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CANCER IS A FUNGUS

A Revolution in Tumor Therapy



EDIZIONI LAMPIS

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EDIZIONI LAMPIS

To my wife Beatrice
To my children Siro and Ginevra
To that endless river of Goodness
Which is always present
In the sorrow of life

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INTRODUCTION

The successes recorded by modern medicine in the last 100 years are unquestionably of great importance for the life of man, as medicine has acquired instruments to help him navigate effectively through the vast ocean of disease.

The organization of knowledge, the consciousness of public hygiene, health education, and the abundant use of scientific discoveries from other branches of science such as chemistry and physics are important factors that have allowed a milestone of quality to mark the end of the obscure medical practices of the past.

The relentless development of pharmacology and the evolution of surgical technology and sophisticated diagnostic instruments are the expression of a growing scientific world which has supplied a solid base for obtaining results that have greatly improved the average state of health of the world community.

An imaginary time traveler coming from the 1800s seeing the progress that has been made would certainly be struck positively by the current state of public health.

That notwithstanding, the goals of earlier generations cannot have the same value for those who are experiencing current medical problems as they had for people in the past. In other words, the level of health that we have reached – which is never to be taken for granted or as a stable situation – needs continuous improvement towards ever greater and more satisfactory levels of well-being.

These can be reached only with relentless vigilance and commitment to the elimination of errors and distortions, the prevention of abuses, and the conceiving of new solutions.

These aspects are becoming more pressing because, for a number of years, many have begun to sense that medicine is becoming stalled. It has become too anchored in outdated concepts, and incapable of proposing innovative ones upon which to build new foundations for medical knowledge.

There is a pressing need for new, life-giving sap to impart vigor to an asphyxiating theoretical structure whose philosophy, research, and practice no longer seem attuned with our times. The advanced and demanding society in which we live is no longer satisfied with knowledge from physics and chemistry dominating the combating of any disease. The need to research and introduce therapies that take the integrity and the permanence of a human being into account is emerging more and more forcefully in our society. This must be in the widest economic field of health as possible, and that is adequate to face those degenerative and chronic diseases that today can no longer be fought with current therapies that are narrow, limited, and obsolete.

There has been a transition in the last century from the predominance of *sthenic pathologies*, that is, those that occur in a young, fit body, to that of *asthenic diseases* that occur in patients who are older and less fit. The notable scientific and social consequences of this change have not been paralleled with the increased medical consciousness necessary to favor a widening of the theoretical boundaries of a disease.

Quite the contrary, there has been a myopic preference for ignoring the consequences of a way of perceiving which is excessively specialized and short-sighted. Priority has been given to the immediate effects of a treatment, leaving the rest to chance.

This attitude demonstrates a deep and grave impasse in the treatment of disease, confirmed by the lack of theories and perspectives that enable us to see a physical disease in a new manner different from the old. So far, there have been partial diagnoses that include only pathogenic analyses in a therapeutical perspective that is only symptomatological. Conversely, it is the entire individual who must be considered, both in his vital dynamics and from a psychological and even spiritual perspective, even if these cannot be measured.

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The soul and the body are not two separate and non-communicating domains, but two manifestations of the same being, and equally responsible for the health of an individual.

Because medical orthodoxy is closed a priori to this concept, the need for a deep renewal is inducing thinkers and doctors to adopt alternative positions with increasing frequency. This is demonstrated by the growth of writing and testimonials that are not in step with the dictates of official medicine. This happens especially in the area of oncology, where a deep state of confusion and resignation is felt the most.

It is in this area, in fact, that the failure of medicine is most glaring; it is here where the symptomatological approach reveals all its limitations; it is here where medical theories end in an infinite number of culs-de-sac.

Genetics, the battle horse of modern oncology, is about to give up the ghost, together with its endless explanations based on enzymatic and receptor processes. Actually, it has already failed – it is just that no one can think of anything else that can take its place. The consequence of the oncological establishment's inability to admit the failure of this line of research, which is at this point scientifically indefensible, is the continuous waste of a great quantity of economic, scientific and human resources.

What road to take? Where to look for those minimal logical elements that can shed light on the ignorance that pervades oncology?

Many thinkers – especially biologists – believe that by applying the Darwinian theory to the evolution of living beings, it may be possible to progress down a new path when it comes to the so-called degenerative diseases such as cancer, cardiopathies, and mental illness. According to this line of thought, these diseases are not attributable to environmental or genetic factors as is presently believed, but to *infections*.

Therefore, the answer to the question of what causes a degenerative disease can be found in the discipline that more than anything else has given luster to medicine, and which has promoted medicine from a mere practice to a science, that is microbiology.

It is in fact clear that, with the exception of bacteriology, the

state of knowledge in this field of research is still quite limited, especially when it comes to viruses, sub-viruses and fungi, whose pathogenic valence, unfortunately, is little known.

It is true that scholars have given more attention to these biological entities recently, and in fact, the concept of “*innocuous co-existence*” attributed to many parasites of the body has begun to be questioned with much greater conviction. More determination is needed, however, in this process of the revision of microbiology so that the close connection between micro-organisms and degenerative diseases can be clarified.

I believe that it is by focusing on just one of these shadowy areas – on *mycology*, the realm of fungi – that it will become possible to discover the correct answers to questions concerning the problem of tumors.

Much evidence indicates that this is the road to take.

The analogy between psoriasis – an incurable disease of the skin that many treat as fungus – and tumors, which are also an incurable disease of the organism, the symptomatological overlapping of *systemic candidosis* and cancer, and the strict genetic relationship between *mycetes* and neoplastic masses make this clear. These are all elements that support and confirm the point of view that *all types of cancer*, as happens in the vegetal world, *are caused by a fungus*.

A fungus infection – that of the *Candida* species – could supply the explanation for why a tumor occurs, and it is in this direction that research should move in the attempt to solve the problem of cancer once and for all.

In my personal experience the only substance that is effective against diffused neoplasms is *sodium bicarbonate*. Years of parenteral administration – that is, administration directly into the tissue through veins, arteries or in cavities – have shown that it is possible to obtain a regression of neoplastic masses in many patients, and sometimes to resolve their state of disease up to the point of healing it.

It is the purpose of this book to explain this new, simple approach that fights a disease that is extremely devastating and variegated. It is my firm hope that the fundamental role of fungi in the

INTRODUCTION

development of neoplastic disease will soon be acknowledged, so that it will be possible to find, with the help of all the existing forces of the health establishment, those anti-mycotic drugs and those systems of therapy that can quickly defeat, without damage and suffering, a disease that brings so much devastation to humanity.

Dr. T. Simoncini,
Rome, October 12, 2005

CHAPTER ONE

Why is Cancer Still Among Us?

The question that many people ask themselves is why, after so many years of study and research, has cancer not yet been defeated?

The problem is indeed scientific, but in my opinion it is even more a problem of a cultural and social nature as it represents the very structure of knowledge at the world level – a structure that prevents that freedom of thought and creativity that is capable of finding the right solutions.

The politicized structure of universities and professional orders which are set up almost as castes, with financing issued only to established institutions that are often almost mummified, and the monopoly of information held by existing political and cultural powers – all these are elements that prevent the most fertile and creative minds of society from having the slightest chance of exploring new paths. This fossilized social attitude is forcing entire populations to exist in a chronic state of fear and suffering when it comes to a disease – cancer – which could be successfully defeated.

Some time ago a patient with cancer sought my help. As I was explaining my mycotic theory on cancer to her, she commented “This perspective at least gives me the dignity to be ill. An infection makes sense.”

The battle to defeat the causes of tumors, however, must first be undertaken against a socio-cultural status quo which is as stifling as it is deeply rooted. Furthermore, individual prejudice, commonplaces, and conformist attitudes that have been seeded and cultivated in the minds of the people by the media must be fought. These attitudes are aimed at numbing any ability to think, to analyze and to open the mind towards anyone who has something new to say.

So in reality, the battle against cancer consists of two distinct battles. The first is against the physical disease itself; the second one is against the mental posture of both those who want to keep their privileges and those who, because of social indoctrination, do not seem interested in trying new ways. I believe that the latter battle is the toughest and the longest – but only by winning it can we be successful with the former.

It is quite true that there are many charlatans and deluded people. This observation, however, cannot be a valid reason to close the door to progress and innovation, especially when, as is the case here, no other valid solutions are at hand.

In any case, what are the criteria for rating the effectiveness of a therapy? Who is entitled to judge who is wrong and who is not? I believe that the representatives and supporters of official oncology – with their trumpeted “reliable scientific methods” – are least qualified to ascertain the integrity and the effectiveness of a therapy that is an alternative to what they practice. Facts clearly demonstrate that, in reality, such people are the expression of 50 years of failure, grief, and suffering. Even worse, they represent half a century of ideological obscurantism, which, through cultural repression and mystification, has prevented finding the solution to the cancer problem.

In the meantime, people keep on getting ill, suffering, and dying.

For the purpose of comparison, it would be useful to know the opinion of current scientists and protectors of our health concerning therapies practiced a century ago by scientists then considered credible and reliable – when, for example,

WHY IS CANCER STILL AMONG US?

they were drilling the ears of patients with otitis, or when they practiced bloodletting to the point of unconsciousness on those suffering from imbalances of the various biles (yellow bile, black bile, and so on). These practices brought people to a state of irreversible physical weakening or jaundice.

Just as we smile today and shake our heads over those past follies, today's scientists may be judged in the same way by future scientists who will look back at how cancer was treated by poisoning patients, torturing them with radiation or by mutilating them without dignity with surgery that was as extreme as it was useless.

At present, the progress of a tumor which has a straight, uniform, and implacable course is not changed in the least by current oncological treatments. Statistics show us that the survival rate always hovers around insignificant figures (2-3 per cent).

The rest is propaganda in favor of oncological orthodoxy. Let us put aside for a moment the cancers that have been cured in breasts, colons, and in lymph glands, that is, the leading claims of official oncology. The recoveries attributed to the standard treatments are the products of lies, misunderstandings, and either individual or statistical mystifications, as we shall examine later on. For now, suffice it to say that those presumed, much-trumpeted therapeutic successes always concern tumors at the earliest stages.

It is not a coincidence that where tumors have reached a significant dimension, *the mortality rate is steady at 99.99 per cent of the cases.*

Failure, deception, and impotence continue to exist only because they are protected and favored by various so-called accredited scientific authorities, at the expense of the truth and of the well-being of citizens.

Cardinal Ratzinger (as he was formerly) used to say:

"How many times the insignias of power carried by the powerful of this world are an insult to truth, justice and the dignity of Man! How often their rituals and great words are, in truth, nothing but pompous lies and a caricature of the duty they are bound by their office to perform, which is that of being at the service of good".¹

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This present work, with the related clinical research and experience, is a voice of rebellion against a national and trans-national oppression. The oppression becomes ever more onerous as it becomes packaged anonymously, whether presented under the colors of the WHO (*World Health Organization*) or through other internationally accredited structures. These health organizations have so far been capable of proposing only ineffective and inane anti-cancer protocols.

I believe that my position is rational, logical, scientific, and humane. It is a conception of *cancer as an infection*, a perspective which does not foresee the need for esoteric intervention, but instead the construction of a therapeutic discipline that is specific, targeted, and often able to quickly and completely resolve neoplastic diseases.

No fault can be attributed if the only substance that today is actually effective against *Candida* is *sodium bicarbonate*, but rather what is greatly wished for is that the pharmaceutical industries will soon become involved, as they would certainly be capable of producing anti-fungal substances that are extremely lethal for neoplastic masses. The use of crude bicarbonate will then no longer be necessary, and a few pills a day may one day be able to uproot all tumors.

Tuberculosis was also a feared and mysterious disease in the 1800s. The dynamics of its existence were unveiled thanks to the research of Koch, and tuberculosis was defeated with appropriate medicines.

In this case, of course, far more testing, verification and experimentation is necessary to give weight to the thesis of cancer as an infection, but unless we start with free thinking and with reason - in other words, with the will to find and experiment with something new - we will only be left with the certainty that the problem of cancer will never be solved.

New Modalities of Medical Knowledge

Cancer is still a mystery given the current state of knowledge of medicine in spite of the enormous efforts made by researchers worldwide.

The survival rates for the most common types of cancer, which constitute 90 per cent of the cases, have remained virtually unchanged for the last 25 years. This is a dramatic piece of information, which cannot be mitigated even by those statistics created ad hoc that refer to a global survival rate of 50 per cent, and that everyone knows are substantially and obviously false.

Given the high mortality figures, it is normal that fear of such a devastating disease pervades all of society, producing a widespread feeling of impotence and resignation, notwithstanding that health institutions always do their very best to convince the population about the merits of official scientific research and the remarkable results that have been reached.

An approach that attempts to shed light on this obscure disease, therefore, must necessarily go through two phases: a *pars destruens*, which highlights the limits of current oncology, and a *pars construens* proposing new conceptual horizons and new fields of research, basically an approach that tries to understand where the mistakes are and that at the same time finds logical and effective solutions.

For that to happen, it is necessary first of all to question the experimental scientific method as it is currently applied to healthy or sick people, since it is inadequate and often makes no sense, and is unable to understand and evaluate man in his entirety.

An excessive "rational" physicality has arisen in western thought since the scientific revolution of some centuries ago, that is, a scientific approach based exclusively on the study of matter and of nature. This way of thinking has influenced the formation of biological and medical theories negatively as it has forced each new observation in those fields to follow interpretations that are valid solely for inert matter but not for living organisms.

This blind application of laws that are valid only for inert systems has led to the neglect of important differences between biology and the physical sciences, especially by those scholars

who take for granted that physics is the science which lays the foundation for the understanding of all others, including biology.

It is instead obvious that the study of living organisms demands additional principles alongside those of the physical sciences. In biology, in addition to the inductive and the hypothetical deductive methods, there are others of fundamental importance - the observation-comparison method and the utilization of experimental approaches that answer the questions "why?" and "to what end?".

While logic in the general and classic sense is based on the category of needs, the logic of living matter requires the combination of case, need, and especially sense. Sense explains the nature of a living organism through its psychic and spiritual choices. These take place in continuous interactions with environmental variables. In essence, the approach to biological entities must imply an observational attitude quite different from that used with inorganic entities that are identical in their material components.

There are always things unique to individuals in organic matter which, if evaluated with the scientific attitude used with inert matter, do not produce the hoped-for results, since living matter cannot be reduced to a simple sum of its molecular components.

If we accept that human reality exists on a plane that is superior to that of the inanimate world, then it is useless to state that there is an indisputable exact chemical identity between living and non-living matter. Rather, what matters is the resulting biological, vital, and energetic value.

This value, as it represents a basic and essential characteristic that cannot be measured, confers to biology that central position and that power to unify all the other sciences - a power that today is improperly and unjustly attributed only to the purely physical sciences.

To inappropriately mix together the various levels of existence in the universe - thus reducing vital phenomena to simple physical and chemical processes - means not only a

loss of spiritual values but also a narrow observation of reality which is heavily materialistic and unproductive.

Although extreme, Hegel's philosophical reaction to an extreme idealism centered on the figure of an emaciated ego which is incapable of including the richness of material reality seems legitimate: "*at night all cows are black*".²

However, condemnation of an obtuse materialism unable to grasp the existence of super-material realities seems equally legitimate.

In a cosmic order of an ethical nature that we could name *The Great Chain of Existence*, all the representative gradations of life are present simultaneously. The gradations can communicate among one another to different degrees and they can be vital and energetic to varying degrees, as a function of the organic level that distinguishes them.

Because of this evident reality, we cannot reduce the numerous differences that we have observed to one identity based solely on quantitative variations. In so doing, we would lose the very sense - and thus the reason of life, of creation, and of all creatures.

The result that we would obtain would be to fall back into a materialistic and ideological obscurantism based exclusively on dogma.

A philosophical approach that is useful to medicine must, therefore, accept that there are various planes of existence, and that each is characterized by its own peculiarities which in turn are molded by the actions of the universe.

There is no question that matter in general, in order to acquire the characteristics of living matter first and then those of human beings, must have undergone a prolonged evolution through time. The present human biological level is a function of the accumulation of vital systems that are ever more complex and that are based on the interchange



Friedrich Hegel

between information from these systems and the inherited genetic patrimony.

However, to fail to recognize the ability of a biological entity – especially of a human being – to tune into and increasingly absorb the energetic forces of the universe according to the individual's own quantum means a failure to recognize the importance of the supra-material (spiritual) factor. This would lead to a shrinking and fossilization of the human mind. We would indeed live on quantifiable planes, but they would be extremely poor and would yield no progress.

Biology and medicine, therefore, need a philosophy that is true to what they actually are.

For this to happen, biology and medicine need to explore not only what is typical of the lower dimensions of human reality (what is physical, biological and natural), but also specific individual dynamics (the body, consciousness, the mind, the soul, and life itself) as well as the general dynamics (such as cultural, social and ethical factors) with the goal of integrating all the aspects and finding ties and reciprocal influences.

This philosophy of biology – human biology in particular – must therefore take the responsibility of being a liaison between the physical and ethical worlds, with the function of understanding both and without attempting useless reductions but, instead, trying to coordinate the lower dimensions of human reality with the higher.

This work attempts to clearly define the central position of medicine, which holds a privileged position in the evolution of man since it possesses the ability to access the various levels of existence of the individual and to study the variations from a healthy to an unhealthy condition and vice versa.

From this position, modern medicine can fulfill its function as an intellectual binder between the material and the supra-material worlds, on condition that it does not allow itself to founder through particularistic thinking and that it follows the entire gamut of human life according to its ancient holistic vocation.

The Logical Insufficiency of Determinism

Comprehension of the pathogenic mechanisms is insufficient for understanding a disease. It is not enough to base oneself on the golden rule that everything that happens has a cause which in turn has another one and so on. Supra-material reality has a richness that cannot be captured by the *laws of determinism*.

But what is determinism?

With this term we mean that any event exists because of a cause behind it, which in turn has another cause behind it and so on. An operational constant is recognized in the relationship between the various events – a constant that proceeds from the first cause and goes on forever. This postulation is illogical and contradictory.

A chain of causality *ad infinitum* implies the existence of endless causal links. This is tantamount to saying that there are no links or determined causes. Thus, quoting Kant, “the regression of the series of phenomena in the world goes on *in indefinitum...*”³ rather than *ad infinitum*.

The practical consequence of the application of this deterministic law to explain the development of a disease is that if we lose the certainty of the constant an event can be determined by uncertain causes, as these exist in infinite numbers.

Logic, therefore, has allowed us to unlock an event from the grip of determinism. If we wanted to continue exploring the *raison d'être* of an event (for example, of a disease), we must at this point move towards a conceptual “metaphysical” level.

In this case, the correct question would no longer be “How does an event happen?” but “Why does it happen?” We have in this way discovered that the need to find the causes of an event is first of all ontological (that is, pertaining to the very nature – even including the spiritual nature - of being) and only secondarily based on the law of cause and effect.

“*Philosophy must end with religion*” said Hegel⁴, that is, it has to end in that unthinkable and indispensable which, for

the very reason that it is unthinkable, is at the basis of every thought.

Determinism therefore has a relative validity – meaning that it can be sustained only in a defined environment. Even when it is possible to pre-configure the chain of events, we must not forget that an event might occur “because of parameters of a higher order” whose roots, as we have seen, originate in what cannot be determined.

As we proceed in our observation from the level of physical matter to that of the human being (and even – to push the concept – to that of the divine being), we notice that the dynamic process is amplified. As the possibility of interaction of the forces at play grows, so does the decoupling from deterministic requirements.



Immanuel Kant

Those who have a taste for the metaphysical (that is, the study of the foundations of reality) and the instinct for freedom and independence of thought cannot appreciate being locked into any mental cage made of rules, standards, and methods that have been set forth by conventional thinking. To admit the existence of infinity means not to accept a priori any preconceived principle. Better yet, it means to accept all the possible and distinct scenarios of reality.

According to the philosopher Comte, the history of western culture has been characterized by three phases of intellectual development: theological, metaphysical, and positivistic. The current positivistic phase, represented by the theories and experimental results of modern sciences, has implied the abandonment of the theological and metaphysical aspects of nature.

If we want to obtain a more complete vision of science, we must reintegrate the two preceding phases, although not entirely. In biology and medicine especially – scientific windows that allow us to see infinity – this exclusion highlights the limitations of a reality perceived by minds that are exquisitely positivistic.

It is true that medical and biological reality can roughly be treated as a whole that is constant and determined. However, when this whole invades other domains of existence, the rules used in one level are no longer sufficient or adequate to properly explain what we observe.

The insufficiency of the deterministic approach in the study of biology and medicine is highlighted in other fields of science as well. The physicist Heisenberg highlighted the insufficiency of the laws of cause and effect at the level of microphysics using quantum theory during the first decades of the 20th century.

Before Heisenberg, science accepted as a fact that unobserved phenomena were governed by the same laws that apply to observed phenomena.

This incorrect interpretation of nature was known as the Laplace postulate. The quantum theory has instead demonstrated that in the world of the infinitely small it is impossible to apply the cause-effect approach to explain the behavior of nature.

The quantum mechanical explanation, when combined with Einstein's postulations of the theory of relativity, demonstrates rather that reality has a statistical-probabilistic character. It follows that nature, contrary to the ideas of classical physics, is "undetermined".

What is the meaning of this physical reality in the medical field? It means that in medicine, up to a certain dimensional level, one can think in observational and cause-effect terms, according to the structure of general and special pathology. However, once that level is passed - that is, when description and enumeration are no longer possible - the passage to a higher organizational level of life entails indefinable and uncontrollable factors that make opinions that are based on quantification and causality useless.

At any rate, how much scientific medicine will advance is not important. The *medical praxis* (practice) will always maintain



Auguste Comte

its supremacy as a method of treatment. This is because praxis does not only mean the actuation of all that can be implemented and is quantifiable, but also means choosing and deciding each time from different possibilities, and thus it always finds itself in relation to the human being in its entirety. Furthermore, what is scientifically feasible can only cover a fraction of the vital manifestations of an individual and will clearly be insufficient to assess a disease thoroughly.

The search for health inevitably ends up losing sight of possible disease generators, which are always connected to the intangible and unquantifiable "vital" aspect of man when it is decoupled from the doctor-patient relationship and instead entrusted to the scientific-technological enterprise, .

Among the natural sciences, medicine is the only one that can never be conceived as "technical", as its practical ability is not in the production of an object but in the restoration of what is natural.

It is therefore necessary that a doctor should possess qualities that are not just technical but human as well – qualities pertinent to his most intimate life experience and making him able to find the invisible balance between health and disease, which varies so much from person to person.

If too much importance is given to the technological domain when diagnosing a disease, there is the great danger of progressively eliminating spontaneity and the faculty of judgment of the therapist.

Furthermore, pure medical science is not able to apply its knowledge in a practical way. In the vital complexity that we call "man" there are aspects (values, preferences, habits, personal interests) that can only be evaluated objectively by the physician, and the experience and wisdom of the therapist always play a predominant role.

The judgment of the physician thus still regulates an area of activity that is quite vast, where the intervention of



Werner Heisenberg

technology can only contribute marginally. When, for example, the figure of the family doctor fades away – a person who knows the patient, his ties, his habits and his problems – we become impoverished socially and a risk emerges for the person who is treated.

It is true: a pathology that is characterized by constant biological processes can be classified, quantified, systematized, but *etiology* (the study of the causes of a pathology) is an array of undifferentiated causes which has its *raison d'être* in chance and thus in infinity.

Let us use an example to better clarify the concept of *indifferent etiology*. Let us assume that a patient manifests the following:

nosological entity (<i>type of disease</i>):	gastric ulcer
symptom:	stomach pain
semeiotics (<i>physical manifestations</i>):	algic dorsal projection
anatomical alteration:	mucus erosion
functional alteration:	hypercloridria
microbiological alteration:	presence of <i>Helicobacter pylori</i>

Obviously, the disease in this example can be codified. However, the data collected becomes insufficient when we move to the etiological level, that is, the level of causes.

In reality, how many and which could be the causes of the ulcer? The answer is, "infinite!" The causes are infinite not so much for the number of them as for the multiplicity and the gradations of their combinations and interactions.

A myriad of factors can act for each observed case – those "non-accidental accidents", as the World Health Organization put it, such as physical constitution, exogenetic aggressions, mental stress, psychological problems, and social tensions. All these factors can produce the disease both individually and in simple or complex synergy.

In general, the whole of pathology can be seen as a

verisimilitude of an indeterministic etiological perspective. In any case, the cognitive value of the underlying pathogenic mechanisms and processes – those which attract the disease, which in the early phases is susceptible of remission, even if intervention is only on the physical level – stands firm.

If it is true – as is becoming more and more evident – that the corporeal part is only one (although the most visible) of the components of human reality, it follows that a therapeutic intervention cannot target the body alone, but must be differentiated to take into account the various existential planes.

Since it is not possible to “measure” health, simply because health represents an intrinsic harmonic state unique to the person, it is not plausible to trust one standardized system exclusively when approaching the disease.

Medical treatment, therefore, cannot be handled as a simple correspondence between cause and effect, intervention and result, symptom and drug. Rather, its objective must be the restoration of that hidden harmony that reflects the “totality” of the human being.

A symptom and a disease cannot come from nothing. They are always the result of a way of being, living, and thinking. How is it possible, then, to believe we can solve the problems of a patient by looking only to his physiopathology, which is a dependant aspect with an emerging value inferior to the totality of his existence?

How can we believe that we can fix a life with a pill?

So, by considering the relative value of the symptom in this light, it is clear that it cannot have all the importance attributed to it today by medicine – an importance so great as to constitute the almost exclusive basis of the therapeutic procedure.

The Symptom

It is said that a person “feels bad” when he doesn’t sleep, doesn’t eat, is tired, doesn’t breathe well, keeps on going to the bathroom, and so on. Even if we describe the symptom

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with scientific terminology which is more or less comprehensible for the layperson (*anorexia, asthenia, dyspnea, tenesmus, and strangury*) this should not make us lose sight of the substance of the disease even if the symptom represents the most important element as far as the patient is concerned.

When an organ or a tissue is damaged in some way, in order to recuperate its complete functional capacity the reaction of the organism bases itself on the classic tetrad composed of *Rubor, Tumor, Dolor, and Calor* – redness, swelling, pain, and heat. ⁵

The anatomical location and the type of combination of the elements of the tetrad in terms of which is predominant over the others accounts for the symptoms and their variations, the causes of which always come from the underlying pathogenetic mechanism.

However, by defining the symptom as a manifestation of the disease, one may ask “which disease”?

The correct answer would be “any disease”! Yes, any disease – because while on the one hand it is true that the symptom comes from a single pathological process, on the other hand it is also true that the symptom does not demonstrate any specific disease.

It is true that a symptom is tied to tissue pathology, but pathology is only the organic manifestation of the disease. Pathology can be seen in its totality only if the causes (etiology) are added. The roots of the causes have to be looked for at the anthropological and environmental level rather than at the physical one.

The great Russian physician A. Salmanoff has said:

“Disease is a drama in two scenes. The first one takes place with the lights off in the silence of our tissues. When pain or other discomfort is evident, most of the time we are already in the second scene.” ⁶

If a person has any symptom - for example, constipation, headache, vertigo or cough - then the single, multiple, complex, synergetic (and so on) causes can be infinite. To objectify a disease with its manifestation or with its pathology

is therefore extremely reductive and dangerous for the health of the patient.

Of course, the usefulness of the symptom as an indicator of dysfunction and energy imbalance of a particular anatomical area - a dysfunction which remains until the body has recuperated completely - is indisputable. Nevertheless, to uproot a disease we must identify the deeper causes. If not eliminated, or if hidden by medical intervention which is related only to symptoms, these risk becoming (and often do become) chronic producers of discomfort that in the long run become irreversible and are no longer controllable.

Salmanoff states: "*True reality is hidden, disguised in the depths of life. The reality that we see on the surface, that which we can observe, classify and order only with a methodical and logical spirit and with creative imagination, offers nothing but the reflections and the signs of the processes in the depths.*"⁷

Pathological Anatomy

The visualization and the study of the organism in its various parts is the field of *anatomy*. If these parts are the object of the analysis when considering a disease, we are in the field of *pathological anatomy*.

A healthy liver, for example, is the concern of the former, while a steatotic liver is the concern of the latter. The same applies to stomach, brain, blood, glands, membranes, bones, and so on.

What does pathological anatomy indicate? That a certain organ or tissue had a disease or, better, that it was the object of the disease. What disease?

Answer, "Any disease!"

It is therefore clear that if an organ or an altered tissue where the pathological configuration is unchanged can be evidence of any disease, in reality it is not evidence of any specific disease. Looking for the roots of the disease in that hidden place where, according to a saying of pathological anatomy, "death speaks of life", is like looking for a needle in a haystack.

While it is true that the organs represent the concrete

supports of the disease, it is equally true that they never constitute the indispensable conditions.

Thus, if the body, the organs, the tissues, turn out to be *effectors*, that is, the material supports of any disease, they can be compared to the resistors of an electrical circuit, where the conductors absorb and subdivide the electric current. In the case of organs, these absorb the neurogenic biological charge that is generated by *supra-neurological* vital inputs.

In the same manner that electrical oscillation, voltage variations, and temporary blackouts can damage resistors (light bulbs, fridges and alarm clocks), so the diminishment of intensity in any form or variation of vital flow can first cause anomalies in the operation of any organ (and here we are in the field of physiopathology), and then within the organ's structure (and here we are in the field of pathological anatomy).

To consider the disease of an organ as the expression of dysfunctions that are not just somatic is, after all, the main theme upon which the various holistic theories of the human being are based – particularly those of psychoanalytical origin.

According to Groeddek, for example, not recognizing the role of psychiatric and moral problems in the genesis of common diseases means applying medicine halfway, since organs must be considered – especially when affected by disease – as “pathways to inwardness”.

Depending on where it is applied, the same disease can cause the most varied organic alterations in different individuals with consequent diversity of symptoms. At the same time, the very same alteration can be the consequence of the most variegated diseases.

Furthermore, the position, quality and seriousness of a disease are not tied to random chance, but are a function of concurrence and interaction of multiple elements, such as:

1. the constitution of the organism, the distribution of body mass and posture,
2. character, temperament and dynamic characteristics,
3. the times when psychological-physical vigor is at its highest or lowest,

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4. fatigue and overload of any type or origin
(mental, psychic, intellectual, social, family, etc.),
5. the presence of vices, tensions and distortions,
6. the quality and quantity of food,
7. environmental conditions.

Attempting to attribute excessive responsibility to an organ or to a tissue on the basis of an anatomical-pathological description seems, therefore, to be most unrealistic. An electrical resistor can absorb more or less energy and can cease to function or even break up, but it will never tell us the reason for the event.

In theory, and purely conceptually, it would be possible through an infinitesimal anatomical-histopathological search of an organ to find the deep causes of the disease for an individual: the organic alteration in this case would be the "picture" of the history of the patient. It is useless to state, however, that this would be well beyond the boundaries of medicine.

In conclusion, the richness of life cannot be enumerated and/or codified.

Medicine and treatment, therefore, can and must move beyond and over the simple physical body, as well as within it. Only in this way is it possible to reach the deepest recesses of life and with them, the explanations of the disease.

Spirit and Body: Anatomical-Functional Considerations

If we want to undertake the description of an individual from a medical and non-reductive perspective, we can take into consideration his statistical components (and here we observe the anatomy), or his dynamic components (and here we observe the physiology).

In any case, both components in their structure reflect the organism in totum, in which, uniquely, any manifestation of life is demonstrated. This manifestation makes possible, the possession of a consciousness of the self and being in relation to the external world and other human beings in a synergy between the nervous system and the extra-nervous elements.

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Although non-neurological components dedicated to the nourishment, support and sustainment of the nervous structure are indispensable to an individual, the neurological component is the gateway to the quality of life of the person in his entirety, which is not limited to his physical aspect.

The nervous structure can be considered as the transit and switch point between physical ability and the ability to think and create ideas.

The various and complex homeostatic, retroactive, and feedback mechanisms that exist in the body, although they are difficult to interpret, cannot invalidate the simplicity of a scheme geared to the integration of material processes and supra-material phenomena.

In this mechanism, the non-neurological part "recharges" the neurological part, which in turn supplies the structure for the nervous and psychic processes in a continuous transformation of quantifiable bodily energies into impalpable mental and spiritual energies.

It is necessary, therefore, to apply further specifications of human reality when dividing the individual into body-mind or into body-soul.

This is not to be done with the intent of losing a wholeness that can be dissociated only for the purpose of observation, but rather with the purpose of making intra- and inter-sectorial dynamics more understandable. The alterations that generate a disease depend on these dynamics.

Man can be visualized in the following "*bands of existence*":

1. Body
2. Neurological structure
3. Mind
4. Intellect
5. Psyche (emotion, volition)
6. Spirit

In more detail:

1. **The body** has neurological and non-neurological components, in turn made up of:
 - a. osteo-muscular-connective apparatus
 - b. a digestive apparatus
 - c. a circulatory system

These have the function of supplying the nourishment to the neurological components after finding, assimilating, and channeling the nutrients.

2. **The neurological structure** is the explanatory pivot of human existence, as it has the function of controlling and regulating the non-neurological aspects of the body. At the same time, it has the function of producing and supplying those essential neurogenic substances required to maintain and acquire the bio-vital processes of each superior order.

3. **The mind** is the dimension of the nervous operations located above simple neural vegetative mechanisms, encompassing rational, reflective, and creative processes.

4. **The intellect** is the widening of the mental horizon, achieved through the amplification of the rational mechanisms, using components that are mainly extra-individual, thus social, scientific, cultural, and religious.

5. **The psyche** is the meeting and inter-relational point of the preceding structures. Its peculiar characteristic is the stimulation (conscious or unconscious) to action or non-action, on a passion-based choice towards what is considered the greater good.

6. Given that **the soul** is the essence of all the components of the individual, in function of energetic (spiritual) evolution, then **the spirit** is the resultant that denotes quality, quantity, and direction of the human being.

It is appropriate to emphasize that the existential levels described above – which are separated only for ease of comprehension – are part of an inseparable whole.

This whole, by acting and reacting through life in a synchronous and homogenous way, each time sets into motion or efficiently utilizes one or more components, and such utilization is always in unity and synergy with the others.

The net of the possible interactions among the bands is extremely variegated, variable, and never preset, since the individual components are continuously confronted with external conditions that are always new.

The well-being, the “feeling good” of an individual depends, therefore, on the sound “operation” of each level of existence,

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which, by conferring stability with its own balance to the whole system, puts the individual in the condition of facing all external events with greater energy, and thus with the greatest possible freedom.

The following examples of sectorial "shrewdness" confer good health on the individual.

1. Healthy diet, good oxygenation, abundant hydration, with salination (*body*).
2. Regular sleep and rest (*neurological structure*).
3. Prudence when building up fatigue of any kind (*mind*).
4. Moderation in expenditure of energy on social, cultural etc. commitments (*intellect*).
5. Moderation in passions and appetites (*psyche*).
6. Choice of superior good, peace, etc. (*spirit*).

It must be clarified that the above-mentioned indications are not the result of a moralistic attitude, but of *simple medical indications* that suggest that one should evaluate, with the right meter, the management of one's own person.

In this way, an individual who goes beyond his psychophysical abilities is exposed to problems that are proportional to the level of abuse perpetrated against his being, since for each of us there are, in different phases of life, definite limitations that must be taken into account.

An effort or an excessive overload inevitably produces dystonias or diseases that occur in relation to the point of application of interest. If, for ease of analysis, we consider only symptomatic effects, we can have, for example:

A colic from a bulimia attack,

A strain from taking too long a jump,

Exhaustion from excessive sexual activity,

A deformation of the vertebral column or a decrease in eyesight from excessive study;

Depression from an unfulfilled desire for social success, and so on for all the possible combinations of behavior which are directly responsible for the operation of the various bio-vital levels.

The Disease

Disease is the loss of energy capable of limiting the life of a person, thus decreasing his/her ability to be autonomous and free. Disease is mainly a nervous event (with the exception of traumatic-accidental episodes), made possible both by supra-neurological causes (which determine its exhaustion) and by corporeal causes which prevent supply and regeneration.

In the interaction and in the balance of the two areas – supra- and sub- neurological – lies the secret of health and the key for reading the disease, the management of which may only be in the hands of those who know and deeply feel the status of the system, its regulations, and its balance. This is the individual himself, even when he is helped and counseled to know, understand, and treat himself. Given that a disease affects the organism in totum, its development in time and space can take on characteristics that are specific and particular to a greater or lesser degree.

Disease can be classified as:

1. *acute* or *chronic*, depending on the duration of its effects through time.
2. *Circumscribed* or *diffused*, depending on whether it is localized at a bio-existential level or not.
3. *Ascending* or *descending* (from the corporeal to the spiritual level and vice versa), if the propagation and the effects tend to specifically involve levels that are different from the original level at which the disease started.

Examples of ascending diseases of spatial type:

- a. a hematoma is a disease which is at first local (extra-neurological), then becomes neurological, but remains at the corporeal level
- b. a pharmacological overdose (of streptomycin, for example) is first local (neurological), then mental,
- c. an alcoholic toxicosis is first local (metabolic-corporeal and neurological), then mental, then psychic,
- d. mnesic cognitive insufficiency is first mental, then intellectual, then psychic.

Examples of descending diseases:

a. an immoral action produces a discomfort at the spiritual level that may lead to psychic distortions,

b. a psychic inhibition can lead to a mental block (example, impotency),

c. intellectual overwork may determine mental effects (example, attention disorders), neurological effects (insomnia), and physical effects (tremors and vertigo),

d. mental stress may affect the body at a physical level, such as in intestinal disorders, disorders of the liver or eyesight problems.

Many examples with multiple characteristics can be added to the examples above. The disease can lead to bi-directional propagations, trans-sectorial effects, complex distributions with incidence and intensity that are both differentiated on different levels, and so on in endless variations that depend on the type and the intensity of the disease as well as on the constitution of the patient.

At any rate, beyond the complexity of the world of the disease, and given its ability to spread at different levels, an extremely important aspect becomes clear. This is that a psychic disturbance may be caused by any alteration of the lower levels, but on the other hand, the body can be the effector, that is, the receiving structure of any cause outside of the physical level.

Moral Presuppositions for Health

When the bio-vital levels are properly “handled” by the ego with continuous nourishment and commitment they become fully saturated, and gain such a biological charge that they spread their energy to each other’s compartments. The other compartments, in turn, can completely saturate, and so on up to the higher level, where the greater bio-vital density exhausts and is the prelude of the search for the greater good.

In other words, the moral sense is an emerging quality which is a direct function of the disposition and the energy of each existential field, which in turn is a function of energy and thus

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of the health of its parts. Once the physical-psyche integration is achieved – integration that in turn produces the maximum bio-energetic potential - that integration in turn creates the consciousness of a spiritual sublimation.

A horizon is opened before the individual at that moment – the horizon of the ethical world, the only one capable of, in its infinity, contributing that personal enrichment which only the interaction with others can give, and that is the precursor to the religious-spiritual dimension, the bearer of peace and serenity for both the individual and the group.

An understanding of the problems of life and health is possible only if human existence is understood in all its richness, and if the human desire of man to evolve towards ever higher levels of energy and good, thus towards an inseparable ethical perspective, is recognized.

Such a goal is impossible for any rigid scientific system.

The difficulty of finding the richness and the ability to see the patient's full spectrum of emitters of human components can, however, imply practical problems for those who treat others.

It is not a case that the medical establishment has produced distinct medical specialties in order to compensate for a situation forced to be deficient.

In fact, the treatment of the different levels of existence, which can be described in the following combinations, is the field of expertise of the various specialists.

Physician – body and nervous structure of the body,

Neurologist – nervous structure of the mind,

Psychiatrist – nervous structure of the intellect and of the soul,

Psychologist – intellect and the soul.

For completeness, we must add another combination to the above which is only apparently not pertinent, that of the:

Priest (or lay equivalent) – soul and spirit.

Given that “feeling good” depends on the proper operation of the compartments we have considered, it follows that all entities that protect the compartments – including the priest – belong to the therapist class.

It is true that the doctor has always been considered at the same level as the priest, and this often creates feelings of awe and gratification, but also of ignorance.

In reality, attributing to the priest a therapeutic ability is profoundly just, since although the priest cures the soul with a spiritual function – that is, through divine projection - the priest's work is often not fully recognized, although it often contributes more to health than the classic specialists can produce.

Shakespeare has Lady Macbeth say, "*That unhappy woman needs more a priest than a physician*".

To reach the maximum balance and thus the maximum acquisition of well-being, it is therefore not sufficient to rely only on the level of grievous corporeal needs. It is also necessary to possess a spiritual projection which always produces – and not just with words, or only a spiritual, other-worldly point of view – tangible and concrete results.

To that end, we must always remember the fortitude (which is not only spiritual) of the saints, or the words that Christ always pronounced when returning health to the sick or the dead: "*May all your sins be forgiven*".

So much is sufficient to demonstrate the essentiality of moral and spiritual values in health.

Moral Presuppositions for Disease

Each individual has a peculiar quantum of personal energy at every moment of his life. The quantum is determined by the sum of its structural components and by the bio-energetic flux connected to it. A lowering of energy – thus, of vitality – may be caused by:

A. a dispersion of bio-energy,

B. a sectorial crystallization (a block) with the consequent impossibility of expanding to the richer, higher levels.

The type of dispersion that is mostly examined is that which acts exclusively on the corporeal or on the neurological level.

This dispersion belongs to the classic medical investigation. The dispersion in the higher fields and the crystallization

pertinent to other domains are affected by the conditions and by the moral behavior of the individual. The following are examples of possible causes for decrement of the vital force.

- An *intoxication* debilitates the organism.
- A *neurotropic virosis* that damages the nervous structure.
- *Narcissism*, an excessive cult of the body which, by crystallizing energy on the physical-esthetic level, prevents the expansion of energy to other levels.
- *Neurosis*, *tics*, and *tensions* of psychic origin are expressions of distortions and moral vice that wear out the nervous system.
- *Lust*, where the term is intended to refer to what exceeds the ability of the psycho-physical capacity of a particular person. It exhausts the mind.
- An *excessive scientific, cultural or social ambition* that stresses the intellect.
- *Envy* or *resentment* which weary and enmesh the soul.
- *Laziness* and *sloth* which make the spirit heavy.

It is easy to notice that at the basis of each distortion and vice there is always an excessive expenditure of neurological matter, the “precious” substance utilized by any activity of supra-material nature. This energy can be predominantly simple (mental, intellectual, psychic, spiritual), or composite (with multi-sectorial implication), or global (when all components are in play).

Since the level of life of the human organism is proportional to the quantity of vital energy that is available at the moment, where there is an absolute dispersion of energy because of an accident or a relative dispersion of energy for a sectorial utilization, the various components of the bio-vital system suffer because of a neurological imbalance caused by the lack of specific substance.

In each individual there is a precise point beyond which the compensation of the system and the return to energetic balance is no longer possible. Once that limit is passed, the disease indicates its presence first through the language of the body and then by involving all the existential levels.

Salmanoff says: *”If the energetic balance of the organism*

*vastly surpasses all the possibilities of the various aggressions, then health is well protected. If instead the balance stands below the threshold, then the organism is no longer able to resist the aggressions and inevitably falls sick.”*⁷

It is clear, therefore, from the arguments developed so far, how an exhaustive medical consideration of human reality cannot be separated from the mental and spiritual components of the individual, as those very components are what, in their infinite interactions, determine the conditions of health and disease.

This is why the current organization of medicine, which is based only on material elements, is deficient: because the scope of its *modus operandi* and thus its efficacy do not cover the totality of the vital sphere of the individual.

Traditional medicine does not consider, in its entirety, the strict relationship of the somatic-psyche, although during the last several decades some schools of thought (such as holism and psychosomatics) have tried with ever growing urgency to call attention to those phenomena and vital processes. These are processes which, in the consideration of personal health, are relegated with an excessively dismissive attitude to an accessory and almost non-influential dimension.

Therefore, to regain a more realistic and more fruitful vision of human reality it is necessary to question the basic presuppositions of the ways of carrying out science and medicine. The position of the soul, which should no doubt occupy a pre-eminent position, must certainly be re-examined in such a questioning process.

The Soul and the Mind-Body Problem

There are mainly two points of view in the search for knowledge in the study of living matter.

There is the vitalist approach, according to which a living organism cannot be satisfactorily explained only through the description of its form and its physical composition, but must also be explained on the basis of principles that must be observed in space and time. There is also the approach called

reductive, which instead supports the conviction that if we thoroughly observe how components interact a system can be represented by physical and mathematical functions.

Unfortunately for the reductionist approach, the analysis of the components of a functional system in the biological world is, most of the time, useless or at least irrelevant.

In fact, in the most common and often most important phenomena of life, the constituent parts are so interdependent that they lose character and meaning and indeed their very existence if they are separated from the functional whole.

This limit, which in itself cannot be reduced, presents further problems of utility when it is evaluated in relationship with other biological entities or, more simply, natural entities, or even in relationship with different temporal positions.

In practice, the reductionist approach in medicine prevents the total understanding of the reality of an individual, with the consequence of stimulating and directing research towards areas that are so restricted and fruitless that they make the research basically useless.

How did we get to this situation? Where does this irreparable break between humanistic and material values in understanding the health of a person come from?

No doubt the roots of such a distortion can be found in the history of philosophy. They have to be imputed to a lack of appreciation for the seeds of enlightenment going back to the rational emancipation of the 1600s – elements that are as clear and linear as they are underestimated or unknown by current researchers.

The strict relationship that exists between philosophy and medicine, in fact, is often not appreciated for the real importance that it has for both theoretical and practical ends. Most of the time particular and sectorial philosophical contents are emphasized, while leaving the general principles at the margins of a disciplinary discourse.

This is done in the conviction that the philosophical approach has no concrete incidence on the health of an individual, particularly in the fields of research, diagnosis, prognosis, and therapy.

This conception is deeply wrong, for the link between the

principles of general philosophy and medicine – the pathway to the spirituality of the individual – is always powerfully present and capable of conditioning the main lines of scientific research and of medical practice.

In particular, the perception of the soul and of the mind-body problem represents a point of fundamental importance in the understanding of health themes. The positioning of that perception in the cultural baggage of a physician and of those who handle the health of others has invisible and dramatic repercussions on the members of society.

In practice, if a physician chooses a corporeal reality that is disconnected and independent of supra-material values and contents, and if he does not believe in the existence of influences which are above the causal chain of events, he/she will implement a detachment and an alienation of the body from the soul in his/her evaluations.

In the case of the first choice, the doctor does not need to concede a corporeal functionality which is in connection with something that is superior - on the one hand there is the soul, on the other, the body. In the latter choice, he/she will close the road to any element that, from the window of infinity, can influence, alter, and interact with the body.

Once such a conceptual position is accepted, the path of studies, research, and medical practice is marked in a “tragically” physical way, as all ties and dependences coming from other domains and other dimensions are severed.

What is the result of these choices? Mainly the existence of a “recipe”, that is acting mainly according to a compilation and prescribing what has been decided by others, namely by the faceless “apothecaries” of the pharmaceutical multinationals who manipulate the entire message.⁸

Today’s physician, therefore, instead of concerning himself with the empirical art of healing the patient, even with the modern tools he has available, concentrates mainly on nosological entities that are well-defined but detached from a whole view of man. The consequence of this partial view of medicine is that all which is external or above a theory or norm that is institutionally codified is either not recognized or is perceived with suspicion.

After all, it is well known how that in every epoch there are only those diseases that the doctors perceive, while, on the other hand, the patients expect only those therapeutic means that are offered to them.

The philosopher Heidegger writes: “*The predominance of the public interpretative state ... prescribes the emotional situation: it establishes what **is seen** and how things **are seen**.*”⁹

In a period such as the present where there is scarce consideration of spiritual problems, we cannot be surprised by the fact that even indicators of diseases of vital importance are not taken into consideration.

But this existential lack of communication that we find in contemporary medicine is not something that came from nowhere. Rather, it is the legacy of an erroneous cosmology that finds its roots in the darkness of antiquity.

We are in facts indebted to the ancients for the dualistic conception that poses the body in the material world and the soul in the world of ideas. The concept of the *Orphic* (initiatory) derivation of a body-tomb or body-prison no doubt inspired Plato, for the images of the biga (the soul) were forced, for some unfortunate reason, by the hyperurania (the superior world) to fall into the material world.^{10,11}

The line of transcendence in Christianity is not between the soul on the one side and the material world on the other, but between God, the source of life, and the creature. In this way, the soul is not supported mainly by its supra-material nature but rather by the dynamics of the creationist principle from which it gets its origin and essence.

At this point, the problem is to find to what point the effects of the power of God can reach, a power which – this, for example, is the thinking of Plotinus – must reach all beings and penetrate to the limits of what is possible.

Plotinus says again: “*If the production of matter is the consequence of anterior causes, then matter cannot be separated from the principle that has produced it, as if this principle that graciously gave existence to matter would stop for the impossibility of reaching it*”.¹²

The difference between soul and matter here takes on a purely formal value, as it consists only of a difference in degree and, at most, all that is left to demonstrate is a mandatory link with matter itself.

Furthermore, these very concepts are also part of a religious tradition that is more ancient than the western tradition: the Indian traditions where “... *Both spirit and matter have their first origin in the Brahma...*”¹³

Therefore, God is the generating principal for both the soul and the body which are perspectives and different ways of indicating the same thing - the various body-mind, body-intellect, body-soul relationships would exist not only on the plane of the same essence but also on that of the same existence. Having established the equivalence *Body=Mind=Intellect=Soul*, we would be facing different attributes of the same substance.

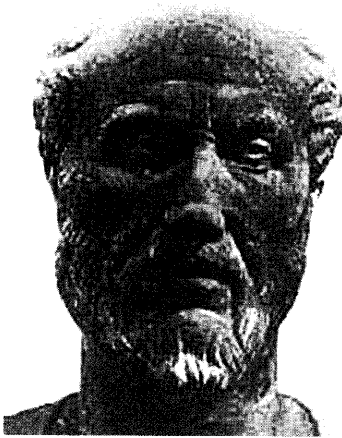
In this formulation we can also see the powerful figure of Baruch Spinoza, to whom we are in debt for the first lay answer that modern thought gave to the mind-body problem. The deductions made by Spinoza are extremely simple and concrete: substance is what in itself possesses the principle of its own existence and of its own intelligibility; no finite thing has such a property.¹⁴

It is therefore licit to state that the proposition of Ethics, the greatest work by Spinoza, supply the criteria for the concept of body in the Body=Mind equation: “*He who has a body capable of many things has a mind whose most part is eternal.*”¹⁵

In Spinoza, therefore, there is a complete re-qualification of matter, where matter is conceived not as something that is inferior and degraded, but at the same level and dignity of thought, seen in a universe as a unity of what is



Martin Heidegger



Plotinus

real that includes both the material and the spiritual. At any rate, given the limitations of the human mind, the consubstantiality that exists in creation can only be partially focused on.

By equating, or better by identifying matter with thought, and by minimizing the importance of *res cogitans* (thought) and of *res exstensa* (matter) which are the only two attributes that emerge after the infinite richness of substance, Spinoza undermines at the basis any possible dualistic conception and makes any presupposition of priority of one of

the components a vain exercise.¹⁶

Therefore, the message of the metaphysical thesis for which mind and body are one *res* considered as an idea or in extension (that is, in its manifestation) is clear and limpid.

In spite of that clarity, doubts and hesitations that led to discordant positions, to oscillations and fears dictated by religious, moral or character reasons which were not always pertinent to the subject under discussion, continued to exist in the following centuries.¹⁷

In the times following Spinoza we therefore see other thinkers almost being embarrassed to accept all the consequences of linear thinking that lead straight to the solution of the mind-body identification problem. This is also and mostly due to the problematic nature of the object of psychology of which we consider Spinoza to be the founding father.

The impossibility of defining the object of psychology has maintained, inevitably and as a consequence, the difficulty of setting the problem of the mind-body relationship.

At this point it is clear how, by taking into consideration the various human components in the identity of the spirit,



Baruch Spinoza

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we can also solve the problem of the interpretation of psychology. In other words, it is not legitimate to separately consider the soul on one side and the body on the other, for the penalty of this is the inability to understand either.

* * *

CHAPTER TWO

Holistic and Allopathic Medicine

We have seen on the basis of the philosophical error discussed in the first chapter that when it comes to human health there has been a separation of the individual into a material and a spiritual part throughout history. Although often unified conceptually, these parts have never in practice been reduced to a common interpretative register. This lack of recognition has determined the dichotomy that exists in current medicine. In fact, with the development of two separate theoretical and applicative domains, their reciprocal incommunicability has continued to grow to the point of irreversibility. This has the consequence that each domain holds its own different theoretical, philosophical epistemological, methodological, and therapeutic set-up.

Today, if we put aside the commendable appeals to a generic holistic vision, the “two souls of medicine” continue to proceed each in their own way, and it is not possible to foresee any chance of interaction and unification since there are no theories able to simultaneously and satisfactorily explain all the expressions of the human being.

In a situation where, on the one hand corporeal manifestations are seen with conceit or lack of interest, and on the other hand themes of a supra-material order are seen as an accessory to the therapeutical view, the implementation of a unified perspective will continue to be impossible.

But if we accept the fundamental and non-experimental value of human existence, and if we introduce the concept of the existence

of a commutative constant between spiritual and material elements, it is possible to free ourselves from the grip of demonstration and to make the individual free from the quantification of his immaterial expressions.

Basically, everyone can lead his life and be free to "waste" his energies – his neurological charge – as he wants and in the ways he sees fit. His behavior has an effect at the corporeal level which can eventually be quantified at the medical level. As much as one lives that much one wastes, and this has consequences at the corporeal level.

What we must do is highlight the concrete joining element of the two compartments, which can be found by not moving exclusively on this or that level, but by identifying the common denominator that generates all the manifestations of the human being.

If we analyze the various components of the organism more carefully, it is easy to notice how the function of conjoining and cementing can be performed only by the nervous tissue, which is the only one capable of absorbing and utilizing signals of somatic origin, and then converting these into the bio-magnetic nervous substance necessary to the activities of a superior order.

Once we accept the existence of a mechanism of interdependence between psychic and somatic (or corporeal) functions through the nervous tissue, it becomes evident how the dynamics of a disease exist either in an insufficient regeneration or in an exhaustion of the nervous substance, both representing in practice the pathologic moments that are the object of both areas.

The deficiency demonstrated by the two different approaches to health is not, therefore, in the inadequacy of the theoretical apparatus of either, but in their dissociation, which makes them unable to account for the global character of the disease.

All in all, a morbid event is not determined exclusively by an organic or psychic imbalance – or by the algebraic sum of the two – but is almost always the result of an overall psycho-physical dysfunction.

In practice, that simply means the implementation of either a theory and practice of medicine for the body without neglecting the spiritual aspects, or a theory and practice of medicine which, in treating the psychic sphere, also includes the corporeal

dimension and converges towards that common nervous level that is the expression of biological identity.

Having established those premises, it is, therefore, not enough to attempt remedies that act simply on the corporeal or psychic level separately in order to find a cure for any type of dysfunction. Rather, it is necessary to dig deeper into the roots of morbid events, which most of the time are made possible by a way of being and living that feeds and perpetuates the state of disease.

It must be said that the critics of official medicine do not contribute anything concrete to the resolution of the conflict. In fact, they do not care about highlighting the organic mechanism through which the psychic components work as disease generators, and in this way continue to favor the lazy status quo of allopathic medicine which, in its material dimension, is not influenced at all by simple theoretical critiques.

As Von Weiszacker says:

*"The fight against the positivism of the natural sciences...is similar to fighting tanks with rubber balls."*¹⁸

However, once the priority of the neurogenic factor in the development of a pathological state is demonstrated and accepted, it will no longer be possible to suppress its spiritual roots, and as a consequence that will force the reformulation of all the dynamics concerning disease conditions.

The rightful entrance of themes concerning the spiritual sphere into the world of disease will mean the recognition of a relationship of interdependence between organic operation and psychic influences. These influences will no longer be relegated to a corollary condition, but will become a determinant necessary cause of the evolution of a disease condition.

Personal Responsibility in Disease

The relationship between the organic and the psychic that emerges in the state of health of an individual is based on a unique totality that can be revealed through the dynamics of the disease, and that is almost always able to show the bodily and psychic double valence of any pathological manifestation.

Modern medicine, although accepting the genetic uniqueness

of each living phenomenon, however ignores the sometimes predominant incidence of immaterial phenomena in the development of pathological processes.

Considering the human organism as a static object with characteristics that are easily classifiable in relationship to external noxae precludes the understanding of diseases, especially where the psychic variations strongly affect the corporeal structure.

Furthermore, the combination of standardization and superficiality evident in today's therapeutics can only come from the mentality of current medicine where adaptations in function of the individual are not foreseen.

A second, extremely negative effect that can be seen in the health panorama is the exclusion of subjective responsibility in most of the morbid processes. Giving the patient the impression that he is almost extraneous to the genesis of his own disease only achieves the result of decoupling him from any commitment and attention - especially at the moral level - for his person.

The spiritual generators of health which are the true roots of morbid processes are obscured by a discriminatory attitude. Thus, we blindly persist in a way of doing medicine which is sterile and obsolete, as well as unfit to supply the necessary stimuli for finding new tools of investigation.

By changing our perspective, that is, by readmitting spiritual components in the nosological consideration of the human being, a new view is created and new light is shed on both the contents and the form of disease processes. It is true that they are determined also by genotypic structure and by external conditions, but disease is mainly caused by the very behavior of the individual who therefore is able to have influence on his own health.

That certainly does not mean that we wish to blame the patient for his disease; nevertheless, a continuous vigilance and alert behavior when it comes to one's psychophysical balance can become a preventative weapon and a force of strength against possible exogenic noxae.

If it is true that the individual builds or facilitates his own disease through behavior - and that he recognizes causes that are not just somatic - then the moral dimension of the human being becomes fully relevant in the consideration of morbidity. This dimension -

and this only - has a duty of care to the psychic and consequently physical components so that they may reach a balance that can protect the organism against any external aggression.

Health, therefore, has its roots in moral fiber and in moral coherence – the jealous preservation of which, through continuous commitment and a high grade of vigilance, represents, with the implicit ability of strengthening the nervous system, the first and most important line of defense against any external cause of morbidity.

Based on the above-mentioned considerations, it is clear how therapeutics that do not take into account the moral contributions and history of the patient can be accepted only in an emergency situation. In all other cases, where the most complex factors of the health of man come into play, such therapeutics should be conclusively relegated to the margins, so as to forever avoid both those improper therapies that are practiced daily (more or less knowingly, at the expense of individuals), and the state of total dehumanization that the world of health finds itself in today.

The Actual State of Oncology

At the beginning of the 1900s, one person out of 100 died of cancer; today it is **one out of three**. We foresee that within a few years one out of two people will die of cancer.

A mortality rate of 90 per cent, that is, 1.8 million deaths out of the 2 million cases recorded every year throughout the world, is observed for the majority of tumors of the digestive apparatus, those for example that are not subject to diagnostic ambiguities (such as esophagus, stomach, liver, and pancreas). The results for lung cancer are always similar, that is, the same 90 per cent death rate, and so on for all those cancers where mystification or data manipulation is not possible.

Cancer is the most important problem in medicine, not only because of its size, but especially because of the long symptomatological line that comes with this disease, especially in its more advanced phases, and the state of extreme psychological suffering which both the patient and their relatives are victims of.

It is no coincidence that the American president Richard Nixon in far-off 1971 proclaimed a real war against the “disease of the

century". Since then, this war has absorbed, worldwide, a quantity of economic, scientific and human resources which exceeds the limit of any imagination, but the results – it is useless to hide it – are a failure. Apart from the continuously renewed commitments, the repeated promises, and the supposedly miraculous most recent findings, there is very little that is concrete: *the cause of cancer is and remains unknown.*

The problem is unsolved.

Each year, millions of people are annihilated by this inexorable disease, as if they had been sucked into a spiral of death and pain which is almost always impossible to fight. Cancer is the enormous sword of Damocles, the terrible vindictive god of a surpassed social system, where defenseless citizens must passively accept a bankrupted management of their health, and are forced to delegate to undeserving others – the blind businessman at the vertex of the pyramid – the care of their disease.

The great lack of trust is evident even amongst doctors. Polls and questionnaires show that three doctors out of four (75 per cent) would refuse any chemotherapy because of its ineffectiveness against the disease and its devastating effects on the entire human organism.

This is what many doctors and scientists have to say about chemotherapy:

"The majority of the cancer patients in this country die because of chemotherapy, which does not cure breast, colon or lung cancer. This has been documented for over a decade and nevertheless doctors still utilize chemotherapy to fight these tumors." (Allen Levin, MD, UCSF, "The Healing of Cancer", Marcus Books, 1990).

"If I were to contract cancer, I would never turn to a certain standard for the therapy of this disease. Cancer patients who stay away from these centers have some chance to make it."

(Prof. Gorge Mathe, "Scientific Medicine Stymied", Medicines Nouvelles, Paris, 1989).

"Dr. Hardin Jones, lecturer at the University of California, after having analyzed for many decades statistics on cancer survival, has come to this conclusion: '... When not treated, the patients do

not get worse or they even get better'. The unsettling conclusions of Dr. Jones have never been refuted". (Walter Last, "The Ecologist", Vol. 28, no. 2, March-April 1998)

"Many oncologists recommend chemotherapy for almost any type of cancer, with a faith that is unshaken by the almost constant failures". (Albert Braverman, MD, "Medical Oncology in the 90s", Lancet, 1991, Vol. 337, p. 901)

"Our most efficacious regimens are loaded with risks, side effects and practical problems; and after all the patients we have treated have paid the toll, only a miniscule percentage of them is paid off with an ephemeral period of tumoral regression and generally a partial one" (Edward G. Griffin "World Without Cancer", American Media Publications, 1996)

"After all, and for the overwhelming majority of the cases, there is no proof whatsoever that chemotherapy prolongs survival expectations. And this is the great lie about this therapy, that there is a correlation between the reduction of cancer and the extension of the life of the patient". (Philip Day, "Cancer: Why we're still dying to know the truth", Credence Publications, 2000)

"Several full-time scientists at the McGill Cancer Center sent to 118 doctors, all experts on lung cancer, a questionnaire to determine the level of trust they had in the therapies they were applying; they were asked to imagine that they themselves had contracted the disease and which of the six current experimental therapies they would choose. 79 doctors answered, 64 of them said that they would not consent to undergo any treatment containing cis-platinum – one of the common chemotherapy drugs they used – while 58 out of 79 believed that all the experimental therapies above were not accepted because of the ineffectiveness and the elevated level of toxicity of chemotherapy." (Philip Day, "Cancer: Why we're still dying to know the truth", Credence Publications, 2000)

"Doctor Ulrich Able, a German epidemiologist of the Heidelberg Mannheim Tumor Clinic, has exhaustively analyzed and reviewed all the main studies and clinical experiments ever performed on

CANCER IS A FUNGUS

chemotherapy Able discovered that the comprehensive world rate of positive outcomes because of chemotherapy was frightening, because, simply, nowhere was scientific evidence available demonstrating that chemotherapy is able to 'prolong in any appreciable way the life of patients affected by the most common type of organ cancer.' Able highlights the fact that rarely



dr. Ulrich Abel

chemotherapy improves the quality of life, describing it as a scientific squalor, while maintaining that at least 80 per cent of chemotherapy administered in the world is worthless. Even if there is no scientific proof whatsoever that chemotherapy works, neither doctors nor patients are prepared to give it up. (Lancet, Aug. 10, 1991). None of the main media has ever mentioned this exhaustive study: it has been completely buried" (Tim O'Shea, "Chemotherapy – An Unproven Procedure")

"According to medical associations, the notorious and dangerous side effects of drugs have become the fourth main cause of death after infarction, cancer, and apoplexy" (Journal of the American Medical Association, April 15, 1998)

Most likely, therefore, the basic theories upon which current oncology rests are wrong, with the consequence of making any research useless and non-productive, even when supported by an economic-scientific apparatus of planetary dimensions.

Descartes says: *"The majority of suffrage is not a reliable proof when it comes to truths that are difficult to discover, for it is much more likely that those truths have been discovered by just one man rather than a whole population".* ¹⁹

The philosophy of science suggests that where it is impossible to find a solution with the conceptual instruments that are commonly accepted, a counter-intuitive behavior (that is, opposite to what has been followed so far) must be adopted.

It follows that the only admissible and logical approach to the cancer problem is *to refute* the principle on which oncological studies are based – that is, that *cancer is caused by a cellular reproductive anomaly.*

However, if we question the validity of the cellular reproductive anomaly, it is also clear that other theories deriving from it are also untenable.

Examples of these are the theory of an auto-immunological process through which elements that defend against agents external to the body instead address their destructive capacity against internal constituents, and the theory that anomalies of genetic structure explain development in an auto-destructive direction.

The attempt to propose a multi-causal theory with oncogenic effect on cellular reproduction (that is, that cancer has many causes) appears more of an empty shield behind which, unfortunately, there are no solutions. This is because such a theory proposes endless causes that are more or less associated with each other and which, at the end of it all, mean that we have found none.

Smoking, alcohol, toxic substances, environment, dietary habits, stress, psychological elements, and various genetic factors are invoked every time, only to produce confusion and resignation. An answer that, after all, may be much simpler than perceived, remains cloaked with mystery.

The Bluff of Genetics and of the "Scientifically Proven"

Each scientific problem is, or should be, first of all a theoretical problem that is used to construct a track that leads to the resolution of a certain morbid condition, that is, to an appropriate therapy. Once the cause of the disease has been identified, the therapeutic, practical approach should be in function of the cause.

Unfortunately, this does not happen in modern oncology, because no one, neither in official medicine, nor in so-called alternative medicine, goes through the trouble of conceiving a specific, logical subject as the origin of neoplastic disease.

In spite of this fundamental deficiency, oncologists and researchers put the concept of the "scientifically proven" in first place in their evaluation of a theory or of a therapeutic system



Descartes

concerning tumors. This concept is the sole and indispensable passport for the acceptance or rejection of any proposal for study or therapy. Schematically, this concept is based on some simple principles of Galilean origin or, more recently, of Popperian origin, which must be observed by those who want to progress in the path of science. These are:

1. the formulation of a hypothesis following the observation of a phenomenon, or combined phenomena,
2. the reproduction and study of the phenomenon so that it can be analyzed,
3. the formulation of a law of judgment describing the phenomenon and allowing the making of predictions and the course of the scientist's actions,
4. the ability to share the results obtained with all other researchers, which enables others to make use of what has been discovered or acquired as the basis of further studies, verifications, and applications.

Who could ever disagree with this? Who could ever refuse such guarantee for the scientific world as well as for society? Nobody would ever dream of deviating from such a system! A scientist who neglected to follow such a method of study would not only not go far in his research, but would surely end up being isolated.

In reality, current oncology is an extremely leaky vessel, and it does no good to try to hang on to the scrupulousness of the scientific method when the practical results have eluded us for decades. What is the cause of such a failure? What are the problems and the misunderstandings in such a state of affairs? No doubt a lack of direction and of innovative ways of thinking!

At the beginning, a theory has a disruptive, revolutionary effect, thus enriching the existing conceptual apparatus. This happens at least at first, when it is able to supply (at least potentially) some interpretations of the reality under study that are more compelling than preceding theories.

However, if a theory is unable to supply all or part of the explanations for the phenomena it studies in a reasonable time, it inevitably slides into such dryness and self-defeat that its studies and experiments become repetitive and unfruitful. It becomes, in other words, a dead theory even when studies and experiments continue to be performed.

What is actually happening is a decoupling of the initial idea from the ensuing concepts and related experiments, so creating a dynamism where the supporting idea drifts more and more towards a metaphysical dimension where it is stored as an acquired fact, safely protected from any criticism and verification. At this point, all the subsidiary hypotheses, together with the pile of fruitless experiments, tend to amplify themselves uselessly to infinity.

Let us take, as an example, the metaphysical hypothesis “the god Vishnu exists because he heals his creatures with the elements of the universe, with the sun, the water, and earth” and let us try to demonstrate scientifically that this corresponds to the truth.

What would scientists do to confirm this hypothesis? Undoubtedly they would set up two tracks of research, an epidemiological one and one treating the chemistry and physics. The size of such research projects would be more or less a function of the monetary support coming in from around the world.

It could be expected that in the richest nations like the United States scientists would start by calculating the intensity of light or its refraction index in relationship to various areas of territory and in relation to the measured medium height and weight of a certain number of individuals taken as a representative sample from different cities. Epidemiological studies would then be set up in different areas of the country and would be extended to the composition of water and earth in relation to the circumference of the abdomen or limbs of individuals, and so on!

The molecular variations of each metabolic process in relation to the leanness or fatness of the individuals would be studied in the lab, as well as the genetic differences of various receptors which could be the cause of a malfunctioning metabolism, and so on.

The only guarantee expected from this experimental plan would be to observe the strictest methodological rigor with particular respect to the accuracy of measurements, the adoption of accepted criteria of evaluation in terms of margin of error, confidence intervals, quality of evidence, scrupulousness of interviews, relationship to published studies, and the prerogative of the repeatability of experiments and thus the sharing of results with the international academic world.

Although the example of the god Vishnu is clearly absurd, the procedure described could be applied in an attempt to demonstrate the genetic theory. *This demonstration is as impossible as it would be to attempt to demonstrate the existence of Vishnu by measuring and studying the world in any conceivable way.*

They both remain an object of faith.

This statement can be clarified with some simple considerations. There are two basic assertions around which the thinking about research and oncological theory rotates.

The first hypothesis is that the uncontrolled growth comes from an alteration of the mechanism of growth caused by a degeneration and therefore *by a malfunctioning of the genes.*

The other assertion is descriptive, to the effect that a tumor is a mass of cells that *tend to grow more and more.* Since the latter assertion is a statement of fact and the former a hypothesis which intends to demonstrate that fact, a further interpretative step is necessary. A further hypothesis is prepared that supplies more detail: the alteration of cellular growth is due to a phenomenon of *exaggerated cellular multiplication.*

This hypothesis, in turn, needs further explanatory elements: what are the causes that determine such uncontrolled multiplication?

The further explanatory hypothesis is that multiplication is determined by a *malfunctioning* of some segment of the DNA pertaining to the genes, in particular, the genes that are responsible for producing those molecules needed for cellular multiplication. The malfunctioning is then attributed to (another hypothesis) *molecular damage* or rather to an endless and at the moment unknown series of episodes of molecular damage.

Why does all this damage occur? What are the factors that determine it? Now, further explanatory hypotheses identify a series of possible generators of molecular alterations operating in hyperplastic functions such as *growth factors, hormones, toxic substances, radiation, viruses, dietary deficiencies, hereditary factors, immunological dysfunctions, excessive neuropsychiatric stress,* and others.

It is clear that the first four of the 14 hypotheses that we have mentioned are exclusively theoretical while the others, by being

more specific, can be subject to experimentation. One can see right away that this is an impossible enterprise, since the number of possible elements for study are almost endless; just think of all the enzymes and proteins that are in a cell, or the myriad of toxic substances that may act on it.

Furthermore, a deeper analysis of the first basic assertions – that is, that a tumor is due to an alteration of the mechanism of growth – highlights the fact that this assertion is made up of different concepts.

• The implicit one, tacitly taken for granted, is that the cell mass tends intrinsically to continue to grow.

• The hypothesis that this happens because of a gene malfunction

• The hypothesis that this is caused by the degeneration of the genes at the molecular level.

• The hypothesis that the malfunction determines a cellular multiplication that is out of control.

What is to be demonstrated here is not just the base assertion, but also its constituent propositions.

Consequently, experiments can be conducted for each constituent proposition, with the result that each experiment remains confined and does not relate to the others because of the infinite number of elements that can come into play.

For example, a line of experiments may concern the characteristics of cellular growth such as the measurable entity, the degree, or the quality of the subtypes in reproduction, differential relationship with the different types of cancer, and so on. A second approach for research might concern which genes are malfunctioning in various neoplasms, so that they can be classified as oncogenics.

Another approach might be to research the synergy of the various genetic clusters to study over a much longer period of time – years or decades – including the process of *in vitro* immortalization in relationship to carcinogenesis. The study of the endless number of toxic factors capable of triggering molecular alterations is another investigative path not to be disregarded.

From the above, one can clearly understand why the genetic theory on cancer is never able to reach any conclusion and/or positive results: by experimenting *ad infinitum* on an infinite

number of phenomena it can only be inconclusive and have no real usefulness. **Genetics and cancer have nothing to do with each other!** Or, as Hume says: “*Either a demonstration is irresistible or it has no power at all*”.²⁰

Heidegger adds: “*...A river of words of an argument does nothing but obscure what is to be understood, giving it the appearance of clarity that comes from cunning and banalization*”.²¹

The conclusion is that the experimental method, even when utilized in the best of ways, comes to no result when it serves an empty idea that is metaphysical and never demonstrable.

It is therefore useless to wag one’s finger or boast of possessing a scientific method that guarantees nothing. Not only is this senseless, it is also at the same level – although in a more educated form – as that of charlatans and of those who try to find the cure for cancer by moving pendulums or by the laying on of hands.

Before refuting genetics, however, it is necessary to understand to what extent genetic explanations have truth, so that it is possible once and for all to unmask the fallacy of this approach, and consequently the absurdity of proposing therapeutic systems anchored to this void.

What then is genetics? What does it propose? On what certainties is it based? What do the sacred books say? And finally, what certainties does it offer to the patient?



David Hume

We should emphasize that these are not just theoretical issues, but penetrate to the essential foundations of official oncological therapies – therapies that *would be disqualified* if the inconsistency of the principles and the deductions of genetics are demonstrated.

The demonstration of the lack of foundations of genetics would have as a consequence the disappearance of the current oncological therapies and, with it, enormous and useless research programs which are capable of

producing only bundles of “ifs” which dangerously abuse the conditional tense.

To better understand the underlying dynamics of a proposed anti-cancer therapy, it is perhaps useful to create an example using a hypothetical dialogue between an oncologist and the patient.

Patient: Doctor, why should I undergo an operation as well as chemotherapy and radiotherapy?

Doctor: Because, you see, there is a cell here that has started to proliferate and to reproduce out of control, since some of its genes have acquired such characteristics as not to have a limit in transmitting reproductive signals, and these signals are boundless. If we could destroy the mass of the degenerated cells with chemotherapy and radiotherapy, or through surgical separation, then we could obtain highly positive results.

Patient: So, the whole problem is the destruction of the sick cells?

Doctor: Correct. And this today is a goal that we can attempt to reach in several ways. You see, research today has taken giant steps: besides the therapies I have mentioned, there is also immunogenetics with active immunotherapy, genetic therapy and monoclonal antibodies, as well as hormone therapy, which is particularly effective with hormone-sensitive tumors such as those affecting the breast or prostate.

Furthermore, we have anti-angiogenetic therapy, which by preventing the generation of new blood vessels feeding the tumor tends to make it regress by “starvation”.

And let’s not forget a whole series of immunostimulant substances which are capable of changing and powering up the response of the immunological system towards those cells that escaped the process of regulated growth.

Patient: No doubt one can be reassured by such advanced scientific knowledge, which penetrates so far into the depth and into the intimacy of the most delicate cellular reproductive mechanisms, doctor.

Doctor: Certainly. Just think, for example, that by using monoclonal antibodies we are able to hit one single peptide or a single anomalous protein with extreme precision , as if we were

using a micro-laser or a micro-scalpel. Imagine that through gene therapy we are able to transfer a suicidal gene into the diseased cells so that we can expose them more easily to destruction by an anti-neoplastic drug, and so on.

Patient: So I may hope therefore to find a winning solution most appropriate for my case in the combination of therapeutic components, doctor. I just hope that you can find what really works best for my disease.

Doctor: Don't worry, I'm sure that we'll find the best way to solve your case by using the new methods of investigation and the work of the specialists in the field.

Patient: Fiat voluntas dei (may the will of God be fulfilled).

We observe three significant points in the above dialogue.

1 All therapies are based on a presumed genetic degeneration which in turn is responsible for the unregulated reproduction of cells.

2 The methods and studies of the research which are observed by a massive number of scientists actually seem very advanced and sophisticated.

3 The patient may rely on the work of a great number of specialists capable of using specialized structures and instruments.

The natural question is: is this enough? Is this a guarantee for the health of a cancer patient?

The answer is: "**Absolutely not, because it is all false!**" Parades of grandeur such as these are worthless when they are based not on certainties but only on an undemonstrated hypothesis.

In fact, nobody has ever demonstrated a link between cellular hyperproduction and cancer, between mutagenesis and malignant transformation, between hyperproductive cellular effects observed in vitro and cancers occurring in flesh-and-bones patients.

The reality of a laboratory is one thing, the reality of life is another.

The presentation by official medicine of inconsistent theoretical oncological positions as truth is not acceptable. They are sold to us as based on acceptable logical structures, while it is well-known that they, at the start, are failures.

Let us take, for example, what is written in “*Oncological Medicine*” (Bonadonna G., Rubustelli G., edizioni CEA, Milan, 1999).

In the explanation of the metastatization process on page 166, we read: “*From what we have shown so far, **it is evident** that aside from mechanical factors such as the dimensions of cells and of the vessel channel as well as cellular deformation, the selectivity for specific vascular locations is tied to the mechanism of adhesion to the vessels’ walls, to the type of degradational enzymes produced by the neoplastic cell, and of inhibiting enzymes present in the tissue of the vessel, to chemeotactical and aptotactical factors that drive the establishment of the single cell in optimal locations for proliferation, to autocrine and paracrine growth factors, and to the possibility of initiating and maintaining the angiogenesis process*”.

From the above, it is clear that what we state about the lack of soundness of the basis of oncological therapies is already shared by others. On the same page, concerning the mechanism of migration and growth on a vascular basis, we read, “*The molecular bases of the phenomenon are not known...*”, and again at page 160, “*The angiogenesis process, finally, occurs when metastatization has taken place already.*”

In summation, the phrase “*It is evident that*” is loaded only with negative outcomes, thus it is *substantially false*, as after all is the rest of oncology, the theories of which in synthesis foresee the existence of the following pathogenetic factors (phenomena).

- A. Alterations of genes and chromosomes.
- B. Molecular alterations.
- C. Neoplastic cellular transformation mediated by the hormones.
- D. Neoplastic cellular transformation mediated by the growth factors.
- E. Cellular transformation favored by a state of immunodeficiency.

The hypothesis of uncontrolled proliferation (*UP*) would depend therefore on the convergence of the five above-mentioned factors.

a. In the first case, the uncontrolled proliferation would be explained by phenomenon A, which in turn is explained by phenomenon B and so on until the last factor.

b. In the second case, the uncontrolled proliferation would be explained by the simultaneous action of all the factors at play.

Schematically:

- 1) $UP < A < B < C < D < E$
- 2) $UP = A + B + C + D + E$

Let us consider, however, what is reported in the work we have cited above concerning the factors mentioned.

Factor A: page 7, third paragraph. "*The mechanism through which chromosomal alterations occur is to date **unknown.***"

Factor B: page 137, last paragraph. "*A more direct use of molecular lesions in a therapeutic sense seems **still uncertain** today.*"

Factor C: page 385. "*...The various methodologies employed in the attempt to discriminate the hormone dependant forms, both in the mammary carcinoma and in other neoplasias have only given **approximate indications.***"

Factor D: end of page 124. "*In spite of the biological interest in this class of proto-oncogens **no growth factor** has so far been demonstrated to be structurally involved in genetic lesions of human tumors.*"

Factor E: page 157. "*... The immunological specific therapy of human tumors, which is the ultimate goal of every immuno-oncology research, is currently **more potential than it is actual...***"

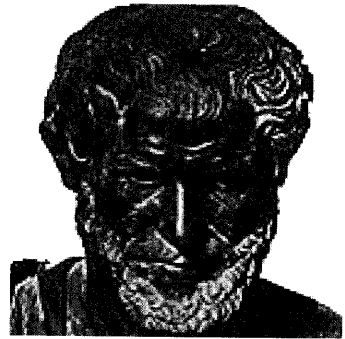
What emerges is that, according to the multiphase (consequential) model, the base hypothesis UP is explained by the unknown phenomenon A, which is explained by the unknown phenomenon B, in turn explained by unknown C and so on, to the point where any number of unknown phenomena can be added to the endless chain.

In the second case, hypothesis UP is explained through the convergence of many phenomena (A, B, C, D, E, n) which are also all unknown.

From what we have explored so far, it is clear that, regardless of the method of explanation used since all factors are unknown, the main hypothesis of oncology remains a mystery, as it is still anchored to the formidable mechanism of multifactoriality, which is able to explain everything without knowing anything.

When faced with such illogical logic, it is natural to question whether the formulation of the fundamental hypothesis of oncology possesses the requisites for a rational proposition – or if, at least, it corresponds descriptively to the truth.

But there we are hit by a surprise: “A tumor is constituted by different populations from the kinetic point of view, as the proliferating cells are often a minority... in solid tumors, instead, the exponential rate of growth takes place only during the initial phase of the life of the tumor.” (Bonadonna, Rubustelli, page 72).



Aristotele

The fundamental principle or hypothesis upon which all of oncology rests is, therefore, clearly false because:

1 it is deprived of a rational truth, since it does not rest on a non-contradictory principle: hyperplasia (the abnormal growth of cells) is and is not admitted at the same time;

2 it is deprived of a sufficient reason because, since all the facts or explanatory phenomena are unknown, it does not exist for any factual reason.

Aristotle says: “On the other hand, it is just because we know that an object exists, that we are looking for the reason why it is; it is instead difficult to understand an object,...when we do not know that it is.”²²

Schopenhauer comments: “What’s the use for explanations that ultimately lead to something which is as unknown as the original problem was.”²³

In conclusion, a non-existent “fact” is explained with unknown phenomena, and furthermore the base hypothesis of a genetic causality intended to explain neoplastic hyper production is reduced to a forced conclusion.



Schopenhauer

That forced conclusion consists of the fact that the mechanisms proposed for the normal productive cellular activity of the body – in simple words, that which occurs every day – would, for unspecified causes,

assume at a certain point a behavior which is contrary to that which generally occurs in the tissues. When considered through this distorted lens then, the very same genes that normally have a positive role in cellular reproduction are defined as proto-oncogenic, and instead those that inhibit the reproduction are called suppressor genes or recessive genes.

For example, the gene on which the thyroidal hormone normally depends, a gene that is produced every day, at a certain point and without a reason – and here is the mystery that supports all the research – becomes anomalous and has repercussions on the growth cycles.

This is tantamount to hypothesizing that the mouth, an organ presupposed to consumption and the mastication of food at a certain point of life and all of a sudden gets utilized to bite and chew one's own hands.

But if the processes of the disease are unknown, the base hypothesis of oncology has no verification in reality, since the presupposition of the hypothesis is a forced interpretation, thus an invention. In practice, if all the levels of the system are falsified, then it is hard to understand why an idea which is totally bankrupt continues to be sustained.

The mysterious and complex genetic factors, the monstrous reproductive ability of a pathological entity capable of deconstructing any tissue, the implicit ancestral tendency of the human organism to deviate in a self-destructive direction – and many other similar arguments – seasoned with vast numbers of “ifs” and “perhaps” combined in exponential ways – can no longer satisfy anybody, as they are only lunatic's ravings.

Kary Mullis, the Nobel Price scientist who discovered the PCR, a method of DNA amplification, in an interview by Celia Farber published in the July 1994 issue of "Spin", strongly criticized those in the scientific community who spread lies passing them as scientific data: *"I observe those people studying oncogens and think: yes, I know what they are doing; the usual trash. Oncogens have nothing to do with cancer."*

Why do scientists continue to promote such a baseless idea? What is driving scholars to continue to profess such a wacky theory? The only true logical motive possible might be the force of habit.

Kant says: “*Where ... someone should be even silent and confess his ignorance...he considers as known what he knows because of frequent and familiar use ... he imagine he sees and knows what his own apprehensions and hopes push him to admit and believe.*”²⁴

This behavior reminds us of the story of the drunk who is looking for something under a streetlight.

A passer-by asks him: “Do you have a problem?”

The drunk: “I lost my key.”

“Where did you lose it?”

“On the other side of the street.”

“But what are you doing here, then?” asks the passer-by, surprised.

“Well, at least here there is light.”

“*It is in this way that science works - comments Noam Chomsky - it looks where there is light, because it is the only thing that it can do.*”²⁵ In this way, “...*Error can dominate for centuries and impose on entire populations its iron yoke*”, adds Schopenhauer.²⁵

The Bluff of Multifactoriality

One of the most important arguments that supports the genetic theory in oncology is multifactoriality.

The basis of this concept is the assumption that the concomitance of more factors (causes) is necessary for the development of neoplasia. These causes act in a combined and multiphase fashion for a more or less extended period of time and then activate that genetic degeneration which in turn is responsible for uncontrolled cellular reproduction, which is the cause of cancer.

Such a conceptual position is, as we have demonstrated, very complex and consequently very obscure, since the variables of the specific components that are often incomprehensible in their formulation, tend to an extremely high number if not to infinity.

But, at a logical level, admitting the existence of infinite causes of a morbid process means admitting ignorance about the real ones.

To propose a multifactorial causal model, where a high number of factors are still unknown, means to admit the ignorance of the cause. This fact has been recognized and accepted in all epochs.

Here are some citations.

"...Through a lesser number of them (propositions) we will reach knowledge faster...". (Organon, Aristotle)

"Complex ideas are much more liable to be false." (J. Locke)

"To invent without any scruple a new principle for every phenomenon, instead of adapting it to one already known; to burden our hypotheses with such multiplicity, this constitutes certain proof that none of those principles is the right one, and that we only want to hide our ignorance of the truth with a pile of falsity." (D. Hume).

"When it (the science) after much appareling and preparation, as soon as it reaches the goal, it falls into embarrassment or to reach the goal it has once again and more than once starts all over again and finds new routes, if the time comes when agreement is not possible among peers on the way through which the common goal must be pursued. The one can always be convinced that such study is still very far from following the proper and safe way of a science and it is instead just a groping..." (I. Kant).

"...That, furthermore, the safest way to reach the truth is always the shortest, for any interpolation of concepts can be the cause of falsehood..." (A. Schopenhauer)

"In fact, the complication of the apparatus has no relationship with its effectiveness and practically no scientific theory of any interest can be expressed in this vast system of minutiae".

(Karl Popper)

Multifactoriality is therefore an empty and bankrupt concept for any research. Better yet, it is a screen that hides the deepest scientific impotence.

The Bluff of Cancer Statistics

One of the most controversial and contradictory arguments of oncology is no doubt that concerning the survival statistics of cancer patients. According to these statistics, one person out of two officially recovers. Although dramatic, the information nevertheless contains a certain amount of hope, as implicitly it provides something positive for both scientists and patients.

To the scientists it says: continue the research as started because it is producing results; do not try alternative theoretical or therapeutic roads, nor get discouraged by the fact that patients

keep on dying every day. To the patients, on the other hand, it provides a warning: you have a 50 per cent chance of making it, as long as you follow the conventional therapeutic protocols without trying useless alternatives.

But in practice, the statistical data presented acts as a scientific and psychological gag for those who, sensing the bankruptcy of official oncology, rightfully feel compelled to send it to hell once and for all for the following reasons.

- 1 Statistics aside, just by recalling our personal acquaintances we can see that those who escape a real cancer can be counted on the fingers of one hand.
- 2 Official therapies produce effects that are devastating and often deadly.
- 3 Many of those patients who move away from the official treatments live better and longer.
- 4 The prospect of discovering the cause of cancer is at least 10 years away.

On the one hand, therefore, we have experience and evidence telling us to shy away from conventional oncological therapies, while on the other hand, that flag showing us a 50 % survival rate is waved in our faces as if it were a guarantee of success.

It is clear that if this information could be confuted even partially, the castle of oncology would crumble immediately. Let us therefore analyze more deeply this statistical world of the 50 % to understand where misunderstandings and frauds are hidden.

First statistical argument: to what or to whom do we refer when we state that 50 per cent of the cancer patients recover?

It is clear that this data is formulated far too generically. It can only create confusion and mystification of the problem, because it can be the object of a vast range of interpretations. Is it intended as an arithmetical mean between the annual incidence of new cases of cancer and those who die of the same disease? If this is the case then we would have 50 patients who die for every 100 new cases.



Karl Popper

Or is the data an average between the survival percentages of tumors of all kinds? For example, if the survival rate for a tumor of the lung is 10 per cent and that for the follicular capsulated carcinoma of the thyroid gland has a survival rate of 90 per cent, one could assert that the global mortality percentage for both tumors is 50 per cent. By the same token, one can obtain an average by calculating the percentages of all tumors.

It is clear however that the second statistical system is totally false, because tumors that have a disproportionately different incidence from each other are placed on the same level. In fact, if the incidence of the occurrence of a lung tumor is 100 in 100,000 people, and that of thyroidal adenoma is 1 in 100,000 people, it is absolutely useless to state that the global mortality percentage is 50 per cent. This is because, given that only 10 per cent of the lung cancer patients survive, maths show that 90 out of 101 cancer patients die.

Second statistical argument: what types of lesions are considered in statistical oncological investigations? As is known, in the evaluation of cancer there is a whole gamut of definitions of masses ranging from the so-called “dubious” neo-formation to what is called simul-cancerous and pre-cancerous up to that which is clearly neoplastic.

These obviously represent a noticeable source of error, because neo-formations that are not tumors at all are often included in oncological statistics, thus greatly diminishing the accuracy.

This is the case for polyps in the rectal-colon or for dysplastic formations of the breast, and for many other harmless neo-formations which indeed inflate statistics but that certainly do not belong to neoplastic diseases.

Third statistical argument: what is the criterion for defining the recovery from a tumor?

Often – if not most of the time – the fairly meaningless term “clinical recovery” is used in the hospital discharge report after a surgical intervention is performed (for example, intestinal resection).

And if after a certain period of time a quick-killing hepatic (liver) metastasis arises, how is this considered? It is clear that if a hepatic

neoplasm is considered to be *ex novo* as often happens, the statistical values are false since the original neoplasia will be recorded as having been recovered from or healed.

Here is another example of data mystification in the statistical calculation: a sick person who is admitted to the hospital many times and is discharged as recovered each time. Each discharge is numerically considered as a percentile case and so inflates the recovery rate.

Third and last example. The patient is treated in a hospital and is discharged as a case who has responded to therapy, thus he constitutes a positive statistical case. When the same patient gets worse later on, is admitted to another hospital and then dies, it seems clear that here too statistics are counterfeit, since the preceding positive statistic should in reality have been negative.

Fourth statistical argument: conflict of interest. The structures and institutions that propose and apply conventional therapeutic protocols are the very same entities that compile the statistics. This is surely an anomaly, since there are no conditions that give any guarantee of how the acquired data is managed.

This makes as much sense as asking an innkeeper who is in competition with another innkeeper to rate the quality of the wines in both establishments.

It is true that science is science and that scientists should by definition and by personal conviction be above any temptation to deceive. But human nature is what it is, and history and the news teach us otherwise, showing how, for example, non-scientific evaluation elements are subtly insinuated consciously or subconsciously in the minds of those who handle statistical studies.

It is sufficient to remember the “Bezwoda affair” of a few years ago ²⁷ that witnessed the falsification on the part of numerous university professors throughout the world of the data concerning high-dosage chemotherapy. The conspiracy was unmasked by US insurance companies, unwilling to pay for a therapeutic methodology that was as greedy as it was useless.

This is not an isolated episode, as much as it seems to be the model for the management of studies and scientific information which is normally engineered and piloted to serve systems and purposes that have very little to do with medicine.

For example, Richard Smith, who is the ex-publisher of the important scientific journal *British Medical Journal*, reveals through an editorial published in *PLoS Medicine* how medical publications receiving massive amounts of money for advertisements have become nothing but an extension of the marketing arm of pharmaceutical multinationals.

Such dependence of medical journals on the pharmaceutical industry would belong – according to Smith – to the least corrupt expression of that dependence, especially when compared to the publication of clinical trials financed by the industry, the results of which are invariably influenced by those who pay for them, that is, *most of the time they are false or misleading*.

Fifth statistical argument: the fading phenomenon. One of the most enigmatic arguments permeating the theory and the practice of current oncology is that concerning the sense and the validity of scientific research aimed at finding those therapeutic strongholds capable of solving the problem of neoplastic disease.

A thick fog, in fact, surrounds this world, which with the passing of years and decades is still mysterious and evasive.

Granted that this is a complex subject to analyze, and granted also that the reliability of the highest research institutions in the world somehow guarantees the best quality available, the reality after over 50 year of experimentation is that the cancer mortality rate is not only not decreasing but is in fact steeply increasing in all geographical areas of the world.

The current research therefore all seems to be useless in spite of the fact that from every researcher and in every single study or clinical trial, this or that positive aspect is demonstrated somehow – an aspect that, it is claimed, improves the understanding of the cellular mechanisms of cancer and thus of improving the therapy for the benefit of patients.

If we go through the mental exercise of multiplying the positive element announced by each researcher by the number of effective drugs discovered by each study, we could surely come to the conclusion that oncological therapy has the power to solve 100 per cent of cancer cases – which is obviously false.

Where is the trick? How is it possible that every researcher is convinced of the goodness of his studies, complete with publication

and journalistic emphasis, in spite of the total state of bankruptcy of oncology? Are we facing people in bad faith or simply incapable of thinking? Or worse, are we facing the intellectual sloth of people who hide behind the conformity of what is “usually accepted” and consensual?

Without getting into the details of the psychological dynamics of these so-called scientists, it seems useful to understand the mechanism that enables these people always to find something good in what they study – that is, the mechanism that makes it possible for all to be right while achieving nothing.

This can be called the “*fading phenomenon*.” No doubt the “fading” phenomenon plays a primary role in decorating the most self-evident facts as important discoveries and in this way hiding away the traces of lies in a confusing track of conclusions that seem to lead somewhere but actually do not.

Any oncological study concerning chemotherapical drugs, hormonal inhibitors, monoclonal antibodies, anti-angiogenetics, or whatever innovation is created with a therapeutical function, is affected by this distortion, which is capable of influencing scholars to the point of hiding the utmost scientific impotence from their own eyes. One example can be used to demonstrate this entire argument:

the hormonal therapy for breast cancer

To restrict the field of research, let us take in particular the recently-created molecules with anti-hormonal action such as aromatase inhibitors or pure anti-estrogens, and let us try to analyze the theoretical and logical path that leads to the conclusion that these are effective substances for therapy against breast cancer.

When studying the scientific articles of the last five years it is noticeable that they start with the basic consideration – explicit, implicit, or commonly accepted – that 70 per cent of breast tumors are hormone-sensitive. This in itself already puts doubt on the acceptability and plausibility of the studies in question.

However, if we look at these studies more carefully, we can see that they are based on another consideration, that is, that only 70 per cent of the hormone-sensitive tumors are responsive to hormonal therapy.

What does “*responsive*” mean? According to the studies, this means that the pharmacological substances that are used are capable of improving certain aspects of the disease such as objective response, time of progression, quality of life and many others.

For the sake of simplicity, let us consider only the objective response (*OR*), which indicates the number of patients who, after being treated, exhibit a regression of the tumor.

Almost all studies indicate that the regression in general ranges between 20-30 per cent of the cases. This information taken by itself seems to have an interesting significance.

However, if we look closely, we realize that the *OR* is composed of two elements: the Complete Response (*CR*) and the Partial Response (*PR*) whose ratio is generally 1 to 10. That means that out of 10 patients who respond to the therapy, nine have a reduction of the mass – which will inevitably expand again in a short time – while only one patient obtains a complete regression.

If, at the end of all this, we carry out some calculations, we can easily see that all the studies on the effectiveness of hormonal therapies on breast cancer are reduced to a soap bubble and are therefore useless.

The facts are these.

1 We start with 70 per cent of the patients having a hormone-sensitive tumor, which means that they have positive hormonal receptors.

2 Only 70 per cent of this 70 per cent responds to therapy, which brings us to 50 per cent of the total number of patients.

3 Out of the aforementioned 50 per cent, only 30 per cent has an Objective Response, which brings the total down to 15 per cent.

4 Finally, out of the 15 per cent we have just mentioned, only 10 per cent obtains a complete regression. We are now down to 1.5 per cent of our original number.

It is clear to any researcher that this is meaningless data, as it is within the conventionally accepted generic fluctuation error of plus or minus five per cent applied to evaluations and measurements, thus it carries no significance.

In other words, the regression exhibited could be due to an endless number of factors ranging from diagnostic error to divine intervention! But nobody can state that any of them has anything to do with the effectiveness of the drug been used.

These results, sufficient in themselves to demonstrate the emptiness of the studies and of the therapies that are performed, become ridiculous when used in studies attempting to highlight the superiority of one anti-hormonal pharmacological substance compared to another.

If we take for example various molecules such as *tamoxifen*, *anastrozol*, *letrozol*, *exemestan*, *fulvestran*, etc., we notice that generally the effectiveness varies in the order of five per cent from one drug to another. This effectiveness, when compared with the 1.5 per cent of patients who respond, exhibits a variation of 0.01 per cent. This tiny number only serves to demonstrate the perfect idiocy of the studies performed.

Sic est! If we multiply this data by the number of anti-neoplastic substances that are utilized in oncological therapies, it becomes clear why cancer continues, relentlessly and unopposed, to kill millions of people.

Sixth statistical argument: suggestive extrapolation.

This method of exhibiting scientific data pretends to show elements that are seemingly convincing in support of certain molecules or therapeutical interventions which in reality have no effect. The suggestive technique is very simple, as it is capable of highlighting the presumed differences in effectiveness between this and that molecule, while at the same time hiding the fact that these analyses are performed on marginal variables which in themselves have an extremely low statistical value and basically have no meaning.

If we remain, for example, in the field of anti-hormonal therapies for breast cancer, and we refer to *tamoxifen*, which is the substance that has been used for decades in the treatment of this neoplasia, its demonstrated effectiveness in the prevention of the development of a counter-lateral tumor is reported: "*Numerous randomized studies indicate that the prolonged administration of tamoxifen adjuvant has been capable of decreasing the risk of development of counter-lateral breast carcinoma by about 40 per cent...*" (Bonadonna, page 728).

This data, which seems so significant, is in reality a statistical bluff. This is because that type of cancer has such an extremely rare record of cases that it is in itself insignificant.

Let us see how rare: "*The incidence of bilateral breast cancer is probably higher than what was believed in the past (about 1 per cent per year)*". (Bonadonna, page 727).

The greatly trumpeted effectiveness of tamoxifen is therefore reduced to a value of 0.4 per cent, tantamount to nothing.

The Bluff of Endless Discoveries

For a long time now we have become used to expecting to hear news about the progress and the scientific conquests of humanity with great interest, from the discovery of lunar rocks to that of water on Mars, and from the cloning of Dolly the sheep to solar-powered automobiles. We are always awed and fascinated by the cognitive potential of humanity, while feeling a deep sense of admiration for that scientist or researcher who has been able to obtain some exceptional result.

This positive feeling is astutely exploited in medicine, and especially in oncology, to either mask or soften the bankrupt condition in which these two disciplines have been for two decades, while successfully convincing public opinion that what is done is the most that can be done.

As in a skillfully directed movie, an important discovery in genetics, molecular biology or other field is published with an almost monthly cadence – a discovery capable of enabling the production of new drugs that are effective against cancer. However, these discoveries that are trumpeted by the media everywhere are like meteors in the sky that punctually fade in the dark and are promptly forgotten.

In this way, scientists who in reality conclude nothing, manage to achieve two objectives, that of bamboozling society in spite of the fact that premature death affects it as a tornado would, and to continue to get financing and grants for studies that are as useless as they are endless.

The strategy implemented to perpetuate this grotesque situation is based on several important elements.

1st - *adoption of a field of investigation* – genetics and molecular biology - which is not accessible to the large majority of people, doctors included.

THE BLUFF OF ENDLESS DISCOVERIES

2nd - *refining and restriction of research* to the most infinitesimal level of investigation, which can only be undertaken with extremely expensive and sophisticated instrumentation.

3rd - *production of a symbolic language* that is very complex and articulate, thus difficult to acquire and master in its structure, and in its constant change.

4th - *exclusive recognition* to those biologists who have cognitive and interpretive power of molecular phenomena, with the consequent marginalization of the role of the physician.

5th - *production of emotionally suggestive subjects* of research chosen from a sea of obviousness, nevertheless emphasized each time as milestones in the battles against cancer.

6th - *media propaganda* sustained by a powerful and dense network of scientific, journalistic, and political collusions.

7th - *magnification and divulging* of successes of oncological research which in reality are either false or random.

8th - *repression and control* by means of institutional and methodological barriers of currents of thought that are either innovative or critical of the system.

In the last analysis, the concept of what is scientific is, in reality, supported only by the opportunity to perform studies and research as proposed and consecrated by state medicine – that is, with a method capable of excluding all those who are not “enrolled” in the system.

Only university professors and institutional notables as such can have access to the economic resources and the structures to perform research. Private individuals can afford that only if endowed with heavy funding – and this, in the last analysis, is almost exclusively possible only for the pharmaceutical industry.

In such a system, on one hand everything that is outside the logicity of power automatically becomes non-scientific, regardless of the goodness of the ideas and of that of the proposed therapies. On the other hand, any wacky theory or poisonous therapy can be administered in the name of the scientific method. The results:

Cancer patients must continue to die powerless, amongst the most atrocious suffering caused by State-Sanctioned Oncological Therapies, conned by a perverse information system that is supported by lies, false information, and bad faith.

If anybody bothered to analyze any study or oncological work on genes, viruses, receptors, molecules, pharmaceutical substances or anything else just for a minute he would immediately realize that he is stepping into a surreal world which is mainly dominated by collective idiocy.

In the studies – some of them reported in footnote 28 – the incredibly high number of relationships existing amongst biomolecules is analyzed with a technical jargon that is incomprehensible to doctors themselves.

One could go on for days studying, for example, the interrelations of a molecular cascade such as that which has been examined. However, one would inevitably fall into an endless spiral because, ultimately, the study is nothing but the *banal description of the molecular passages of any living cell*.

But there is more. If one sets up research that involves the experimentation of the substances that amplify or depress the activities of such molecules for each of the molecules that have been examined, such as carcinogens, DNA fragments, viruses, and chemotherapeutic drugs, we have a total Babel Tower, with the result that one can package the wackiest anti-cancer therapeutic protocol.

But why do we have to go insane to study ad infinitum the smallest molecular passages of a cell if all we have to do to effectively affect an enzyme or a protein of the organism is to find the **right poison that kills the cell**? This is what happens in reality: on the one hand, we have millions of banal and useless studies, and on the other, clinical and pharmacological experimentation with poisons which is completely decoupled from research, and which is used only as an excuse to enable blind cellular bombardments.

The bluff can be summarized here: useless studies and endless experimentation so that nobody understands anything, while the scientific impotence and the inadequacies of the current ontological systems are kept well in the dark.

The Contradictions of Oncology

Today, after so many years of disappointed expectations in oncology we should firmly discard the genetic matrix as cause of cancer. It is inconceivable that this theory should be supported

because the theory is anything but logical. It is an issue of faith rather than a scientific theory, and this becomes abundantly clear when one reads the "sacred texts" available on the market. By turning the pages of any of these texts or treatises on oncology or internal medicine, one can in fact realize that the positions, the conclusions, and the results of genetic theories are strikingly contradictory and illogical, and thus not acceptable. Given their foundations they cannot be any different.

We have examined the treatises "*Oncological Medicine*"²⁹, already mentioned, and "*Internal Medicine*"³⁰ where often, at the beginning of a paragraph, a model for explanation is proposed, and that model is infallibly refuted at the end³¹ to substantiate our conclusions. Careful reading of the two texts highlights how obscure the description of genetics currently is: there are thousands of "ifs" which never ever amount to a "yes". Furthermore, there is nothing concrete in the discussions concerning possible future results.

The excerpts reported in footnote 31 are sufficiently descriptive of the smokescreen of genetics, and clarify once and for all its illusions. They demonstrate that it can be dealt with only as a debate but certainly not at a scientific level and therefore is to be discarded. It is depressing to notice, however, that all of society and worse, the individual citizen, must suffer tremendously because of an endless entanglement of so many "*ifs, perhaps, could, and would*".

If we refute the validity of the current oncological perspectives, it is legitimate to ask how we are supposed to perceive the successes obtained by both official and alternative medicine. It is in fact true that almost every day, we hear from many sources that cures have taken place with this or that therapy.

At this point it is necessary to clarify that, if we admit to the possibility of improvements and cures, then logically it is not admissible to attribute them to this or that treatment that is more or less official. This is because, given that the majority of the components at play in the "object tumor" cannot be specified, then conditions that decisively establish the goodness of therapies cannot subsist.³² Paradoxically, the possible positive effect of any therapeutic system could stem from unknown and unforeseen elements which, in turn, could be influenced or determined somehow by any of the aforementioned therapeutic systems.

In other words, we could be in the situation where all therapies, including those of official medicine, would rightfully have the right to magnify their point of view, although the real reason for their success is unknown for any of them.

In this case, even the most accurate and rigorous experimentation would take on a fictional character rather than that of true correspondence with reality. It is for this reason that, at this point, we have to accept that oncology as we know it is dead. Nothing can be done, therefore, other than looking beyond it and moving forward.

The Real Odds for Cancer Survival

Everyone knows that cancer is an inexorable disease that gives no chance to those who are affected. Every one of us is aware that when an acquaintance, a relative, or a friend becomes sick with this terrible disease, his or her chances of survival are very slim, and only a miracle can save them!

Conversely, official statistics show percentages that are very encouraging and report an average recovery rate of about 50 per cent; that means that one person out of every two is saved. On the one hand, therefore, we see high mortality statistics coming from the real world; on the other, we see percentages that are somewhat reassuring and stem from “scientific analyses”.

How did we get to such a contradiction?

What are the motives and the causes that at this point just produce a feeling of resignation among citizens? I believe that the distorting elements can be divided into three categories: those that are related to the individual researcher, those where data is elaborated in a subjective manner, and those which are simply accepted in an uncritical manner. To the **first category** belong:

1. *Conformity*

A mental behavior that tends to take for granted what is proposed by other researchers.

2. *Complacency*

This behavior is stimulated most of the time by the actual conditions in which the researcher finds himself.

For example, the structure in which he operates, economic compensations, and so on.

The information acquired is consciously or unconsciously interpreted according to the way the research has been set up, that is, in a preconceived cognitive disposition.

3. *Bad faith*

A self-serving behavior in which people who are aware that a notion is false pass it on nonetheless.

4. *Fraud*

Where the data is consciously falsified.

5. *Fear*

This can take various forms: fear of mistakes, fear of causing damage, fear of being reported to authorities, of looking bad, and more. ^{32a}

The elements of distortion belong to the **second category**.

These elements are represented by those conditions of the researcher attributable to his mental structure and mental formation. In this case, one can talk about thoughtlessness.

6. *Lack of preparation*

This is the case when a researcher who is very good in his specific field of research lacks sufficient knowledge of other scientific arguments that are related to his studies. ^{32b}

7. *Lack of reason*

This occurs when data is accepted which is actually not acceptable. For example, the statistical data on bladder carcinoma shows a survival rate ranging from 13-45 per cent. ^{32c}

8. *Lack of attention*

Here the conditions are similar to those of the preceding point. In this case, however, the results and the wacky data normally furnished by oncological studies are neither identified nor focused on because the scholars – busy with other affairs (political, institutional, managerial, or other) – actually have no stimulation or interest to really understand in-depth what they are studying.

9. *Lack of energy*

Unfortunately, we are all immersed in a world with too fast a pace where we need to act frantically to keep in step with it.

If we add to this that medicine is a very complex and compelling discipline, one can easily understand how doctors and academics are subjected to workloads and mental stresses that are extremely high. ^{32d}

All those factors that condition a doctor or a researcher , generally without his awareness, belong to the **third category**.

10. *Passive acceptance of dominating ideas and ideologies*

Some examples should suffice: knowledge always acts gradually; experimentation is the only appropriate instrument for medical progress; neoplastic disease has multifactorial origin.

11. *Passive acceptance of ideas and theories from eminent researchers.*

One of the most common human mistakes is that of believing that the ideas and the opinions of doctors and scientists that are in eminent positions are more valid than the opinions of others.

So, for example, when a Nobel Prize winner, a doctor who is a former government minister, a full university professor, or even the man on the street who ends up being on television, comments on important themes such as the state of medical research, the developments of anti-cancer therapies or something else, we tend to accept what is said in an uncritical manner, as if what we hear were some kind of divine word. ^{32e}

12. *Reverence towards the great researchers of the past*

This attitude tends to overestimate the great figures of history and to accept their theories, although the evolution of scientific thinking demonstrates that most of the time they are false and/or belong only to the history of ideas. ^{32f}

13. *Passive acceptance of studies that are planned on a world scale* ^{32g}

The elements of distortion that we have examined induce scientists to often commit gross errors of judgment, and these errors get amplified each time they pass from researcher to researcher.

This is particularly true in oncology where, because of the absence of a rational principle and thread, the exact opposite of what is officially said takes place.

Officially, on the one hand, we hear of the constant achievement of positive results but, at the same time, we hear of the constant increment of cancer deaths. Doctors, scholars, and scientists parade their confidence while we see people who are desperate before the inexorable spread of the disease.

How can such antithetic realities coexist?

It is clear that the people who suffer and continue to die have

the right to a cure. Everything else just sounds like jackasses braying, reverberating more loudly by being accompanied by conceited authority.

What about the role of scholars, scientists, ministers, professional orders, scientific journals, journalists, and educational broadcasting? Is it possible that they all lie? Worse.

They create a junk information network where, except for a few exceptions, most are in bad faith and the rest are conformists complete with degrees and exploited for the sole purpose of servitude to economic interests.

At this point we should ask ourselves whether the statistics and scientific facts that are so freely bandied around are true or are products of imagination. Granted that they already contain, as we hoped to have demonstrated, remarkable elements of distortion, it seems useful to explore these statistics much more closely and to analyze the data that is *officially reported*.

Here comes the surprise. Even with all the tricks and distortion of statistics, a rate of cancer recovery gravitating *around seven per cent* is reported in classical books and treatises.

This means that, after the necessary corrections, the rate is effectively zero, as shown in table 1 next page.

What is it then that allows the scholars to package those captivating and reassuring statistical tables that keep on conning public opinion? The trick is possible if you work in that no-man's land that separates real tumors from those diseases that are not tumors.

Let me explain this better.

There is an international classification (the *TNM system*) that classifies tumors on the basis of their gravity. They are subdivided into stages I, II, III, IV, and into sub-groups.^{32h}

It is clear to any trained eye that initial lesions that are doubtful or at the limit of malignancy represent the overwhelming majority of the observed "neoplasias".

It is equally clear how often these presumed neoplasias, which are often subject to both misunderstanding and manipulation, inflate those statistics to the point of implausibility. So, in the early stages of tumors (the dubious ones) the recovery rates are extremely high, while in the following stages – that is, where they

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certainly are tumors – the rates are barely above zero.

The example of skin neo-formations, as they can be analyzed in a direct manner, may be useful in helping to understand such a contradictory system better. It is self-evident that, of all the nodules that can be observed (malignant tumors, benign tumors, cysts, lymphomas, dermatitis, warts, small scars, and more) just a tiny proportion belongs to the category of neoplasias.

For the neo-formations of the internal organs – where it is not possible to directly see and check – it is legitimate instead to expect

TUMOR		SURVIVAL TO 5 YEARS
1.	Malignant glomes (brain)	< 10 %
2.	Cervical-facial district	< 5 %
3.	Malignant melanomas	< 20 %
4.	Mastoid and ear neoplasias	< 25 %
5.	Lung	7,5 %
6.	Pleural mesothelioma	0 %
7.	Esophagus carcinoma	< 10 %
8.	Stomach carcinoma	< 13 %
9.	Small intestine neoplasias	25 %
10.	Liver carcinoma	0-2 %
11.	Gall bladder carcinoma	< 3 %
12.	Pancreas carcinoma	2 %
13.	Breast carcinoma locally advanced	5 %

*Table 1 Survival rates for some important neoplasias ³²ⁱ
(the sign "<" means "less than").*

almost as a rule both error and deceit.

The statistical manipulation phenomenon we have described above becomes even more obvious in its complexity when the objects of the study are those malignant neoplasias that in themselves tend to have benign characteristics, such as, for example, those of the thyroid, other glands, or other organs that are well-structured.

Where distortions and misunderstanding are difficult to implement – as, for example, in parenchymal organs (lung, liver, or brain) - the recovery statistics instead report negligible values because the statistics are forced to show the truth.

In conclusion, where does the famous fifty per cent recovery rate come from? From fraud! We must also highlight that the success of surgical removal of neo-formations under 1 cm are of little interest, as they never create a problem.

Conversely, if they wanted to demonstrate their effectiveness, the official oncological therapies should cure or at least achieve regression of the advanced neoplasias. But here, no doubt, the failure of classical oncology is complete.

* * *

THIRD CHAPTER

Candida: a New Theory of Cancer

Preliminary Considerations

If we neglect the most refined specifications of pathology, we can roughly subdivide diseases on the basis of their origin with respect to the human body as internal or external

The diseases coming from within are called *endogenous*, while those of external origin are called *exogenous*. Those that have elements of both are called *mixed*.

If we consider nosology to encompass all three of these areas it is possible to make the understanding of the relationship between therapeutics and pathology much simpler.

It is easy to see that endogenous diseases include all the imbalances and energy decompensations stemming from the behavior of the individual (mental, intellectual, psychic, spiritual, nutritional, genetic, and constitutional).

Exogenous diseases represent, conversely, the injuries caused to the organism by environmental and accidental conditions, as well as by infections. The mixed diseases, finally, consist of all the morbid entities where there is an interdependence between the elements of the two aforementioned divisions, with special reference to the interaction between personal elements and infections.

The scheme proposed above, although apparently simple, in reality presents more than one difficulty, because it is often not easy to find the actual influence of each component, especially

when the incidence of the external factors acquires different values for each subject.

For example, an earthquake, a legal act, a humiliation, or other past experiences with psychological repercussions, are external factors. The perception of them is nevertheless a function of the neuropsychic structure of the individual.

Moreover, suffering and debilitation can follow – a debilitation responsible for a possible increased receptivity to infection, exposure to intoxication, or simply poor diet. By understanding this, we can better understand the difficulty of finding a logical thread for diseases and syndromes that often show a polycentric genesis and a complex manifestation.

The in-depth analysis of the causes of diseases leads, therefore, to an important theoretical result. In order to improve the health condition of individuals, to advance in the field of research and defeat today's diseases requires simultaneous action on all available fronts. This means acting both at the holistic and allopathic level and using the weapons of a wise balance in life and a strenuous defense to external aggressions.

This essentially means following two principles.

First, that a doctor, clinician or more simply someone who wants to cure others, must have the courage to engage the world of life in all its manifestations - relying not only on a codified system of ideas, but also using his own personal qualities (such as sensitivity and humanity) to enable him to unveil the true and profound causes of the disease of each patient.

Second, that any experimenter, biologist, pharmacologist, and so on, cannot just lock himself in a laboratory in search of those solutions created only by an endless *additio partis ad partem* as the main thing he must do is understand important critical cues. Such a person needs first of all a clinical background upon which to plan his experiments and evaluate his results.

Only by keeping humanity, clinical work and experimentation united is it possible to acquire the enhanced interpretative dynamism needed to unveil the complex causal steps of diseases which are the result of events in space and time and escape our scrutiny given the current static methods of investigation.

One could ask why we should change the current set-up of the health system. The answer seems clear to me: given the current state of medicine, it is evident that man, the doctor, the scholar and the scientist have lowered their guard against the true enemies of health, and dazzled by a myriad of superficial and irrelevant themes have lost the only effective tool - microbiology - upon which it has been possible to build results, respect, and honors.

A renewed fight and one which is very energetic against infections must, therefore, be undertaken in a way that employs significant human resources. This is especially true today, when we are forced to shift to ever more refined levels of research.

My wish is that we will soon be able to study and master these infinitesimal planes with similar results to those obtained by the last century's microbiology, especially with respect to cancer. The hope is to free people from the nightmares of today's diseases, and to empower them with a greater autonomy of life.

On the basis of the above considerations, a solution to the problem tumors represent must necessarily be looked for in the three areas described before (autogenous, mixed, and exogenous diseases). In the first case, cancer would be caused exclusively by factors peculiar to the individual (genetic, auto-immunological, psychological, etc.). Those causes would therefore be necessary and sufficient for the development of a tumor.

In the second hypothesis, those causes (in synergy with external ones) would be necessary but not sufficient for the development of tumors.

In the third hypothesis, autogenous causes would be irrelevant, since only external pathogenic agents would be responsible for the neoplastic disease. Let us consider then *the facts about cancer* that we know at present.

1. Tumors belong to the realm of chronic disease.
2. Tumors attack any anatomical area.
3. They effect a worsening state of debilitation up to the point of cachexia.
4. They are responsible for a whole gamut of symptomatological manifestations, particularly for those conditions of non-specific general suffering.

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5. They invariably induce symptoms that are more grave when the organism is younger or more reactive.

6. They rarely produce hyperpyrexia (high fever) except in terminal phases.

7. Most of the time they dramatically worsen as a result of conventional therapies.

8. In some cases, considered miraculous, they regress completely without an apparent cause.

9. If "benign", thus always a cyst, they do not lead to nefarious or grave outcomes.

10. They can be experimentally reproduced with a variety of techniques, such as the use of radiation, the inoculation with oncogenic viruses, or the administration of more or less toxic substances (here it must be noted that even water, when applied as "Chinese drops" has been reported to have an oncogenic action).

11. They are able of causing an upset in the tissue levels which sometimes is so profound as to induce, especially when examined at the anatomical-pathological table, a feeling of disgust.

12. They constantly manifest, at the histological (tissue) level, cellular and nuclear alterations that are proportional to their malignancy (for example, the most undifferentiated type is the worst).

13. They are often considered to be a function of particular genetic configurations.

14. They never attack muscles.

15. They are often grafted on pre-existing pathological conditions (ulcer, cirrhosis, polyposis, etc.).

16. They are the outcome - and this is unanimous - of the combined action of a group of factors; that is, not of one element but a network of causes.

It is obvious how the above description of cancer, although summary, brings us in a direction that is different from current oncology, where only endogenous elements are considered pre-eminent, although amplified by the concurrence of a myriad of con-causal factors in an all-or-nothing game.

It therefore seems useful to consider various points in comparison with such a set-up.

a) If the real cause of tumors is unknown, then it does not seem legitimate to continue to push and propagandize the thesis of multifactoriality, firstly because it distracts the mind from acutely observing a single factor, and second because to do so favors a prejudicial feeling of impotence due to the diversity of material requiring study that cannot be individually dealt with.

b) The terms "invasive" and "metastasizing" must be distinguished clearly because the former has a primarily local meaning, while the latter has that of consequentiality. Thus, the presuppositions of the two terms are quite different both from the causal and from the pathogenic point of view: an invasion is not a colonization.

What is interesting, first of all, is the genesis, the beginning of the invasion, because it is upon this that a neoplastic attack is founded, and indeed it can be tracked to a process that has an internal or external origin. It is clear that the first hypothesis about the causes of cancer, the aforementioned autogenous one, poses major difficulties. How is it possible, we may ask, that a functioning physiological mechanism all of a sudden *ex nihilo* generates a self-destructing element?

The thesis that organisms, tissues, cells, can contain in themselves the conditions for an autonomous neoplastic degeneration demonstrates an attitude of faith rather than of science, first because it is intuitively difficult to admit that there might be a natural tendency of a living structure to autophagocytosis, and second because the reason for the passage from a normal to a pathological state is not logically explained.

The exercise of attempting to support such arguments by invoking auto-immunological or ultra-dimensional and ultra-complex genetic factors invariably turns out to be useless. This is because even unlimited specifications of a guiding concept that is insufficient can only contribute insufficiently. An exasperated analysis can indeed offer an exasperated explanation, but it can add nothing new to the original idea.

c) A demonstration of the point made above can be found in those rare cases that are non-fatal and that testify as to how a

neoplastic process can also have the character of reversibility. In effect, both when the recovery is attributed to a medical intervention and when it is depicted in almost supernatural colors (whether right or wrong in either case), the possibility of an actual regression of the tumoral disease is inarguable, and this effectively eliminates all those theories that are founded on an endogenous development.

d) Departing, therefore, from the difficulty of recognizing that the origin of the tumor is caused by an internal anomaly, both macroscopic alterations (of the organ or of the tissues) and microscopic alterations (cellular, nuclear) must be ascribed only to external harmful solicitations, either because of their direct effect (it is the disease that produces them) or as an endogenous reaction (they are the demonstration of insufficient defense).

It follows that organic deformities and degenerations, disruption of tissues, cellular atypicality and monstrosity, although very suggestive, can only be formally described outside of any causal analysis.

e) A question that is always posed in general pathology, and that is usually dismissed with excessive ease, is the phenomenon of the "benign tumor", relegated to a quiescent dimension which, since it usually poses no problems or concerns, is actually one of those shady areas that are underestimated and beyond which reason tends to stall. If this tumor is not considered to be a tumor in all its effects, then for the purposes of clarity it would be advantageous to log it as an appropriate nosological structure.

If instead we believe that it is a fully-fledged member of neoplastic pathology, then it is necessary to take into account its non-invasive character and consequently ask ourselves why it has such a character. The theses founded on a presumed predisposition of the organism to autophagocytosis are forced to admit the existence of a graduation even for the innocuous type of tumor, and thus stumble into additional difficulties to the point of making them look extremely improbable.

f) Some experimental data susceptible of non-univocal interpretation could be shown that is clearly not in line with the

train of thought that is being formed. We are talking about those cases when a cancerous formation is experimentally induced through toxic substances or radiation.

Such experiments demonstrate - this is the opinion of the supporters of autogenous development - that the organism contains within itself the seeds of tumoral degeneration. This is demonstrated by means of stimulations that, given their non-specific character, can only testify to the "natural" tendency to deviation of any bodily structure.

It is, however, easy to counter this statement by asking why, under normal life conditions and except for ecological disasters, there is almost never a high concentration of such a disease phenomenon. Since there are insufficient elements for the classification of a cancerous manifestation within a precise context, this can only demonstrate that when damaged past a certain point certain tissue cannot recuperate.

Instead, since external factors are always involved, it seems more logical to look for connections with the external world, possibly by investigating similar carcinogenic potentials and what other causes are capable of determining states of debilitation of tissue that are so grave as to prevent "natural" recuperation.

In this context, then, the useful message to extrapolate from strained and often ridiculous experimental positions (such as carcinogenic water, for example) is only to note that something, at a certain time, can have the power to "exhaust" a certain anatomical area which, if stimulated or attacked beyond its ability to recuperate, arrives at an irreversible condition.

g) Given that the plausibility of a prevailingly extracorporeal tumoral cause (etiopathogenesis) is crystal clear, the next step to take is that of associating it with available clinical information in an attempt to find the common denominator of all the elements at play, both theoretical and practical.

h) Lastly, the question arises of how official medicine has underestimated some experimental data which is highly significant as it shows the link between cancer and infections.

In reality, several authors have hypothesized the existence of

an infectious process as being at the basis of neoplastic lesions:

◦ As long ago as 1911, *P. Rous* obtained the development of malignant tumors with transmission by cellular filtrates of cancerous masses. ³³

◦ In 1939, *W. Reich* demonstrated that cancer is transmissible and thus of infectious origin. ³⁴

◦ *I. Ginsburg* has demonstrated how tumoral mouse cells infected with *Candida Albicans* and injected into synergistic stock exhibited remarkably increased aggressiveness and ability to grow when compared with tumoral cells that were not infected. ³⁵

◦ *G.C. Perri* has reported high incidence of neoplasias in mice fed with additional quotas of protein obtained from *Candida* ³⁶

Based on the above, it is now possible to outline a cancerous pathology in a sufficiently clear way:

Cancer is a disease caused by an external aggression which is favored by particular organic conditions. Its development is primarily and essentially local, but with further involvement of the whole organism to the point where the organism may be consumed.

But a real external aggression where living tissues and cells - that is, living structures - are involved, can only come from other living structures.

This is to say that it occurs through an infection that, no matter how atypical (or, rather, unknown), can only be explained by microbiology, and that can be studied, or perhaps studied again, with a new syntax that is in tune with the times.

The field of research, then, since it must necessarily involve all vital forms in relationship with the individual, can be explored both by revisiting and reconsidering knowledge already acquired and by exploring the horizon of unknown micro-organisms. In both cases, we must try to overcome the current scientific mentality, which is too static.

This can be achieved, for example, with the introduction of evaluations of temporal or spatial character.

It seems evident that the most profitable road to follow is that which includes all the known facts produced by the current scientific system. This is not because of the amount of data,

especially the descriptive data, but because we may find new ways to interpret that data. To that end, it is useful to remember the example of *helicobacter pylori*, a micro-organism whose pathogenic value has always been neglected, and which turned out to be the causal agent of gastric ulcers.

In view of the data available, the answer for neoplastic disease may be hidden in one of the elements of microbiology, that is, bacteria, viruses, or mycetes.

The solution emerges as soon as we turn to clinical experience which, combined with a wealth of descriptive elements, can only suggest that the mycetes or fungus is the sole agent responsible. It is the only one that can explain the incubation, rooting, course, and symptomatology of tumors. There are also several clinical considerations in favor of this theory.

1) Generally speaking, a bacteriological infection with a non-occasional pathogenic character causes elevated levels of exhaustion and the regression of exhaustion in a short time.

It is accompanied by an elevated fever, it generally produces a pathology of the organs with related symptomatology which is globally stereotyped. Its action, therefore, takes place in a determined organ and in a precise temporal space.

2) A viral infection exclusively of the endocellular type is characterized by such rapidity, and ensuing *hyper-pyretic climax* (high fever), as to be sometimes instantaneous because of the viruses' small dimensions, which allow for immediate diffusion.

Its action takes place and terminates in an extremely short time, with cellular effects that are exclusively necrotizing, but not in the direction of a metaplastic induction power.

In the cases where, instead, chronic pathology is produced, such as cirrhotic hepatitis, the causal agent can be found easily.

3) The morbid manifestations of bacterial origin with a more marked tendency to become chronic belong to that species of germs that show as mycetes, or, rather, their spores do, with a high content of lipids (fatty acids) in their structure.



Wilhelm Reich

It is for this reason that the bacillus of a chronic bacterial disease such as tuberculosis is called a mycobacterium.

4) Even real oncogenic viruses (actually rare) for which an actual malignancy in animals has been observed show a high lipid content in their structure.

From everything we have considered so far, the most logical and real cause of neoplastic proliferation would seem to be a fungus, and most likely one of those somehow pathogenic to humans.

The World of Fungi

As early as the nineteenth century, the German biologist *Ernest Haeckele* (1834-1919), when using the Linnean concept³⁷ that makes two great kingdoms out of all living things - that of vegetables and that of animals - reported difficulties of classification for all those microscopic organisms that because of the properties and characteristics could not be put into either the animal or the vegetable kingdom. He, therefore, proposed a third kingdom, that he called *Protist*.

O. Verona says:

"This vast and complex world ranges from entities with a sub-cellular structure - and here we are at the limit of life - such as viruses and viroidals, to get - through microplasms - to other organisms of higher organization: bacteria, actinomycetes, myxomycetes, fungi, protozoa, and if we want, even some microscopic algae." ³⁸

The common element of all these organisms is the feeding system, which, save for a few exceptions, takes place with direct absorption of soluble organic compounds. That differentiates them from both animals, which nourish themselves by ingesting solid organic materials that are transformed with digestive processes, and from vegetables, which synthesize the organic substance from mineral compounds through light energy.

Although perfected, the current tendency of biologists is to adopt the concept of the Third Kingdom. Some go even further, arguing how fungi must be allocated to a different classification.

Again, O. Verona:

"If we put in the first kingdom pluri-cellular organisms provided

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with photosynthetic abilities (plants) and in the second the organisms not provided with photosynthetic pigmentation (animals) - both constructed of cells with distinct nuclei (eukaryotes), and additionally we put in another kingdom, finally, to possess a distinct nucleus." ³⁹

Furthermore, unlike all other micro-organisms, they possess a curious property, that of having a basic microscopic structure (*hypha*, Fig. 1), and at the same time the tendency to reach remarkable dimensions (even several kilograms) while they keep unchanged their ability to adapt and to reproduce at any size.

In this way, therefore, they cannot be properly considered as organisms but as aggregates of cells of their own kind with an organismic behavior, since each cell keeps its potential for survival and reproduction intact and independent of the structure to which it belongs. Therefore, it is strikingly clear how very difficult it becomes to identify such complex living

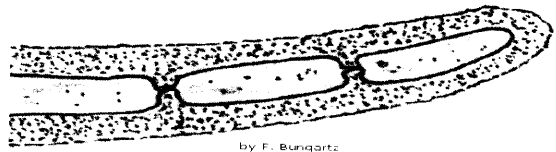
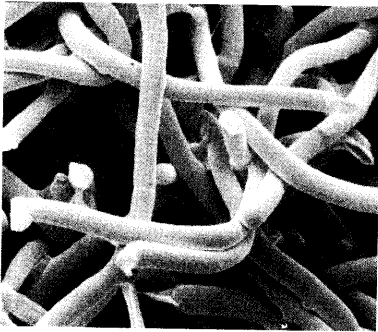


Figure 1

Typically, fungi start from spores, growing as filaments called *hyphae*, with a diameter of about 5-10 microns thick (it isn't that *hyphae* grow from a body; the fungus itself is a *hypha*).

As *hyphae* grow, they continuously produce new ramifications.

As *hyphae* of a single fungus come in contact with those of other fungine cellular units, they form an organism of bigger dimensions called a *mycelium*. The layer of mold on bread can give an example of this aggregation. All its mass is a single fungus but, if it is subdivided in smaller parts, still these form living, autonomous units.

Hyphae grow at their apices (right figure), transporting their protoplasm (the internal, cellular substance) into the space where they grow.

This mechanism allows a steady growth towards new nutritional areas, even through the penetration of solid surfaces, such as are the cell walls of plant and of living organisms.

realities in all their biological processes. In fact, even today, there are huge gaps and approximations in the taxonomic characteristics used in mycology.

It is worth the trouble to stop and examine in greater depth this strange world with its peculiar characteristics, while attempting to highlight those elements that somehow pertain to the problems of oncology.

1) Fungi are *heterotrophic* organisms (they depend on ready-made food) and therefore they need pre-formed compounds to obtain carbon and nitrogen. The simple carbohydrates of these elements (for example monosaccharide glucose, fructose, and mannose) are the sugars that are the most utilized.

This means that in their life cycle they depend for nutrition on other living beings which have to be exploited in various ways, both in a saprophytic (nourishment through organic waste) and in a parasitic manner (attaching themselves directly to the tissues of the host).

2) They are classified as *eumycetes* with sexual reproduction (that is, perfect fungi) and as *deuteromycetes* with asexual reproduction that does not stem from any fecundation process.

In both cases, the reproductive cycle takes place through unicellular or pluricellular spores.⁴⁰

The extreme complexity of the reproductive panorama of fungi is exceedingly interesting, because their very polymorphism highlights such biological variety that we can infer an unlimited adaptability and therefore an unlimited pathogenic potentiality. In this way, the great variety of reproductive manifestations (sexual, asexual, gemmation, which can often to be observed in a single mycetes) combined with great morph structural variety of the related organs, is geared to the creation of spores to which the continuity and spreading of the species is entrusted.

3) It is often possible to observe a particular phenomenon called *heterocariosis* in mycology, which is characterized by the coexistence of normal and mutated nuclei in cells that have undergone a hyphal fusion. Today there is great concern by the phytopathologists about the formation of individuals that are genetically quite different from the parents and which takes place through reproductive cycles termed parasexual.

The vast use of phyto drugs, in fact, has often caused mutations in the nuclei of many parasite fungi with the consequential formation of heterocarion. Sometimes these fungi are particularly virulent in their pathogenicity.⁴¹

4) As a parasite, fungi can develop some specialized structures shaped like a roster of variable size from hyphas (the base implant).⁴² These roster structures make penetration into the host possible.

5) The production of spores can be so abundant that each cycle always includes tens, hundreds, and even thousands of millions of elements that can be dispersed at a remarkable distance from their starting point. A small movement, for example, is sufficient to set off their immediate dispersal.

6) The spores possess a very strong resistance to external aggression, as they are capable of staying dormant for many years if the environmental conditions dictate it while preserving their regenerative potential unchanged.

7) The development coefficient of the hyphal apexes (the tips) after germination is extremely fast (100 microns per minute in an ideal environment), with a branching ability, and thus with the appearance of a new apex region, which in some cases takes only around 40-60 seconds.⁴³

8) The shape of the fungus is never defined, as it is imposed by the environment in which the fungus develops.

It is possible to observe, for example, the very same mycelium existing in a status of simple isolated hyphas in a liquid environment or existing in aggregations ever more solid and compact up to the formation of pseudo-parenchymas (stromas or supporting structures) and mycelial filaments and strings (rhizomorphs).⁴⁴

By the same token, it is possible to observe the same shape in different fungi where they must conform to the same environment (the phenomenon is usually called dimorphism).

9) The partial or total substitution of nourishing substances induces frequent mutations in fungi and that testifies to their marked adaptability to all substrata.

10) When precarious nutritional conditions exist, many fungi respond with hyphal fusion (between neighboring fungi), which allows them to explore the available material more easily and

with more complete physiological processes. This property substitutes competition with cooperation and sets fungi aside from any other micro-organism. For this reason, some biologists call them *social organisms*.⁴⁵

11) When a cell gets old or is damaged (for example, by toxic substances or drugs) many fungi whose intercellular septi are provided with pores react with the implementation of a defense process called protoplasmic flux through which they transfer both the nucleus and the cytoplasm of the damaged cell into a healthy one while preserving all their biological potential unchanged.

12) How the development of hyphal ramification is regulated is unknown.⁴⁶ It consists of either a rhythmic development, or in the appearance of sectors that, while originating from the hyphal system, are nevertheless self-regulating,⁴⁷ that is, they are independent from the regulation and the behavior of the rest of the colony.

13) Fungi are able to implement an endless number of modifications to their own metabolism to overcome the defense mechanism of the host. These consist of plasmatic and biochemical actions as well as volumetric increments (hypertrophia) and numerical increments (hyperplasia) of the affected cells.⁴⁸

14) They have exceptional aggressiveness. They attack not only plants but also animal tissue, food supplies, and even other fungi as well as protozoa, amoebas and nematodes.

The hunt for nematodes, for example, takes place with special hyphal modifications that constitute veritable mycelial traps, which may be criss-crossed, viscous, or ring-shaped.

These traps immobilize the worms which are subsequently invaded with hyphas. In some cases, the aggressive power of fungi is so high as to allow a cellular ring made of only three units to surround, imprison, and kill a prey in a short time despite its desperate wiggling.

From the short notes given above, it would therefore seem appropriate to pay more attention to the world of fungi, which we have seen are living objects representing the twilight layer between plants and animals. Special attention is to be paid if

we consider that both biologists and microbiologists, when called to describe or interpret the form, the physiology and the reproduction of a fungus, *always show large knowledge gaps*.

It seems therefore very logical to assume that a cause of neoplastic proliferation could be a fungus - the most powerful and most organized micro-organism known. Furthermore, the cause might be found in those imperfect fungi (so named because of our lack of knowledge about their biological processes) whose essential prerogative is in their ability to ferment.

The gravest disease of humanity may be hidden within the small group of pathogenic fungi. Perhaps the cause of cancer can finally be located with some simple deductions that may lead us to a solution to the problem.

Pathogenic Mycetes in Humans

When compared with the whole universe of fungi forms mycetes that are pathogenic for humans are not very numerous.

They usually cause diseases called mycosis, which are commonly divided into superficial (when the infection is limited to the cutis, body hair, hair of the head, and nails) and deep (when the infection attacks internal organs such as lung, intestine encephalus, bones, and others). The fungi are generally classified as:

1. *Dermatorphytes*, causing afflictions that are typical of the epidermis (tinea).

2. *sporotrichum schenckii*, which are also almost exclusively located on the epidermis.

3. *Criptococcus neoformans*, responsible for a diffused infection of the lung (the organisms are inhaled with dust) as well as chronic meningitis.

4. *Histoplasma capsulatum*, which in humans produces the nodular cutaneous form, mucous form, the pulmonary form, and the systemic form.

5. *Actinomyces*, with pathogenic action on the cutis, lungs, and intestine.

6. *Chrysosporium parvum* (causal agent of the *adiasphyromycosis*), a cosmopolitan disease where the

respiratory tract constitutes the primary and only localization of the infection.

7. *Aspergillus fumigatus*, cause of the Aspergillosis, whose most frequent location is in the lungs, followed by a secondary location in the cerebrum and in the kidneys.

8. *Paracocci dioides brasiliensis*, which causes the paracoccidioidomycosis, a primary pulmonary infection that can become diffused in immuno-depressed patients.

9. In recent years, *Pheoiphomycosis*, *ialiphmycosis*, *pennicilinosi* (marneffeii), *zigomicosis* and other rare mycotic infections are acquiring more and more importance since they can be responsible for pathological scenarios that are sometimes very serious because of the compromised conditions of immuno-compromised patients.

10. *Candida*, both as *Albicans* and as any other pathogenic stock which afflicts the cutis, nails, internal mucus membranes (oral cavity, vulvar vaginitis, urethritis, balanitis, perianal infection), bronchi and lungs.

Candida is also responsible for causing generalized forms of septicemia of remarkable gravity.

The gravest disease of humanity is, therefore, hidden within this grouping of fungi. Some further analysis will make it easier to identify the cause.

Dermatorphytes and sporotrichum are responsible for a morbidity that is too specific. We know from experience that Actinomycetes, Criptococcus, Hystoplasm, Chrysosporium, Paracoccidioides and other causal agents of Pheoiphomycosis ialiphmycosis, pennicilinosi, zigomicosis are very rarely part of a pathological context. Finally, *Aspergillus* can be considered a variation of *Candida*. Only one of the six kinds described above remains as the *sole responsible agent for tumors: Candida*.

To that end, it is useful to call the reader's attention to the fact that in recent years the infections spread by the *Candida* species (*Albicans*, *Glabrata*, *Krusi*, *Parapsilosis*, *Tropicalis*, and others) - that is, systemic candidosis - have been raised to great importance in oncology. These infections today represent, according to the majority of scholars, the main cause of morbidity

and mortality in patients afflicted by neoplasias. It is sufficient to consider that Candida-related sepsis alone has increased 400 times in the last few years in American hospitals.

Why is there such pathological parallelism in the evolution of cancer and Candida? Isn't it perhaps simpler to assume that the two converge up to the point of being considered the very same disease? Actually, if we stop and reflect for a moment on Candida's characteristics we observe many analogies with neoplastic disease. The most obvious of these are:

- a. ubiquitous rooting. No organ or tissue is spared
- b. constant lack of hyperpyrexia (high fever)
- c. sporadic involvement of muscles and nervous tissue
- d. invasiveness of the almost exclusive focal type
- e. progressive debilitation
- f. refractoriness to any treatment
- g. proliferation favored by a multiplicity of undifferentiated concomitant causes
- h. basic symptomatological configuration with structure tending to become chronic
- i. frequent formation of parparenchymal masses that are morphologically similar to neoplastic masses.

Why Candida is Cancer

Generally, mycetes have a recognized and almost unlimited ability to adapt, made possible by their seemingly endless ways of reacting to biological substrata, and ranging from simple metabolic variations to radical morphological changes.

In the human organism, other than their presence in various forms, we can observe that mycetes have a variability of biological expression depending on the function of the tissue or organ they are interested in. The current classification into superficial and deep forms stems from this variability.

The characteristics described above are the prerogatives of the entire fungin spectrum. However, they have particular relevance in Candida, as it is no doubt the most significant representative of the kind.

It is enough to consider this fact: about 70 species are

recognized as a saprophytic, that is, a micro-organism that gets its nourishment from decomposing substances and 20 as a pathogen.

As far as the interaction of fungi with humans is concerned, should we be content only with the usual classification proposed, superficial and deep mycosis, which is exclusively founded on what can be directly observed? In other words, can we be sure that this wonder of adaptation called *Candida* cannot find a way to survive in more infinitesimal biological dimensions?

Obviously not.

Unfortunately, the technology available to medical science may not be able to see it in all its vital excursions and as a result may relegate it to more or less a dimension of semi-saprophytism, which may be very false and dangerous.

Indeed, there is an exceptionally high pathogenic potential in this mycetes with the size of a few microns, which, although it cannot be found with the current tools of investigation, cannot be dismissed from the clinical point of view.

In fact, we frequently observe recurrent candidoses that are so obstinate - and for which the only evolution is markedly in an irreversible and chronic direction - that they are insensitive to any medical treatment.

This is because *Candida*, the moment it is attacked by the immune system of the host or by a conventional anti-mycotic treatment, defends itself by transforming into elements that are ever smaller and undifferentiated, while staying fully fecund up to the point of almost hiding its presence from both the hosting organism and diagnostic investigations.

Its behavior also shows an "elastic" nature: when rooting conditions are favorable it thrives on an epithelium (a vital surface), but as soon as the tissue reaction is engaged, it transforms itself massively into a less productive form but one which cannot be attacked, the *spore*. If sub-epithelial continuity solutions arise that are conjugated with a hypodermic areactivity, the spore is able to wedge in and then sink into the underlying connective tissue and hide in such a way as to be invulnerable and irreversible. In short, *Candida* takes advantage of a structural interchangeability that it utilizes according to the difficulties it encounters in its biological niche.

WHY CANDIDA IS CANCER

In the soil, in the air, in the water and in vegetation - that is, where there is no antibody reaction - Candida is free to grow to a mature vegetative form. In epitheliums it takes on a mixed form which is reduced solely to the form of spores (at least in the initial phases when it penetrates to deeper levels).

Again, Candida has an unlimited pathogenic potential which is underestimated, perhaps because of the way it is commonly described and understood, although there are already many studies that testify to its carcinogenic power.

Why, one could ask, should we assume a different and enhanced activity for Candida Albicans, since it has been extensively described in these pathological manifestations?

The answer is that it has been studied only within a pathogenic context, that is, only in relationship to the tissues that cover a diseased organism. In reality, Candida possesses an aggressive valence which is diversified as a function of the tissue it is interested in. It is only in the connective or in the connective environment - and not in differentiated tissues - that Candida finds the conditions for unlimited expansion.

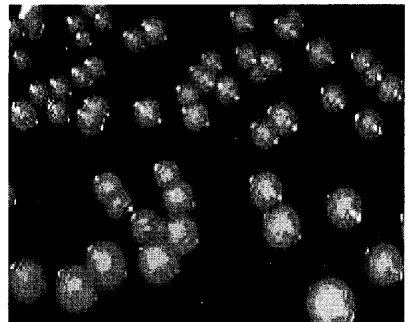
Over 50 years ago, Wilhelm Reich wrote:

"If in the connective tissue which is directly in contact with the tumor the specific structures are disintegrated, the physiological barrier which normally exists between epithelial and connective tissue is destroyed and the cancer cells have free rein." ⁴⁹

This becomes even clearer if we stop for a moment to consider what the main function of the connective tissue is: that of carrying and supplying the cells of the entire organism with nourishing substances.

In this context, in fact, it can be considered as an external environment sui generis next to the more differentiated cells such as those of the nerves and muscles; it is here where the competition for nourishment takes place.

On the one hand, the cellular elements of the organism try to defeat all forms of invasion while on the other, the fungin cells try to absorb



Spores of fungi in the process of division (fission).

ever-growing quantities of nourishing substances, as they must obey the biological needs of the species which is that of tending to the formation of ever larger and spreading masses and colonies. This is a biological thrust sometimes capable of producing aggregates of unusual dimensions, the most striking example of all being the fungal colonies in the United States which cover 44 hectares of land.

It is therefore possible to hypothesize the evolution of a candidosis from the combination of the various factors concerning the host and the aggressor.

◦ **1st stage** *intact epitheliums*, absence of debilitating factors. *Candida* can exist only as a saprophyte.

◦ **2nd stage** *non-intact epitheliums* (because of erosions or abrasions), absence of debilitating factors, unusual transient conditions (such as acidosis, dismetabolism or dismicrobism). *Candida* expands superficially (classic exogenous and endogenous mycosis).

◦ **3rd stage** *non-intact epitheliums, presence of debilitating factors* (toxic, radiant, traumatic, neuro-psychic, and other).

Candida penetrates deep into the sub-epithelial levels from which, eventually, it is carried into the whole organism through blood and lymph (intimate mycosis).

The first and second stages are the most studied and known, while stage 3, although described in this morphological diversity, is often considered to be either a silent saprophytic form or a type of opportunistic pathology with the same characteristics as epithelial infections.

This assumption is not logically acceptable.

In fact, to assume that *Candida* could have the same behavior as can be observed on the epitheliums when it successfully penetrates to deeper biological levels is risky to say the least, and that is because the assumption would have to be supported by concepts that are absolutely uncertain. Not only should we admit a priori that the connective environment is not fitted to the volumetric development of *Candida* from the point of view of nourishment, but also that the defenses of the host allow a mycotic organic structure that is very aggressive only through a linear and unsteady invasion of the deep levels of tissue.

The ability of Candida to attack all internal organs is amply documented by clinical mycology. We should ask ourselves why Candida should just limit itself and not phagocytize a tissue or an organ all the way.

To hypothesize a presumed tendency by a pathogenic agent such as a fungus (which is emphatically the most invasive and aggressive micro-organism that exists in nature) to a state of rest or compromise with the host is an assumption that has the full flavor of scientific irresponsibility.

Furthermore, the old doctrine of commensalisms, according to which germs would tend to evolve, in their own interest, in a direction of peaceful coexistence with the hosting organism is no longer accepted by any scholar today.

What must be clearly and repeatedly highlighted is the degree and the quality of the aggression of Candida. While it is on epitheliums or is in the first phases of advancement in the connective tissue under the epitheliums, its growth is only in the context of spatial competition - that is, it just conquers its space by nourishing itself with the substances in the connective tissue. As time goes by, Candida manages to feed on the structural components of the colonized tissues, up to the point of attacking and, step by step, completely 'eating' the organ or organs that have been invaded.

To further clarify the concept, we can say that Candida acts as if its mycelial aggregate takes on the characteristics of a tiny and sui generis little animal, able to phagocytize parts of the organism although deprived of any masticating organ.

Based on the considerations above, it is therefore urgently necessary to acquire consciousness of the dangerousness of such a pathogenic agent which, if we need to repeat it again, is able to take on the most variegated biological configurations, both structural and biochemical as a function of the organism it feeds on, with great ease.

The expansion gradient of the fungus is in fact greater when the tissue object of the mycotic invasion is less eutrophic (in a state of well-being) and therefore less reactive.

It follows that every element in the human body, whether external or internal, that determines a decrement in the state of

well-being of an organism, organ or tissue, possesses an oncogenic potential - not so much because of a possible intrinsic ability to cause damage as much as because of a generic property that favors fungin tumoral rooting.

Thus, the causal rooting of cancer so often invoked in contemporary oncology, and that indicates toxic, genetic, immunological, psychological, geographical, moral, social, and other factors, finds an appropriate collocation only in a context of mycotic infection, where the arithmetical and temporal sum of noxious elements works as co-factor for the external aggression.

As we believe that the above has demonstrated the theoretical equation tumor = fungus, it becomes clear how this interpretative key stimulates a series of questions about both oncological (currently utilized without a factual basis), and anti-mycotic (now utilized only at a superficial level) current therapies.

As we need to go into more detail in the context of a comparative interpretation between the official oncological matrix and the infectious matrix, let us now proceed with the examination of their common and conflicting points.

Candida's Opportunism

Candida is defined as an 'occasional and opportunistic saprophyte fungus'. This official label, which is both appealing and reassuring, in reality says and explains nothing, as it rather underhandedly hides the dangerousness of the disease.



Candida Albicans

The adjectives 'occasional' and 'opportunistic' actually side-track the vigilance of the scientific conscience of an individual who is cheated by the soporific tone of the phrase and by a natural tendency to accept what 'experts' have always said and shared.

That is a mistake for two reasons. Firstly, it has been abundantly demonstrated that ideas that are old and widely shared are not necessarily the best, otherwise, there would have

been no scientific progress. Secondly, the term 'opportunistic' does not at all suggest harmlessness; rather, it suggests a remarkable level of danger, as it highlights an elevated adaptability and polymorphism. This has often been reported, for example by *B. L. Wickes, T. Suzuki, and T. J. Lott.* ⁵⁰

A study by *F.C. Odds* ⁵¹ shows how infinite variants of *Candida* can be formed from identical or similar stocks, even as a function of different geographical areas. This testifies as to how *Candida* stocks can adapt to any type of variable not just to the biological ones. It is sufficient to consider that the so-called opportunism of *Candida* hides in reality such aggressiveness as to make it capable of attacking and colonizing even synthetic materials that are used as substituting prostheses for internal organs, as reported by *Ell and Schaz.* ^{52, 52a}

If the "opportunist *Candida*" description means to signify its ability to pass, metabolically and structurally, from a harmless to a pathogenic state, who could argue about the plausibility of a further transition - under certain conditions - from a pathogenic to an invasive, that is, tumoral, state by means of further stages of differentiated opportunism?

Candida is Always Present in Cancer

There are a large number of works that document the constant presence of the mycetes in the tissues of cancer patients, especially in terminal patients.

In recent years, we have observed a crescendo of voices addressing this terrible fungus to the point of defining it as "the most important and most urgent problem that oncology has to solve." The following figures concerning the coexistence of *Candida* and cancer have been collected by several authors: ⁵³

<i>R.L. Hopfer:</i>	79%
<i>U. Kaben:</i>	80%
<i>W. T. Hughes:</i>	91 %
<i>T.E. Kiehn:</i>	97%

The percentages observed are truly impressive, especially when considering the difficulty of seeing *Candida* in the organic materials to be examined. This was also reported by *R.S. Escuro, Z. O. Karaev, and T.J. Walsh.* ⁵⁴

The positive results quoted allow us to confirm that *Candida* is always present in the tissues of cancer patients. Not only that, but *Candida* species represent today, according to several scholars, the first cause of morbidity and mortality in patients affected by neoplasias of the *hemolinphopoietic* system. ⁵⁵

O. Uzun even analyzed all data from 1974 to 1999 concerning the presence of candidosis in patients and the prognostic factors including predictable elements of mortality and came to the conclusion that the global rate of mortality in cancer patients varies between 33% and 75% and that this is independent of the type of infecting *Candida*. ⁵⁶

The phenomenon is usually interpreted as a consequence of the weakening and of the exhaustion of the organism because of neoplastic lesions. Conversely, we have to believe that the aggression of *Candida* takes place in the carcinogenic sense after the superficial pathogenic phases - that is, the *classic epithelial candidosis* - in several stages:

- a) rooting in the deep connective tissue (in the various organs).
- b) expansion with evoking of an organic reaction that attempts to encyst the fungin colonies, with the outcome being the formation of neoplasias.
- c) growth both in the surrounding tissue and remotely (metastasis).
- d) progressive exhaustion of the organism with consequential global organism invasion. This is the stage that is most commonly observed and that is considered "opportunistic".
- e) exitus.

In summary, *Candida* is not a post hoc but an ante hoc cause. Several works support what has been stated here concerning a causal link between *Candida* and cancer: ⁵⁷

- | | |
|--------------------------------------|---|
| - <i>A. Pedersen and J. Trotoux:</i> | The Formation of Epidermoidal Tongue Carcinoma. |
| - <i>K.V. Zhang and O'Grady:</i> | Oral Cavity's Neoplasias. |
| - <i>J.N. Hicks:</i> | Larynx's Neoplasia. |
| - <i>E. A Field and F.R. Wang:</i> | Lung Cancer. |
| - <i>P. Joseph:</i> | Streaked Mixoma. |
| - <i>A. Rumi et al.:</i> | Esophagus Cancer. |
| - <i>T. Taguchi:</i> | Intestinal Carcinoma. |

- *V. Raina*: Hodgkin's Disease.
- *M. Piazzzi*: Kaposi's Disease.
- *A. Mannell*: Pancreas's Tumor.

The considerations and the works cited above testify that *Candida* possesses a great carcinogenetic ability, and confirms that today it is no longer acceptable to conceive solely a pathogenic role for *Candida* that is consequential to a state of post-tumoral exhaustion.

Many amongst the authors we have cited and others that we have not cited⁵⁸ admit without hesitation to a direct causal role of the mycetes in the genesis of cancer, but the error they often make is that of believing *Candida* solely responsible for the production of substances that modify the genes that are preposed to the functionality of the cell. This evaluation prevents them from attributing a direct responsibility to mycetes, and this is the aspect that would finally plough the way to the conclusive discovery of the cause of cancer.

Because of the evidence that currently exists, it is not at all logical therefore to insist in seeing *Candida* as a micro-organism in the twilight zone between pathogenicity and harmlessness. Rather, it should be investigated as the sole, terrible causal generator of neoplasias.

Tumors Are Conceptually One Phenomenon

Tumors are one phenomenon, but there are many types. Why?

According to official views that see genetic alteration at the basis of neoplastic development, it is possible that the alteration can manifest itself in any environment with all possible typological differentiations.

From the microbiological point of view, instead, it is always *Candida* that invades various anatomical parts, evoking different reactions as a function of the organs it feeds on.

These behaviors are a function of the quantity and quality of the affected tissues. An organ whose connective tissue has been invaded defends itself with cellular hyper-productions that attempt to encyst the fungin colonies which are trying to completely colonize the organism.

It is in this way that the whole histological variety of neoplasias

can be explained. The histological variety appears not to be influential in the determination of the cause, which is always and only *Candida*.

It is in this way that during a neoplastic event some genes can be hyper-expressed - that is, amplified - in a defensive effort determined by hyper-productive needs of the tissue. This reaction is normal and not anomalous at all.

Consider the following example. If we take an inert thorn, for example that of a sea urchin, and we inoculate it first in the skin, then in the bronchi, the bone, brain and in other body areas, we evoke an immune response of a cellular type tending to encyst the thorn, that is, to form some kind of a cocoon in which to enclose it.

By the same token, the immune system interprets fungin colonies beyond a certain dimension as extraneous foreign bodies stimulating an encystment reaction that is produced with the type of cells of the invaded tissue.

The thorn or the fungus can therefore cause, according to the case, an epithelioma, an adenocarcinoma, an osteosarcoma, a glioblastoma, and so on.

In the first moments of the invasion, the organism is able to send mature cells to contain the proliferating fungi: this is the phenomenon of a differentiated tumor. As the colonies become more powerful, and tissues are exhausted, cells become more and more immature up to anaplasia.

Furthermore, the ratio between differentiated tissues and connective tissue existing in an organ determines the reaction capability and thus the degree of malignancy of a neoplasia. The fewer noble cells there are, the more malignant and invasive the tumor becomes.

So, on the one hand we have noble tissue which cannot be attacked (muscles and nerves), and on the other the simple connective tissue. The glandular tissue which is halfway between these two elements, just because it is provided with that complex structure that confers to it a certain ability of encysting the fungi, can oppose their invasion by producing the phenomenon of the benign tumor. For example, if we consider the thyroid, we can see how in this gland neo-formations can take any

graduation of malignancy even when they possess benign histological characteristics, as is the case for capsulated follicular carcinoma, long ago called metastasizing benign adenoma.

This can happen because the concept of a 'benign tumor' does not have an absolute value. In this case, even if it is true that fungin cells cannot normally go through the differentiated cells barrier, that does not mean that under particular conditions they cannot be successful.

It is for this reason that such neo-formations are considered 'odd' in oncology.

But such oddities can be easily explained with the interpretation key of fungin infection. When the glandular tissue is exhausted, the benign tumor becomes a malignant one.

For all intents and purposes, it is always the same *Candida* attacking different tissues, each time adapting itself to the type of environment it finds. The specifications usually assigned to the various candidas (*Candida Albicans*, *Krusei*, *Parapsilosis*, *Glabrata*, *Tropicalis* and others) underestimate the fact that they all come from one single progenitor which, when it genetically mutates to attack the host, transforms itself into this or that stock.⁵⁹

R.L. Hopfer, for example, found no less than four different *Candida* species in the post-mortem cultures of a leukemia patient.

N. Aksoycan demonstrated that seven different stocks of *Candida* actually have the same antigenic structure.

F.C. Odds reports how the same *Candida* stock can colonize different anatomical areas at different times.

J. Hellstein has found the common clonal origin in *Candida Albicans* for both commensal and pathogenic stocks.

Candida Shows the Same Genetic Structure as Cancer

Paradoxically, the title of this section describes something that is so relevant it can demonstrate how *Candida* can actually be the cancer, but that is not even taken into consideration by official thinking.

The authors cited below, although they confirm the genetic identity, report the issue in a sterile descriptive way:⁶⁰

◦ *G.A. Werner* reports to have found the homologous sequences in DNA samples extracted from *Candida Glabrata*, *Candida Parapsilopsis*, and from cells of biopsy material taken from squamous cell carcinoma of upper airways.

◦ *K. Yasumoto* and *S. Kawamoto* demonstrate how the specific monoclonal antibody directed against the C cytochrome of *Candida Krusei* also reacts in the presence of a cytoplasmic fraction of cells of lung cancer.

◦ *G. Schwartze* suggests utilizing specific antibodies against *Candida* in the diagnosis of malignant melanoma.

◦ *E.H. Robinette Jr.* describes a remarkable resistance to the inoculation of lethal doses of *Candida* in mice into which a Lewis pulmonary carcinoma or carcinoma of other anatomical areas was previously implanted.

◦ *A. Cassone* and *J.B. Weinberg* highlight a significant anti-tumoral response in mice that have been inoculated with materials from the cellular wall of *Candida Albicans*.

There is, therefore, beyond interpretations that are more or less reductive, a high degree of relationship between *Candida* and tumoral tissues.

If we then consider the endless phenotypical variability of the mycete together with the extreme difficulty in finding and classifying the various existing stock, it seems legitimate to assume the existence of a deep genetic relationship between cancer and *Candida* in its various differentiations, or at least to try to understand what the deep link is between these two morbid entities.

The Phenomenon of Metastasis

According to the official viewpoints, metastasis is the development of some malignant cell which, after escaping from the primary location of the cancer, migrates to another anatomical area.

From the microbiological point of view, instead, although it indeed develops from cells escaping from the original cancer, the base unit is not a “cell gone crazy” but an infective fungin cell that has managed to colonize another organ. To create an analogy, think of a pulmonary tuberculosis that, through time,

produces localization in the kidney, in the bones, meningitis, or something else.

Furthermore, the opportunity and the basis of the metastasis are a function of the more or less healthy condition of the organs and of the tissues, which can mount a more or less effective resistance to counter the rooting of new colonies.

Local spreading aside, a primary tumor can be spread through:

- absence of metastasis – when other organs, if healthy, are provided with an elevated reactive ability
- formation of a metastasis – where an organ has cellular or tissue structures that are weakened
- formation of multiple metastasis in multiple locations – when the whole organism is dying and all organs become vulnerable to attack.

The possibility of metastatization depends not only on the energetic condition of the various tissues and organs, but also on Candida's ability to metabolically adapt itself to different micro-environmental situations.

This eventually – as it favors the spreading of the mycete – accentuates the weakening of the tissues where a process of ongoing and steady demolition of the host's reactive abilities are rooted *ex novo* – and this goes on until the host surrenders.

In this context it becomes clear how any intervention or treatment that has a certain degree of potential to cause damage to the tissues can turn out to be extremely dangerous, because it is in this way that the spreading of the metastasis is facilitated.

Surgery, chemotherapy, and radiotherapy, therefore, can be among the main causes of metastatization, as they always establish such tissue suffering as to predispose various organs to tumoral invasion – and this is actually and often reported by many scholars.⁶¹

The thesis of the “crazy cell” that reproduces itself in various areas of the organism seems, therefore, far less logical than the infectious model – especially when we consider that the premises upon which genetic theory is based are totally random.

It is worth highlighting the emblematic phrase printed in the main text of Italian oncology – that of Bonadonna and Robustelli mentioned before:

“A tumor is constituted by different populations from the kinetic

point of view. The proliferating cells are often a minority.... In solid tumors, instead, the exponential growth rate takes place only in the initial phase of the life of the tumor. “ 62

What else do we want?

To conclude, on the basis of the argument put forward, it is therefore legitimate to state that *Candida* is the etiological cause of cancer. In fact, it turns out that:

- *Candida* is always present in patients affected by neoplasia,
- it can produce metastasis,
- it has a genetic patrimony that can be overlapped with that of tumors,
- it can be utilized for an early detection of cancer,
- it can invade all types of tissues and organs,
- it has unlimited aggressiveness and adaptability,
- it produces a symptomatological trend that can be overlapped with that of neoplasias,
- it possesses the demonstrated ability to promote neoplastic degeneration.

What further confirmations do we need?

Candida is truly the cancer and it must be fought from this standpoint in all its pathogenic variants.

Psoriasis is Like Cancer

A positive contribution to the understanding of the mechanism of tumoral pathology can surely come from understanding psoriasis, a fairly common skin disease for which the casual mechanism is unknown.

Contemporary theories on psoriatic lesions move – as happens for tumors – along a line that is too vast, generic, and sterile for the lack of a specific direction. The hypotheses assume that the disease prefers to localize itself in areas that are subject to continuous micro-traumas (for example, in the joints).

But if we pay attention to the typical disarranging of the cutaneous tissue by psoriasis, the perception we get is that of observing an infection – something often suggested by medical errors in which a mycosis is diagnosed instead of psoriasis.

However, what prevents the acceptance of this – and thus classification in the lists of infectious disease – is the absence

of an *ens morbi*, of a verifiable cause (at least with the current investigative methods) during biopsy.

If instead we lean towards a microbic genesis for psoriasis, many analogies with tumoral pathology emerge, in which psoriasis would share the traits of invasiveness and irreversibility.

As in every tissue or organ the venue of neoplastic proliferation is the connective tissue, so, plausibly, the point of engagement of psoriasis can only be in the cutaneous hypoderm, where particular conditions of exhaustion can favor the rooting of the infection at a certain time.

Once we have assigned the same causal identity to both diseases, then the acting mechanism of psoriasis becomes simple and glaringly clear.

The local predisposing noxae favor the penetration of *Candida* into the hypoderma, where the *Candida* attempts to expand – according to its own biological configuration – in a vegetative sense, that is, by producing its classic ramifications or hyphas.

On the other hand, the connective tissue tries to prevent the natural evolution of the aggressor and at the same time tries to overcome it by using its specific immunological properties. This in turn actuates a sort of compression on *Candida*.

Candida is therefore forced to take not only a defined biological form, but also a “micro-vegetative” parasitic dimension, plausibly very similar to a virus, and thus it becomes impossible to uproot.

The substantial difference that exists between psoriasis and a tumor, however, consists in their different evolution: benign in the former, and malignant in the latter.

In other words, while with psoriasis we look at a relatively harmless chronic condition, with cancer we look instead at an almost invariably unfortunate outcome. Although we are faced with the same pathological entity, it is possible to tell the difference if we reflect on the localization of the disease – external in one case, internal in the other.

The former can be attacked or circumscribed in a manner and with means that change according to the point of invasion.

In psoriasis the development of *Candida* can in fact be limited to the small hypodermic space, both because of the scarce

nourishment on an anatomical basis, and because of the natural refractivity to mycotic infections of the underlying muscular stratum and of the cutis above.

It is as though we were in the presence of a “linear benign tumor” of the skin. By contrast, the development of tumor takes place in an intimate area of the organism where the rapport between connective tissue and differentiated tissues can be much greater.

The disease, therefore, turns out to be much less coercible and thus inevitably invasive. That also happens in tumors of the skin. The tissue upset that ensues is nothing more than the expression of the defensive capacities of the tissues involved.

Where *Candida* is successful in the occupation of connective areas, first the epithelia and then all other available cells of the invaded organ rush immediately to contain the invasion. This results in an intense activity and an all-out fight, the limit of which is represented by the anatomical, functional, and vascular needs of the colonized organ.

As long as compensation is possible, there are no problems or particular symptoms, but once the balance is broken and a degenerative state is reached, the situation irreversibly crumbles in an invasive sense, producing that sequence of symptoms that is so painful in neoplastic patients.

It is important to understand that the fungin colonies can normally exert their destructive action only at the superficial level of the epithelia. This is because, in order to penetrate the more intimate tissues through blood or lymphatic circulation, they have to separate into the base units – spores – which are easily phagocytized by the cells of the immune system.

However, when conditions in the organism arise that prevent optimal functionality, conditions are created for re-aggregation of the spores in an internal organ or tissue.

For example, the effect of continuous painting of tar on the tongues of mice, rabbits or dogs – or their exposure to the most varied carcinogenic substances – comes after all from a certain tampon activity with respect to the immune system.

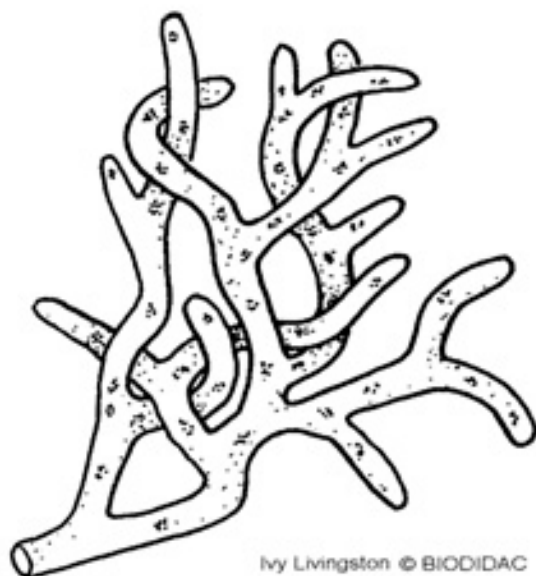
In other words, those substances create a sort of barrier that prevents the molecules that have immunological activity from

PSORIASIS IS LIKE CANCER

quickly reaching the place where the “enemy” is nested, thus allowing the enemy to get organized and to proliferate.

If we add to this simple concept – especially in human beings – other negative factors such as stress, fear, psychic tensions, intoxication, pharmacological drugs or others – all elements capable of attenuating immunological reactivity – we can better understand how the imposing construction of cancer’s multi-factorial causality as it is presently proclaimed by oncology can be reduced to a summation of undifferentiated con-causal elements, in other words, to a soap bubble.

As I have tried to illustrate – although briefly – a conceptual itinerary that is different from the usual ones, I believe that it is now useful to explore the most immediate consequences – especially the therapeutic ones – with the purpose of validating and completing what I have said up to this point.



FOURTH CHAPTER

Therapy for Cancer-Fungus

W **Therapeutic Considerations**

we have already seen that the pathogenic framing of *Candida* takes place through infective levels that we can differentiate conceptually. To counter this mycelial chameleon, we need therapeutic diversification that addresses both the static and the dynamic components of the morbid entity.

To that end, to help to visualize the existence of *Candida*, it may be useful to hypothesize a biological form that is analogous to that of any representative of the vegetal world – for example, that of a tree. As the trunks, the leaves, the male and female sexual organelles, the fruits and the seeds of the tree may not be considered as part of the same plant if seen separately, by the same token the various mycelial components known and unknown can hide their common genesis, or, worse, the vital link underlying the different structural changes.

A focused therapy, then, should take into account not only the macroscopic and static manifestations of *Candida*, but also the ultramicroscopic ones, especially when it comes to its reproductive dynamics.

The locations for attack must be found in the points of dimensional transition in decontamination or clearing that includes a spectrum of biological expression, including the parasitic, vegetative, sporal, or ultra-dimensional.

If instead we stop at the most evident phenomena, we risk administering ointments and unguents throughout the life of the patient (as happens with psoriasis) or clumsily attacking the enigmatic tumoral masses with surgery, radiotherapy and chemotherapy, with the result of merely favoring their propagation, which is already sufficiently overexcited in the fungin forms.

What road should be taken, then, when faced with a cancer patient, since conventional oncological treatments which do not attack the cause of the disease can only occasionally bring positive effects?

In a fungin context, the effectiveness of surgery, for example, turns out to be remarkably reduced by a mycelial aggregate's character of extreme diffusion and invasiveness.

Surgery's power to solve the problem is therefore random, and tied to the conditions in which we are lucky enough to completely remove the entire colony. That could happen in the case of sufficient encystment – but here we are almost bordering on benign tumors.

Unfortunately, most of the time chemotherapy and radiotherapy solutions can instead produce only negative effects, both in their specific ineffectiveness and for their high toxicity and potential for damage to tissues, which in turn favor even more mycotic aggression.

Conversely, a specific antifungin-antitumoral therapy should take into account the importance of the connective tissue together with the reproductive complexity of fungi. It is possible to hope to uproot them from the human organism only by attacking them in all the dimensions of their existence and in whatever environment of nourishment they use.

The first step to take, in any case, is that of reinforcing the cancer patient with generic reconstituent measures such as diet, integrators, regulation of rhythms and vital functions. These measures alone are already able to non-specifically reinforce the organism's defenses.

As to the possibility of having at our disposal those curative drugs that unfortunately do not exist today, and in the attempt to

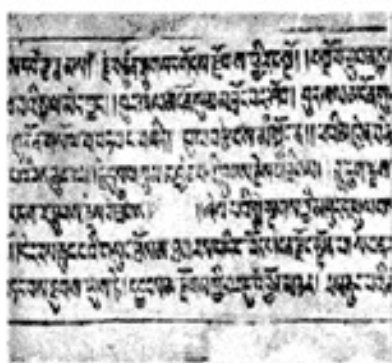
find an anti-fungin substance that is very diffusible and thus effective, it is useful to consider the extreme sensitivity of fungi to saline and electrolytic solutions. These solutions, because of their extreme capacity for diffusion, are able to reach all the mycelial biological forms, including the most infinitesimal ones.

The complete effectiveness of salts against fungi, in fact, is easily seen, especially where there is an abundance and great concentration of them: that is, in the thermal sacks where it is impossible to discover any fungin reproduction.

This is because the great quantity of salts, by making the "terrain" completely inorganic, eliminates the slightest organic fonts that the fungi could use for nourishment.

In this context, *sodium bicarbonate*, which is currently used particularly in children's oral candidoses, appears to be a simple and handy weapon capable of uprooting, inhibiting, or attenuating any neoplastic formation wherever it is possible to apply it easily. This anti-neoplastic power of "carbonates", by the way, was already known to Indian populations, as documented by the ancient Veda books, where indications are supplied on how to prepare solutions and how to use them against neoplastic formations.^{62a}

The anti-tumoral action of sodium bicarbonate, furthermore, is indicated today in many world-class studies. These studies, however, only highlight its anti-acid power, which is somehow able to inhibit the genetic instability on a degenerative basis (such is the thinking of these scholars) which in turn is responsible for cellular hyper-productive reaction. The articles that document acidosis and the related hyper-alkalification therapeutic implication that characterizes tumoral tissues are reported in footnote 63. Theoretically and on the basis of the considerations given above, if we find treatments which can expose the fungus to high concentrations of bicarbonate, we should observe the regression of the tumoral masses. That has actually happened in many cases treated with this technique.



Fragment of the Rig Veda

Cancer and Fungus – a Path of Personal Research

One of the questions that I am asked most frequently when the issue of this new anti-cancer therapy arises concerns the beginning, those first moments when I was struck by the idea that cancer could be a fungus, and the motives and events that induced me to drift away from official oncology.

The whole thing began when I was assisting introductory lessons in histology. When the professor described tumors as a terrible and mysterious monster, I felt a reaction of pride – the same you feel when you are challenged. *“Everybody’s powerless against me”* – that was the implicit warning of cancer – *“because your minds are too small to understand me”*.

A war started at that moment - my personal war against cancer. I was aware that I could win it only if I could focus all my resources and mental energy, conscious and unconscious, in the right direction, which I believed could be found only with a critical attitude towards official thinking - thinking which is based on many “ifs”, but on very few certainties.

The biggest effort, therefore, consisted in first of all acquiring the necessary knowledge for the studies, while at the same time performing a critical analysis on anything I was studying; in other words, I had to keep well in mind that everything I was learning might well be false.

So the years went by, and through them my convictions gained strength – especially when working in hospital wards later on I realized that medicine was not only unable to resolve the cancer problem, but also the majority of diseases.

That is unfortunately still true today, since aside from a sectorial effectiveness in the treatment of specific symptoms of these diseases, medicine is unable to offer any conclusive benefit for such diseases as hypertension, diabetes, epilepsy, psoriasis, asthma, arthritis, Crohn’s Disease, and more.

Aside from a distrust about the effectiveness of medicine, time and clinical experience had burdened my soul with such a load of suffering that I was barely able to withstand it, and which, each time it was stimulated in the presence of desperate cases, caused me an existential crisis that at first pushed me toward running away but immediately after warned me to stay in the trenches, to

fight to understand and try to find new solutions. A little bit at a time, however, in the endless hours of the university's pediatric oncological ambulatory ward where I was working to complete my thesis, my mind began to become free and abstract.

Towards the end, I was almost unable to see the patients, their relatives, the professors, the colleagues, the nurses – even the people. I felt almost completely alienated from a system that I could feel and believed was totally bankrupt.

I asked myself ... *and my profession, the university career, my social position, where would they go?*

After all, it would have been very difficult to live only with ideas, especially in a medical world where personal spaces were shrinking every day, until any dignified options for work were almost exhausted.

On the other hand, I was not particularly attracted by the university environment. In fact, I perceived it as an enmeshed and repulsive mass that prevented the achievement of any scientific goal, and where the best intellectual and personal resources could only be distracted from science and channeled towards irrelevant and superficial arguments.

At that point my road was laid out. I abandoned the faculty of medicine and enrolled to achieve a degree in physics. I followed the courses for several years with the intention of acquiring a more scientific mentality and of getting into those infinitesimal dimensions of study that I felt I had to explore in detail.

At the same time, I started to get in touch with other medical realities and with that alternative medicine which, although officially ridiculed, had many followers, especially amongst those patients who could not stand excessively aggressive therapeutic methods. From experience after experience, I understood that the *raison d'être* of these alternative movements was the inability of conventional medicine to solve the problems of patients who seemed, instead, to get greater benefits from those therapies which evaluated them and *treated them as a whole being* and not only with limited symptomatological remedies.

It is when I was implementing a naturopathic set-up for my career that I had the idea that cancer could be caused by fungus. As I was treating a patient affected by psoriasis with corrosive salts, I understood that the salts worked because they were

destroying something – and that something were fungi.

From that realization my mind followed a syllogistic path that was to give me the solution I had been waiting for so long: if psoriasis, an incurable disease, is caused by a fungus, then it is possible that cancer, another incurable disease, could be caused by a fungus.

That link was what started all the experiences, the experiments, the verifications and the results, through relentless and “underground” work that brought great professional satisfaction to me and that allowed me to perfect a therapy that is very efficacious against neoplastic masses, that is, against fungin colonies.

Once the causal role of fungi in neoplastic proliferation was hypothesized the problem of how to attack them in the intimacy of the tissues arose, since in those areas it was not possible to use salts that were too strong.

It then came to my mind that in the oro-pharyngeal candidosis of breast-fed babies, sodium bicarbonate was a quick and powerful weapon capable of eliminating the disease in three or four days. I thought that if I could administer high concentrations orally or intravenously I might be able to obtain the same result. So I started my tests and my experiments, which provided me immediately with tangible results.

Amongst these, one of the first patients I treated was an 11-year-old child, a case which immediately gave me the indication that I was following the right path. The child arrived in coma at the pediatric hematology ward around 11:30 in the morning with a clinical history of leukemia. Because of the disease the child had been transferred from a small town in Sicily to Rome, going through the universities of Palermo and Naples, where he underwent several chemotherapy sessions.

The desperate mother told me that she had been unable to speak with the child for the past 15 days, that is, since the child had departed on his journey through the hospitals.

She said she would have given the world to hear her son’s voice once again before he died. As I was of the opinion that the child was comatose both because of the brain invasion by the fungin colonies and because of the toxicity of the therapies that had been

performed, I concluded that if I could destroy the colonies with sodium bicarbonate salts and at the same time nourish and detoxify the brain with glucose phleboclysis, I could hope for a regression of the symptomatology.

And so it was. After a continuous infusion with phleboclysis of bicarbonate and glucose solutions, I found the child speaking with his mother, who was crying, at around 7 p.m. when I came back to the university.

Since then I have continued on my path and have been able to treat and cure several people, especially during a period of three years during which I was a voluntary assistant at the Regina Elena Tumor Institute in Rome.

In 1990, although I was almost fully occupied in a diabetes center, because of changes in my personal life I decided to intensify my studies and my research in the field of cancer, a disease that was always foremost in my mind, although in the recent years I had been forced to neglect it.

Before resuming my war against cancer, however, I felt the need to explore the logical content of medicine and thus of oncology better so that I could acquire those rational, critical and auto-critical instruments needed to understand where errors might be hidden. I enrolled in courses for a philosophy degree, which I completed in 1996.

That was the year when I started my contacts with the world of oncology again, this time steadily, attempting first of all to make my theories and treatment methods known, especially within the most accredited institutions.

The Ministry of Health, Italian and foreign oncological institutes, and oncological associations were therefore made aware of my studies and my results, but there was no acknowledgement at all. All I could find were colleagues, more or less qualified, who tended to be condescending and who seemed only to be able to speak the magic word: genetics.

“We’ll never get to heaven like that,” I mused.

In fact, I found myself in a situation with no way out. I had so many great ideas and some positive results, but no opportunity to check them with patients affected by tumors in an authoritative, scientific context.

CANCER IS A FUNGUS

I chose to be patient and to continue to get results, treating patient after patient and at the same time trying to get known by as many people as possible, especially in the environment of those alternative medicines where at least there was openness and an opportunity to contact professionals who already had a critical attitude towards official medical thinking.

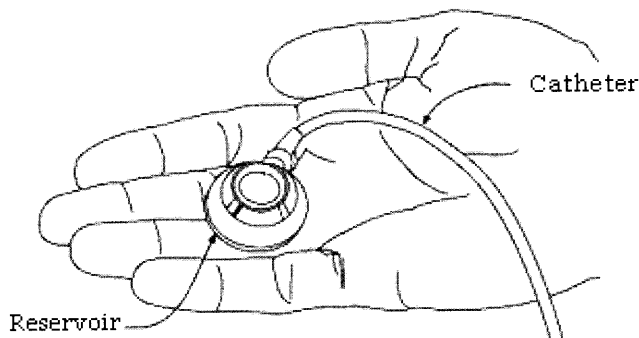
It was in that process that, for the lack of any alternative, I started navigating on the Internet, where I soon found those contacts, those friends, and those consensuses that allowed me to spread my theories but – even more importantly – they gave me the psychological thrust needed to continue my personal fight against a sea of sterility and self-evidence in official medicine.

I took comfort from the knowledge that my idea, my little flame, would not go out but could take root somewhere. I started to hope again that, given the validity of the message, it would sooner or later find a way to be shared and accepted by an ever-growing number of people.

I was slowly able in that way to get my oncological infection theory known and to expose it to the public through conferences, interviews, and conventions. All that widened my field of action and gave me the opportunity to accumulate a remarkable amount of experience and clinical results.

Friends made me understand, however, that my therapies with sodium bicarbonate solution, although they were effective, needed a methodological evolution, as some types of cancer could either not be reached in any way or reached only in an insufficient manner.

Sodium bicarbonate administered orally, via aerosol or



Port-a-cath

intravenously can achieve positive results only in some neoplasias, while others – such as the serous ones of the brain or the bones - remain unaffected by the treatment.

For these reasons, I got in touch with several colleagues, especially interventionist radiologists, and I was finally able to reach those areas of the body that had previously been inaccessible.

This was achieved through positioning appropriate catheters either in cavities for peritoneum and pleura, or in arteries to reach other organs.

Selective Arteriography

The concept forming the foundation of my therapeutic system is the administration of solutions with a high content of sodium bicarbonate directly on the neoplastic masses which are susceptible to regression only by destroying the fungin colonies.

It is for this reason that the ongoing search for ever-more effective techniques that allow me to get as close as possible to the intimacy of tissues drove me to *selective arteriography* (the visualization through instrumentation of specific arteries) and to the positioning of the arterial *port-a-cath* (small basins joined to the catheter).

These methods allow the positioning of a small catheter directly in the artery that nourishes the neoplastic mass, allowing the administration of high dosages of sodium bicarbonate in the deepest recesses of the organism.

In the past, for example, when I had the opportunity to treat a brain tumor, although I was able to improve the condition of the patient, I could not deeply affect the masses.

How many times have I uselessly begged neurologists and neurosurgeons to perform the operation of inserting the catheter so that I could use it for further local treatments!

Today, with selective arteriography of carotids, it is possible to reach any cerebral mass without the need for surgical intervention and in a



Example of use of a port-a-cath.

completely painless manner. By the same token, almost all organs can be treated and can benefit from a therapy with bicarbonate salts which is harmless, fast, and effective – the only exception being some bone areas such as vertebrae and ribs, where the scarce arterial irrigation does not allow sufficient dosage to reach the targets.

Selective arteriography, therefore, forms a very powerful weapon against fungi that can always be used against neoplasias, firstly because it is painless and leaves no after effects, secondly because the risks are very low.

Technically, it is performed as follows. After having established a sterile field and having anesthetized the superficial levels, a needle is introduced in the artery that is to be utilized as an inlet port (usually the sub-clavian) and then a metal guide that is visible to the angiologist is inserted through this port and can be used to locate the selected artery.

The last step consists of getting the small catheter used to administer the solutions at the point indicated by the guide. After that, the catheter is fitted to a subcutaneous port-a-cath that stays in the selected location as long as necessary. This very low-risk intervention has a pain symptomatology similar to that of an intravenous injection and allows the patients to be treated at home, although under constant medical scrutiny.

General Considerations About the Therapy

The fundamental reason and the motives that suggest a therapy with sodium bicarbonate against tumors is that the development and the local and remote proliferation of these tumors have a cause that is exclusively fungal, although with the concurrence of a myriad of variable co-causal factors.

In theory, any neoplasia can regress with the treatment described, although sometimes situations may exist that prevent the utilization of sodium bicarbonate solutions at full dosage and in an optimal manner.

In this connection, special care must be taken with patients with cardiopathies, as the displacement of the electrolytes of the neuro-cardiac conductive system can sometimes establish, although briefly, situations of cardio-circulatory insufficiency.

GENERAL CONSIDERATIONS ABOUT THE THERAPY

A condition of renal insufficiency, or the presence of a single kidney as it produces less excretion of the infused electrolytes, also substantially limits the quantity of bicarbonate that can be used, and that negatively affects the outcome of the therapy.

In fact, an administration that is limited in an absolute and in a relative sense inevitably compromises the effectiveness of the therapy, as a total uprooting of the neoplastic masses becomes impossible over time.

Everything is much more complex, for example, when we are faced with a terminal patient who no longer feeds himself, does not move from the bed or does not evacuate regularly. On one hand, the bicarbonate cannot be expelled quickly and therefore there is the need for low (thus less effective) dosage.

On the other hand, although the solution can affect the fungin masses, the exhausted immune system cannot phagocytize and drain the treated anatomical areas, and because of that, it is often impossible to destroy the existing colonies sufficiently.

In all cases, however, important symptomatological benefits are achieved such as the reduction or the elimination of pain, vomiting, or blood loss. It is a fact that numerous cases that have been defined as terminal managed to recover or to survive for a long time with a prospect of recovery.

Another element that prevents the correct irrigation of the tissues affected by neoplasia is the presence of surgical or radio-therapeutic interventions, that is, of those scars where spores that may have been missed by the treatment can nest, and where it is very difficult to treat them from outside.

Furthermore, the administration of conventional pharmacological therapies (both those that are specifically anti-cancer and the generic symptomatological ones) overload and intoxicate various emunctories, and very much weaken the action of bicarbonate, which is more powerful when the metabolism is dynamic and reactive.

The range of action and therefore the good results of an anti-neoplastic therapy based on bicarbonate depend mainly on two factors: the irrigation of the masses and the ability of the organism to get rid of the by-products. Clinical conditions that have been described as negative also belong here.

It is clear, however, that the most important aspect for the

success of the therapy is the dimension and the location, whether more or less spread out, of the neoplasias that exist at the beginning of the treatment.

These are the parameters that establish the speed of destruction of the masses and thus the possibility of their complete re-absorption which can occur only through the action of the immune system.

To better understand the process engaged with the action of sodium bicarbonate, one may think of an onion which is made of many concentric layers. This shape is reminiscent of the structure of a neoplasia that has been successful in this configuration as it has managed to elude the limiting action of humoral immunological factors. In other words, the neoplasia has been able to reach a configuration that, although it can be attacked on its external layers, preserves unchanged its reproductive potential on the inside where the immune system cannot reach.

The ratio between surface and volume of the tumoral mass is inversely proportional to the invasiveness of the tumor, because the larger the mass, the greater is the decrement of the vulnerability of the fungin cells to the humoral immune system, with the consequence that the mass can grow undisturbed.

Faced with the inability to dissolve the progressing colonies, the organism activates and enhances those defenses able to physically oppose the colonies in the “mass effect” – that is, mainly the defenses of cellular immunity that include all the acute phase proteins, fibrinogen, and others that are able to create some defense against the fungin phalanges.

In a fungin reproduction that tends to be unlimited and that is countered by the factors of cellular immunity that try to block it, the form and the formation of a mass that constantly grows is the result of the impotence of the organism to defend itself.

As the process proceeds, the blood becomes poorer up to the point when it is completely exhausted and spreads into the tissues and the cavities, bringing an anemic condition that becomes increasingly acute, up to the point of irreversibility.

Sodium bicarbonate can act at all levels in this pathogenic process, as it inverts the power ratio between the immune system and the fungi. Its destructive power on superficial colonies causes

a stratified disintegration – just as if removing the layers of an onion – and the layers are quickly reabsorbed in the bloodstream.

It follows that the regression of a fungin mass can occur only in layers in consequential synergy between bicarbonate and phagocytes that is optimal for a certain total quantity of fungin masses in the organism.

When a massive dissemination exists in one or more organs, although the fungicide properties of the bicarbonate are unchanged, the immune system does not act fast enough on the fungin cells as these, being spread over a vast area, physically exceed the regenerative abilities of the human body's defense apparatus.

The difficulties of administering a sufficient perfusion, together with the relative insufficiency of the immune system, establish that stasis that allows the survival and the return to activity of the fungin generation.

Theoretically, we should still be able to achieve some good results if we could increase the dosage of bicarbonate in circulation. However, beyond a certain limit – normally beyond 600-650 cm³ daily – side effects of such gravity occur as to prevent this type of administration.

Dreaming about the wonders of medicine in the future, a possible solution to this problem could be something like dialysis – the positioning of a micro-catheter in the small arteriole nourishing each mass, and the administration of an extremely high dose of bicarbonate through this catheter which is then recuperated and drained through the outgoing venula in this way preventing the solution from entering the bloodstream.

For the time being, however, we have to work with what we have – bicarbonate and the immune system – and try to exploit them at the top of their potential, on the one hand by utilizing the maximum salt concentration possible for each patient, on the other by implementing those expedients that can optimize the functionality of the organism's defensive systems.

The Need to Change Medicine's Mentality

In the future – I hope soon – I am convinced that it will be possible to treat and cure any tumor within 15-30 days with either a pill or an injection in the morning and in the evening when there

is targeted pharmacological research. But, again, we now have to work with what we have. Since the administration of bicarbonate is valid and simple to perform, we must act as much as possible on empowering the defensive abilities of the organism and attempting to exploit all the facilitating elements. We can contemplate the future of benefits and knowledge that the application of this simple technique will bring. A great vista will open for medicine where all therapeutic methods and conceptions of health currently held will have substance and a logical rationale.

These methods can be categorized in two groups: those aiming to counter neoplasias at a causal level and those attempting to augment the power of the immune system. It is often possible to observe both groups in one single therapeutic set-up.

Chemotherapy

Let us consider conventional oncology first of all, which contemplates action on the masses and support as well as reconstitution of the immune system.

From a fungin causality point of view, it is clear that a direct intervention on neoplasias (chemotherapy, radiotherapy, surgery) turns out to be problematic if not counterproductive.

This is mainly because it is not clear how it affects the colonies, and because by strongly debilitating the organism such intervention makes the invasion of the mycetes faster and more ferocious.

Chemotherapy, in fact, destroys everything, and how it can make the fungin mass regress is still a mystery. It is a given fact that it dramatically exhausts the cells of the marrow and of the blood, thus allowing a greater spreading of the infection.

It irreversibly intoxicates the liver, thus preventing it from building new elements of defense, and it mercilessly knock out nerve cells, thus weakening the organism's reactive capabilities and delivering it to the invaders.

Professor Gianfranco Valsé Pantellini in the treatise interview "*The Individual, Disease and Medicine*" says this of chemotherapy: "*It has a devastating action on the whole organism...It is based on an axiom – rather, on a paradox ... that which causes cancer cures it. Look at what level of absurdity we manage to get to...*". (Andromeda, Bologna, third edition, Oct. 1995).

Nobel Prize winner Kerry Mullis in the same interview (page 75):

“The drugs we use – all those damned chemotherapics – are no less toxic than AZT. And we prescribe them to all. Every one of us has an aunt who has been irradiated or who has undergone a chemotherapy that is killing her.” “...we are dealing with a bunch of charlatans. The entire medical profession – aside from some instances such as the treatment of fractures – is truly rotten.

We are talking about people who have just become socially important and very rich thinking that they are able to cure the diseases that afflict us. In reality, they can do nothing. It is frightening, but that’s the way it is.” Raul Vergini (care of), “Aids is an open question.” Andromeda, Bologna, 1995.

That notwithstanding, the cost benefit ratio in terms of health of the application of chemotherapy should be thoroughly evaluated. I am referring to those cases where there is the need for a fast regression of the neoplasias such as, for example, some types of lymphoma where, in my opinion, there is great synergy in the formation of masses because of the concerted action between viruses and fungi.

Here it is possible to observe how the association of bicarbonate + chemotherapy often has devastating effects on neoplasias.

Radiotherapy

My experience has taught me that radiotherapy, whether it is used as the first treatment option, or later in the progression of the disease, very rarely brings positive lasting results. This is with the exception of some tumors – for example, in bones or lymph nodes – that can actually benefit from this treatment.

In these cases, especially when there is circumscribed localization in bones, radiotherapy always turns out to be a useful and fast weapon when associated with the simultaneous administration of bicarbonates and drugs that protect bony tissue.

Surgery

The issue is slightly different for surgery. Although in a limited way, surgery can in some cases be very useful, especially where the dimensions of a tumor do not ensure a sufficient perfusion of saline solutions.

This is the case, for example, of intestinal neoplasias that are difficult to reach with endoscopic catheters. It is the case for all testicular tumors, themselves resectable before metastatization occurs because of their position which is located at the extreme

end of the anatomical vascular and spermatic structures. Possible auto transplants with marrow “washed” in bicarbonate, tumors of excessive dimensions requiring a drastic preliminary reduction of their mass (peritoneal, pleural, skin tumors and others) can also need surgical intervention.

In all cases it is wise to highlight the need always to administer sodium bicarbonate solutions, before and after the operation, as they prevent new germinations of fungi and thus the formation of metastases.

I am convinced, for example, that a resection intestinal intervention for neoplasia combined with infusions of sodium bicarbonate would succeed in almost all cases, as local or remote relapses could not occur.

Supporting Drugs

I am of the opinion that an extremely cautious attitude should be taken when adopting conventional therapies for almost all the remaining neoplasias, and that at any rate these should always be associated with sodium bicarbonate.

As to supporting drugs, it must be said that their effectiveness – except for a generic action of vitamins and mineral integrators – turns out to be quite dubious most of the time, and in some cases even quite harmful.

Interferon, as well as interleukin and other modulators of biological responses, in fact invariably causes negative reactions.

This is because they are conceived to act exclusively at the cellular or para-cellular level, and the high doses that are usually injected produce massive phenomena of global organic suffering such as fever, pain, and more, while their positive and targeted therapeutical contribution in any neoplastic disease is still dubious.

Hormones and Anti-Hormones

We really do not know how to consider hormones and anti-hormones other than as tonics and thus as having a certain reconstituting action, or as molecules capable of specifically antagonizing cellular hyper-proliferation.

In both cases, their use does not seem clear other than to cause aggravation of a metabolic system which is already fatigued.

Therefore, in the hypothesis that a reproductive anomaly of the cell has nothing to do with cancer, the supposed hormonal genetic-receptorial interactions are just words in the wind. It is in fact

known how the process of cellular production starts from signals issued by genes, how it takes substance and is sustained by the interactions of the endocyttoplasmatic structures, and is completed on the external surface of the cell.

The cascade of millions of mechanisms that operate in the formation of active terminal molecules essentially consists of the interaction of two classes of enzymes: the phosphatases and the kinases.

These are the enzymes that transfer phosphorus to the molecules and those that remove them in such an intricate and indefinable maze of interactions as to allow only the detection of some marginal passages – which is too little to avail the slightest anti-tumoral therapeutic ability.

What we have said for the hormones can also be applied to any other type of supposed oncological causality: from carcinogens to psychosomatics, from viruses to anti-oxidants, from environment to heredity and so on.

From this point of view, any research proposing such a tangled conceptual mess is no longer a scientific and rational fact, but becomes almost a quasi-religious fight sustained by principles that are metaphysical and indemonstrable.

This kind of research can be fuelled to infinity for the very reason that its fields of application are infinite. Any research program that is so structured – even if it is well planned and shared amongst the greatest research centers of the world – is and always will be a drop in the ocean because of the galactic dimensions imposed on the problem.

If, hypothetically, we were to assign to New York, Washington, Bethesda, or other American centers the study of various oncogens and recessive oncogens, and then to the European cities the study of hormones and biological response modulators, and finally to the rest of the world environmental and viral carcinogens, maybe we would be able to discover one per cent of what we should discover.

It would all be useless.

Having said that, when we hear on television or read in the papers of the discovery of the action of a certain protein, gene or enzyme that could shed light once and for all on the problem of

cancer, we can't help but feel that we are all being taken for a ride, more or less in good faith, and that we are just wasting time.

"*But we know so much already!*" one could say:

"*v-onc, p53, rb1, telomerase, the Philadelphia chromosome, anti-monoclonal missiles, killer genes, the value of tyrosinkinesis, growth factor receptors, etc. etc.*"

It is just propaganda. All of it.

In conclusion, official oncology does not give and cannot give any assurance either at the theoretical level nor at the therapeutic level. Public opinion – intuitively aware of oncology's state of bankruptcy of ideas – is looking more and more for therapeutic alternatives that are more effective and less devastating.

It is sufficient to say that in an article of Nov. 11, 1998 published by the *Journal of the American Medical Association*, it was reported that in 1997 Americans made 629 million visits for alternative medicine against 386 million visits for conventional medicine.

This occurs because a state of psychophysical well-being is often easier to reach with non-conventional therapies even when they are based solely on the suspension of official therapies and on the administration of abundant hydration and on reconstituting cocktails.

The Therapy with Sodium Bicarbonate

A logical solution to the cancer problem, based on the arguments put forward so far, seems to stem from the world of fungi against which, at the moment, there is no useful remedy other than, in my opinion, sodium bicarbonate.

The anti-fungins that are currently on the market, in fact, do not have the ability to penetrate the masses (except perhaps early administrations of azoli or of amfotericina B delivered parenterally), since they are conceived to act only at a stratified level of the epithelial type. They are therefore unable to affect mycelial aggregations that are set volumetrically and also when masked by the connectival reaction that attempts to circumscribe them.

We have seen that fungi are also able to quickly mutate their genetic structure.

That means that after an initial phase of sensitivity to fungicides, in a short time they are able to codify them and to metabolize them without being damaged by them – rather, paradoxically, they

extract a benefit from their high toxicity on the organism.

This happens, for example, in the prostate invasive carcinoma with congealed pelvis. There is a therapy with anti-fungins for this affliction, which at first is very effective at the symptomatological level but consistently loses its effectiveness with time.

Sodium bicarbonate, instead, as it is extremely diffusible and without that structural complexity that fungi can easily codify, retains its ability to penetrate the masses for a long time. This is also and especially due to *the speed at which it disintegrates them*, which makes it impossible for the fungi to adapt so that it cannot defend itself.

A therapy with bicarbonate should therefore be set up using a strong dosage, continuously, and in cycles without pauses in a work of destruction which should proceed from the beginning to the end without interruption for at least 7-8 days for the first cycle, keeping in mind that a mass of 2-3-4 centimeters begins to regress consistently from the third to the fourth day, and collapses from the fourth to the fifth.

Generally speaking, the maximum limit of the dosage that can be administered in a session gravitates around 500 cc of sodium bicarbonate at five per cent solution, with the possibility of increasing or decreasing the dosage by 20 per cent as a function of the body mass of the individual to be treated and in the presence of multiple localizations upon which to apportion a greater quantity of salts.

We must underline that the dosages indicated, as they are harmless, are the very same that have already been utilized without any problem for more than 30 years in a myriad of other morbid situations such as:

- Severe diabetic ketoacidosis ⁶⁴
- Cardio-respiratory reanimation ⁶⁵
- Pregnancy ⁶⁶
- Hemodialysis ⁶⁷
- Peritoneal dialysis ⁶⁸
- Pharmacological toxicosis ⁶⁹
- Hepatopathy ⁷⁰
- Vascular surgery ⁷¹

Treatment Limitations

I believe that we cannot administer full dosage for cancer patients with severe heart, renal, and hepatic problems. In any case, however, it is best to try to reach the maximum tolerable quantity, as a dosage that is too low or too thinly distributed over time cannot be effective in depth.

In some patients, although not afflicted by other pathological conditions other than a tumor, if there are many masses or the masses have large dimensions we have sometimes observed a remarkable increase in the temperature up to 39 degrees centigrade in the first days of therapy with bicarbonate.

This is the effect of the brutal lysis of the colonies, which in some cases is even responsible for the high amylose contents and for transitory renal insufficiency sometimes associated with a bladder urinary block which can be solved through catheterization.

Hypertension or hypotension events as well as episodes of relapsing cephalaea complete the picture of side effects which, it is wise to emphasize, are rare and brief, that is, without negative after effects.

The therapy that is most indicated to counter all the instances described above is the fast intravenous infusion (about one hour) of glucose phlebos at 5% or 10 % solution with the addition of potassium chloride, and physiological solutions that are capable of complete resolution generally without the utilization of any symptomatic drug by helping the drains to bring the circulating catabolites back to the standard value.

The use of antibiotics, anti-pyretics, diuretics, sedatives, cortisonics, and other drugs should be avoided or extremely limited except for some particular cases at least during the treatment with sodium bicarbonate, since any additional toxic element in circulation weakens its anti-fungin effect. From this point of view, as well, natural medicines show an undisputed superiority over official medicines because they at least preserve the organs in a condition that is sufficiently energetic and reactive.

Vegetal, a-proteic, vitamin therapies with fasting or other means, variously adopted by this or that therapy system and often underestimated, are based fundamentally on this principle – that is, that a clean organism has a more dynamic circulation and may

rely on a more active immune system: in short, it is better able to defend itself.

Use of an allopathic formulation is, therefore, not indicated – contrary to what is usually proposed – in the treatment of tumors, because fungi are able to exploit any element that weakens the tone of the organism and that overloads its metabolism.

What is needed is not to delay or attenuate the reaction of defense; conversely, we must accentuate them by avoiding any drug or any food that is “too heavy”.

Examples of Therapies with Sodium Bicarbonate Solutions

Oropharynx Cancer

The privileged anatomical position of being in contact with the outside allows a very easy perfusion of the neoplastic masses that are in the mouth and the tongue, on the palate and in the pharynx. The perfusions with sodium bicarbonate solutions are very concentrated and simply obtained by adding one-and-a-half teaspoons of the substance to a glass of water.

The treatment, to be administered twice a day, goes on for 10 days. The treatment is repeated once a day for another 10 days at the end of this first period. The treatment is repeated after a week of rest if some small residual neoplasia persists.

In cases of irritation, the administration of the bicarbonate can be alternated with one day of rest, and, in the presence of blood, by the administration of sodium chloride – that is, simply salt in water. If the epipharynx or nasal cavities are affected, it would be useful to prescribe inhalations and conjunctival instillations.

So far the therapy is easy. That, however, becomes more complex in a presence of a deeper neoplastic process, that is, when neoplasias gain ground within the bodily structures. The impossibility of reaching them from the outside imposes an arteriographic treatment through the external carotid possibly combined with local infiltrations.

Stomach Cancer

One of the tumors that are easiest to treat because of its easily reachable position through the mouth is that of the stomach. Patients I treated 20 years ago lived for a long time without

mutilation. Some of them, among which is a relative of mine, are still living.

Administration and dosage:

one teaspoon of sodium bicarbonate in one glass of water 30 minutes before breakfast and dinner for 15 days, then only in the morning for another 30 days, making sure that the patient assumes all the positions (prone, supine and lateral) so that contact with the salts is achieved with all the mucus of the organ.

It may happen sometimes that the double daily dosage causes diarrhea discharge, but suspending the evening dose should be able to solve the problem.

Generally the blood in the feces disappears after five to 10 days, digestion begins to normalize and the feeling of heaviness tends to regress with the result that the patient manages to gain weight.

Everything is fairly simple, therefore, when the neoplasia – even of large dimensions – remains confined to the stomach wall and to some peripheral lymphonoids.

In cases where there is a visible spreading in the adjacent structures – especially in the ligaments – stomach cancer, as it is impossible to reach completely, becomes extremely difficult to uproot. The colonies, in fact, are not touched by the bicarbonate administered in the stomach and work as a receptacle for a more marked proliferation where they cannot be attacked.

They become the reference position for all the others, sustained in the fight for survival by those elements of biochemical solidarity that are at the basis of the formation and of the progression of the masses.

To better understand this concept, one can imagine a great spider web formed by voluminous aggregates in the corners, and elements of linear connection that join them and that work as communication means between the cells.

When an element, an aggregation or a great part of the structure is attacked, the alarm signals move from the more exposed colonies to those which remain outside of the field of any toxic substance so that their defense reactions can be activated and increased without limitation.

Furthermore, a displacement of nuclear elements from each cell towards a non-endangered location takes place through the porous

cellular network, with the result that a greater concentration of noble reproductive structures can work undisturbed, even having the time to perform genetic changes as a function of the noxious agent.

It is in this way that all forms of resistance to drugs and to other compounds (including bicarbonate) is developed, even though when it comes to the latter the adaptation is to be conceived in terms of resistance to the low dosage used in the therapy.

The biological reactive network therefore explains the phenomena of communication and defense between the aggregates, cells and spores that are even quite distant from each other. It also explains the mechanism of the metastases, which are nothing but new fungin masses that have colonized an organ after departing and being fed by the mother colony.

Assuming, however, that the spider web is widespread and that it touches many organs, one can ask why metastases are produced gradually, first in one organ and then in another, and so on.

The explanation consists in the fact that, as long as a tissue has integrity and tone – that is, it is reactive – no fungin rooting is possible. When it weakens for a wide variety of causes and during the progression of the disease beyond a certain limit it becomes more susceptible to attack and thus it can be colonized.

This is the reason why the main causes of metastasis are often the official therapies, as they produce such tissue suffering as to render those tissues defenseless to the fungi.

Going back to the stomach cancer, the points that are less accessible for the therapy with bicarbonate are the ligaments, starting points for the defense and the regeneration of the colonies. If, besides the ligaments there is also an involvement of other organs, especially the liver, it all becomes even more difficult.

It is therefore appropriate to treat the stomach tumor as soon as possible and with the greatest possible intensity in order to uproot it completely and once and for all before it is able to get itself “organized”.

The positioning of a catheter in a perigastric location and an arterial one in the celiac tripod through which it is possible to administer the bicarbonate directly on to the fungin masses can allow the regression of the disease even in complex cases.

Cancer of the Liver

All types of organic tissue, both primitive and metastatic, can be reached through selective arteriography by utilizing a catheter positioned in the hepatic artery through which it is possible to administer 500 cm³ 5 % solution daily, possibly combining this with oral intake.

The regression always takes place if there is a sufficient quantity of working hepatic parenchyma – at least 30 % - even in the presence of an infection from hepatitis virus. The life expectancy is a function of the size of the masses and it can increase constantly as treatments are repeated over time up to the restoration of normal life conditions.

The therapeutic scheme normally includes a cycle via the artery of 6-7 days, repeated every 3-4 weeks and a teaspoon of bicarbonate dissolved in water taken on an empty stomach during the rest day in the intermediate period. Although rare, side effects occurring during the therapy are:

- *Elevation of body temperature up to 38 °C, in some cases up to 39°C.*
- *Cephalea.*
- *Moderate hypertension/hypotension episodes.*
- *Pain in the hepatic area, caused by the action of bicarbonate in the presence of hemorrhagic elements.*
- *Urinary retention.*

All the symptoms described above are caused by the bicarbonate that immediately disintegrates the masses causing regress in a short time – about 30-60 minutes – through abundant oral hydration or with the administration of phleboclyses that dilutes the catabolites. The phleboclyses contain 10 % glucose solution with the addition of potassium chloride and physiological solutions.

In addition to the above therapeutic scheme, it may sometimes be useful to position a small catheter directly inside the neoplastic mass in which we can infuse the sodium bicarbonate in order to attack a mass that does not regress fast enough.

If appropriately treated, liver cancer regresses in a very high percentage of cases (90%) with equally elevated final recovery rates (70-80%). The exceptions are cases where all or a vast part of hepatic parenchyma (the hepatic matter) has been replaced by the neoplastic masses.

Peritoneal Carcinosis

Almost all the neoplasias of the abdomen can expand either because of contiguity or after surgical intervention in the peritoneal cavity, and gradually spread in all possible directions.

Stomach, intestine, pancreas, bladder, prostate, uterus and ovaries are the organs from which an expansion in the cavity with possible formation of ascitic liquid of the neoplastic type most frequently takes place.

In fact, once the fungin colonies penetrate in the peritoneal serosa and they get used to metabolizing it, there is no more obstacle to their advancement. In this way, the phenomenon of carcinosis takes place – a morbid event that is outside the range of any conventional therapy.

Conversely, the method of therapy that I propose, as it is based on the filling of the cavity with bicarbonate solution, is able to reach the fungin masses in their totality and it appears to be extremely effective in their destruction.

The method consists in the positioning of a transdermal catheter in the abdomen through which the invaded tissues are irrigated abundantly for about 30-40 days after draining the pre-existing liquid.

For the first three days, 300-400 cc of sodium bicarbonate 5 % solution is introduced and left inside the peritoneal cavity. This is drained the day after before the new administration.

For the following 12 days, the dosage is lowered to 100-200 cc of solution, to be drained 1-2 hours after the treatment. The procedure is repeated from the 15th to the 30th-40th day with a cycle of one day on and two off.

The dosages described above are to be considered as indicative, as they change as a function of the response, of the weight of the body and by the side effects that may take place.

Flatulence and a feeling of fullness that often already exist as well as more or less marked pain are almost constant symptoms, especially in the first days, but the symptoms regress sharply as the therapy proceeds.

Hypertensive or hypotensive episodes as well as thirst and lack of appetite complete the picture of possible undesirable side effects. The most serious complication may be the development of an infection inside the cavity, generally caused by the lack of a

thorough daily medication of the catheter and the bandages. If this occurs, it must be treated immediately with high dosages of intramuscular antibiotics which can resolve it in a short time.

In the presence of carcinoses of large dimensions, an intervention for the resection of the masses must be performed with the purpose of “lightening up” the abdominal cavity and making the action of bicarbonate more effective.

Intestinal Cancer

The choice of the treatment to perform with sodium bicarbonate depends on two factors: the size of the mass and the depth of infiltration in the intestinal wall.

In cases where the neoplasia – regardless of its shape – is all inside the intestinal lumen, the most effective method of attack is colonoscopy, through which it is possible to administer 150-200 grams of sodium bicarbonate in two liters of lukewarm water, going as far as the ileum-caecal valve.

Even when the masses regress conspicuously within a few days it is best to program from seven to nine sessions for a period of three to four weeks, keeping in mind that the first ones must be close together to have an immediate effect, and that the last ones are for the purpose of consolidation.

The possible crossing beyond the intestinal wall, or the simultaneous presence of a hepatic metastasis imposes a specific therapy for these organs as well.

Temporary episodes of diarrhea can take place during or after each session with bicarbonate salts, but this is not a reason to interrupt the therapy; at most, it may be appropriate to pause for some days.

Under a certain size, that is if the tumor has not completely invaded the intestinal lumen to the point of sub-occlusion or occlusion, the endoscopic treatment turns out to be very efficacious for obtaining regression of the masses.

Where, instead, there is an extreme situation or the simultaneous presence of another synchronous tumor, that is, existing in other sections of the intestine, and where it would be very difficult to reach after passing the first mass, then surgical intervention is indicated in such cases, as it saves the performance of the canal down to the anus.

This is possible through terminal or lateral anastomosis of the resected stumps, both treated later in the surgical theatre and through post-surgical draining with local and regional administration of sodium bicarbonate capable of preventing the formation of possible local or hepatic relapses.

When tissues are more vulnerable in the cicatricial points where reactivity equals zero, or at the hepatic level because of the toxic effects of the anesthesia, treatment with bicarbonate prevents that fungus regrowth that most of the time causes a return of the disease and is impossible to cure. The indications for prevention in this case are the same as those for the therapy of peritoneal carcinosis.

Cancer of the Spleen

The only efficacious method is selective arteriography of the splenic artery. This provides excellent results immediately and in general does not cause troublesome side-effects.

Compared with splenectomy, which is the treatment chosen conventionally, not only does it spare the organ, but it also prevents the possible neoplastic propagation at the hepatic or systemic level.

In any case, even if surgical intervention is chosen, a preventive measure applied locally and generally with sodium bicarbonate turns out to be extremely efficacious in preventing a return of the neoplastic pathology.

Tumor of the Pancreas

Here too, the arteriographic therapeutic approach applies, although sometimes the side-effects are more disturbing than they are for the spleen.

The nausea and heaviness episodes are in fact more acute during the first infusions, as is the pain felt at the moment of the infusion at the pancreatic artery because of its small diameter, which causes reactions due to its temporary and forced stretching.

One positive reaction which indicates the quick sensitivity of the colonies to sodium bicarbonate is the fast attenuation of the existing dorsal pain. It may be that anomalous vascular conditions have sometimes occurred when surgical or biliar interventions have been performed. In this case, arteriographic therapy may not be

very efficacious. The crossing of the colonies in adjacent tissues or in the liver imposes a specific therapy even for these pathological conditions.

Bladder Tumor

The therapeutic approach depends on the anatomical configuration of the neoplastic invasion. That is, on whether the tumor is limited to the internal walls or if it goes over into the pelvic cavity.

In the presence of carcinomas that are superficial or partially infiltrating, it is sufficient to administer bicarbonate solutions directly in the bladder through a catheter and also by administering an oral therapy of one teaspoon in a glass of water on an empty stomach to obtain very positive results almost all the time.

In general, after two or three days and also in the presence of large projecting masses, we can observe a regression of the painful symptomatology and, if present, the elimination of hematuria episodes.

Dosage:

150-200 cc through a catheter for four consecutive days, then every other day for two weeks, then one day on and two off for two further weeks, with suspension for one or more days in the presence of evident pain or erythrocytarian diapedesis.

The vesicle epithelium, in fact – burdened by the disease or by previous endoscopic instillations of mythomicine or other drugs – demands particular attention and vigilance because of its suffering condition. That means a continuous therapeutic modulation as a function of the subject.

Both selective arteriography and abdominal catheters are indicated in the case of pelvic overflow through which it is possible to attack the masses in a concentric and conclusive way. Sometimes a neoplastic affliction of the urethras may be present, and that is very difficult to perfuse with sodium bicarbonate solutions through the vesicle catheter.

In this case, the position of a transdermal catheter in the afflicted urethra – that is, a nephrostomy – allows those masses to be reached and destroyed that have been missed by the sodium bicarbonate.

Vesicle tumors are very sensitive to the action of sodium bicarbonate, which almost always causes the regression of the masses.

Prostate Tumor

If there has been no surgical operation, it is possible to first attempt to treat the neoplasia through urethral catheters which allow the spreading of the saline solutions inside the prostatic lobes through the ducts.

It is possible to combine this with periglandular infiltrations applied transrectally by utilizing very long needles of the type used for amniocentesis.

Where it is not possible to treat the mass adequately or in the presence of post-surgical relapse, the administration of sodium bicarbonate repeated in cycles of 6-7-8 days per month directly in the pudendal artery generally turns out to be extremely effective.

In the presence of a concomitant invasion of the pelvic cavity, it is possible to adopt the same therapeutic scheme used for peritoneal carcinosis, that is, by using a small catheter to position inside the abdomen and close to the mass.

Possible bone metastasis, instead, requires a completely different therapeutic approach, which depends on both the number and location of the lesions.

If the lesions are not numerous, it is appropriate to program a cycle of targeted radiotherapy for each one, supported by 500 cc sodium bicarbonate phleboclyses to be administered after each session with the purpose of preventing a further germination and spreading of fungin cells.

Each physical treatment that destroys neoplastic matter, in fact, implies the simultaneous destruction of a quota of the tissues of the host. It is this cellular death that works as both bait and lifesaver for the fungin cells which manage to survive by nourishing themselves with the decomposing tissues.

Radiotherapy, laser therapy, or thermo-ablation generally fails for this reason, as they leave those cellular units that are able to vigorously resume the proliferation once the treatment is over at the periphery of the treated area.

I am convinced of this because I have studied the behavior of the fungin colonies in depth, especially during the first years of

application of my method of therapy. Where there were epithelial tumors, I even tried burning them with instruments that were red hot, and well beyond the actual size of the tumors, but it was useless. After just 10-20 minutes, I was observing fungin cells at the periphery of the burn that were more vital than ever.

Pleura Tumor

There is no doubt that primary or secondary pleuric neoplasias are amongst the easiest to treat with the therapy method I propose, as I have observed in almost all the cases the complete regression of the disease unless in the presence of a previous pleurodesys intervention.

Method: after the positioning of an endopleuric catheter with the ecographic guide and after the drainage of the existing liquid administer 150-200 cc in the cavity for three consecutive days, then on alternative days for 12 days. Administer 100-150 cc from the 15th to the 30th day, and drain after one hour – this to be performed one day on and two off.

Normally, after the fourth-fifth day, the hemothorax – if it was present – disappears, and after 10-15 days (except in some rare cases) it is no longer necessary to aspirate liquids, as the pleura has gone back to normal. Much attention must be paid to the medication of the gauzes and of the catheter, as both can become very dangerous sources of infection and of pleuric empyema – an event that can also occur in cases where too elevated dosages of salts are administered.

Tumors of Limbs

There are a great variety of tumors that develop in the upper and lower limbs, which may be both primary and metastatic. Osteosarcoma, Ewing's sarcomas, condrosarcomas, and others mainly belong to a juvenile pathology while the metastatic types concern more adult pathology.

The attempt to destroy them consists of using sodium bicarbonate solution at five per cent in doses that are proportional to the weight of the patient. This is achieved through the application of catheters in the afferent arteries to each limb. All the masses downstream of the application point generally regress almost completely, even though in some cases the effects of the therapy become visible only

three to four months later when, that is, the tissue re-absorption and reshaping phenomena are almost completed.

The only real problem with this therapy is that the arteries of a young patient are of small cross-section, and that means that for each administration the insertions and the stretching of the nerva vasorum produce a steady, painful symptomatology.

The symptoms, however, are temporary, and apply only during the period of administration. Nevertheless this sometimes forces the suspension of the treatment for one or two days.

In the case of bone metastasis, it is possible to obtain an almost complete remission of the painful symptoms by performing direct percutaneous infiltrations on each lesion. This can be done by leaving a cannula needle in contact with the bone.

Brain Cancer

All brain tumors both primary and metastatic in general regress or stop growing after therapy with sodium bicarbonate at five per cent solution. The therapy must be performed for at least six to eight days for the first cycle because the disease starts again in a relatively short time and often becomes irreversible if the period is less than six days.

The administration of the solutions takes place through sequential catheterization of the two internal carotids and of the Willis' Circle with 150 cc in each area in order to obtain total perfusion of the encephalus.

The perfusion must always be quantitatively modulated as a function of the location of the largest masses.

For example, if there is one mass in the right frontal area, it is appropriate to deliver 250 cc of solution in that anatomic compartment while the remaining 250 cc are subdivided in the other two vascular areas.

The patient is conscious during the infusion, and he is actually the person who dictates rhythm and speed, because the slightest vascular effect is sensed immediately.

The therapeutic scheme is based on the dimensions of the masses - the larger they are, the more they need additional cycles delivered arterially. The dimensional limit of 3-3.5 cm within which a rapid shrinking of the masses is possible turns out to be a determining factor.

Instead, when masses greater than 4-5 cm have to be treated – or in the presence of multiple locations in all hemispheres – it is necessary to increase the amount and frequency of the cycles of therapy.

An ever-present side effect during the therapy is thirst. A general but momentary sense of pain as well as tachycardiac events are the most common symptoms.

In cases where the masses are very large or in the presence of a diffused meningeal carcinosis, a loss of mental performance may be observed after the first treatment sessions which, although sometimes acute and may persist for several hours, completely disappears after the treatment.

Lung Cancer

In general, this neoplasia responds very well to the therapy with sodium bicarbonate five per cent solution, which is implemented through arteriographic transcatheter catheter positioned in the pertinent pulmonary artery. This allows the administration of the optimal doses against the mass or masses.

An eight to nine day cycle is sufficient to cause the regression of the disease. However, when the mass is present in the bronchial lumen as well, it is appropriate to program a cycle of at least 4 to 5 bronchoscopies through which it is possible to percolate in the bronchial airway 30-50 cc of bicarbonate solution to be left in the location. After the first treatment it is already possible to notice a reduction of the bronchial stenosis and edema with evident improvement in symptoms.

Aside from possible generic symptoms related to the administration of bicarbonate, the therapy is always well-tolerated and presents no problem except when the hyper-alkaline environment caused by the infusions favors the development of bacteria which demands immediate treatment with antibiotics.

This applies especially in heavily debilitated patients.

Anti-tumor therapies that are specific to each anatomical area must be applied when the pleura or other organs are involved.

Breast Cancer

Deep peri-lesion infiltrations may be sufficient if the cancer is of small dimensions. The infiltrations must be performed after local

anesthesia by combined intravenous phleboclysis using 400-500 cc on alternate days for a month.

If the mass is large it is also necessary to apply a catheter to the internal mammary artery through which the sodium bicarbonate five per cent solution can be infused directly on to the neoplasia in a six or seven days cycle.

Apart from a slight soreness there are no significant side effects. As can be noted, we are talking about harmless and quickly effective methodologies that are capable of preventing surgical intervention.

These methods should be always attempted in any case, even when there is doubt as to the final result, since they give positive responses in a short time without compromising the possibility of other therapeutic approaches.

The issue becomes more complex when other organs have been metastasized involving additional therapies of the colonized tissues complicating any possible future positive outcome. In every case – even in the presence of a diffused neoplastic disease – the bicarbonate therapy always attenuates the para-neoplastic painful symptoms, thus increasing both the quantity and the quality of the life of the patient.

If the patient is uncertain about what to do or if she has a preference for partial or total surgical intervention, a back-up treatment with sodium bicarbonate administered through phlebo or mouth is always appropriate, as it is capable of preventing and countering the metastatization of other organs (brain, liver, bones), which is very frequent with this type of neoplasia.

Skin Cancer

All skins cancers are always caused by Candida fungus which has adapted itself to metabolizing the most proteinaceous constituents of the epidermis and that can, therefore, only rarely be treated with sodium bicarbonate solutions.

The treatment to choose for epithileomas, basaliomas, and melanomas is iodine solution at seven per cent, as it is capable of precipitating the proteins of the body of the fungus and destroying them completely in a short time.

If the lesions are fairly small, they must be painted with the solution 10-20-30 times twice a day for five days and then once for another ten days so that they become very dark. When the eschar

is formed and it is higher than the epidermic plane, it is necessary to continue to paint under and above it, even if at first this causes a sharp pain.

This very same operation must be repeated for the second eschar that is formed. At this point, the lesion may be considered destroyed, because after the third cycle it is possible to reach the center of the neoplasia, where the colonies try to resist to the last.

In the presence of a tumor of large dimensions it is necessary to perform a cycle of subcutaneous infiltrations with sodium bicarbonate at five per cent solution under the lesion for the purpose of liberating the tissue from the possible invasion of the deep planes and of the basal lamina before performing the treatment with iodine solution.

If this is not done, we risk the fungus, once destroyed at a superficial level, defending itself by trespassing into those levels where a conclusive action of the iodine solution is impossible.

In cases where the tumor has invaded a cutaneous-mucous transitional zone such as the anus, eyelids, vagina, or mouth, it is necessary to perform a preliminary treatment of the mucous area with bicarbonate and then, after the elimination of the colonies existing there, proceed to treat the cutis with iodine solution.

It is appropriate to highlight that the same type of therapy is also to be applied to psoriasis and to the known fungin afflictions.

In fact, the difference between cutaneous mycosis, psoriasis, and tumors consists only of a variation of aggressiveness and thus of depth of rooting, since the causal agent is always the same: a fungus. Sometimes other corrosive salts can be used as a function of the location in the body for the therapy. What is certain is that dermal ointments and lotions are only rarely effective.

Conclusions

It may have been still possible 40, 30, or even 20 years ago to somehow convince people of the goodness of official oncology and of its results, but today, after results that are as continuous as they are inane, although trumpeted regularly by the media, nobody accepts being seduced by words, hypotheses, and promises that are undelivered and undeliverable any longer.

The painful awareness, which almost everyone has experienced,

CONCLUSIONS

of the miserable end of this or that relative, friend, or acquaintance, is associated with these failures.

We must surrender to the evidence that contemporary oncology is incapable of giving us the answers and the necessary therapy to those who are cancer patients and that, therefore, it is our moral and ethical obligation to try to find the correct solution for the gravest and most painful disease of our time.

The fungin infection theory and the cases we have presented represent a new way of perceiving tumoral diseases by rejecting the myth of the genetic causality of cancer. In my opinion, the fungin theory is the only successful logical option today.

Furthermore, when considering that the successes and the recoveries we have described have been obtained by operating in a non-continuous and unfavorable manner, it is legitimate to assume that with appropriate structures and equipment, the results could become extraordinary and could give back the hope of life to hundreds of thousands of people in the world.

Unfortunately, the current representatives of the medical intelligentsia worldwide do not seem to be able to comprehend something that, although simple and self-evident as this anti-cancer therapy is, nevertheless falls outside their habits and their narrow sectorial knowledge.

Furthermore, with their network of scientific acquaintances and collusions, with their conformity, politics, economics and media powers, they represent a formidable obstacle to the victory over cancer. For these people, anyone who thinks or looks for solutions in a different way must be put aside or suppressed altogether.

We need the help of those who work in the health sector and in politics as well as those people of integrity who are capable of seeing beyond simple and bleak conformity, and especially beyond the social and economic returns conformity brings, in order to unlock the current status quo which so painfully afflicts so many so intimately.

We need an effort of association, cooperation, and even spiritual complicity today that is capable of dismantling structures that are based and built on mistakes and lies. As to genetics and its portents, we will soon realize that in the deep darkness of ignorance too many have mistaken the light of a match for that of the sun.

APPENDIX

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Note

For the full documentation on
the clinical cases
presented here,
refer to:

www.cancerfungus.com

CLINICAL CASES

The clinical cases presented here (chosen from amongst many because they are sufficiently explanatory) represent the therapeutic set-up whose theoretical foundations have been explained earlier, although they are not sufficient in number to be defined as part of experimental work.

First Clinical Case Lung Cancer

This patient with pulmonary neoplasm was taken into my care at the end of 1983, before he was due to be operated on at the Istituto Regina Elena in Rome, where he had been sent by another hospital. We show the X-rays before (Fig. 1) and after (Fig. 2) the therapy with sodium bicarbonate.

In my opinion, the development of the tumor mass, that is, of the mycotic colony, took place because of a morbid process that started in the liver.

The stages of the formation of the neoplasm were hepatic dysfunction, raising of the right side of the emidiaphragm, pulmonary stasis, and susceptibility to mycotic rooting.

The therapeutic treatment was based on two essential elements: liver detoxification simultaneously with the administration of bicarbonate salts orally, through an aerosol, and intravenously.

The mass completely disappeared after about eight months of bloodless and painless therapy. More than a year after the end of the therapy the X-rays showed only a thickening of the interlobe separation, which is the result of healing.

The patient is still alive some 20 years after the therapy.

Declaration by the patient after 20 years:

*"I, the undersigned a resident of Rome,
declare as follows:*

I made the acquaintance of Doctor Simoncini at the "Regina Elena" clinic in Rome, where he was a voluntary assistant and where, in 1983, I was supposed to be operated on for lung cancer. As I decided not to undergo the operation, at the moment of my discharge from the hospital the doctor told me that, if I wanted, I could attempt

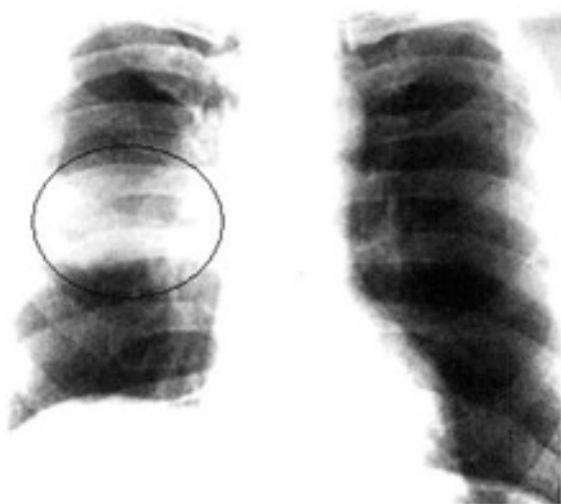


Figure 1. Situation before therapy.

The X-rays show a homogeneous thickening on the regular lower margins and at the upper vanished margin located correspondingly in the medium field of the right lung. The cancer area before the therapy is white in color.



Figure 2. Situation after therapy.

The X-rays of the cancer area after the therapy. As can be seen, only the white outline is left, which is the scar which indicates the elimination of the cancer.

a therapy with his method. The therapy consisted of the administration of baking soda orally, via aerosol, and intravenously. Doctor Simoncini told me only that the therapy was available for trying, because, according to him, I could hope for some positive result. He behaved very simply and humanely and I understood that he could really help me. The results have been excellent, for today, after almost 20 years, I still have my lungs."

Second Clinical Case Hepatocarcinoma with Pulmonary Metastasis

A 59-year-old patient who, in June 2001, showed a neoplastic liver mass of considerable dimensions also showed multiple metastatic nodules in both pulmonary fields.

He started the therapy with sodium bicarbonate at five per cent solution administered through a catheter in the right hepatic artery at the beginning of July. This caused the regression of the pulmonary lesions and a modest reduction of the hepatic tumoral mass.

After an alternating cycle of intravenous phlebotomy, always with sodium bicarbonate, the patient underwent a new cycle of treatment administered through the arteries in November, which caused the reduction of the liver cancer mass from six centimeters to two centimeters, and there were still no pulmonary lesions.

After a cycle of intravenous phlebotomy, a liver ecotomography in February 2002 showed a further reduction of the liver tumoral mass to 13 by 5 millimeters, and this no longer showed on an ecographic scan in June 2002.

Clinical documentation:

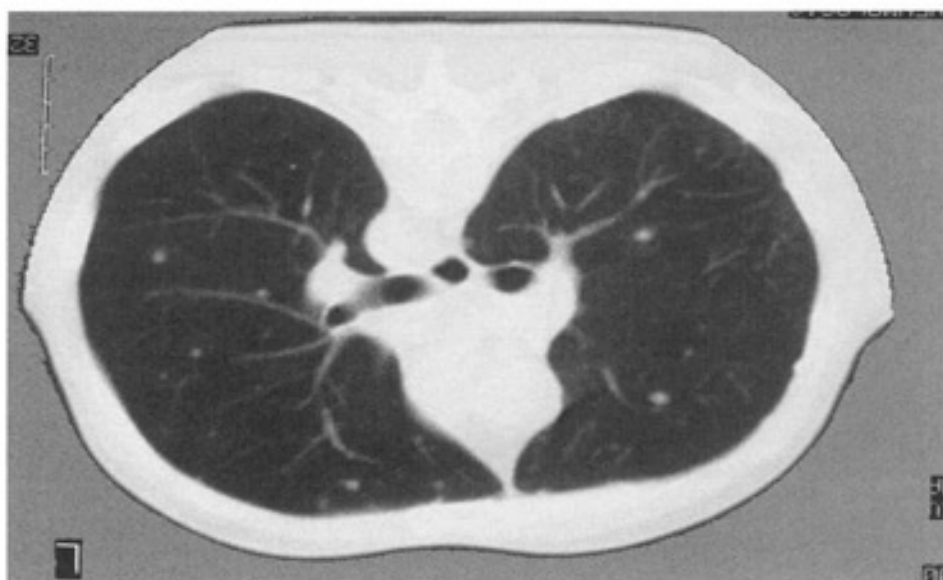


Figure 1 Pulmonary CAT scan June 12, 2001, before treatment.

- Thorax X-rays, as documented on June 11, 2001:

"Multiple nodular opaque areas in both pulmonary fields due to repetitive lesions..."

- The report of a CAT scan of the thorax of June 12, 2001, states:

"Multiple roundish nodules are shown bilaterally in the pulmonary parenchyma. The nodules have the density of soft tissue consistent with secondary lesions (Fig. 1). Hypo-dense neo-formation in the basal segment and non-homogeneous enhancement (after contrast) in the VI-VII hepatic segment."

End of June – at the end of June and beginning of July, 2001, the patient underwent therapy with sodium bicarbonate at five per cent solution for a week. The solution was administered through a catheter located in the right hepatic artery through selective arteriography. CAT scan report of July 5, 2001: *"[There are] no pathological images in the pulmonary parenchyma and in the pleurae (Fig. 2)...Liver of increased dimensions. In the VII segment we report a structural alteration of about 6x3 cm maximum diameter ... The aforementioned lesion appears to be moderately reduced when compared with a previous examination of June 15, 2001 performed in other facilities and brought for reference."*

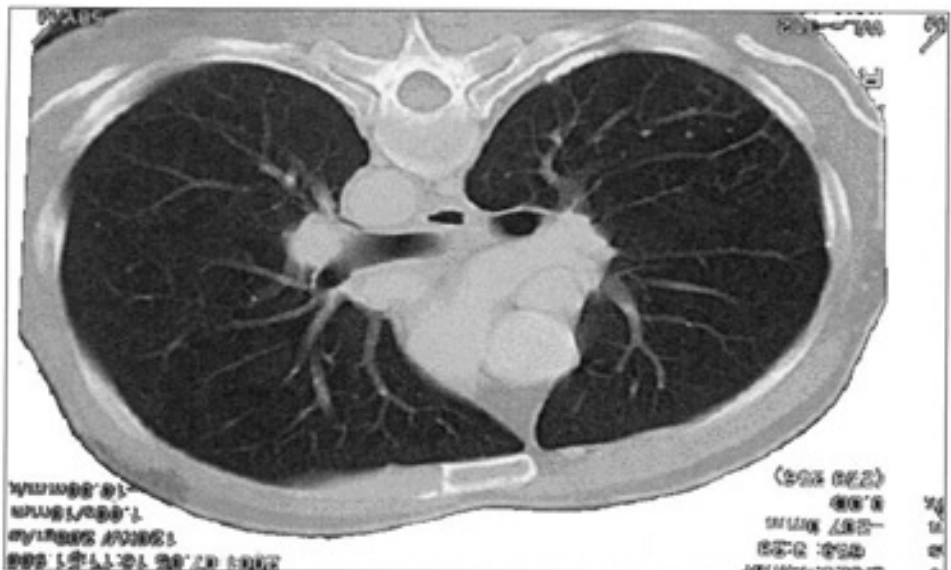


Figure 2 CAT scan of July, 2001 after the first treatment, highlighting the re-absorption of the metastasis.

HEPATOCARCINOMA WITH PULMONARY METASTASIS

CAT scan of thorax abdomen of Nov. 15, 2001: "... We note the presence of a discario-kinetic region with increased power in a late phase. The region is localized at the level of the VI and VII segment and it shows a hypo-dense area peripherally, with a diameter of about 2 cm, both before and after the administration of [stain]."

The pulmonary CAT scan images of November (Fig. 3) confirmed the total regression of the pulmonary metastases which had already occurred five months earlier, and the result was confirmed.

The comparison of the liver CAT scans performed in June 2001

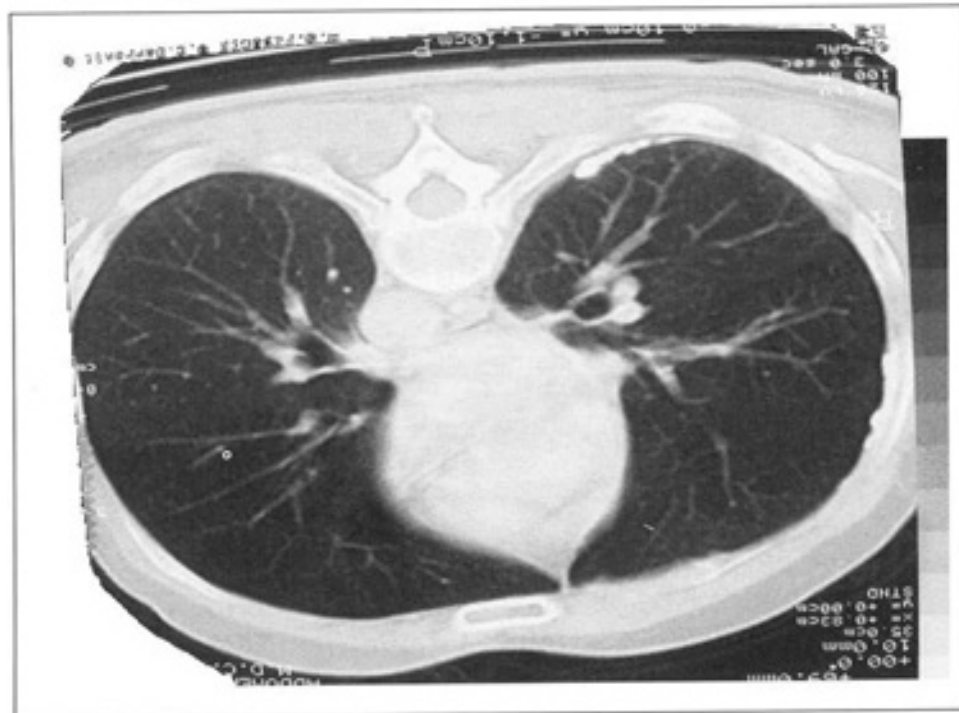


Figure 3 Lung CAT scan of November 15, 2001, five months after the first treatment. The scan highlights the re-absorption of the metastasis.

before the treatment (Fig. 4), with the November scan after the treatment (Fig. 5), shows that the massive non-homogeneity is re-absorbed almost completely. The ecotomographic report of Jan. 16, 2002 (Fig. 6), states: " ... Expanded ecostructural non-homogeneity because of the presence of regenerative nodules: there is an area of greater visibility... diameter 13 x 5 mm in the undercapslar area of the right lobe, 7th segment."

CANCER IS A FUNGUS

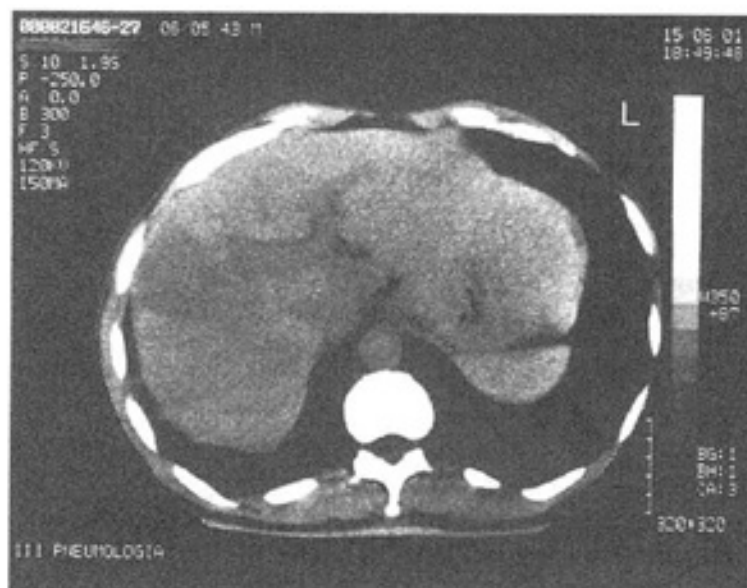


Figure 4 Liver CAT scan of June 15, 2001.



Figure 5 Liver CAT scan of November 15, 2001

HEPATOCARCINOMA WITH PULMONARY METASTASIS

In the report of June 3, 2002 “...*The presence of the hypoeoidal area at the 7th segment is no longer evident.*”

The patient released the following declaration on October 31, 2002:

“I, the undersigned..... resident in Palermo, declare the following:

In the month of June 2001, I was diagnosed with a liver tumor of about 8 cm with pulmonary metastasis. It must be said beforehand that I was already (and I still am) affected by hepatitis C. The agony of my family was great, and they didn't know how to face this with me, since I had been kept in the dark about the problem up to the time of my meeting with Doctor Simoncini.

My (homeopathic) doctor....., to whom my family turned, wanted to contact a French homeopathic colleague, an expert in the field of tumors, but since he had lost contact, he asked my son Daniele to search the internet to find him again.

My son, seeing the gravity of the problem, searched the internet thoroughly but was unable to find the contact we had hoped for.

Fortunately, he stumbled on the A.N.F.E.T. site where the cases of liver tumor treated by Doctor Tullio Simoncini were described.

My son and my wife reported this to Doctor who got in touch with Doctor Simoncini and set up an appointment for me in Rome.

For the love of truth, I must state that the Doctor (also cousin), when I had informed him about the outcome of the visit in Rome and queried him about his professional opinion, answered that he was unable to establish whether the unofficial therapy practiced by Doctor Simoncini would be efficacious in my case (he did not know either the theory or the scientific soundness of the treatment).

He was, however, sure that if an attempt had to be made for my own good, the baking soda-based treatment would not damage my body, while official therapies would have caused me useless suffering, especially in consideration of my condition as a sufferer of hepatitis C.

This conviction induced my family, upon the suggestion of my cousin, to convince me to go to Rome and to visit a specialist using the pretext of trying to find an effective palliative therapy to eliminate the suffering from the pain in my shoulder and in the area of the liver.

CANCER IS A FUNGUS

It was in these circumstances that I met Dr. Simoncini and for that I thank GOD.

After about 15 months my liver cancer has disappeared and with it the metastasis to the lungs. The metastasis disappeared after the first cycle of therapy.

I followed two treatment cycles with baking soda phleboclysis administered directly into the arteries of the liver and of the lungs.

I've also undergone cycles intravenously and orally, always using baking soda.

Since the start, Dr. Simoncini never gave any guarantee of recovery. He only told me that the tumors were, in his opinion, of mycotic cause and therefore if we worked with patience and determination, we might be able to obtain some positive result.

The first objective was to block the growth of the tumor and then slowly to try to make it regress, and so it has happened.

I hope that other patients with cases similar to mine can undergo the same type of therapy and I wish for Dr. Simoncini that his discovery can be universally divulged and accepted.

Palermo, October 31, 2002

* * *

Third Clinical Case

Hepatic Metastases from Colangiocarcinoma after Surgical Intervention

The patient I visited at the beginning of May, 2002 showed a grave weakening because of a liver neoplasia 10 cm in size. The mass was able to reach that size in spite of a prior surgical intervention on the colangiocarcinoma and 11 cycles of chemotherapy. The therapy was abandoned because of negative repercussions on the patient's body.

The infusions with sodium bicarbonate five per cent solution through a catheter located in the hepatic artery at the dosage of 400-500 cc a day for six days immediately resulted in a sharp improvement of clinical conditions.

Further treatment cycles through arteries alternating with oral cycles led to the reduction and then to the disappearance of the hepatic neoplastic formation in the following months.

IO SONO SCRIVA _____, HO CONSTATATO IL DOTT. TULLIO SIMONCINI NEL MAGGIO 2002, PERCHÉ AFFETTA DA UNA GRAVE FORMA DI CARCINOMA AL FEGATO, DOPO AVER SOPPORTATO BEN 11 CICLI DI CHEMIOTERAPIA E COSTRETTA AD ABBANDONARE TALI TERAPIE A CAUSA DELLE GROSSE PROBLEMATICHE CHE FISICAMENTE HA AVENDO CAUSATO, COME DETTO SOPRA COSTATAI IL DOTT. SIMONCINI, CHE DOPO AVER ACCURATAMENTE VISIONATO IL MIO STATO DI SALUTE, MI PRESCRISSE LA SUA CURA A BASE DI BICARBONATO DI SODIO.

INIZIAI LA CURA CHE ESEGUI ALLA LETTERA, SENZA PROBLEMI, CHE NEL GIRO DI POCCHI GIORNI MI FECE RITROVARE BENESSERE E MI FESSE UN GRADO DI VIVERE DISCRETAMENTE LA MIA GIOVINEZZA.

ADESSO DOPO QUESTI UN ANNO DALL'INIZIO DELLA CURA DEL DOTT. SIMONCINI MI SENTO ESTREMAMENTE BENE, SVOLGO UNA VITA NORMALE MA LA COSA PIÙ BELLA È CHE IL TUMORE DELLE DIMENSIONI DI 7 CM QUALE ERA, AL REFERITO DELL'ULTIMA TAC DEL FEBBRAIO 2003 HA SUBITO UNA RIDUZIONE NON INDIFFERENTE SEGNO CHE LA MALATTIA STA RETROCEDENDO.

DEL DOTT. SIMONCINI INOLTRE POSSO DIRE CHE È UNA PERSONA ESTREMAMENTE DISPONIBILE ED ONESTA, CE NE VOUREBBERO DI MEDICI COSÌ DISPOSTI AD AIUTARE CHI VERAMENTE NE HA BISOGNO.

SPERO VERAMENTE CHE PERSONE GRAVEMENTE MALATE COME LO SIEI IO, TROVINO RIMEDIO NELLE CURE DEL DOTT. SIMONCINI.

TENGO A PRECISARE OLTRETTUTTO CHE IL DOTT. SIMONCINI NON MI HA MAI DATO CERTENZE DI GUARIGIONE, NE ILLUSIONI RIGUARDO ALLA SUA CURA, I RISULTATI SONO VENUTI DA SOLI PERCHÉ TANTE PAROLE TALUOTA DETTE A MANIERA DA NOCHI MEDICI, NON SERVONO AL MALATO, QUELLO CHE CONTA SONO I RISULTATI.

*Declaration of the patient about one year after
the beginning of the treatment.*

**Fourth Clinical Case
Ewing's Sarcoma**

A nine-year-old child was hospitalized in October 1999 and diagnosed with Ewing's Sarcoma on the right humerus.

Several chemotherapy cycles were performed until he underwent surgery on February 2, 2000, during which the neo-formation in the humeral bone was removed and a peroneal bone segment grafted on and stabilized with two splints and nine screws.

The histological diagnosis of February 21, 2000 confirms that the patient was suffering from the Ewing/PNET Sarcoma.

More chemotherapy cycles were performed in 2000.

An ecographic scan of the right arm performed on October 9, 2000, however, states as follows:

"...Sharp irregularity of the humerus's bone profile...".

He was hospitalized on January 29, 2001 with a diagnosis of relapsed Ewing's Sarcoma of the right humerus and with: *"...Clear re-absorption of the splint..."*.

Later, on February 12, 2001, a second surgical operation was performed with a new peroneal graft and stabilization with splints and screws. A new relapse in the auxiliary cavity was noticed and removed during the operation.

An ecographic scan of May 7, 2001, however, showed another three instances of Ewing's Sarcoma to the right arm with the following dimensions:

First: 60 x 30 x 40 mm

Second: 24 x 18 x 20 mm

Third: 44 x 31 x 32 mm.

In June 2001 the child's father decided to proceed with the sodium bicarbonate salts treatment, which was administered by catheter into the right sub-clavian artery in order to administer the salts (phleboclysis of 500 cc at five per cent) directly on the tumoral masses.

Results:

CAT of July 2, 2001

"Post-surgical results of the positioning of metal osteosynthesis means in location of humerus without evidence of local tissue tumefaction."

EWING'S SARCOMA

Echo scan of July 9, 2001

"The results show an almost complete regression of the expanding formation of the upper third and of the medial face of the arm; however, the expanding formation of the third lower medial (anterior lateral face) persists."

PET of July 11, 2001

"An area of hyperactivity is noticed on the anterior lateral surface of the third lower medium of the right arm, probably para-osseous."

Echo scan of September 10, 2001


"The ecographic results show a complete regression of the expanding formation of the third superior and of the medium area of the arm; the expanding formation of the third medium distal (anterior lateral face) persists.

However, the formation exhibits a sharp volumetric reduction of about 50 per cent when compared to the scan of July 9, 2001"

Conclusions: After the sodium bicarbonate salt treatments, only one of the 3 masses shown by the ecographic scan of May 7, 2001, sized respectively a = 6.5 cm; b = 4.4 cm; c = 2.4 cm is left.

Its size is 1.5 cm.

This is most likely caused by residual scarring, as shown by the echograph of September 10, 2001.

	Unità Operativa di Medicina Nucleare 2
Data: 13/07/01	N. archivio: 102142
Sig./ra:	
Provenienza Esterno	
PET totale corporea Radiofar. 18F-FDG - 370 MBq ev.	
Premedicazione Nessuna	
Data esame 11/07/01	
Referto:	
Esame condotto con scansione orecchio- bacino, in euglicemia, in condizioni di riposo senza e con correzione per l'attenuazione; sezioni ortogonali di 4.3 mm. Registrazione iniziata dopo circa 45 min. dalla somministrazione.	
Descrizione:	
Si rileva una area di iperattività in corrispondenza della superficie antero-laterale nel terzo medio-inferiore del braccio dx, verosimilmente paraossea. Tale iperattività risulta a basso metabolismo glucidico. Utile rivalutazione a distanza.	
Non si rilevano altre significative iperattività.	
<i>Il Medico Nucleare</i>	
<small>In caso di ripetizione dell'esame riportare referto e documentazione allegata. presente documento e' conforme alle norme di legge sulla radioprotezione del paziente (D.L.vo 230/75 e sulla tutela delle persone rispetto al trattamento dei dati personali (Legge 675/96)</small>	

Pet of July 11, 2001.

Fifth Clinical Case Terminal Carcinoma of Uterine Cervix

Towards the middle of October 2002 I was called by the relatives of a 63-year-old patient. The patient was affected by carcinoma of the uterine cervix to which the doctors of the organization for terminal patients that had her in their care gave a maximum life expectancy of about a month.

Discharge document of October 21 2002:

“Today, October 1, 2002, we discharged Mrs. ZG (clinical file 2002/...), hospitalized since September 29, 2002.

The patient who is already affected by advanced uterine neoplasia has shown metrorrhagia and a vomiting episode. Infusional treatment, intravenous antibiotics administered because of the presence of hyperpyrexia, and topical vaginal treatments have been applied. The patient does not accept palliative chemotherapy. Home nursing and periodic checks for nephrotomies have been initiated. Please find enclosed copies of the examinations performed.”

I went to great lengths to explain to the relatives the therapeutic difficulties that exist when treating patients that are in such an advanced disease state. This is not because the sodium bicarbonate solutions are no longer effective, but because an endless number of uncontrollable events may intervene.

A first intervention, at any rate, could be performed only on the largest mass, while I warned them that it was necessary to wait for the evolution of the disease to decide if intervention was appropriate for another mass which was in contact with the ileopsoas muscle and for other lesions that were in the liver. That notwithstanding, the relatives decide to proceed with my method of therapy.

The abdominal mass massively occupied the abdomen from the uterine cervix to the umbilicus, and it was in such an advanced stage that it infiltrated and compressed both rectum and urethras to the point that implanting of two nephrostomachal apparatuses to allow the evacuation of urine was necessary.

Given the size of the mass, radiotherapists did not recommend even a palliative radiation therapy.

Furthermore, there was continuous fever as well as a remarkable loss of weight and a persistent, painful symptomatology which was treated with analgesics.

After I visited the patient at home with the assistance of a radiologist colleague, it was decided immediately to position a catheter inside the mass for the purpose of draining the necrotic material as much as possible and subsequently to implement treatment with a sodium bicarbonate solution of five per cent in the attempt to destroy all the neoplastic colonies, and in the hope of producing cicatrization of the neoplastic mass.

A treatment with sodium bicarbonate solution via the vagina was also begun.

After about two weeks, it was possible to inject only a few cubic centimeters of sodium bicarbonate. That indicated that a remarkable reduction of the mass had taken place and this assumption was supported by a descending transnephrostomal pyelography performed on November 15 2002 which reported a "regular opacization of the calicopyelic cavities... the urethral constriction, at any rate, does not prevent the transit of contrast fluid which quickly reached the bladder". In other words, the patient had also begun to urinate in a natural way.

The reduction of the mass was demonstrated in the abdomen CAT performed on November 29 2002.

After constantly improving the clinical conditions of the patient, it was decided that treatment with sodium bicarbonate solution at five per cent should be intensified, in an attempt to destroy the tumoral colonies as much as possible.

Two catheters were positioned for this purpose: one in the peritoneal cavity to inject the solutions into the floor of the small pelvis, and the other directly into the hypogastric artery which was afferent to the location of the uterine and rectal neoplastic mass.

Furthermore, the nephrotomic apparatuses were removed and thus the external urine receptacles. That was achieved with the urethral positioning of two double J catheters.

Clinical situation in February 2003:

◦ The patient is living and in a condition of good health – to the point she can undertake independent train voyages hundreds of kilometers long in spite of the sinister prognosis predicting her death by November of 2002.

The tumoral mass has been noticeably reduced.

◦ The painful symptoms have disappeared.

◦ The patient has started to gain weight again.

Declaration by the patient's relations:

"We the undersigned..... resident in Busto Arsizio (Va), respectively brothers and sister-in-law of resident in Busto Arsizio and a patient of Dr. Tullio Simoncini, hereby testify on the development of the disease of the aforementioned patient, having followed in detail all its phases, starting from the first days of September 2002 up to the present.

Last September 12 was urgently hospitalized in the gynecological division of the Azienda Ospedaliera of

The presence of uterine neoplasia was ascertained after the appropriate examination as well as a CAT scan of the abdomen. Because of its dimensions, the neoplasia was compressing both the urinary tracts and the intestine and simultaneously causing a renal and intestinal block.

The renal block was rectified by the application of a bilateral nephrostomic apparatus and the intestinal block was rectified with occasional enemas. The head physician of the department, on the basis of the CAT report, called the relatives of the patient and clearly and openly said that her condition was totally hopeless because she was carrying a uterine tumor that was so developed that it could not possibly be operated on. The only possibility left at that point was to attempt radiotherapy or chemotherapy to reduce the tumoral mass so that it could be operated on – but that was a possibility so remote as to be almost nil.

In the following days, the results of histological examinations and the opinions of the specialists as to the devastating effects that radiation therapy or chemotherapy inoculations would have had on the already fragile body of the woman, whose weight was only 32 kg, induced the department team to abandon any attempt to save the patient.

Only the head doctor kept open the possibility of chemotherapy to stretch – perhaps by a few weeks but certainly not months – the life of the woman. The life expectancy from that time on (middle of September) was about two months.

However, if chemotherapy did have some effect, could have survived until Christmas. At that point, the undersigned went to the Centro Tumori ofwith all the clinical documentation available – and without the patient, because she could not be moved – to hear the opinion of a center that was highly qualified in that

field. The doctor who examined the scans expressed the conviction that that tumor was at least five years old and agreed with the statements issued by the doctors of the Busto Arsizio hospital.

To make the departure of the lady as comfortable as possible (renal and intestinal blocks were foreseen as well as vomiting of feces and so on), the use of traditional therapies was not recommended and the only therapy proposed was that of pain control.

After the opinion of the Centro Tumori, the head doctor of the Busto Arsizio hospital, being confirmed in his conviction and in consideration of the uselessness of the hospitalization, discharged the patient. However, a sudden worsening of..... condition forced a second hospitalization and it seemed that the end was near.

While this second hospitalization period was in progress, as we were not resigned to the destiny of the sister, the brothers kept on looking for an alternative that could yield some hope. It was at this point that, through the direct experience of some acquaintances, we heard about the therapy of Dr. Tullio Simoncini.

Immediate telephone contact was made with the doctor and clinical situation was explained. He offered the possibility of experimenting with his therapy. The decision to attempt this new road found immediate approval both from the patient (who on various occasions already expressed to both doctors and relatives her will not to undergo either surgical interventions or radio or chemotherapy treatments), and by the relatives.

In the meantime the hospital saw no reason to keep the patient any longer, notwithstanding that the tumoral mass grew enormously (the patient's abdomen was as swollen as that of a pregnant woman). The patient was entrusted to the service of Palliative Care, which opted for home-based treatment since that was more adequate to the psychological inclinations of the patient.

On October 21, 2002, the lady was finally discharged by the Busto Arsizio hospital. On the 25th day of the same month, Dr. Simoncini came to house. From the CAT scan documentation he understood immediately that the enormous tumoral mass was filled with liquid that had to be evacuated immediately. And this he did. Almost one liter of putrid liquid came out of the abdomen.

What happened was that an abscess had formed on top of the tumoral mass. The abscess was probably at the origin of the massive infection in progress, which was indicated by the high body temperature.

After the intervention, the patient had a feeling of emptiness and faintness, but she gradually normalized.

The tumor was emptied of its putrid contents and, in its place, a certain quantity of sodium bicarbonate was injected through a permanent catheter. Dr. Simoncini took care to scrupulously show the relatives the therapeutic procedure to be followed. He said that we were not to have any illusions about the effectiveness of the therapy. It was necessary to wait several days to see how the patient would respond. Many variables were acting against the patient, amongst them the advanced condition of the disease and irregular responsiveness.

The doctor stated that, according to his statistics, when the action of the bicarbonate is positive from the beginning, its effectiveness continues up to the end – that is, in cases of positive response, the problem could be solved within three to four months and sometimes even less.

Conversely, if the bicarbonate were to be ineffective from the beginning, it would have been ineffective throughout. It was therefore alright to have hope without, however, having excessive expectations of recovery. At any rate, given condition, a condition that was equivalent to a death sentence, according to both the relatives and the patient herself there was nothing to lose in attempting this new road.

After the intervention, since one abdominal catheter was added to the two nephrostomic apparatuses – thus increasing the danger of infection – Dr. Simoncini prescribed five vials of antibiotics to be injected intramuscularly. The sodium bicarbonate was also prescribed as a vaginal douche so that the tumoral action was circumscribed as much as possible. The doctor returned to Rome after making sure of having explained everything with the maximum possible clarity, and after confirming his availability for further clarifications and intervention .

The day after, the patient was already improving, and that was confirmed by the family doctor during his visit. As the days went by, the improvements became more and more evident, as the fever quickly diminished and eventually disappeared, while there was no longer any need for antibiotics other than those prescribed by Doctor Simoncini. In the meantime, again felt the stimulus to urinate naturally while intestinal evacuation went back to normality

and regularity. These were clear signs that the pressure exercised by the tumoral mass on the urethras and intestine was decreasing. The confirmation came after a month, when a CAT scan was performed by the Busto Arsizio hospital. The scan showed that the tumoral mass was considerably reduced.

The hospital doctors proposed chemotherapy again at this point, but clearly refused to undergo such treatment. Doctor Simoncini, comforted by the excellent results already obtained and respecting the will of the patient, set up to proceed towards a more targeted intervention intended to deny the tumor any possibility of expansion. That endeavor had the full consensus of the patient and the family.

On December 14 2002, the patient visited Dr. Simoncini in Rome. Two catheters were applied – one arterial and one peritoneal – through which she continues her therapy to date. After the Christmas holidays, Gabriella had the joy of removing the two nephrostomic apparatuses and started urinating exclusively urethrally, even though for the time being the urethras are sustained by double Js that were positioned by Dr. Simoncini during the second visit to Rome.

After this last intervention, quality of life has noticeably improved: she moves on foot and in cars in a completely autonomous way, good spirits are back, and she actively supports and divulges Dr. Simoncini's therapy to friends and acquaintances.

The news of the judicial investigation started against the doctor who has given life and serenity back to has surprised us immensely. These undersigning this declaration were resigned and ready to face the death of our sister, and but for this reason would have stated that the hospital's doctors were killers as they acted in good faith in her best interest with the therapeutical instruments that their school of medicine made available. Instead, the theory of Dr. Simoncini has produced a therapy capable of bringing Zanarella back from death to life, from desperation to hope and trust, from tears to smiles.

Can this be called fraud?

In spite of these results, which in themselves are exciting and deserving of the greatest gratitude, we know that cancer is a horrible and implacable enemy, and thus it may eventually prevail over our sister. If this is the case, can we call homicidal he who has been as much as he could, the savior of the patient?

HEPATIC CARCINOMA

The undersigned declare themselves available to confirm, upon request, the contents of what is stated above in the appropriate forum and specify that we have preferred not to involve the patient directly in order not to cause further psychological stress at such a delicate moment.

Busto Arsizio, February 9, 2003

Enclosed photocopies of identification documents.

The improvements are therefore evident. A CAT scan of June, 2003, however, although highlighting the constant regression of the main tumoral mass, revealed that in the anatomical areas that were not previously treated – the liver (totally substituted) and lesion of the ileopsoas – the disease tended to progress quickly and brought the patient to her death at the end of the year.

* * *

Sixth Clinical Case Hepatic Carcinoma

This case had final negative results.

However, it still demonstrates that the infusion therapy with sodium bicarbonate at 5 % often causes a dramatic regression of the neoplastic masses.

The 72-year-old patient that we examined was HCV positive (that is, he suffered from hepatitis C), and he was affected by hepatic carcinoma that was 120mm x 115mm x 105mm (as shown by an ecographic scan on January 16, 2001).

He underwent treatment with sodium bicarbonate solutions at 5% solution that was administered directly into the hepatic arteries (the plural is because there were two arteries instead of one) from March 7 to March 10, 2001.

After about one month, the size of the mass was reduced to 30mm x 15mm. However, there was ascetical liquid that was produced by the hepatitis in the pelvic cavity. This is the disease that certainly caused the death of the patient several months later, since a CAT scan previously performed showed **the disappearance of the neoplastic mass.**

Seventh Clinical Case
Peritoneal Carcinosis in Adenocarcinoma of Endometrium
Following Surgery

A 62-year-old patient underwent surgery in December 1998 for endometrial adenocarcinoma, followed by successive cycles of radiotherapy and anti-hormone therapy.

Following the thickening of the peritoneum and the growth of several lymph nodes due to carcinosis, the ovarian CA antigen increased progressively notwithstanding treatment with Tamoxiphen up to a value of 125 UI/ml (v.n. 0-35) on June 3, 2002.

From the clinical point of view, the patient's condition deteriorated with the presence of exhaustion, general swelling, intestinal meteorism, irregularity of evacuation, steady feeling of heaviness and blood pressure instability.

An endoperitoneal catheter was inserted in July and October 2002, through which sodium bicarbonate was administered at a 5% solution (400-500 cc) in cycles alternating with intravenous cycles. The clinical condition of the patient constantly improved up to a normal condition of health.

The ovarian CA antigen progressively decreased and in March 2003 it reached a value of 49.70 UI/ml, a value that was also confirmed in June, 2003.

A last CAT scan performed in June 2003 confirmed the regression of the peritoneal carcinosis and a stabilization of the size of the lymph nodes when compared to the preceding year.

Declaration of the patient:

"I was operated on December 18, 1998 for endometrial edemocarcinoma.

In February-March 1989 I underwent 29 sessions of radiotherapy. The routine checks performed in the last months of 2000 have indicated alterations to the ovarian Ag Ca.

The CAT scan highlighted the presence of tumoral cells in the lymph nodes. The oncological department initiated treatment with Tamoxiphen which, however, I abandoned after a while as I chose to undergo Dr. Tullio Simoncini's therapy.

On July 20, 2002, Dr. Roberto Gandini installed an endoperitoneal

transdermal catheter and I started the sodium bicarbonate 5% solution therapy.

The CAT check performed on September 6 has highlighted a stabilization when compared with the previous scan of May 2002, while the previous thickenings likely due to peritoneal carcinosis are no longer visible.

I would like to highlight that when I was telling Dr. Simoncini that I was feeling good his answer was: "May God help us, sister: I don't say anything, for only the check-ups can say something; I can ensure nothing, we shall see."

Dr. Simoncini updated me on the situation on October 5. The radiologist, Dr. Roberto Gandini, once he had examined the check-up CAT, stated that since an internal abscess had formed, this had prevented the outcome they had hoped for.

He therefore suggested the installation of a new catheter, which was done on October 16, 2002 by Dr. Clazzer.

From this moment on, I continued with the sodium bicarbonate therapy on a regular basis. The various hematochemical check-ups give better values each time; starting from the ovarian 125 Ag Ca of June 2002 up to the present 49.70 of March 7, 2003.

Furthermore, the CAT performed in December 2002 showed that the situation of May 2002 has not changed.

It is to be highlighted that, from the clinical point of view, my condition has steadily improved. The intestinal and hepatic suffering has gone, the blood pressure has regularized, and the swelling of the heels is gone along with the general swelling.

I am aware that much is still to be done to reach the security of the complete regression of the disease, as I am often reminded by Dr. Simoncini, who is always very conservative.

At any rate, and given the results that have been reached, there is the hope that, working steadily, we can get to a final resolution of the disease. I would like to formulate a wish: if Dr. Simoncini had the opportunity to work in his own clinic he could help many other people who are hit by cancer.

I thank God for giving me new life and Dr. Simoncini, who has been His instrument to help me."

M.T.B.

8th Clinical Case
Relapsing Bladder Neoplasia;
Nephrectomy due to Renal Metastasis.

Clinical history started for a patient affected by a polyp formation with a diameter of 28 x 21 mm in June 1996.

A twice-yearly check-up program was begun, during which continuous endoscopic resections were performed as well as instillation cycles with mitomicine and BCG.

The neoplastic formations continued to reproduce constantly, and not only that, surgery was performed to remove the left kidney because of a renal tumor of the pelvis in February 2001. An intra-vesical instillation therapy was proposed again, but the therapy had to be suspended in May 2001 because of intolerance.

At this point an understandable mistrust on the continuation of a conventional treatment arose. I was contacted to attempt a new therapy upon the suggestion of a homeopathic doctor in Florence who obtained positive results in a test for Candida.

After 15 months of vesical "rinsing" performed in cycles with sodium bicarbonate at 5% solution and oral administration of the same substance, the patient was doing well, and had not undergone painful instillations for over a year. Furthermore, lab tests gave negative results for neoplastic disease and, most importantly, the fear and the anguish for the danger of the disease attacking the other kidney began to disappear.

In the UCS (cystoscopic) report of September 18, 2002, where the diagnosis and the previous nephrectomy intervention is reported as well, we read: "No repetitive lesions".

Declaration of the patient's daughter:

"I, the undersigned, living in Manerbio declare the following as to my personal experience concerning the doctor-patient relationship of my father and Dr. Tullio Simoncini. On my own initiative I contacted Dr. Simoncini by phone on May 2001 after the nephrectomy operation my father underwent in February 2001, as he was affected by vesical neoplasia, first seen in June 1996 and since then continuously treated with alternating and repeated cycles of endovesical chemotherapy, followed by repeated vesical resections due to continuous relapse

(vesical neo-formations).

Even after the last intervention, **another endovesical chemotherapy cycle was proposed once again**, and this time was interrupted voluntarily by my father at **the seventh application** because of intolerance, as stated by the medical report.

In reality my father was not only no longer able to physically tolerate these specific applications, but in general was no longer willing to undergo the series of treatments that had been applied, given the discouraging outcome and the stress of constant physical and psychological suffering.

I then convinced my father to try a new approach to the disease, the homeopathic one. In this way, we got to the cyclic endovesical instillations with sodium bicarbonate solution that started in September 2001 as proposed by Dr. Simoncini.

He visited my father at home upon my specific request. The doctor was available for that and in that way satisfied my father's expectations by avoiding any traumatic discomfort and by ensuring the most favorable situation for the physical and psychological comfort of the patient.

Since then, I have constantly and systematically stayed in contact with Dr. Simoncini by phone who has always been available. During those contacts, I kept him informed as to developments in the status of my father's disease, and on the progress of the therapy, after the doctor examined the laboratory and diagnostic reports following the cycles of endovesical instillation of sodium bicarbonate solution.

All of the above has been performed without the demand for any compensation or professional fee except for one payment for the first house call, for which [the doctor] issued a regular invoice.

I would like to highlight that the aforementioned examination and endoscopic check-ups have always been performed through ambulatory visits or hospitalization, with periodic scheduling at the department of urology of the civil hospital of the city where my father has been treated since the beginning of the disease.

Dr. Simoncini has always been, since the beginning of this relationship, of exemplary correctness, clarity and transparency concerning the information on the method of approach to the disease and on the nature of the proposed therapy.

The therapy was centered, on one hand, on a diet that changed as time went on, and on the other hand on cycles of endovesical

RELAPSING BLADDER NEOPLASIA

instillations with sodium bicarbonate solution that was available in drugstores and could be administered in the house of the patient, without the need for hospitalization, since we stated our availability to function as nurses as needed for the treatment with the catheter.

I must also attribute a clear human sensitivity and a shared solidarity towards my father to Dr. Simoncini, especially by encouraging him to lead a normal life, while delicately sharing at the same time my original choice to keep my father uninformed about the true nature of his disease – a vesical carcinoma – for the mere knowledge of that would have surely devastated him, given his subjective psychological fragility.

It is more than one-and-a-half years now since we have seen relapsing and vesical neo-formations through constant and systematic endoscopic examinations and without the need to turn to chemotherapy. My father is well from the physical and psychological point of view, and in a condition of full well-being.

This is intended to be my testimonial concerning the case of the disease of my father, and a recognition of the behavior and the correct professional conduct of Dr. Tullio Simoncini as well as the positive effects and results of the new therapeutic approach that has been adopted concerning this specific case.

Faithfully,.....

Manerbio, February 14, 2003

* * *

9th Clinical Case Non-Hodgkin's Lymphoma

The patient was affected by adenopathy of a left lateral cervical lymph node. After histological examination performed on biopsy material, the patient is diagnosed with Non-Hodgkin's Lymphoma. The treatment with sodium bicarbonate salts was started in November.

500 cc at 5% solution was administered in the peritoneal cavity twice a week for two months. At the same time, the same quantity and solution was administered intravenously for two months, two days on and two days off.

CAT scans performed on August 29, 2000, December 1, 2000, and February 27, 2001 showed a remarkable decrease of the neoplastic masses.

The last CAT report says: "*Instead of a massive adenopathic conglobate, there is only the presence of circumscribed streaks of thickening...*", (we can add that this is enough to deduce their origin as from cicatrizing).

10th Clinical Case Prostate Adenocarcinoma

An 80-year-old patient was diagnosed in June 2002 with adenocarcinoma of the prostate after a transperineal biopsy. Having refused any surgical intervention, the patient attempted hormonal therapies which had to be abandoned immediately because of intolerance.

In May, 2003, I recommended that, before considering more massive interventions such as selective arteriography, a treatment with sodium bicarbonate solution at 5% administered intravenously and through urethral catheter should be performed.

The treatment might turn out to be effective since the clinical condition of the patient was good.

An ecographic scan performed a month after shows that there were no longer lesions of the malignant type.

**11th clinical case
Hepatic Carcinoma**

A 70-year-old patient was affected by hepatic carcinoma. He underwent a thermo-ablation intervention by means of RF (radio frequency) in the neoplastic lesion of the fourth hepatic segment .

Later, a further 3 cm neo-formation was seen in the eighth segment, and yet another between the fifth and the sixth.

As the disease was in a progressive state in spite of the therapies performed, the patient no longer had trust in official therapies.

He therefore decided to undergo a treatment cycle with sodium bicarbonate solution at 5% administered directly in the liver through a catheter in the hepatic artery.

A CAT scan performed after about 20 days from the start of the treatment with sodium bicarbonate showed only the scar of the previous thermo-ablation intervention: “...**no other focal lesions are observed**”.

The disappearance of the previous neoplastic nodules was confirmed by a further CAT scan performed on February 19, 2002.

The above is also confirmed by the patient’s own declaration:

“I, the undersigned,..... declare what follows.

I turned to Dr. Simoncini because I had a tumor in the liver. After conventional treatment, instead of one I found myself with two lesions. At that point, I decided to turn to Dr. Simoncini upon the advice of my son.

I underwent a cycle of infusions with sodium bicarbonate at 5% that were injected directly in the liver area. After that, I also underwent oral and intravenous cycles .

Dr. Simoncini gave me no certainties, but he gave me a hope that I have been able to cultivate more and more on the basis of the results. He also told me that it would be wise not to have any unrealistic hopes before at least one year had elapsed.

From the readouts of all the CAT scans I underwent – the last one in July 2002 – it turns out that, after about one year, the tumors are absent, and what’s left of them is only the scar from the thermo-ablation that was performed before I met Dr. Simoncini.

I have suffered no negative collateral effect.”

Rome, October 1, 2002

12th Clinical Case**Hepatic Carcinoma with Pulmonary Metastasis**

A 65-year-old patient was affected by hepatic carcinoma. The carcinoma was of a remarkable size and had pulmonary metastasis (as shown by a CAT scan of April 19, 2002). A transcatheter catheter was positioned in the pulmonary artery, and another catheter in the hepatic artery. The patient underwent a cycle of daily endoarterial infusions with 500 cc of sodium bicarbonate solutions at 5% for eight days. The neoplastic hepatic mass was still 10 cm in size in the month of July. Further cycles of intravenous infusion as well as oral administrations were performed in the following months. A CAT scan performed on December 4, 2002 showed a reduction of the hepatic lesion to 7 cm and an almost total regression of the pulmonary metastasis.

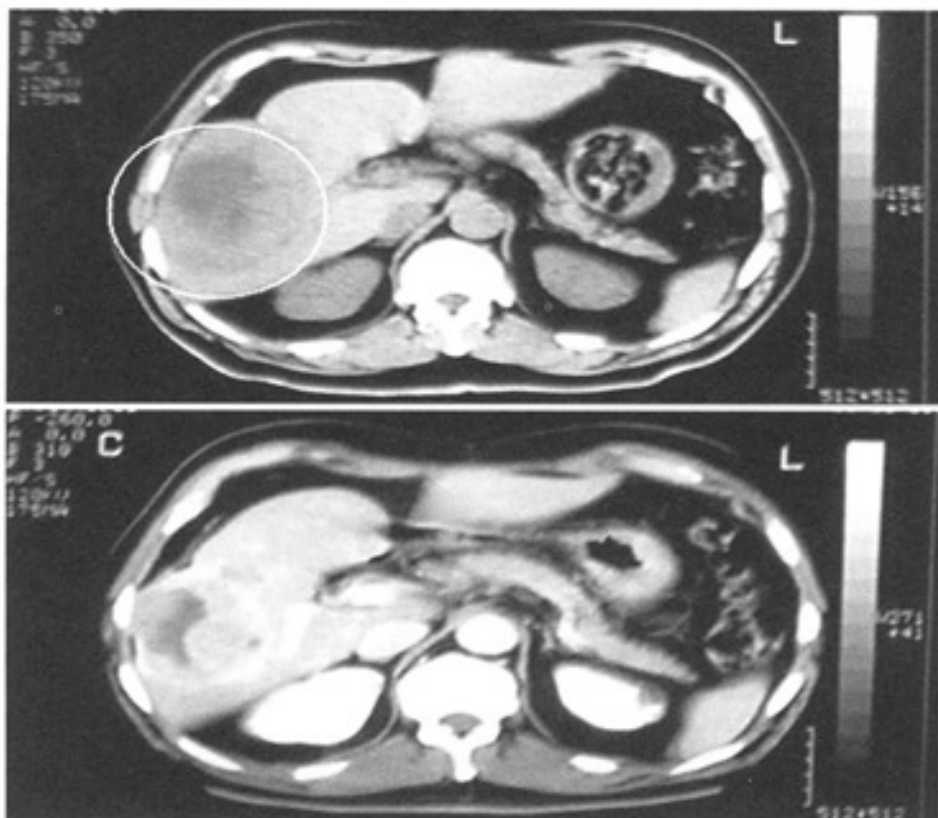


Fig. 1 and 2. CAT scan of liver before (above, July 23, 2002) and after (December 4, 2002) the treatment.

HEPATIC CARCINOMA WITH PULMONARY METASTASIS

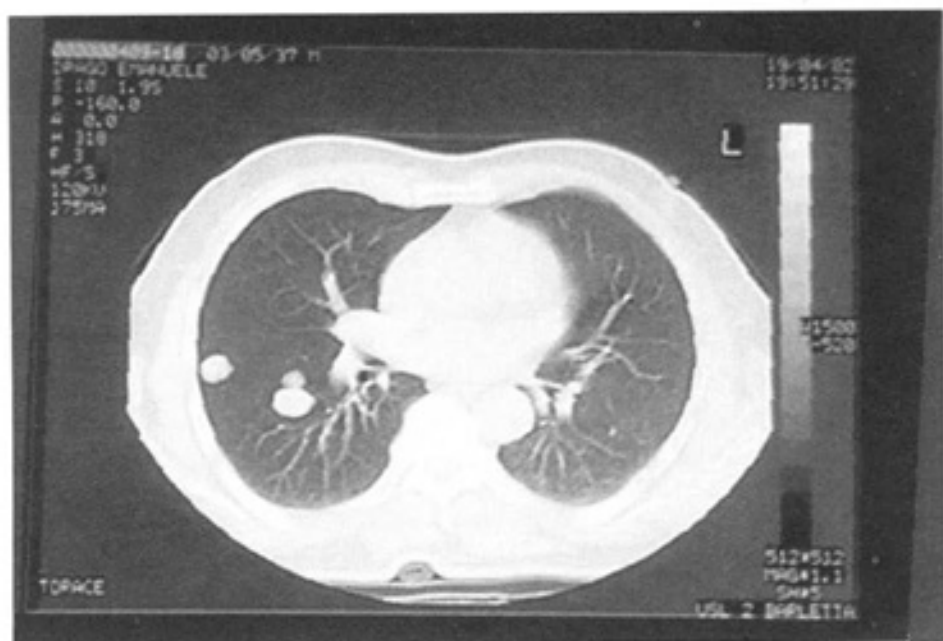


Fig. 3. Lung's CAT scan before the treatment, taken on April 19, 2002.

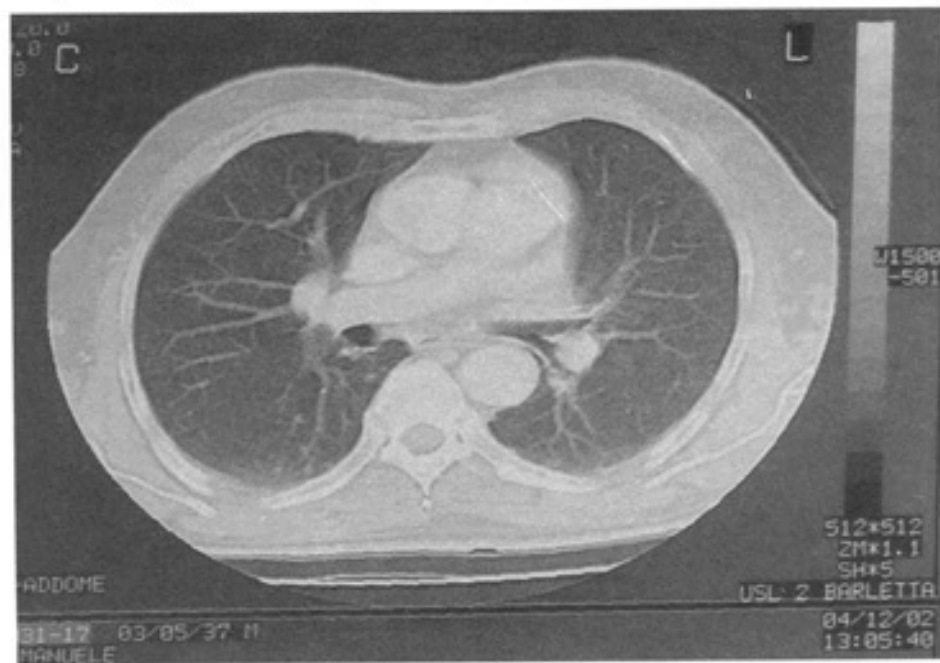


Fig. 4. Lung's CAT scan after the treatment, taken on December 4, 2002.

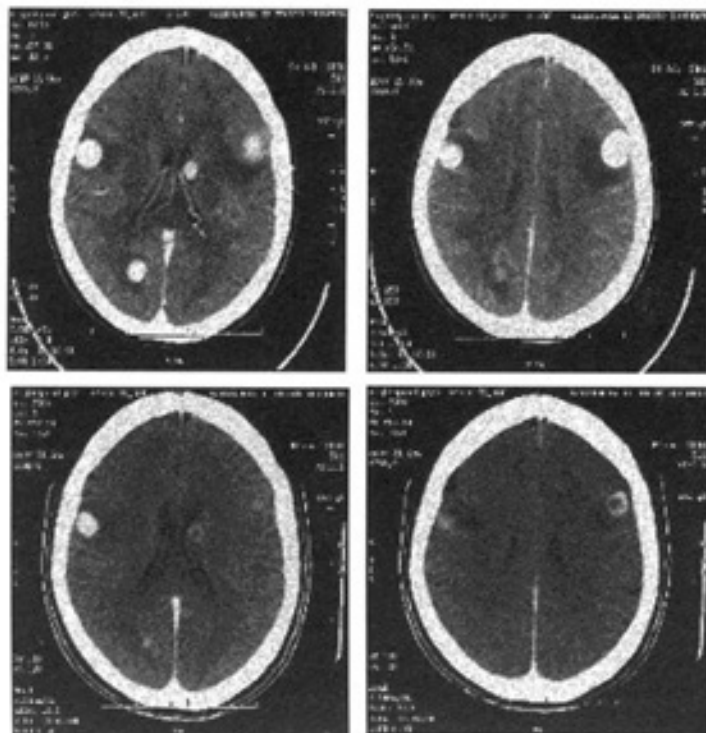
13th Clinical Case

Cerebral Metastasis in Diffused Melanoma

A 45-year-old [female] patient had undergone surgery on the left leg for melanoma about one-and-a-half years earlier. After that, the patient underwent surgical intervention on the upper left pulmonary area for metastasis.

In spite of several chemotherapy cycles performed at the end of the year 2000, numerous metastases were found in the brain. These metastases continued to grow despite several subsequent chemotherapy cycles. Furthermore, there were metastases in the suprarenal glands and in the colic area.

The patient started a treatment cycle with intravenous sodium bicarbonate solution in March 2001 which was able to stop the progression of the metastatic localizations. It was therefore decided to start a more aggressive treatment cycle, through the administration of sodium bicarbonate directly on the masses by using selective arteriography of the cerebral arteries, through which it was possible to position catheters in the arteries that nourished



CAT scans of February 24, 2001 showing the major metastases.

CAT scans of May 30, 2001 showing the reabsorbed metastases.

CEREBRAL METASTASIS IN DIFFUSED MELANOMA

the tumoral formations. The metastases appeared to have visibly regressed after a six-session cycle performed in mid-May 2001.

The patient should have undergone another cycle between June and July to eliminate the cerebral masses completely. However, intra-abdominal lesions appeared in the meantime.

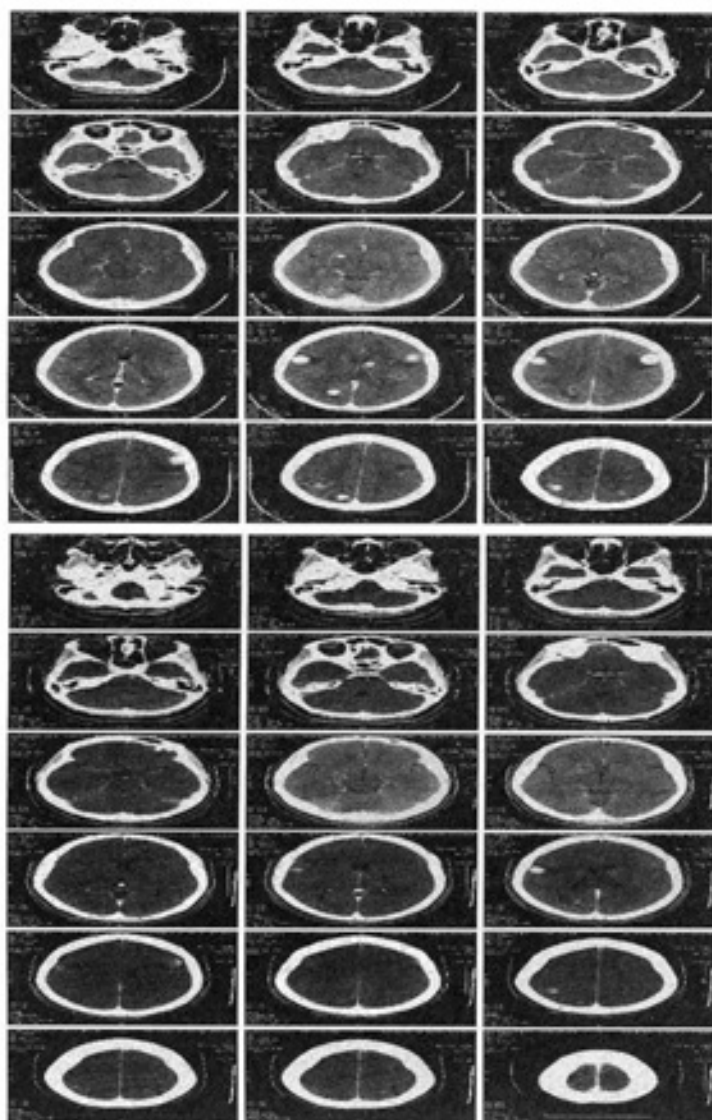
After the installation of a catheter to treat this the patient experienced an infection which delayed further treatment for the

cerebral masses, making it impossible to adequately treat and destroy them.

The patient died several months later.

In spite of the negative results, the case still demonstrates that the infusion therapy with sodium bicarbonate at 5% often causes a dramatic regression of the neoplast.

Complete CAT scans of February 24, 2001 (above) and of May 30, 2001 (below).



14th clinical case
Medullar Metastatic Compression

The 40-year-old patient underwent surgical intervention (left radical mastectomy) for mammarian carcinoma seven months earlier. After three months of chemotherapy, the patient was affected by: “diffused pulmonary and hepatic metastasis; bone metastasis particularly to the fifth and sixth lumbar vertebrae, with invasion and compression of the medullar channel, which is causing extreme pain [which makes the patient] unresponsive to any treatment.”

All pain suppressant drugs – morphine included – were totally ineffective and the patient was totally prostrate. A palliative radiotherapeutic treatment was proposed to her, but she tried to avoid this as she was conscious of the possible negative effects.

As I agreed with the view of the patient, I tried to buy time and get in touch with a neurologist colleague or an anesthetist who was capable of performing a lumbar injection with sodium bicarbonate solutions salts which I believed to be the only substance capable of destroying the tumor – that is, the fungal colonies amassed in the medullar channel – in a short time with consequential relief for the patient.

For some reason (maybe fear? Lack of knowledge? Or...) I could not get any specialist to cooperate... Eventually, and out of pity for the patient, I was forced to administer the lumbar injection myself. As I administered it by slowly injecting 50 cc of sodium bicarbonate solution at 8.4 %, the patient tossed and turned and confessed to me in a faint whisper that she had only slept two hours in the last week. Exhausted, she whispered to me: “If only I could sleep half an hour tonight.”

But the day after, she called me on the phone and said:
“I have slept all night”.

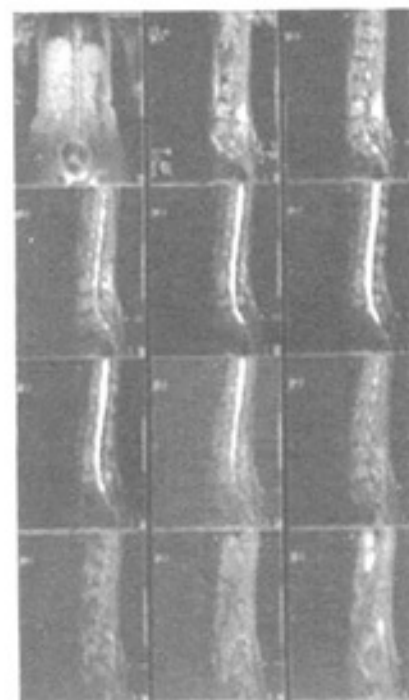
Since then, I performed two more lumbar administrations of sodium bicarbonate solution after a month and the pain disappeared completely.

The magnetic resonance scans performed before and after the treatment were defined by a radiologist friend who is a hospital department head as “amazing” in their difference.



Before treatment, August 25, 2000.

Fig. 1. RMN dated August 25, 2000. The metastatization of the 4th and 5th lumbar vertebrae and the mass that obstructs the medullar channel can be seen in image 8a . Please note the tumoral mass that has invaded the marrow of the sacral part as well.



After the treatment, October 11, 2000.

Fig. 2. RMN dated October 11, 2000. The same section in the fourth image after the treatment with sodium bicarbonate through lumbar injection is being observed. The noticeable reduction of the local mass can be seen with total elimination of the tumoral mass in the marrow in the inferior sacral area. There is a noticeable reduction in the medial area, with re-canalizing of the medullar channel.

Fig. 3. Complete RMN of August 25, 2000, before the treatment.

15th Clinical Case Tumor of the Colon

I visited the patient, who is affected by stenosis adenocarcinoma of the ascendant colon, at the beginning of January, 2000.

The patient's condition was very critical, to the point that in December, 1999, he had undergone two blood transfusions because he had a hemoglobin value of 6 mg.

The therapy started at the beginning of January with appropriate diet, reconstituents, and sodium bicarbonate taken orally.

After a few days, the intestine began to recanalize and evacuation normalize. The patient improved constantly, later even reaching normalized hematochemical parameters (hemoglobin and CEA). Notwithstanding the optimism about the results that have been achieved, the patient was warned about the dimensions of the neoplasia which could not be eliminated by oral administration only, both because with this procedure only a barely sufficient canalization is obtainable and because the bicarbonate cannot be used for excessively extensive periods.

It was therefore decided to program a cycle to start at the end of April to the beginning of May (possibly to be repeated several times). The cycle consisted of endoluminal administrations of sodium bicarbonate solutions through the endoscope.

The intention was to amplify the destructive effect on the fungin colonies (*Candida*), which was causing the development of the tumoral mass.

The endoscopic examinations of April 26, 2000 showed that the tumoral mass occluded the intestinal lumen (Fig. 1).

The *Candida* (after the "washing" of the epithelium with water)

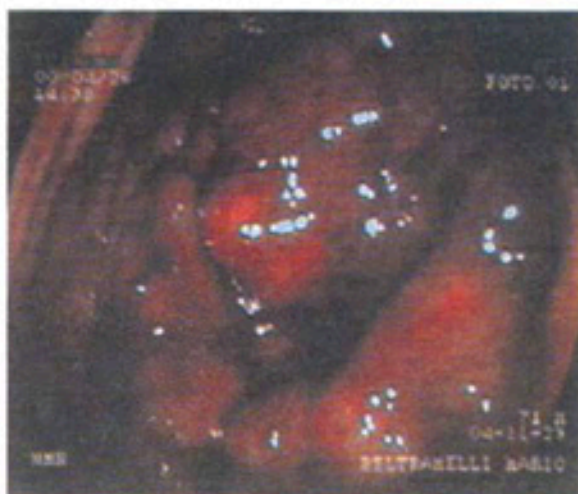


Figure 1. Endoscopy of April 26, 2000.



Figure 2. Endoscopy of April 26, 2000.
(after the "washing").

Furthermore, the direct aspersion technique with sodium bicarbonate demonstrates with certainty that it is the only substance able to destroy the fungin colonies colonizing the tissues and generating various types of tumors. It is appropriate to highlight that the action of sodium bicarbonate takes place not only as a correction of acidosis, but also because of its specific ability (that

is well visible (Fig. 2). A dramatic reduction was evident (Fig. 3) after one day, and this was further confirmed in the following days (Fig. 4).

The endoscopies therefore shows that the fungus (*Candida*) was the causal element of the tumoral masses.

It is in fact possible to see them at the sub-epithelial level after the removal of blood with physiological solution, because of their whitish color. Furthermore, the direct aspersion technique with sodium bicarbonate demonstrates with certainty that it is the only substance able to destroy the fungin colonies colonizing the tissues and generating various types of tumors. It is appropriate to highlight that the action of sodium bicarbonate takes place not only as a correction of acidosis, but also because of its specific ability (that is, not possessed by other basic compounds) to destroy fungin colonies.

It acts by destroying the connections - the intercellular bridges that exist between the cells - thus preventing them from communicating and becoming a common body against the immune system.

In this way, the fungin cells that are then individually exposed to the defense mechanisms of



Figure 3. Endoscopy of April 27, 2000.

the host, can be easily and quickly phagocytated.

Bicarbonate allows humoral immunity to be effective and to disintegrate the colonies, thus favoring the cicatrization of the tissues.

The immune reaction is impotent when faced by colonies already so large that they cannot be intimately penetrated and therefore disintegrated.

The whole mystery of the rooting of the fungi and of the cause of cancer is right here – in the decrease of the effectiveness, up to the extinction of the humoral defensive capabilities when the colonies manage to conquer sufficient grounds and expand enough. The sodium bicarbonate has the ability to completely reactivate the defensive functions of the organism.

This action explains the cases of reversibility and healing of tumors – which occur for various reasons: therapeutic, dietary, or environmental – when the fungin cells, reduced to the size of a colony that is not sufficiently large or consolidated, can undergo changes that makes them able to be attacked individually.

This is the key to the interpretation of the formation of cancer that can develop only if it manages to go beyond the humoral immunity defenses.

This is possible only with the convergence of all the factors usually invoked – spiritual conflicts, stress, endogenous and exogenous toxicosis, bad diet, malnutrition and more – that act for a given time period on a given tissue or target organ.



Figure 4. Endoscopy of May 5, 2000.

16th Clinical Case
Bronchial Adenocarcinoma

The patient was 32 years old.

After a therapy cycle in December, 2001 with sodium bicarbonate 5 % phlebos administered directly on the remarkable pulmonary neoplastic mass on the right side through the pulmonary artery, a further therapy cycle was programmed by utilizing the fiber bronchoscope to attack the neoplasia in the bronchial lumen, which is difficult to reach internally through the blood circulation.

The patient underwent a washing of the bronchi invaded by the cancer (Fig. 1) with sodium bicarbonate solution at 5 % using a total of 80 cc on February 11, 2002.

He underwent the same treatment but with ever-increased dosage on the following days, reaching 140 cc on the fourth and last day, February 14.

The photographs of the bronchoscopies show that a bronchus was recanalized after one day.

On the fourth day, that is, after only four administrations, the bronchi were accessible (Fig.2). *See also note 72: reports of February 11 and February 14, 2002.*

The medical reports stated the following.

February 11, 2002:

"...from the right principal bronchus abundant fluid milky secretions surface.

The origin seems located in the upper lobar bronchus where there is whitish vegetation taking space and occluding the dorsal branch B2 B3. The same situation is observed on the medium lobar bronchus."

February 12, 2002:

"... a recanalization of the dorsal branch of the right upper lobar bronchus can be observed."

February 14, 2002:

"... a fair recanalization of the upper right lobar bronchus, of the medium lobar bronchus and of the apex-dorsal branch of the left upper lobar bronchus is observed."

CANCER IS A FUNGUS

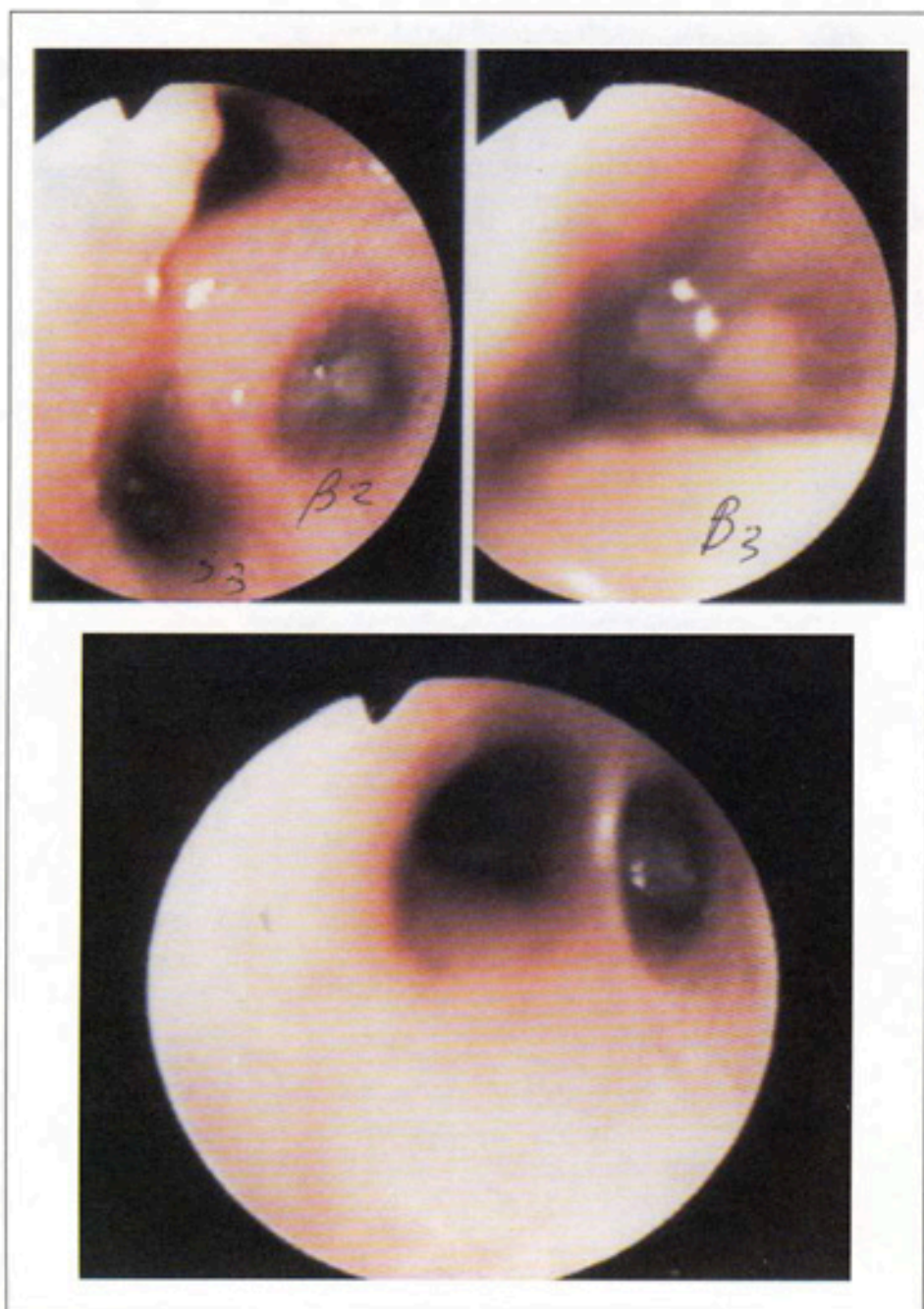


Figure 1. Bronchoscopy of February 11, 2002.

BRONCHIAL ADENOCARCINOMA

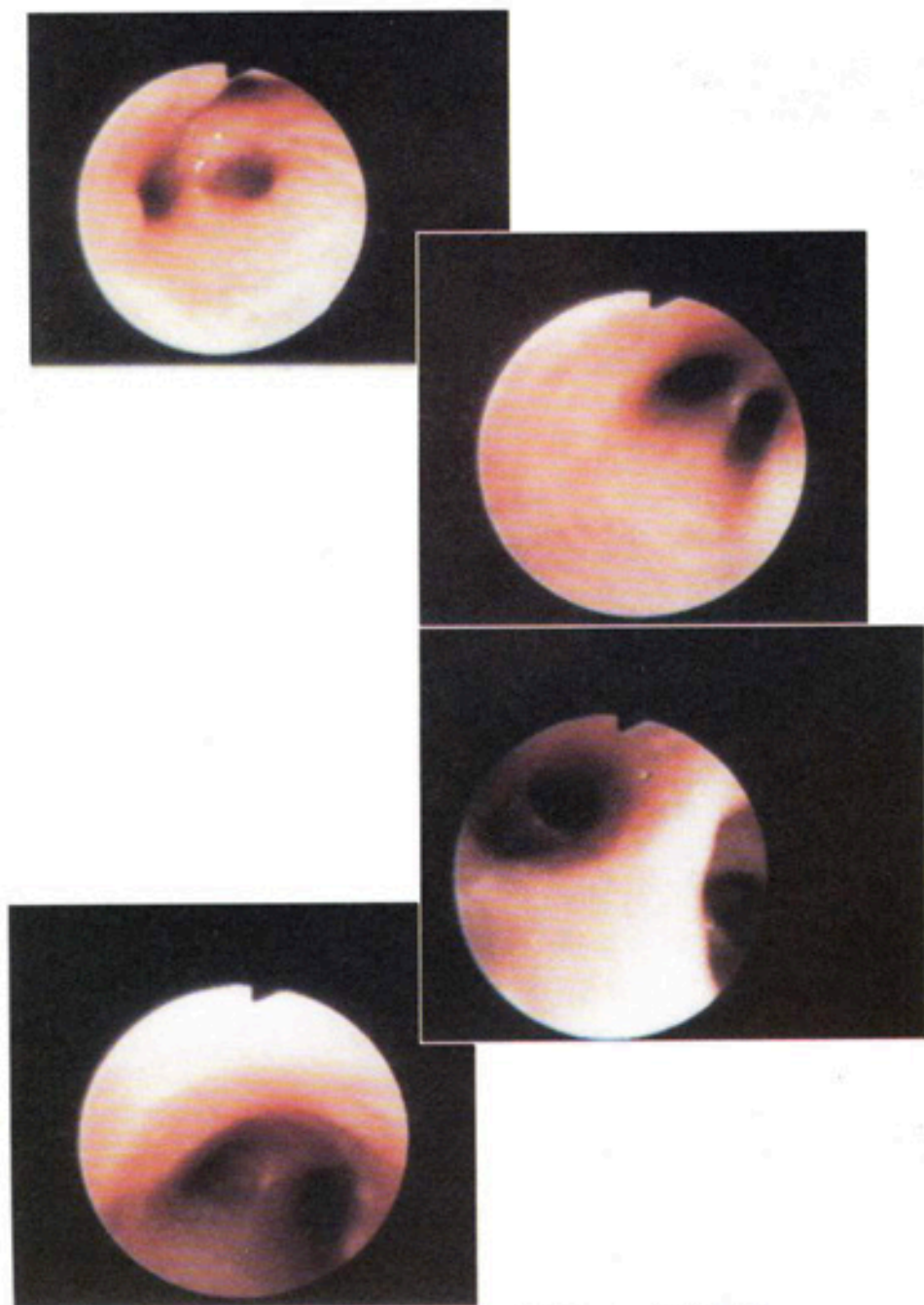


Figure 2. Bronchoscopy of February 14, 2002.

17th Clinical Case Prostate Carcinoma

A prostectomy for prostate carcinoma was carried out in 1995.

Three years later I noticed a relapsing nodule in the prostatic area after an ecographic scan, (Fig. 1). Treatment with hormonal therapy, and treatment with ultra-sound in July 2000.

Increase in the TSP values (prostatic specific antigen), and an increment in the size of the nodule after the first months of 2001.

A magnetic resonance scan with endorectal coil was performed on July 23, 2001, which highlighted the nodule and showed the dimensions to be 2.2 by 2.5 cm.

A catheter was positioned in the hypogastric artery on July 25, 2001. 5% bicarbonate solutions (500 cc) were administered through it every day for seven days.

Values constantly dropped after the treatment from August to October. A magnetic resonance scan performed with endorectal coil highlighted the dramatic reduction of the nodule which was now round, hyaline and fibrous (Fig. 2).

A second consolidation cycle was performed intravenously about two months later. A magnetic resonance scan with endorectal coil performed in March 2002 showed that even the residual nodule noticed in October had completely disappeared (Fig. 3). The PSA values decreased constantly since October, 2002.

This is the patient's statement 15 months after the therapy:

"I the undersigned... live in Rome and I am a medical surgeon, and I declare that I turned to Doctor Simoncini for a prostate tumor relapse which, in spite of conventional therapies, was progressing. Specifically, I underwent the treatment with arterial administration of sodium bicarbonate at 5%.

Afterwards, Doctor Simoncini performed peritoneal washing on me with the same substance by introducing a needle in the epigastrium, that is, in the opening to the stomach. Doctor Simoncini gave me no certainties before the treatments; he just told me that his treatment could be efficacious.

However, what convinced me beyond words was his conviction and great vital energy. I realized that he acted professionally and with honest intentions. After the therapy, the tumor disappeared and I had no negative effects."

PROSTATE CARCINOMA



Figure 1.
Nodule condition before
treatment, July 3, 2001.

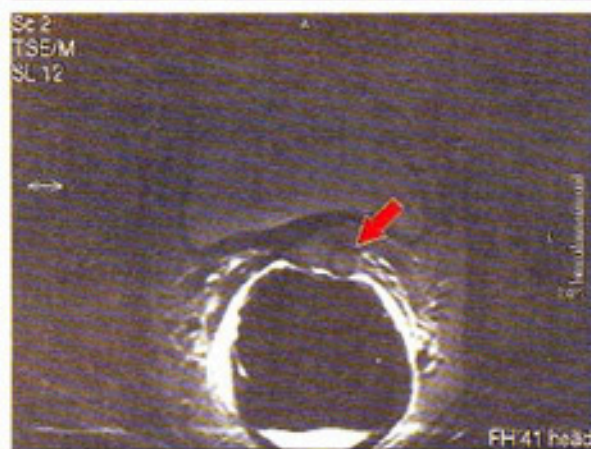


Figure 2.
Nodule condition after
treatment, October 19, 2001.

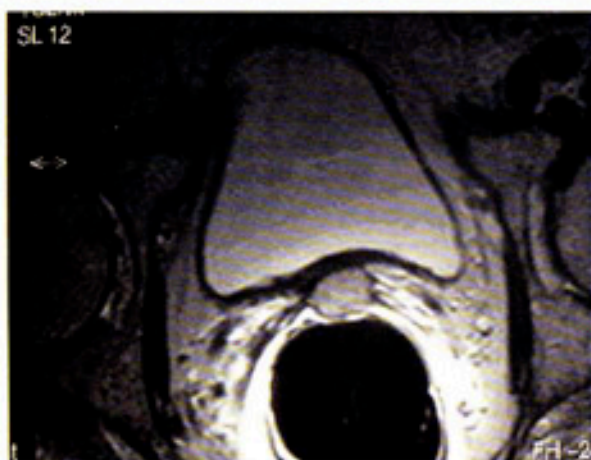


Figure 3.
March 2002. The residue
completely disappeared.

**18th Clinical Case
Right Eye Melanoma**

A 60-year-old patient was affected by melanoma of the right lower eyelid with progression in the conjunctiva.

A laser treatment with surgical intervention followed by plastic reconstruction was proposed in October 2000. The patient put those therapies on hold and submitted herself to my therapies.

She performed washing with sodium bicarbonate solution in the conjunctiva for 10 days, which completely eliminated the mass that was protruding in it.

A daily painting with 7% iodine solution was performed on the neoplastic mass during the whole of the following month. The painting was repeated 20-30 times in the same session. The result was the almost complete destruction of the neoplasia.

An identical cycle was repeated a month later and this totally eliminated the melanoma.

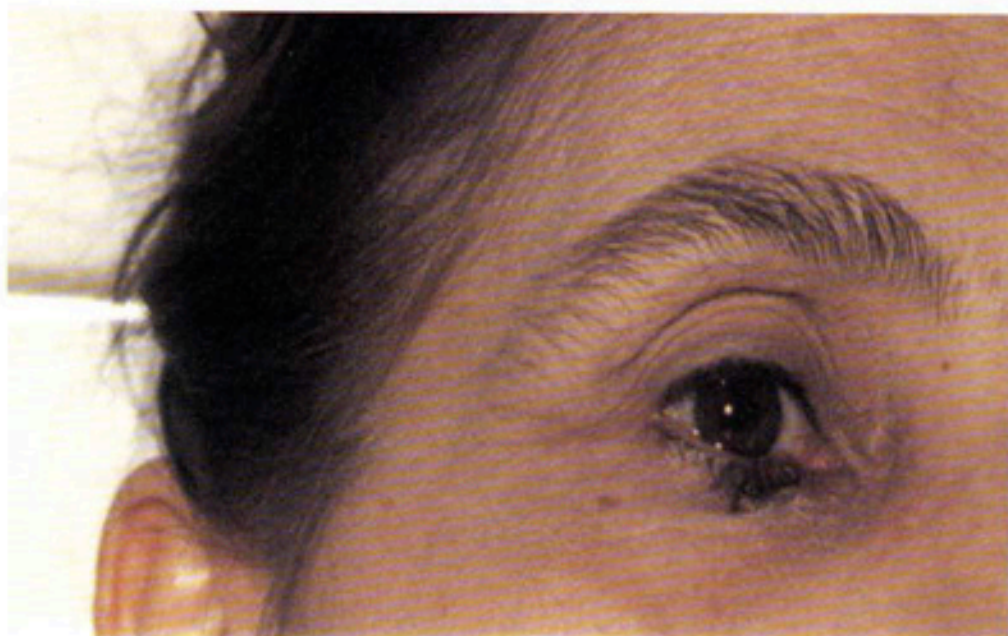


Figure 1.

Condition of melanoma at treatment already started, October 2000.

RIGHT EYE MELANOMA

Picture 1 was taken in October 2000 when the first phase of the treatment with sodium bicarbonate had already started. the mass in the eye was even more noticeable before the beginning of the treatment.

Picture 2, taken in May, 2002, shows that the neoplasia, once it had disappeared, no longer reappeared after one-and-a-half years, and only a tiny scar was left.

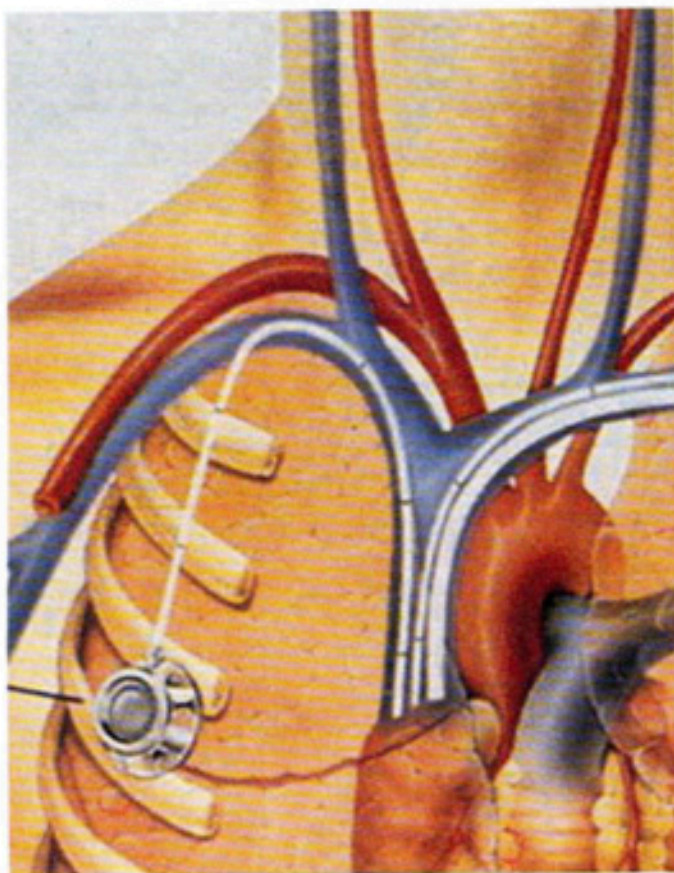


Figure 2. Scar condition in May 2002.

* * *

EXAMPLES OF PORT-A-CATH USE

EXAMPLES OF PORT-A-CATH USE



GLOSSARY

Allopathic – medical approach utilizing more synthetic drugs to obtain symptomatic relief and the healing of the disease

Anaplasia - shapeless cellular immaturity

Areactivity - inability to react

Autocrine and paracrine – pseudo-hormonal release mechanisms

Bio-energetic fluid – energy flux emanating from a tissue or organ (example, heat)

Cachexy – terminal state of debilitation

Consubstantiality – the characteristic of being of the same substance

Empyema – infection

Encystment – encapsulation

Ens morbi – morbid entity

Epithelium – tissue that wraps the organs and living tissues

Gene – groups of molecules made of DNA containing the hereditary traits of a species

Genetics – the branch of biology that studies genes

Heteroplastic rooting – this refers to cells that should not be present in the tissue examined

Heterotrophus – refers to an organ that depends on ready nourishment, that is, it is unable to synthesize nourishment by itself

Holistic – synergetic approach to combined physical, emotional and spiritual aspects of health and human disease

Homeostatic – that which maintains internal equilibrium

Hyperchlorhydria – gastric acidity

Hyperplasia – abnormal increase of cells

Hyperpyrexia – high fever

Hyphas – fungin cellular unit

Immunosuppression – suppression of the natural immune defenses of an organism; it can be caused by chemical, emotional, energetic and other factors

Metabolic disorder (dismetabolism) – altered metabolism

Metabolism – energetic-chemical activity of the organism

Metaphysics – study of the fundamental principles of life beyond sensory perceptions

Metastasis – cancer masses that develop and migrate from an initial tumor. From the Greek metastasis = what comes later

GLOSSARY

- Microbial disorder (dismicrobism)* – abnormal microbial development
- Multifactoriality* – multiple causality, concomitance of many factors
- Mycetes* – fungus
- Neurotrophic virosis* – neural disease that attacks the nervous system
- Nosology* – classification of disease
- Noxa* – disease
- Parenchymal* – part of an organ's matter
- Pathogen* – what produces the disease
- Phagocytosis* – cellular activity that assimilates/ingests external particulate elements
- Phyto-drug* – vegetal type drug
- Phytopathology* – study of disease in the vegetable kingdom
- Pleuradesis* – operation on the pleura
- Polymorphism* – the quality of an organism to assume different forms
- Port-a-cath* – small subcutaneous device connected to a vascular catheter
- Psoriasis* – a cutaneous disease characterized by scaly dry whitish patches
- Quantum physics* – branch of physics that studies the energy characteristics of matter at a subatomic level
- Saprophyte* – a micro-organism that feeds on decomposing substances
- Selective arteriography* – radiological methodology to visualize specific arteries through a special instrument called an angiograph
- Sodium bicarbonate* – chemical compound used in the Simoncini therapy for the disintegration of the fungin masses that cause cancer
- Steatotic* – fat

* * *

FOOTNOTES

Chapter One

1. Cardinal Joseph Ratzinger – Rome, Friday March 25, 2005. <http://www.signoraggio.altervista.org/>
2. (G.W.F. Hegel *Fenomenologia dello spirito*, Italian Edition, Ed. Nuova Italia, Florence, 1973, page 13.
3. I. Kant, *Critique of Pure Reason*, Italian Edition. Laterza, Bari, 1996, page 341.
4. (G.W.F. Hegel, *Scritti teologici giovanili*, Italian Edition. Guida, Naples, 1972, page 500.
5. Leaving aside further and more detailed specifications concerning general pathology.
6. A. Salmanoff, *Segreti e saggezza del corpo*, Italian Edition. Bompiani, Milan, 1963, page 160.
7. A. Salmanoff, *Segreti e saggezza del corpo*.
8. D. Gracia, *Fondamenti di bioetica*, Ed. San Paolo, Milan, 1993, page 13.
9. Martin Heidegger *Essere e tempo*, Italian Edition. Longanesi, Milan, 1971, page 214.
10. <http://www.filosofico.net/big.html>
11. We are witnessing a net separation between body and soul, in the name of a vision of degraded matter which is not similar at all to the beauty of a spiritual part, moved by divine command and cosmic needs to inform the lower level of its intelligence. The doctrine of purity and simplicity of the soul, similar to the ideas as described in Fedone, in reality does not reconcile with its development by Plato in *The Republic*. Here, the tripartite division into reason, spirit and appetite

consists in a different perspective, generating in itself a dichotomy in the interpretation of Platonic thought.

The position of the spirit in Gnosticism is instead well-defined. Here we assist in a real dichotomy or trichotomy in the human being; here the spirit, *pneuma*, is the divine spark, prisoner in a body, while the spirit, the *psyche* is an inferior entity, and the body is all in the realm of the demiurge, inferior creator of this world.

The image – rather the Neo-Platonic concept of a fall of souls and of their estranging from *nous* (mind) was present in some fringes of Christian thought, as in Origen and others, while in some Semitic Christian environments, the idea of a sleep of the soul with the body while waiting for resurrection was spread. Christian orthodoxy remained mid-way between, admitting that soul and body could be separated and therefore a liberation from the body's miseries while affirming a temporariness and unnaturalness of such state while waiting for resurrection.

In the theoretical formulation of the concept of soul of later Christian writers, it is possible to see both Neo-Platonic tradition and, in more lasting form and at least at the technically philosophical level, the Aristotelian doctrine of soul as substantial form of the body..

12. U. Bianchi, "La soteriologia del Cristianesimo", Ed. Nuova Cultura, Rome, 1992, page 70.
13. Helmut Von Glasenapp, "Filosofia dell'India", Italian Edition, Soc. Ed. Internaz. Turin, 1988, p. 53.
14. The *res cogitans* (thought) and *res extensa* (matter) are defined as model attributes which, in a revision of the finite's ontological statute, are reduced to modes of substance considered in its indivisibility. Indivisibility does not mean empirical inseparability of the single bodies or indistinguishability of the single minds.

It means homogeneity of nature and interdependence of the final forms (modes) in which the substance multiplies and produces itself. Therefore the distinction and bodies and minds is not a real but modal, hence the negation of the existence of

a plurality of spiritual and corporeal substances. Our mind, therefore, totally consists in the presentation of states of the body – especially of the brain, which remains an irreplaceable means of the knowledge that the mind has of the world and of itself, in the acquisition of a certainty or awareness by the idea represented by the notion that in any case the mind cannot be uncoupled from the body.

15. B. Spinoza, *Ethics*, Italian Edition. Editori Riuniti, Rome, 1988, page 314.

16. In this light, as any substantial distinction between spirit and body becomes captious, and as it is absolutely impossible to find in which way one or the other might have ontological autonomy, Spinoza marks the end of the parabola of the dualistic conception of the soul.

This parabola had its last champion in Descartes, who was however forced to somehow explain the fact demonstrated by experience that “my soul is joined in a particular way to a particular body” with solutions patched together through interventions of pineal glands and animal spirits that convinced nobody “. ...he (Descartes) conceived the mind so distinct from the body ,” Spinoza thought, “that he could not attribute any single cause either to this union or to the mind itself, but he felt it necessary to turn to the cause of the whole universe, that is, to God.” (cit., p. 293).

17. For example, in the physician and philosopher B. Mandeville we find hesitations which have no consequence at all on his way of thinking. In the *Treatise on Hypochondria* first he clearly undertakes a way of reasoning that both in the postulations and in the conclusions is based on the identity of soul and body. Then, as it comes to the end, he takes his distance, he hesitates and in short he suspends a solution already taken for granted: “I have no intention of engaging in disputes concerning the soul”. Bernard Mandeville, George Olms Verlag, 1981, Hildesheim-New York.

Another philosopher and physician, J. Locke, takes instead a more precise position and states: “Those who consider how it

is difficult to reconcile (...)existence with anything that has no extension, confess to be very far from knowing with certainty what their soul is". J. Locke "Saggio sull'intelligenza umana", Italian Edition Ed. Laterza, Bari, 1988, page 613. In the meantime, however, Locke exhorts us to prudence in judgement and warns against allowing oneself to be dragged into positions that are too rigidly extreme.

Chapter Two

18. Viktor Von Weiszäcker, "Philosophy of Medicine", Italian Edition. Ed. Guerini, Milan, 1990, page 73.
19. R. Descartes, "Discorso sul metodo", Italian Edition. Laterza Editore, Bari, 2001, page 23.
20. D. Hume, "Treatise on Human Nature", Italian Edition. Bompiani, Bari, 1987, page 45.
21. M. Heidegger, cit. page 208.
22. Aristotle, "Organon", Italian Edition. Ed. Adelphi, Milan, 2003, page 375.
23. A. Schopenhauer, "Il mondo come volontà e rappresentazione", Italian Edition. Ed. Laterza, Bari, 2004, page 151.
24. I. Kant, cit. page 316.
25. - Noam Chomsky, "Understanding Power" Italian Edition. Ed. Marco Troppa, Milan, 2002, page 355.
- A. Schopenhauer, cit. page 59.
26. - Aristotle, "Organon", page 342. "...better is the demonstration based on a smaller number of elements". Aristotle, "Organon", page 343.
- J. Locke, "Essay on Human Intelligence", Italian Edition. Bari, 1988, page 433.
- D. Hume, "Treatise on Human Nature", cit. page 296.

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- I. Kant, "Critique of Pure Reason", cit. page 13.
 - A. Schopenhauer, cit. page 95.
 - Karl Popper, "Logica della scoperta scientifica", Italian Edition. Ed. Einaudi, Torino, 1970, page XXVIII.
 - " Maybe you will not accuse me of arrogance if you take into account the fact that, since there is only one truth for each question, he who discovers it knows as much as it is possible to know", Descartes, "Discorso sul metodo", Ed. Laterza, Bari, 2001, page 29. "On the other hand, an argument is clear and evident ... if it is closed in such a way as not to make any question necessary ..." (ibid., page 636).
27. <http://www.vectorsite.net/v2004m10.html#m3>.
28. Any recent work on any molecule, protein or enzyme can be consulted. Thousands are available. For example, let us consider HGF (hepatocyte growth factor). Here is the extract from an article:
- "Hepatocyte growth factor enhances protein phosphatase Cdc25A inhibitor compound 5-induced hepatoma cell growth inhibition via Akt-mediated MAPK pathway."*
- Wang Z, Wang M, Carr BI. J Cell Physiol. 2004 Nov 8.
- We have previously shown that Compound 5 (Cpd 5), an inhibitor of protein phosphatase Cdc25A, inhibits Hep3B human hepatoma cell growth.
- We now show that hepatocyte growth factor (HGF), a hepatocyte growth stimulant, can strongly enhance Cpd 5-induced growth inhibition in Hep3B cells, and this enhancement in cell growth inhibition is correlated with a much stronger ERK phosphorylation when compared to cells treated with Cpd 5 or HGF separately.
- We found that HGF/Cpd 5-induced ERK phosphorylation and cell growth inhibition were mediated by Akt (protein kinase B) pathway, since combination HGF/Cpd 5 treatment of Hep3B cells inhibited Akt phosphorylation at Ser-473 and its kinase activity, which led to the suppression of Raf-1 phosphorylation at Ser-259.
- The suppression of Raf-1 Ser-259 phosphorylation caused the induction of Raf-1 kinase activity, as well as hyper-ERK

phosphorylation. Transient transfection of Hep3B cells with dominant negative Akt c-DNA further enhanced both Cpd 5- and HGF/Cpd 5-induced ERK phosphorylation, while over-expression of wild-type Akt c-DNA diminished their effects.

In contrast, HGF antagonized the growth inhibitory actions of Cpd 5 on normal rat hepatocytes, thus showing a selective effect on tumor cells compared to normal cells.

Our data suggest that Akt kinase negatively regulates MAPK activity at the Akt-Raf level.

Suppression of Akt activity by either combination HGF/Cpd 5 treatment or by dominant negative Akt c-DNA transfection antagonizes the Akt inhibitory effect on Raf-1, resulting in an enhancement of Cpd 5-induced MAPK activation and cell growth inhibition. (c) 2004 Wiley-Liss, Inc.

This complex study is in turn part of a network of other enzymatic and molecular cascades, each of them includes every element of the system described.

In simple words, a protein or an enzyme can be a ring of the chain examined, as well as that of other hundreds of chains that include its function and that “go through” that ring. Cpd 5, Cdc25A, ERK, Ser-473, Akt Raf-1, Ser-259, MAPK are the constituting elements of the above-mentioned molecular cascade, but each of them is also part of other cascades.

So for example as the study shows for ERK (extracellular signal-regulated kinase): “Persistent ERK phosphorylation negatively regulates cAMP response element-binding protein (CREB) activity via recruitment of CREB-binding protein to pp90RSK.”

Wang Z, Zhang B, Wang M, Carr BI. *J Biol Chem.* 2003 Mar 28;278(13):11138-44. Epub 2003 Jan 22.

Compound 5 (Cpd 5) or 2-(2-mercaptoethanol)-3-methyl-1,4-naphthoquinone, is an inhibitor of protein phosphatase Cdc25A and causes persistent activation of extracellular signal-regulated kinase (ERK) and cell growth inhibition.

To study the mechanism(s) by which persistent ERK phosphorylation might induce cell growth inhibition, we used Cpd 5 as a tool to examine its effects on the activity of CREB (cAMP response element-binding protein) transcription factor in Hep3B human hepatoma cells.

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We found that CREB activity, including its DNA binding ability and phosphorylation on residue Ser-133, was strongly inhibited by Cpd 5, followed by suppression of CRE-mediated transcription of cyclin D1 and Bcl-2 genes.

Cpd 5-mediated suppression of CREB phosphorylation and transcriptional activity was antagonized by mitogen-activated protein kinase kinase inhibitors PD 98059 and U-0126, implying that this inhibition of CREB activity was regulated at least in part by the ERK pathway.

The phosphorylation of ribosomal S6 kinase (pp90(RSK)), a CREB kinase in response to mitogen stimulation, was also found to be inhibited by Cpd 5 action. This inhibition of pp90(RSK) phosphorylation is likely the result of its increased association with CREB-binding protein (CBP), which subsequently caused inhibition of CREB phosphorylation and activity.

To support the hypothesis that Cpd 5 effects on Cdc25A inhibition with subsequent ERK activation could cause CREB inhibition, we examined the effects of Cdc25A inhibition without the use of Cpd 5. Hep3B cells were transfected with C430S Cdc25A mutant, and ERK was found to be phosphorylated in a constitutively activated manner, which was accompanied by decreased CREB phosphorylation and increased recruitment of CBP to pp90(RSK).

These data provide evidence that CBP.RSK complex formation in response to persistent ERK phosphorylation by Cpd 5 down-regulates CREB activity, leading to inhibition of both cAMP response element-mediated gene expression and cell growth.

Here the cascade is:

Cpd 5 Cdc25A (ERK) CREB Ser-133, cyclin D1 Bcl-2 PD 98059 and U-0126 S6 kinase pp90(RSK), CBP, C430S Cdc25A cAMP. Let us examine another element of the first cascade, for example MAPK (mitogen-activated protein kinase), but inserted in another molecular sequence as, for example, in "Differential regulation of the phosphoinositide 3-kinase and MAP kinase pathways by hepatocyte growth factor vs. insulin-like growth factor-I in myogenic cells". Halevy O, Cantley LC. *Exp Cell Res.* 2004 Jul 1;297(1):224-34.

Hepatocyte growth factor (HGF) promotes the proliferation of adult myoblasts and inhibits their differentiation, whereas insulin-like growth factor I (IGF-I) enhances both processes. Recent studies indicate that activation of the phosphoinositide 3'-kinase (PI3K) pathway promotes myoblast differentiation, whereas activation of the mitogen-activated protein kinase/extracellular signal-regulated protein kinase (MAPK/ERK) promotes proliferation and inhibits their differentiation.

This simple model is confounded by the fact that both HGF and IGF-I have been shown to activate both pathways. In this study, we have compared the ability of HGF and IGF-I to activate PI3K and MAPK/ERK in i28 myogenic cells.

We find that, although the two stimuli result in comparable recruitment of the p85alpha subunit of PI3K into complexes with tyrosine-phosphorylated proteins, the p85beta regulatory subunit and p110alpha catalytic subunit of PI3K are preferentially recruited into these complexes in response to IGF-I. In agreement with this observation, IGF-I is much more potent than HGF in stimulating phosphorylation of Akt/PKB, a protein kinase downstream of PI3K.

In contrast, MAPK/ERK phosphorylation was higher in response to HGF and lasted longer, relative to IGF-I. Moreover, the specific PI3K inhibitor, Wortmannin, abolished MAPK/ERK and Elk-1 phosphorylation in HGF-treated cells, suggesting the requirement of PI3K in mediating the HGF-induced MAPK pathway. UO126, a specific MAPK pathway inhibitor, had no effect on PI3K activity or Akt phosphorylation, implying that at least in muscle cells, the MAPK/ERK pathway is not required for HGF-induced PI3K activation.

These results provide a biochemical rationale for the previous observations that HGF and IGF-I have opposite effects on myogenic cells, consistent with studies linking PI3K activation to differentiation and MAPK/ERK activation to proliferation in these cells.

Moreover, the finding that PI3K activity is required for HGF-induced MAPK activation suggests its additional role in proliferation, rather than exclusively in the differentiation of adult myoblasts. The molecular system described here is: PI3K, MAPK, ERK, HGF, IGF-I, p85 alpha subunit of PI3K p85

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- beta subunit, p110 alpha catalytic subunit of PI3K, Akt/PKB, UO126.
29. Bonadonna G., Robustelli G., “Medicina Oncologica” Ed. Masson, Milan, 1999.
 30. Stein, J.H., “Internal Medicine”, Italian Edition. Ed. Momento Medico, Milan, 1995.
 31. From the treatise “Medicina Oncologica”, Bonadonna G., Robustelli G., Milan 1999.

Page 5:

The main cause of tumor consists in alteration of the genome at the level of the expression or function of genes that act to control growth and cellular differentiation.

The model that is most interesting today: cells within a clone (that is, coming from one single cell) undergo consecutive genetic variations that cause the genome to malfunction and confer to its phenotype characteristics that are favorable to proliferation.

Page 5 beginning:

The numerous changes in genes cause the cells to proliferate ever more, as in a niche in the host tissue.

Page 5 line 17:

The biochemical mechanisms of oncogens to transform cells are **still little known**.

It is believed that one single oncogene is not sufficient to entirely transform a cell. But a polyphasic process where more oncogens participate is necessary. The majority of tumors originate from one single cell.

Cellular mutations represent a continuous cumulative process from embryo to old age; thus, the oncological risk is hereditary as well. Current research tries to identify the altered genes.

End of page 5:

We hope that **in the near future** the genetic profile **will be more complete**.

Page 6:

The future challenge will have to move from the description of mutant genes to their use against specific targets for anti-tumoral therapies. The genetic tests that have been recently adopted and which are still in development have the potential to identify subjects at risk. **The effectiveness** of the possible modes of prevention of genetic tests **has not yet been established.**

Page 7, second indentation:

Starting from the beginning of the 1980s it has been demonstrated that specific and recurrent chromosomal rearrangements, including translocation and deletions constituted critical points in the complex event of malignant transformation.

Page 7, third indentation:

The mechanism through which chromosomal alterations occur **is still unknown.**

End of page 74:

The factors of growth are a not better defined group of polypeptides able to modulate the cellular function and of exerting a regulating action which is specific and potent in the growth of the target cells.

Page 77, first indentation:

The results of the most recent research clearly indicate that further future progress will occur through the unveiling of the various mechanisms through which the growth factors control the expression of the oncogenes and these in turn control the expression of the growth factors.

End of page 124:

In spite of the biological interest of this class of proto-oncogenes, **no growth factor** has been so far demonstrated to structurally be **involved in genetic lesions of human tumors.**

Page 77:

...identified 20 viral oncogenes, each of them possesses a counterpart of normal cells. **The expression of these genes** in normal cells **does not translate into the development of a neoplasia.** The alteration of the proto-oncogenes can result in the development of a malignant cell.

Page 77:

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In the future, **dozens of genes that today are unknown** will be identified. Those genes will be useful to perfect our knowledge in the intricate process of cellular regulation and differentiation.

Beginning of page 124:

Multiple experimental evidence has confirmed that neoplastic transformation, as proposed by Boveri about a century ago, is caused by lesions of the cell's DNA.

Beginning of page 7:

As Boveri foresaw at the beginning of the century, an abnormal chromosomic picture is intimately associated with the malignant phenotype of the neoplastic cell. Chromosomic aberration in fact represents an important help to find the genes that have a central role in the process of malignant transformation.

Page 7, third indentation of second column:

The concept of chromosomic anomaly, as an event that is exclusively tied to the presence of malignant cells **must be revisited**. There are in fact chromosomic alterations that are specific to a series of benign neoplasias such as lymphomas and fibromas of the ovaries, polymorph adenomas of salivary glands, and polyps of colon and endometrium.

Page 136:

The study of molecular lesions of human tumors had a strong impact on the management of the oncological patient. Molecular lesions, in fact, represent formidable markers of disease by far superior to the techniques used for the reading of serum markers.

Page 137:

... genetic lesions represent an important diagnostic and prognostic marker in clinical practice.

Page 137 last indentation:

In spite of the irreplaceable contribution of molecular analysis of human tumors, **the impact on therapy is only indirect. A more direct use of molecular lesions in a therapeutic sense still seems uncertain** today.

Although various experimental observations have demonstrated how the manipulation of the genes involved in the molecular lesions of human tumors is able to modify the

biological behaviour of the tumor in vitro, **the application** of these results to clinical practice **is problematic** and it will require delicate efforts of research.

Page 138:

...virulence of cancer ... which in the majority of the cases is not controllable in spite of the application of various forms of therapy.

Page 139:

The successes achieved by the vaccinations against infectious disease have raised hopes for acting in similar ways on tumors, departing from the assumption that tumoral cells have antigenic characteristics that are completely peculiar and different from those of normal cells ... those characteristics would make them a possible target of specific antibodies. Scientific publications on the issue fill libraries but **the results so far obtained have been disappointing.**

Page 157:

We can see that we are talking about **still desperate attempts** in the field of anti-tumoral vaccination, in the manner of Icarus, even though they are highly technological. Nevertheless, it is still an open road that can lead to therapeutic – perhaps even prophylactic – successes.

The immunological therapy specific to human tumors which is the final goal of any immunological research is more potential than actual, although some valid theoretical basis exist as well as some possible practical application. There is no doubt that the “acceleration of science” that is taking place before our eyes will lead to successes that could be enormous, as we all hope.

Beginning of page 165:

Although remarkable progress in the identification of the molecular processes responsible for change related to the specific stages of the neoplastic progression (such as mutation of dominant oncogenes or reduced expression of suppressive genes) have been made, the appearance of metastatic phenotype **has so far eluded** any characterization at the level of molecular genetics.

End of page 176:

...although the data reported for some factors such as c-erb

FOOTNOTES

and p53 (antioncogenes) are suggestive for a possible “identification” of the type of neoplastic agents to administer to obtain better probabilities of response, today **any use of these factors is premature** as predictors for response in daily clinical practice.

Page 659:

The biological response modifiers (BRM) have the property of regulating growth and differentiation of different cells and thus of modifying the function of biological systems, such as the immune system.

Numerous substances of bacterial, vegetal, viral, origin and so on have been employed to treat tumors.

Amongst the BRMs, linphochines are of particular interest. The intense work of these years has also allowed the acquisition of new biological and clinical information that only a scientifically correct study will allow **to evaluate their therapeutic potential in the years to come.**

Page 669:

Active immunotherapy (vaccination) and gene therapy.

Retroviral vectors transfer in normal cells or neoplastic genes, such as those of cytochines or of bacterial enzymes capable of metabolizing a profarmaco. In active immunotherapy, the transfer of genes augments the ability of the receiving cell to stimulate the immune system, while in gene therapy the transfer genes, by metabolizing the profarmaco into cytotoxic (suicidal gene), exposes the cells to the destruction of the drug itself.

(This)...is an area of scientific work that **in the future could give new weapons** to the doctor of oncology.

With the preparation and availability of monoclonal antibodies (MA), the attempts for the serum therapy of tumors have so far intensified with **limited success.**

Page 721, second line:

For many decades, there has been the strong suspicion that hormones are involved in the etiology of mammary carcinoma.

Page 721, second-last line:

In summation, epidemiological and experimental studies suggest that, at least for the most part, and especially by the duration of regular ovarian activity, the risk of contracting

mammary carcinoma is determined by the duration and intensity of exposure of the mammary epithelium to extrogens and to prolacine.

Page 723, beginning of second paragraph:

The **pathogenesis** of human mammarian cancer **is still little known**.

Page 720, fourth paragraph, line 18:

The most solid risk factors are represented...by family history of malignant neoplasia, especially when it concerns relatives of first degree (mother, daughter, sister) ...

Page 720 fourth paragraph, third last line:

Patients with a form of mammary carcinoma of the familial or hereditary type (including those with bilateral neoplasia) have a global rate of survival comparable to that of other patients with mammary neoplasias.

From the treatise “Internal Medicine”, Stein J. H., Ed. Momen-to Medico, Milan, 1995.

End of page 1184:

In our environment, numerous physical and biological agents of carcinogenesis have been identified. Up to a short time ago, very little about the cellular targets of those agents was known. Both the process that leads to a malignant transformation, and the genetic components of the host that are implicated in this transformation are **obscure**. However, in recent years the “base” research on cancer has discovered a group of cellular genes that are the probable substrata of carcinogenesis.

Although **much is still to be learned** we now possess a picture of the genetic events that accompany malignant transformations.

From this knowledge comes the possibility for understanding how environmental agents could interact with the elements of the host in the production of cancer. In conclusion, this work will be useful for both prevention and treatment of neoplastic diseases.

Page 1185, second indentation:

The mechanisms at the basis of carcinogenesis from foreign bodies **have not yet been clarified** (asbestos, prosthetic implants, vessical infestation by schistosoma hematobium).

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Page 1185, second paragraph:

It must be noted, furthermore, that current epidemiologists do not support the hypothesis for which the incidence of tumors is currently growing because of these environmental sources of carcinogens.

Page 1185, third paragraph:

With the exception of schistosoma hematobium, all the known biological agents that in living beings are at the basis of a neoplasia are viruses ...some viruses have been strongly implicated in principle neoplastic forms.

Although many animal models of retrovirus-induced tumors are well characterized, the modalities of human leukemia of T cells **have not yet been determined.**

Pages 1185-1186:

The growth and cellular differentiation are subject to regulatory influences of both positive and negative type.

The genes that have positive roles...in the process of growth are called proto-oncogenes or dominant oncogens. The genes that principally act in inhibition...are named suppressor genes. The reciprocal action of these two classes of regulatory genes in the development of tumors is being gradually clarified.

Page 1186, second paragraph:

Although **we only have fragmented information** about the function of proto-oncogenes, in normal cells the available data suggest that these genes undertake a role in the regulation of cellular proliferation, functioning as elements of a multi-component apparatus of signal transduction.

Page 1186-1187:

Mitogenic signals can be unleashed by the cascade transmission of (transduction) signals.

End of page 1187:

Although identification and sequence of each state of signal transmission **have not yet been given**, we are now able to describe significant components.

Page 1188, last indentation:

The control of growth involves tumor regulatory processes concerning the transduction of signals. Those processes **are not yet fully known.**

Page 1188, end of first paragraph:

Although the precise roles of multifunctional proto-oncogenes **have not yet been clarified**, it seems possible that they work as bridges between different components of the mitogenic regulating apparatus.

Beginning of page 1192:

It is interesting to note that not even two oncogenes are sufficient to generate the complete tumoral phenotype of all the characteristics. The tumors arising from the transfer in normal cells of the common oncogenes myc and ras activated, **do not invade and do not metastasize ...**

Page 1190, second paragraph:

One of the first observations on human tumors concerns the number and the morphology of chromosomes that can become extremely anomalous (thickening of cromatine, translocations, etc.). This, for example, is studied in chronic mieloid leukemeia CML whose Philadelphia chromosome is a chimerical gene).

Page 1190:

...When the exact basis of this remarkable tropism **is clarified**, we will have acquired an exhaustive knowledge of the processes that are in control of growth and differentiation in the lymphopoietic and ematopoietic tissues.

32. To this end, it useful to remember that current epistemology has demonstrated how the contribution of causality in contextual and co-textual elements of a theory, if indefinable, are random, especially in ultra-dimensional areas. That means, in practice, that the data or facts that are considered probative of a basic principle – for example, the aforementioned cellular reproductive anomaly, obtained by utilizing a limited number of variables next to the complexity of human disease, are not reliable, since they depend exclusively on the initial hypothetical conditions.
- 32a. These situations, which cause such psychic conditions, almost always induce the overestimation of the neo-formations in the tissues, especially when they are dubious or of small dimensions. In particular, when faced by a lesion that is not clearly benign, or by a small neo-formations which it is difficult to classify,

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the doctor will most of the time define them as malignant lesions just in case.

- 32b. For example, a surgeon, a radiotherapist or an oncologist who studies chemotherapy could be highly competent in performing epidemiological investigation or accurate clinical experimentation.

However, if he does not know the genetic molecular steps proposed by biologists, he is actually conducting brainless research because it cannot fit any logical development. Thus, deductions and conclusions are baseless.

- 32c. Noted by Bonadonna, p. 995. Another example: the survival median (that is, the time in which half of the patients die) for many tumors in many cases varies by a few months after a surgical or radio therapeutic intervention chemotherapy is performed.

Example: in the studies examined, radiotherapy alone has achieved a survival median of 9.4 months, while the addition of adjuvant chemotherapy following the radiotherapy has elevated the survival median to 12 months, as Bonadonna notes at page 784.

It is clear that this is all nonsense, whose misleading positive value should make scholars suspicious and bring them to the point of questioning all oncological research.

- 32d. As little energy remains, it is normal that most of the time they are unable to see – better, unwilling to see – beyond the oddness they have been proposed.

To that end, it serves to remember the prophecy of Russian physician Salmanoff, already quoted, who before the 1950s foresaw the progressive paralysis of medical thought, programmed and actuated through the explosion of data and scientific knowledge.

- 32e. Most of the time, however, these “scientists” say only what is convenient for them. (See, for example, the television fundraisers). That is, they speak lies shrouded in authority.

For example, if we consider the unsolved problem of cancer,

CANCER IS A FUNGUS

we can see that the most famous medical representatives are the very symbol of failure because they keep on branching out in the dark.

For what reason should we keep on believing them and continuing to consider them receptacles of truth? No doubt an unconventional doctor, a veterinarian or even an engineer could make better suggestions than these people who seem to have sclerotic minds.

32f. So, for example, Bernard's theory that "the terrain is everything and germs are nothing", Boveri's intuition that cancer is caused by a genetic alteration, and other more recent or older theories are only part of the archeology of thought.

32g. The Humean error of psychological assonance enters in the souls of doctors and scholars who become aware: a great research for a great truth. However, there are (and in medicine they are the majority) world-wide studies that support only world-wide nonsense.

32h. Referring to the T letter describing the extension of tumors, the Tx, T0, Tis, T1a, T1b stages are reported for less severe configurations (for example for mammarian cancer), whose dimensions, often not visible, can reach 5 millimetres or a little more (Bonadonna, page 734).

32i. Bonadonna: 1, page 779; 2, page 804; 3, page 847; 4, page 850; 5, page 857; 6, page 898; 7, page 913; 8, page 925; 9, page 949; 10, page 937; 11, page 939; 12, page 948; 13, page 752.

Chapter Three

33. JAMA 1983 Sep 16, 250 (11): 1445-9.

34. Reich, W., "La biopatia del cancro", Ed. Sugarco, Varese, 1994, page 61-62.

35. Science 1987 Dec. 11;238(4833):1573-5.

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36. Toxicol Eur Res. 1981 Nov;3(6):305-10.
37. Carolus Linneo (1707-1778), Swedish botanist.
38. Verona, O., "Il vasto mondo dei funghi", Ed. Agricole, Bologna 1985, page 1.
39. *ivi*, page 2.
40. Sexed spores, according to the type of fecundation (whether it occurs between single elements or in groups or furthermore if there is a simple disposition or a disposition in particular involucre), are subdivided in Oospores, Zigospores, Ascospores, Basidiospores.
Instead, when it comes to asexual spores, they are distinguished or classified in Tallospores and Conidiospores. The former, coming from the transformation of pre-existing parts of the mycelium, cannot easily detach.
The latter, conversely, as they are neo-formed elements, always take the external terminal position. Finally, Tallospores, because of the mode of gemmation, are subdivided in Blastospores, Clamidospores, Dictiospores and Aleurospores.
41. Rambelli A., "Fondamenti di micologia", Ed. Zanichelli, Bologna 1981, page 3.
42. Called *appressorio and austorio*.
43. *ivi*, p. 28.
44. Verona, O., *cit.* page 5.
45. Rambelli, A., *cit.* page 31.
46. *ivi* p. 28.
47. *ivi* p. 29.
48. *ivi* p. 266.

49. W. Reich, cit. page 296.
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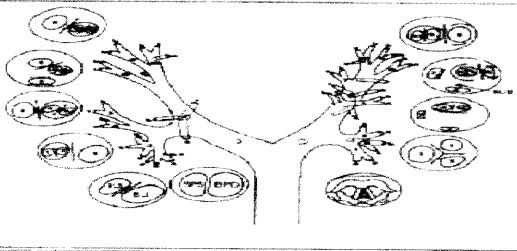

72. From 16th clinical case (page197). Bronchial Adenocarcinoma:

AZIENDA OSPEDALIERA
U.O.D. Malattie dell'Apparato Respiratorio
SERVIZIO DI ENDOSCOPIA BRONCHIALE (C.C. 51200 - U.O. 5170)

32 A A
DATA: 11/02/02

Esame fibrobroncoscopico n.:

Cognome e Nome: _____ Telefono: _____
Provenienza: _____

Preanestesia: Si	Fargan	B + Atropina	B
Anestesia:	locale	generale	<input type="checkbox"/>
Via d'introduzione:	nasale	orale	<input type="checkbox"/>
		stomica	<input type="checkbox"/>
Procedura:	Agoaspirato transbronchiale Biopsia transbronchiale Lavaggio bronchiale Biopsia bronchiale Brushing bronchiale Lavaggio broncoalveolare Terapia endobronchiale (Farmaco: _____)		

NOTIZIE CLINICHE
Atelectasia polmonare dx con interessamento polmonare apicale sin. In M di Hodgkin.

REFERITO
Prima anestesia locale con novocaina, si introduce lo strumento attraverso la narice dx. Faringe, laringe e corde vocali normali. Trachea in uso, con mucosa iperemica. Carena solida, in sede liberi i 2 versanti. Presenti alcuni condomi sul bronco principale sin. A sin l'emissione bronchiale esplorata fino ai rami di S1, non mostra alterazioni degne di nota per aspetto, motilità e pervietà e sottigliezza degli speroni. Dal bronco principale dx affiorano secrezioni lattescenti fluide, abbondanti. L'origine pare localizzata a carico del bronco lobare superiore dx e sono presenti vegetazioni biancastre occupanti spazio ed occludenti il ramo dorsale B2 e B3 (vedi foto). Stessa situazione la si riscontra a carico del bronco lobare medio (vedi foto). Si prelevano frazionatamente sia nel ramo cutaneale di sin, che nel bronco lobare superiore e medio, un totale di 80 ml di sol di bicarbonato di na al 5%.

Codice Fiscale e Partita IVA 04735061006 - Codice attività 8511.2

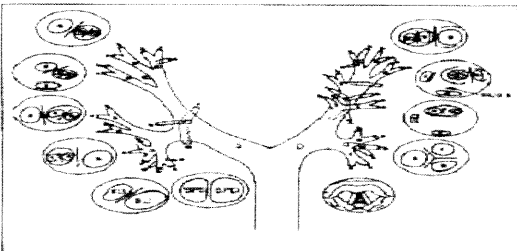

Medical report from February 11, 2002.

AZIENDA OSPEDALIERA
U.O.D. Malattie dell'Apparato Respiratorio
SERVIZIO DI ENDOSCOPIA BRONCHIALE (C.C. 51200 - U.O. 5170)

32 aa
DATA: 14/02/02

Esame fibrobroncoscopico n.:

Cognome e Nome: _____ Telefono: _____
Provenienza: _____

Preanestesia: Si	Fargan	B + Atropina	B
Anestesia:	locale	generale	<input type="checkbox"/>
Via d'introduzione:	nasale	orale	<input checked="" type="checkbox"/>
		stomica	<input type="checkbox"/>
Procedura:	Agoaspirato transbronchiale Biopsia transbronchiale Lavaggio bronchiale Biopsia bronchiale Brushing bronchiale Lavaggio broncoalveolare Terapia endobronchiale (Farmaco: _____)		

NOTIZIE CLINICHE
Atelectasia polmonare dx con interessamento polmonare apicale sin. in M di Hodgkin.

REFERITO
Dopo aver effettuato anestesia locale con novocaina, si introduce il fibrobroncoscopio attraverso la narice sin. Si va a medicare rispettivamente il ramo dorsale e quello anteriore del bronco lobare superiore dx e successivamente il ramo laterale del bronco lobare medio ed il ramo apico-dorsale del bronco lobare superiore sin, introducendo globalmente 140 ml di soluzione di sodio bicarbonato al 5%. Dopo aspirazione del materiale refluo si osserva una discreta ricanalizzazione del bronco lobare superiore dx (foto 1); del bronco lobare medio (foto 2); del ramo apico-dorsale del bronco lobare superiore sin (foto 3). La quarta immagine mostra una residua iperemia del tratto distale della trachea e della carena dovuta al ripetersi delle manovre aspirative.

Codice Fiscale e Partita IVA 04735061006 - Codice attività 8511.2

Medical report from February 14, 2002.

FOOTNOTES



* * *

IMPORTANT FACTS ABOUT THE LIFE OF FUNGI

Yeast and molds belong to a broader family of life called fungus, one of the very few "Kingdoms" of life (other Kingdoms are plants, animals, and bacteria). Mildew, bread mold, mushrooms, and toadstools are other types of *fungi* [plural of fungus, pronounced *fun'ji*]. The terms "yeast" and "fungus" and "mold" are often used interchangeably even though there are distinctions. The branch of science that studies fungus is mycology.

Some fungus feed off dead organisms, nature's garbage disposal, while other, parasitic fungus, feed off live organisms.

These pathogenic fungus cause plant, animal, and human diseases such as athlete's foot, swimmer's ear, ringworm, dandruff, Valley Fever, fingernail and toenail infections, rosacea, and yeast infections. Typically, fungus sprout from a spore and grow as filaments termed *hyphae* [pronounced *high'-fee*], about 5-10 micrometers diameter (see photo page 101). (It's not that there is a main body that produces hyphae, the fungus is the hyphae.)

As the hyphae grow they branch repeatedly.

Hyphae from individual fungus cells interconnect with hyphae from other cells, forming one large organism termed the *mycelium* [*my-sill-ee-um*]. The fuzzy mass of a bread mold is a good example.

The whole thing is a single fungus -- cut it up into pieces and each piece keeps on living as a single fungus.

Hyphae extend at their tips, while drawing the protoplasm (the internal stuff of the cell) forward as they grow.

Tip growth enables fungus to grow continuously into fresh zones of nutrients and also to penetrate hard surfaces such as plant cell walls, insect cuticle, your skin, etc. This is why fungus are so important as plant pathogens and as decomposer organisms. Fungal cells are strong and rigid. When given the chance, fungal hyphae can grow *straight through human cells*.

The basic cell construction of fungus is different from that of bacteria, plants and animals. Bacteria, plants, and fungus cells have a rigid cell wall; animals do not have a cell wall.

The cells of all organisms have a "plasma membrane", what you might think of as the "cell wall" of our own cells. A plasma membrane is soft, pliable, and somewhat permeable so that nutrients

and other necessary chemicals can get in and out of the cell.

Bacteria, plant, and fungus cells are double-layered, having a cell wall that is like an outer, open weave scaffolding over an inner plasma membrane that keeps its internal stuff (protoplasm) inside where it belongs.

A major component of fungal cell walls is *chitin* [*kite-in*] (also found in the exoskeleton of insects), whereas the major component of plant cell walls is cellulose. Chitin and cellulose are chemically similar, and the fungal cell wall also includes cellulose. The plasma membrane of fungal cells contain ergosterol, whereas animal membranes have cholesterol and plants have sitosterol.

Pathogenic Activity

Fungal Hyphae penetrate Throughout Tissues

The spheroid form of the yeast cells is only half their life story. The other half is more sinister. Yeast can transform themselves and grow hyphae (or very similar structures called pseudohyphae). At 37 degrees C, which happens to be 98.6 F, body temperature, the insidious *Candida* grows hyphae that burrow into its food source (you). You can't just scrape off athlete's foot because it has grown deep into the tissues, and intestinal *Candida* infections aren't just clumps of yeast stuck to the inside of the intestines, the *Candida* yeast penetrates and permeates the wall of the intestine.

Hyphae can intertwine into the fibers of the substrate, penetrating the pores. As it consumes the substrate, it can also create it's own route by dissolving pathways into the material. This is one of the reasons it is so difficult to kill and/or clean up mold on organic substrates.

If you remove the surface growth, those bits of hyphae within the substrate are ready for re-growth upon the return of moisture.

Fungal Spores Attack the Lungs

Fungus produce astonishing numbers of spores, and most fungi have a mechanism of releasing the spores into the air. Consequently, many human fungal illnesses are contracted through the lungs. Other fungus and yeast may produce spores that are wet and sticky and may cling to insects, rodents, etc. as a mode of travel. Some yeasts, such as *Candida*, can generate a type of spore-producing hyphae called *chlamydospores* (*cla-mid-o-spores*) .

Fungi Release Toxins to Digest Their Food

Whereas plants produce their own food by using the energy of the sun through photosynthesis, fungus have no such capability and so must eat other organism, such as plants and people. Fungus, yeast, and molds live in damp environments so that the hyphae can absorb nutrients that are dissolved in water.

They absorb simple, soluble nutrients (sugars, amino acids, etc.) through their walls, and release extracellular enzymes (exoenzymes) into their environment to degrade more complex nutrients like cellulose that they cannot absorb. We eat our food and then digest it; fungus digest their food and then absorb it.

In addition to simple enzymes, such as those that break down starches into sugar, many fungus produce toxins (called mycotoxins) that aid the process in a variety of ways (perhaps to kill a bacteria first, then digest it).

The spider injects a toxic venom having both a nerve agent and enzymatic action that paralyzes the victim and dissolves its insides, turning the victim's innards into a liquid that the spider can suck out. Fungus and yeast are similar to the spider. They produce toxins and enzymes that can disable, kill, and dissolve their food sources so that the nutrients can be assimilated.

Some toxins, such as gliotoxin produced by *Candida* and *Aspergillus* (among others), disrupt the immune system. Gliotoxin inactivates a number of important enzymes, induces free radical damage, and is cytotoxic - it kills cells, especially white blood cells, by interfering with their DNA.

It should be no surprise, then, that fungal and yeast infections are frequently associated with "mysterious" illnesses such as Chronic Fatigue Syndrome and arthritis. The fungus is injecting its host (you) with toxins to dissolve and digest you. Even if the infection is localized, the toxic enzymes are transported by the blood stream throughout the body.

The Major Pathogenic Fungi

Like various kinds of virus and bacteria, fungus, mold, and yeasts are carried through the air (primarily as spores), and are omnipresent. Small amounts of yeast and other fungal organisms compose a normal part of the body's microflora. They normally are well tolerated by those with healthy immunity. If they increase in

number, however, they create additional stress to the immune system, which can lead to an overgrowth. Conversely, those with weakened immune symptoms become susceptible to overgrowth of these (and other) microbial agents. Some, the true pathogenic fungus, can cause infections in otherwise healthy people.

Candida albicans represents about 50% of clinical infections.

Most pathogenic fungi are spread by airborne spores, and the common initial mode of infection is in the lungs. Notice that Aspergillosis may cause "allergic bronchopulmonary response" which mimics asthma.

How to Address a Fungus

The scientific convention for naming organisms is to use the Genus and Species names together. In the case of *Candida albicans*, "Candida" is the name of the genus, and "albicans" is the name of the species. To avoid ambiguity, the species name is never used without the genus name. The genus name is capitalized and frequently abbreviated; the species name is written in lower case. The terms are written in italics.

So, the correct form is either *Candida albicans* or *C. albicans*.

From *FungusFocus*: http://www.fungusfocus.com/html/fungus_general_info.htm

* * *

Is Cancer Caused by the Candida Fungus?

Interview with Doctor Tullio Simoncini

By Emma Holister

Candida International Blogspot - March 5, 2007

Emma Holister: Having read your articles about your revolutionary cancer therapy, I cannot help but wonder how difficult it has been for you to continue working as an oncologist in the world of mainstream medicine. What has been the response of the medical authorities to your work?

Tullio Simoncini: Suppression. Plots. Defamatory TV programs. When a scientist has an effective and revolutionary idea, the medical institution attempts to suppress his work because he threatens the interests of the ruling class. No matter how effective the therapy in question is, their aim will be to destroy him.

Those in power ensure that the following things are put into action:

- 1) dismissal from the medical associations,
- 2) instigation of newspaper and TV campaigns portraying him as a charlatan,
- 3) mounting attacks against him from the judicial system,
- 4) constant police harassment at home.

EH: What are the things preventing our current medical system from embracing your theories about cancer being caused by a fungus (Candida) and your treatment of tumours using sodium bicarbonate?

TS: One: there is a selfishness and lack of spirituality within the medical ruling class. It prevents them from looking beyond their acquired ignorance.

Two: the fundamental theory behind cancer is based on the hypothesis that it is caused by a genetic disorder resulting in an over-reproduction of the cancerous cells. This theory is simply wrong and has never been demonstrated.

EH: Do you believe these problems can be overcome, and if so, how?

TS: Yes, I do. It will be achieved



through grassroots activism, which will establish freedom in medical research.

If large numbers of people in a country gather and work together, it is possible to demand that the authorities allow for freedom in medical research. This can be done through demonstrations and informing people via the media.

EH: How many cases of cancer have you been able to cure? Surely your results must have at least attracted the attention of your colleagues in the medical world?

TS: I have treated hundreds of patients. Most of them had extremely advanced cancer, especially after having been subjected to conventional therapies. Many of them made a complete recovery and are still alive and well years after the treatment.

In the cases of cancers caught early (lumps smaller than 3 cm, with minimal incidence of metastasis) 90% of patients have made a recovery. Many doctors agree with my methods and have used the sodium bicarbonate treatment.

EH: Is there no way that you could use this evidence to put pressure on the establishment to take your work more seriously?

TS: No, because it is necessary to demonstrate one's results with many hundreds of fully documented cases. This is not possible unless you work in a cancer clinic.

EH: Many women suffering from Candida are plagued by persistent long-term gynaecological problems, from thrush to reproductive cancers. What would be your advice to them?

TS: To uproot persistent gynaecological fungal infections one should do a douche every day with two litres of pure water (that has been boiled and left to cool) containing two dissolved tablespoons of bicarbonate of soda.

This should be kept up for two months, stopping only during one's period. Candida is very persistent and it takes a long time to kill an infection.

EH: Although your views on cancer and fungus are revolutionary within the context of mainstream medicine, within alternative medicine your views of what Candida is and how it functions in the body

appear to differ from many alternative practitioners who view Candida as a systemic problem affecting the whole body and originating in the intestines.

From what I gather you do not see the Candida problem as residing in the gut. If you believe that the Candida yeast is not the cause of the various intestinal problems usually associated with Candidiasis, what in your opinion is the cause?

TS: The main cause is environmental.

Secondly, there is a resulting lack of energy caused by alterations in the blood circulation. Thirdly, diet. The problem is, why does a person have intolerances to sugar, yeast, eggs, milk etc?

Before these developed, damage had been caused. The gut's epithelium is impaired and that causes the intolerances.

It is important to cure this, and then it is possible to see if the related problems continue.

It is not good to avoid a particular food for ever, because it doesn't deal with the root cause of the illness, which is usually caused by problems within the environment, from impaired energy levels and poor diet.

For example, a person who has heart disease may suffer from chronic dilatation of the gut (in this way the heart works less), and an intolerance is the result . . .

Another example is a person who suffers from cooling syndrome. This provokes congestion and consequently intolerances. And so on. Therefore it is necessary to cure the illness at its root cause, not just the symptoms by avoiding this or that food.

EH: Finally, what is your opinion of the situation that many alternative health practitioners find themselves in with regard to the anti alternative medicine campaigns being waged against them by the medical authorities, the medical press and national media, for example Quackbusters?

What do you feel is needed to protect alternative therapists such as yourself, and the patients who come to you for help?

TS: My opinion is that the alternative practitioners are scared and don't have the means to fight the lies perpetrated by mainstream medicine. The medical world needs to be liberated in order to allow

CANCER IS A FUNGUS

patients freedom of choice in healthcare. Most illnesses are the result of an unhealthy lifestyle, and as such, drugs are useless and can only do damage.

Furthermore, archaic institutions such as the medical associations frequently pressure doctors into prescribing only useless, toxic and harmful treatments.

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www.cancerfungus.com

*Interview by Emma Holister for
Candida International Blogspot
<http://candida-international.blogspot.com/2007/03/is-cancer-caused-by-candida-fungus.html>*

* * *

The Author

Dr. T. Simoncini (1951), is born in Valentano (Viterbo, Italy) is a 53 years old doctor.

He is a surgeon specialized in oncology, diabetology, and metabolic disorders. After his degree in medicine, he studied Physics and Philosophy in order to better understand the rational presuppositions upon which medical thought is founded, obtaining a degree in Philosophy at the University of Rome.

These studies reinforced, at a scientific level, his strong opposition to any type of intellectual conformity, which is often based on based on suppositions without foundation, or worse on lies and falsehoods.

If one considers the total failure of official oncology, which is obvious to all, one can understand his strongly critical position of an Italian and global medical system operating in what is a scientific dead end that is of no help whatsoever to the patients.

Simoncini's personality is pervaded by a strong humanitarianism which triggered him to reflect on how little and inadequate medicine's fundamental knowledge is, as shown by the impotence of medicine when faced by the pain of patients. This empathy for the pain of others has been the constant motivator on the path of his personal life.

His tendency to medical and scientific synthesis also stems from a natural sensitivity that tends to perceive the harmony of the whole as distinct from the value of its constituent parts. This quality is reinforced and expressed by his feeling for music, and has been cultivated by playing musical instruments such as the piano and classical and modern guitar.

During his time as a student in high school and university his musical abilities led him to form various musical bands that toured central Italy. Dr. Simoncini also believes in sports and takes care of his mind and body by following elementary natural rules such as a healthy diet, physical activity, and the practice of moral responsibility. His favorite sports are jogging, skiing, and soccer.

* * *

Dr. T. Simoncini

CANCER IS A FUNGUS

A Revolution in Tumor Therapy

At the moment the constant, uniform, and implacable growth of a tumor is in no way affected by current oncological treatments. A recovery rate for cancer that fluctuates at around the 7% is mentioned in the classical books and treatises in spite of all the tricks and distortion of statistics. After making the necessary corrections, this amounts to virtually nil.

The rest is propaganda for orthodox oncology.

On the basis of the scientific considerations in this book which demonstrate that cancer is caused by fungal masses (of the *Candida* type), sodium bicarbonate is the only useful remedy that is now available for healing the disease.

Unlike antimycotics, sodium bicarbonate has a very high diffusion rate and is free of structural complexities that can be easily decoded by the fungi. It retains its capacity to penetrate into the masses for a long time, also and in particular because of *the speed at which it breaks them down*, which makes it impossible for them to adapt themselves sufficiently to defend themselves against it.

The basic principle of the treatment system is the administration of solutions with a high concentration of sodium bicarbonate (5%) directly onto the neoplastic masses.

The search for increasingly more effective techniques with which to get as close as possible to the tissues has brought Dr. Simoncini to *selective arteriography* (charting specific arteries using instruments) and inserting arterial *port-a-caths* (catheters with reservoir).

These methods allow a small catheter to be inserted directly into the artery supplying the neoplastic mass, so that high doses of sodium bicarbonate can be administered to the deepest corners of the body.

The treatment with bicarbonate must then be started immediately with high doses, in continuous cycles and without interruption for at least seven to eight days for an initial cycle in order to destroy the fungal colonies. It must be borne in mind here that a mass of 2 to 4 centimeters begins to get consistently smaller from the third to fourth day and collapses from the fourth to fifth day (the maximum dose per session is around 500 cc).

It must be emphasized that the doses indicated, because they are harmless, are the same as those that have been used without any problems for over 30 years for a large number of other complaints such as:

- *Serious diabetic keto-acidosis.*
- *Cardio-respiratory resuscitation.*
- *Pregnancy.*
- *Hemodialysis.*
- *Peritoneal dialysis.*
- *Pharmacological toxicosis.*
- *Hepatopathy.*
- *Vascular surgery operations.*

Dr. Simoncini's method follows the 'classical' oncological approach by treating the cancer directly, even in an advanced state. The level of pain experienced during treatment is the same as that of an intravenous infusion and the procedure can be carried out at home. The average success rate for the method is 90%. Eighteen clinical cases treated are described in detail in the book. Because of the laughably low costs of the solution used,

the ease of use and above all because of **its success**, the method is now supported by more and more doctors.

For further information see:

www.cancerfungus.com



EDIZIONI LAMPIS

