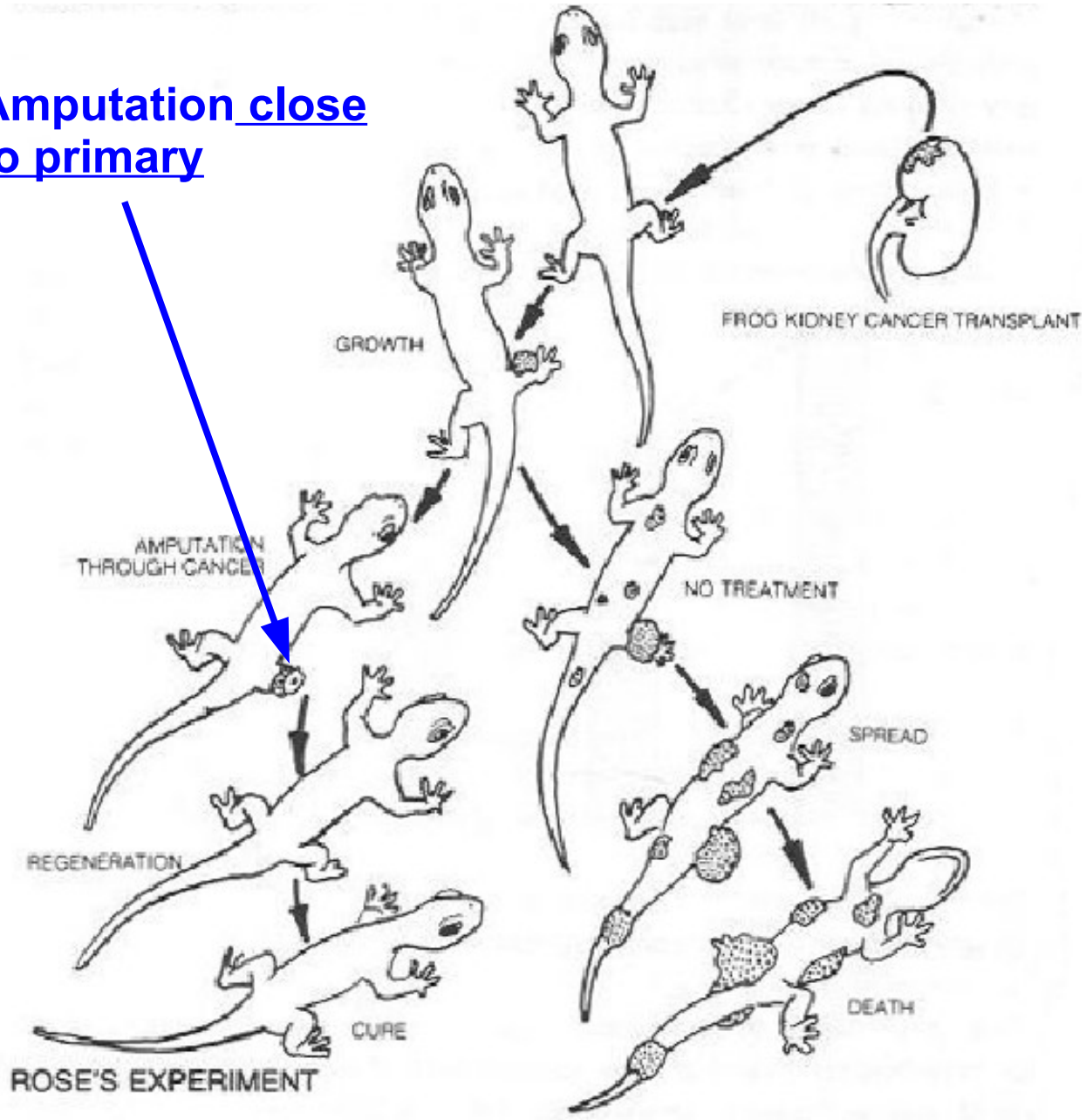
Seilern-Aspang F, Kratochwil K. “Experimental analysis of the controlling factors responsible for the proliferation of the epithelium and malignant epithelial tumours of Triturus". Arch Geschwulstforsch [Neoplasms]. 1963;21(2):113-37. PMID: 582686

Seilern-Aspang F, kratochwil K. “Experimental activation of the differentiation ability of malignant cells”. Wiener klinische Wochenschrift. Supplementum [Viennese clinical weekly revue]. 1963 May 10;75:337-46. PMID: 13992629.

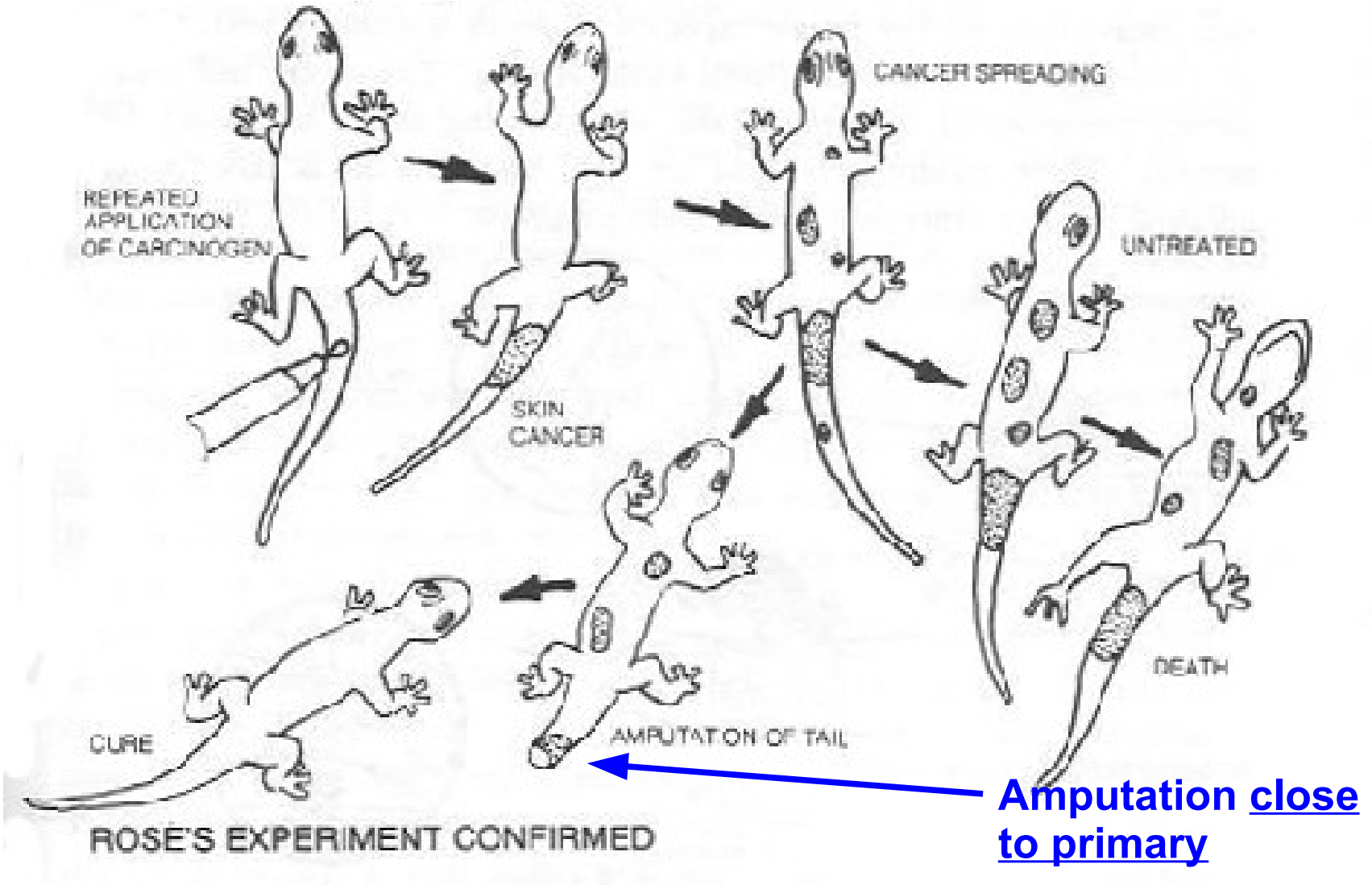
Pizzarello DJ, Wolsky A. “Carcinogenesis and regeneration in newts ”. Experientia. 1966 Jun 15;22(6):387-8. PMID: 5961676.

Becker RO, Seldon G. The Body Electric: Electromagnetism and the Foundation of Life. Morrow, 1985, pp155-156.

Amputation close to primary

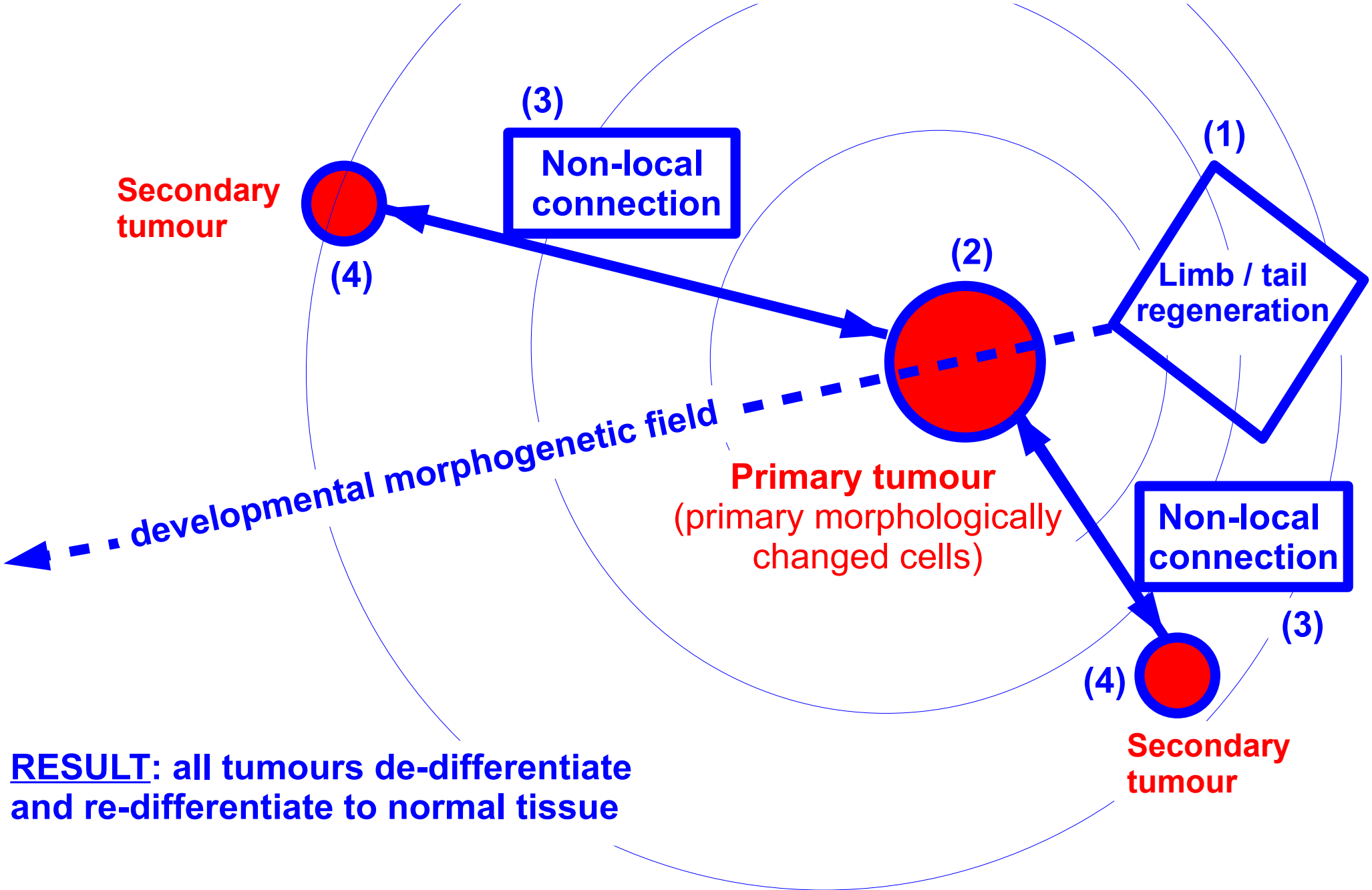


Amputation - - - > primary tumour de-differentiates and re-differentiates to normal tissue



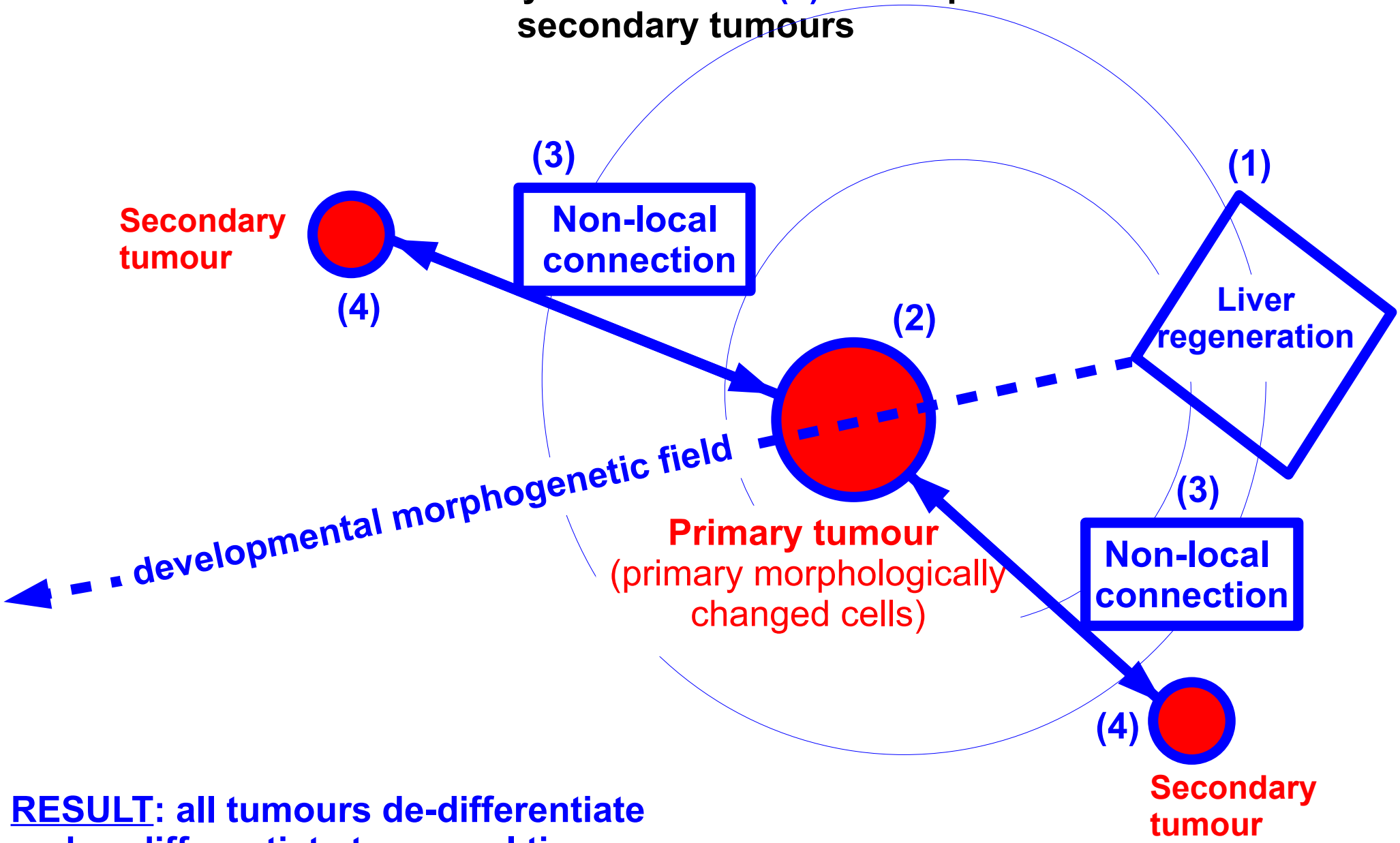
Amputation - - - > primary tumour and all metastases de-differentiate and re-differentiate to normal tissue

(1) Morphogenetic field of regenerating part ---> (2) local developmental effect on primary tumour ---> (3) primary tumour non-local morphogenetic connection with secondary tumours ---> (4) developmental effect on all secondary tumours



RESULT: all tumours de-differentiate and re-differentiate to normal tissue

(1) Morphogenetic field (strong) of liver ---> (2) non-local developmental effect on distant primary tumour---> (3) primary tumour non-local morphogenetic connection with secondary tumours ---> (4) developmental effect on all secondary tumours



<u>RESULT</u>: all tumours de-differentiate and re-differentiate to normal tissue

Comparison between stages of regeneration in salamander after amputation and recovering human liver from viral infection

Primary tumour to distant tumour connection in salamander after amputation	Liver to remote tumour connection in human after initiation of liver treatment
Presence and action of primary tumour	Non-necrotic, non-lysing morphological cytopathic effects in virally infected liver
Regeneration process is activated after amputation close to site of existing primary tumour: regeneration site close to primary tumour (primary pathology)	Mitotic phase regenerative process activated in the liver at the beginning and for the duration of treatments that remove non-organic toxins and inactivate viral infection(s): regeneration site overlaps with morphological cytopathic changes (primary pathology)
Increased cellular developmental information transmitted around site of limb regeneration de-differentiates and re-differentiates proximal primary tumour to normal tissue and secondary tumours to normal tissue via nested morphogenetic fields	Increased cellular developmental information involved in mitotic phase liver hyperplasia de-differentiates and re-differentiates distant primary tumour to normal tissue and secondary tumours to normal tissue via nested morphogenetic fields

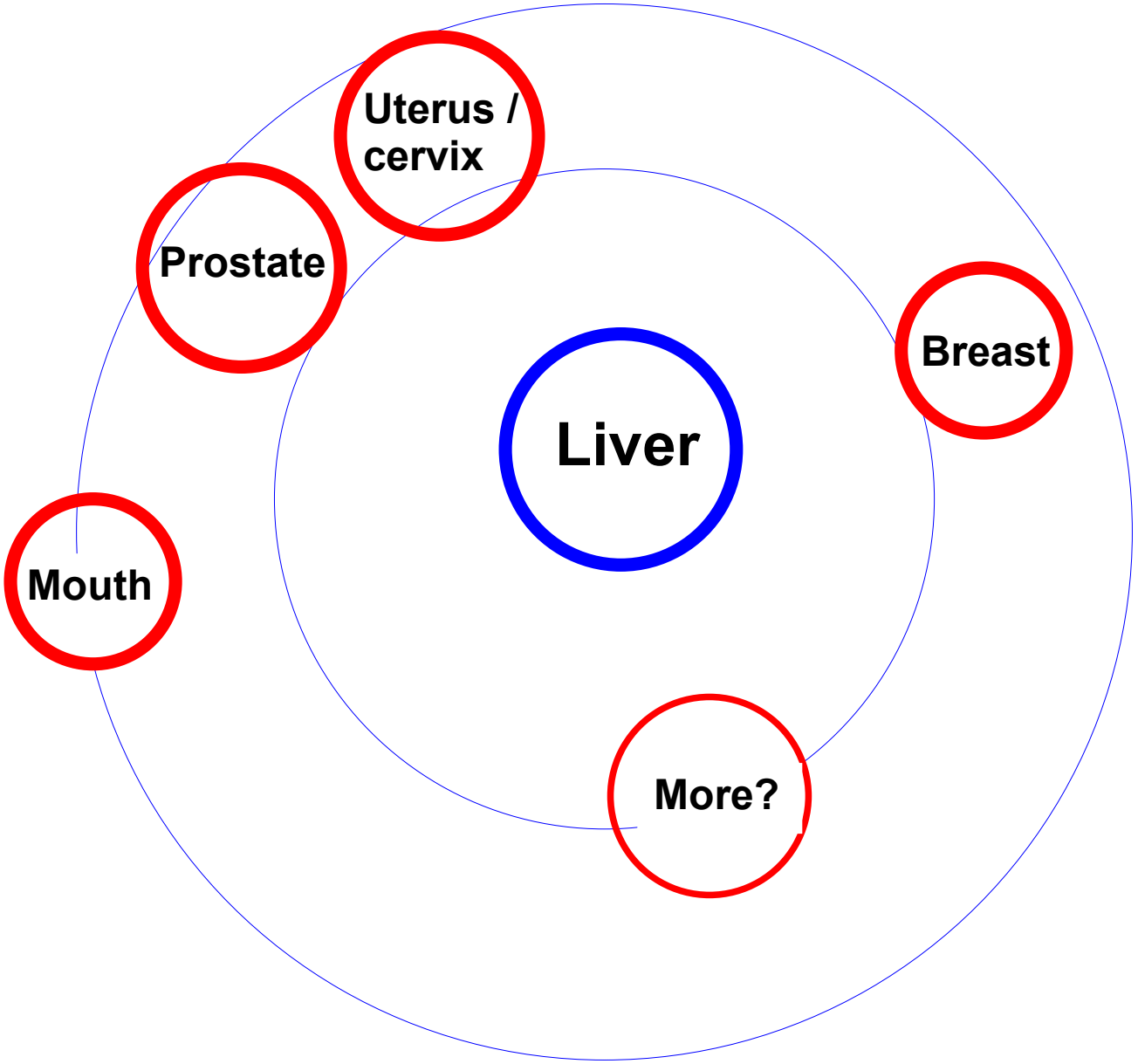
Classical Chinese medicine ideas about the liver

. . . the Liver ensures the "smooth flow of qi"? The Chinese words for this function literally mean "to flow" and "to let out". When Chinese texts explain this function they use such terms as "disperse", "extend", "loosen", "relax", "circulate"... [in that] the Liver ensures the smooth flow of qi throughout the body, in all organs and in all directions.

In health, Liver qi rises upwards and spreads in all directions to promote the smooth flow of qi in all parts of the body.
Maciocia, Giovanni (1989), The Foundations of Chinese Medicine. New York: Churchill Livingstone

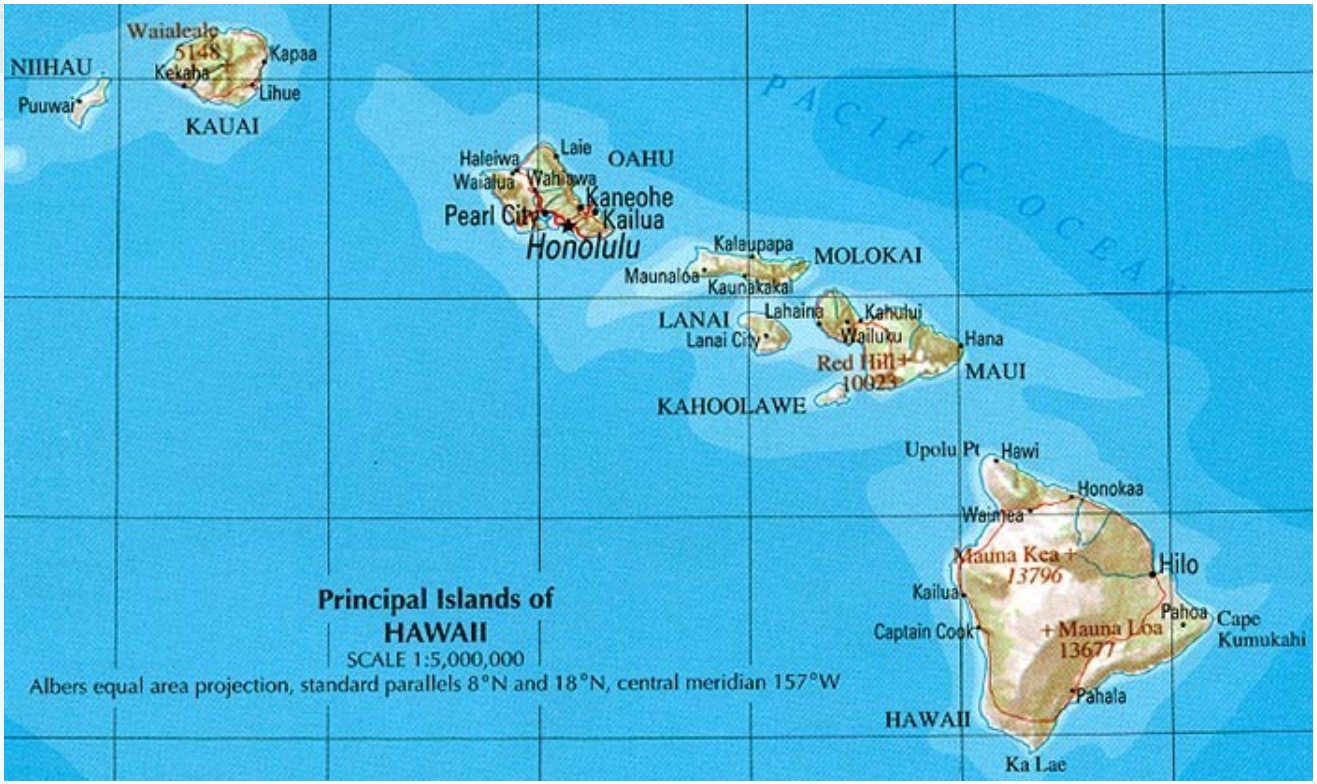
The Liver is a regulatory organ. (Simple Questions, p68)
The Yellow Emperor's Classic of Internal Medicine – Simple Questions (Huang Di Nei Jing Su Wen) (1979). Beijing: The People's Publishing House. First published c.100 BC

Liver ---> tumour connections found so far



Thank You


INDONESIA
Australia
INDIAN OCEAN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Kaneohe
Pearl City
Kailua
Honolulu
Kalaupapa
MOLOKAI
Maunaloa
Kaunakakai
LANAI
Lahaina
Kahului
Lanai City
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Waimea
Mauna Kea 13796
Hilo
Kailua
Pahoa
Cape Kumukahi
Captain Cook
Mauna Loa 13677
Pahala
HAWAII
Ka Lae
PACIFIC OCEAN
Principal Islands of HAWAII
SCALE 1:5,000,000
Albers equal area projection, standard parallels 8°N and 18°N, central meridian 157°W