

The Cancer Revolution: A Groundbreaking Program to Reverse and Prevent Cancer: A Special Interview With Leigh Erin Connealy

By Dr. Joseph Mercola

JM: Dr. Joseph Mercola

LC: Dr. Leigh Erin Connealy

JM: Cancer will affect you personally or someone you love. What can you do about it? Hi, this is Dr. Mercola, helping you take control of your health. Today we are joined by Dr. Leigh Erin Connealy, who is going to help us answer that question. Just to expand on the likelihood of you being affected by this, 1 in 3 women and half of the men will come down with cancer in their lifetime. We're not talking about benign skin cancers. We are talking about the real deal.

This is a serious issue that you need to be certainly well-informed on to know your options, because there are so many forces that are going to give you misleading information and sending you on paths that are not going to solve the problem. Welcome and thank you for joining us today, Dr. Connealy.

LC: Thank you, Dr. Mercola, for everything that you do to spread the message of health and changing people's lives. It's great to be here.

JM: Yes. I met you initially at Dr. Lee Cowden's conference, I believe. He's actually having another one. I believe you're speaking there. Are you? In November?

LC: Yes. That's correct.

JM: We'll both be there. If you have any interest in this topic or brain dysfunction, because this year's going to focus more on brain – but actually, the treatments are almost identical – I would strongly encourage everyone to go to Orlando. You can hear not only Dr. Connealy and myself, but probably two dozen other speakers there. It's going to be a delightful event. November 2nd, 3rd and 4th in Orlando. We'll have details on that on the page.

You, like me, are a family physician. I'm wondering if you could share your journey on how you started to focus and specialize on treating cancer in your clinic.

LC: Well, that's an interesting story. I was born in the '50s. I'm number three of six children. [When] my mother was pregnant with me – we're about five months – she started bleeding. She went to the doctor. The doctor gave her a drug called DES, which was diethylstilbestrol. That was given to women in the '50s to prevent miscarriage.

Approximately 16 years later, my parents received a letter. I was living in Houston, Texas at the time. They said, "This drug causes cancer, hormone problems and anatomical problems. You need to go to University of Texas MD Anderson Cancer Center and get full workup."

At 16 years of age, I started getting pap smears, colposcopies, biopsies until about 21 years of age. Then they told me, because I was moving to Chicago, that I would need to be followed continuously for this problem. I went to University of Texas School of Public Health and I did my Masters on DES and understanding all the complications as a result of DES. I had many of them. Today, I still have many of them.

My whole mission is not to get cancer because I was so high risk. Luckily in my journey, obviously researching and meeting people at the conferences that you and I both attend, I met unbelievable other practitioners, doctors who had cancer themselves and fought it and won. I always tell people, “You learn from someone who’s already been down that path and has become a master of healing themselves.”

JM: Thank you for sharing your personal history with that, because I think that gives people a better framework to understand your perspective. I’ve written a book, *Fat for Fuel*, which was motivated out of my passion to also treat cancer. I never personally had cancer, no one in my family has had cancer, but it’s an enormous impact. It brings me to tears to think of the millions of people that are dying needlessly. Sixteen hundred people a day in the United States alone and the vast majority, probably 90 to 95 percent, don’t have to die from cancer. That was the motivation for the book. We’re not going to talk about dying here.

I think we’re both in agreement about optimizing the body’s ability to burn fat as your primary fuel. We’re going to go into the other ancillary components. Another area that we’re not going to talk about, but I’m really also passionate about, is the importance of EMF, electromagnetic fields, cellphone radiation and all those. That’s important too. We’re going to talk about some of the things that you really dive deep into in your book.

One of them is toxins, another really crucial component. I briefly discuss them in the book but don’t go into depth into some of the specific strategies you can use to eliminate those, but it doesn’t diminish their importance. I’m wondering if you could discuss the connection between toxins and cancer.

LC: Yes. In my book, I have a whole chapter on that. There’s a myriad of toxins. There are hundreds and hundreds of thousands of chemicals that are utilized every single day in our water.

JM: Tens of thousands.

LC: Yes. Water, air and soil. It’s so many. I tell people, if you’re going to live in today’s world – we’ve progressed to the civilized society – but if we’re going to live in this world today, the No. 1 thing you need to do is detox on a regular basis, somehow, some way. A lot of it you can do at home all by yourself. If you’re going to live in this world, that’s what we’ve got to do.

What’s interesting is I just read a report. They just had the international meeting on aluminum toxicity. I will send you the info because I think it is something that would be a great topic for you to talk about. People don’t even think about aluminum toxicity. Where would you get aluminum? Well, it’s in manufacturing. It’s in vaccines. It’s in your daily deodorant that you use.

JM: It's in the rain.

LC: It's in the rain. Exactly. Now, we do heavy metal testing and toxic load testing for every single one of our patients. It's very easy to do with urine samples for toxicity, for toxins like phthalates, and fix the big ones. That's the next big thing. It's phthalates.

Phthalates are everywhere, effervescent in every single one's life. I mean National Geographic and CNN have done plasticizing of the world. We know it causes cancer, heart disease and diabetes, but a lot of reports say it's the No. 1 pollutant in man.

Then you talk about all the heavy metals – mercury, cadmium, lead, oxides, aluminum and arsenic. Then you talk about all the benzene compounds. Then you talk about just indoor air pollution, outdoor air pollution. Then you talk about toxic teeth. People don't realize their teeth are connected to the rest of their body. There are the toxins that are being produced by all of the different infections and/or root canals.

Then if you have an infection, those are live organisms living in you. They produce toxins. If you just have candida, think about all the mycotoxins that are produced from candida, from parasites, viruses, etc.

Then you have just your daily water that people are drinking. Today, most people are utilizing water purification of some kind. I tell people even if you can't afford anything, just at least get a Brita or something that is better, because Popular Science magazine did a phenomenal article on all the pharmaceuticals in the water. Even if you're not taking it with a prescription by your doctor, you're getting it in the water. Whether it's blood pressure pills, chemo pills, birth control pills, chemo whatever it is, it's in the water supply. You're getting it regardless of getting water purification.

JM: Yeah. Probably the most important type of filtration is to filter your shower, because that's where these chemicals get volatilized. Your absorption of them is magnificently increased as opposed to drinking them. You can get like a week's worth of toxins from your shower worth of drinking water. You've got to put one on your shower if you're going to take long hot showers. Or you can take cold showers in like a minute or two.

LC: Yeah. Exactly. But you're right. All the chemicals are in there, whether it's in the drinking water or the shower. Your skin is the largest organ of your body, so you're absorbing.

If you look at the Physicians' Desk Reference, you absorb 10 percent orally, 30 percent through your skin. Your skin absorbs way more than something you're taking orally. You're right. It is a more powerful force of toxicity, not to mention the chlorine, the fluorine and all the other chemicals that displace our iodine.

We are living in a sea of toxins. This is what no one is talking about except people like you. We've got to create this awareness and this education and enlightenment with people that this is a real problem.

JM: Yes. There are many strategies that one can do to detox. We won't go dive deep here but some of the ones that are useful would be far-infrared sauna coupled with the near-infrared light, and then a whole variety of different detoxifications you can take with that to help get these out on a regular basis. This is something I do pretty much every day when I'm home. I think it's that crucial.

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As you mentioned, we're exposed to tens of thousands. If you're healthy, you're probably at 20,000. If you're not, you might have 50,000 or 60,000 of these chemicals, just because of your exposure in living in a modern industrialized society. You need to get out, even if you're eating clean and if you're living in a relatively not polluted society that you're exposed to. It's an important strategy. You want to elaborate on that a bit?

LC: Yeah. That's funny. I've had a sauna in our office for probably 17 or 18 years now. I tell people the single greatest investment they can make in their life in living well today is investing on an infrared sauna, because of not for just detox, but for so many other things. Cancer cells don't like heat, Krebs's circulation, etc.

Now today, they have portable saunas. They are easy and affordable. When you think about it over a lifetime, it's nothing compared to how you feel. You talk to someone who's been in a sauna a month, they tell you, "Oh my god. I feel great."

Another simple thing they can do is coffee enemas. They get the right kind of coffee and do coffee enemas in the comfort of their home. The other thing I tell people if you don't want to get a sauna or you can't afford it or whatever and maybe save up for it, I have my patients do baths of Epsom salts, baking soda and clay. Clay has been around for years. That's what the animals use to take care of themselves. They do a bath in that. The medicinal effects of just Epsom salts are phenomenal. It relaxes the nervous system. Magnesium's involved in 400 chemical reactions in your body. It relaxes the entire muscular system.

Then baking soda. People look at the original catalog on baking soda when it came out in 1926 or 1936, something like that. It's amazing. It helps oxygenate. It's antimicrobial. It alkalinizes the body. These are simple little things that we can do just in the comfort of our home. Detox is powerful.

Yes, you mentioned I use zeolite. I love zeolite as a daily detox for people to use. Even just juicing along, making regular juice. I drink 10 ounces of green juice every single morning. Taking vitamin C every day. Vitamin C is a great anti-bug, anti-chemicals, anticancer, alkalinizing agent. People sometimes say they can't afford some of these things. Yes, you can afford. You've got to put your priorities in place. Health is our most important asset for all of us. Today, health is a commodity because our children are sick, our young people are sick, and now, our older people are getting sick.

JM: Let's go into more detail because I think it's important to understand some of these concepts.

For saunas, you can get pretty inexpensive ones that are called tent saunas, T-E-N-T, where your head's out. I don't particularly enjoy having my head in the sauna. I don't think there's a lot of benefit. It's not important to detox your skull. I mean you're going to get it by increasing your internal core temperature anyway. In this way, your head's out and you're more comfortable. You just want to make sure it's low-EMF because most of the far-infrared saunas, there's a complication. They have a material that the tent is made of that's not outgassing toxic substances. It's putting it back in your system.

LC: Right. Very good point.

JM: There's another thing you can do. It's add ozone to it, which is a magnificent way, because when you're in the sauna, your skin pores are open and you're more likely – as you said, the skin is a magnificent absorption area – you can get all the benefits of ozone, which is another potent anticancer therapy.

Ideally, you can go to a spa center and get an ozone generator. Hook that up to an oxygen generator so that you can get clean oxygen, high concentration of oxygen to go with the ozone generator. Just put it right into your sauna, maybe a little fan to blow away the excess because you don't want to breathe it. But it's a good strategy.

But with respect to the zeolite, you have to be careful because, as you mentioned, aluminum is a toxic metal. We don't need it. In fact, aluminum, lead and mercury are the top three. But zeolite is aluminosilica, and the silica is really important. That really grabs the aluminum up. But some of this zeolite, you have to be careful.

LC: Yes.

JM: With you, that worked well, because they can actually make you worse. But if you find the right one, it's magnificent.

LC: Yes. You're absolutely correct. Just like anything. Just like you said, like getting the right sauna that's not outgassing chemicals and electromagnetic field (EMF). You're right.

JM: I neglected to mention earlier that you wrote a book, *The Cancer Revolution: A Groundbreaking Program to Reverse and Prevent Cancer*, which is why we're having this conversation, which goes into this in far greater detail. If you want more specifics, certainly that's a resource for you to consider.

But one of the things you discuss in your book is cancer screenings. I'd like to go into that now because we've written a lot about that – most recently, the colonoscopies, and certainly in the past, mammographies and prostate-specific antigens (PSAs). These are the common cancer screenings that conventional medicine uses to detect it at an early stage, which makes sense.

I mean I'm a big advocate for prevention, but these tests actually don't prevent things. They actually cause more harm than good almost all the time. If you do the numbers, you're more

likely to receive harm from this than benefit. Why don't you talk about that? After you address that, maybe talk about some of the cancer screenings that can be effective.

LC: Right. What do we have for cancer screening? For females, we have the pap smear, a mammogram and a colonoscopy. They don't recommend the colonoscopy until you're 50, but if you read the news, which I know you have, that the fastest growing cancer is colon cancer in 25- to 35-year-olds. They don't do colon cancer screening. But then I tell patients, "What about all the other cancers? What screening are you doing for that?" Nothing. A pap smear, yes, I think a pap smear is a good tool.

Mammograms, of course we know all the different variations. If you do regular mammograms, as they say, you have an increased risk of cancer. I always tell people, "They say on the report – I get it every day – you will miss 20 percent or more pathology with this mammogram." That means the mammogram is an inadequate, incomplete tool of investigation for cancer, especially if it says you have dense breasts. That means you're going to miss a lot.

In my practice, I recommend ultrasound and thermography. The standard of care, which you know, is for a patient to get mammography. That's what I'm supposed to tell patients. But I tell people, "Look. You're not going to get all the answers." I've been doing thermography for a long time. I find most of the breast cancer on thermography, as opposed to mammography. I also utilize ultrasound. But these are very inadequate to determine cancer. I'll talk about that in a second.

What do you have for men? PSAs, we know, are very, very inaccurate and invaluable tools to decide on prostate cancer. I personally use that as a tool. Let's say you're coming to see me for a physical every year and your PSA is blank every year, then all of a sudden it goes up to two. There's a very good chance that you have prostate cancer. Most of the time that is the case. But I do not use those in today's world. Like you said, cancer is 1 in 2 men and about 30 to 35 percent of females. That means that we're not getting good at diagnosis, but we have fabulous tests available.

One of the tests you can do on a regular blood test is the CRP, the C-reactive protein, which is a non-specific marker for inflammation. Inflammation is the precursor for all diseases. It doesn't tell me where the cancer is, but it tells me something is brewing. It doesn't necessarily mean cancer, but we want to see C-reactive protein less than one. Then the other blood test that I use on every single man, woman and child –

JM: C-reactive protein ideally should be high sensitivity, would you agree?

LC: Yes. That's correct.

JM: Yeah. Because you just don't want a regular CRP. You want the high sensitivity.

LC: You want the highly sensitive CRP. Correct. And then you have the Hemoglobin A1C. The Hemoglobin A1C is a 90-day reflection of your blood sugar over 90 days. The Hemoglobin A1C, anyone with high sugars is predisposing themselves and has an environment for cancer.

Just those two tests that are done on a regular blood test will tell us that you have an environment for cancer.

More specifically, there are a couple of blood tests that I've used for many years. One is the cancer profile that is out of Florida. It's American Metabolic Laboratories. It checks for quantitative human chorionic gonadotropin (hCG) in the blood and urine, and checks for phosphohexose isomerase (PHI), which is the enzyme of hypoxia, which means low-oxygen. Cancer thrives in a low-oxygen. Nobel Prize winner, Otto Warburg, discovered that many years ago.

It checks the dehydroepiandrosterone (DHEA) sulfate, which is your hormone of stress, immunolongevity. It checks your thyroid, because low-thyroid people tend to have a predisposition to cancer, then the gamma-glutamyl transferase (GGT), which is a sensitive marker of liver. Then it checks arachidonyl-2-chloroethylamide (ACEA), which is a non-specific marker for many cancers. That has a pretty high accuracy rate of whether cancer is simmering, fermenting or brewing.

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Let's make a point that from one cancer cell to a tumor takes about 10 years. By the time you see the lump and bump on a mammogram, a colonoscopy, ultrasound, computed tomography (CT), positron emission tomography (PET), whatever, it's 10 years old. That means we have 10 years. Ten years of opportunity to prevent cancer. We know that the cure for cancer is prevention. The cancer profile is a great starting tool.

Another test that I have used is ONCOblot. ONCOblot was discovered, I don't know, a couple of years ago. It has about a 95 percent accuracy rate. It measures the ENOX2 protein. It will determine about 31 or 33 tissue types of cancer. I personally, Dr. Mercola, do not use one testing because I like to check and triple check what I'm doing. But that is a pretty accurate test. Like I said, it's not 100 percent. Then you can do routine tumor markers, but I find at least 50 percent of the time, a patient can have stage 2, 3 or 4 cancer and their tumor markers are completely normal. Normal. That means those are not a good tool.

What I do is I try to get a tapestry of the patient to figure out where all their imbalances are, whether their nutritional deficiencies, toxic substances, toxic [inaudible 21:21], heavy metals, do they have the right antioxidants, are their mitochondria working or not working? Then I do all the hormone testing. Then I also look for cancer, because I tell people now, we all have to embrace this prevention. We have to.

We're talking about cancer today, but we could be talking about autism. We could be talking about diabetes. But cancer now is plaguing every single person's family and everything. We all together need to create this open discussion about all the possibilities that we can treat a human being.

JM: I couldn't agree more. I personally lived my life strategy as if I have cancer, a terminal cancer, to employ a whole variety of bio hacks and dietary strategies to optimize it, which essentially makes it impossible, virtually impossible – nothing's impossible but close to it – of

ever coming down with this or pretty much any other chronic degenerative disease. A lot of the tips I have are on *Fat for Fuel*.

But the purpose of this discussion is to really focus on cancer, which, you know, is your specialty. You had mentioned these screening tests that you're doing, and also the GGTP or GGT, which is a measure of liver function. But more recently, it's been found to be actually another very sensitive screening for inflammation.

LC: Yes.

JM: It really complements the HSCR. I'm wondering if there are other unconventional tests. If you could discuss where one can get them, because these are not done at your typical Quest or LabCorp blood draw facility. They have to be sent out. Many times it's not a pull-out. It's just another type of sample that's required to expedite shipping with frozen samples. How would they access this? Most likely, I would suspect finding a clinician who knows how to interpret the results, and then work with that person.

LC: That's a good point. The cancer profile, I believe they can just call up American Metabolic Laboratories and get a kit. It is a fasting blood and urine kit. Dr. Emil Schandl is fabulous about going over with the patients their results. I tell them they should always be seeing a doctor who understands that interpretation. I agree with that.

They definitely need to work with a doctor, because just getting PHI, the testing for low oxygen, it's an art to get that down. They definitely need to be working with the doctor who understands the significance of each aspect of the test. Now, the ONCOblot, they can call ONCOblot and they will say, "Here are the doctors that order ONCOblot."

Now, the other testing that we didn't even mention is the circulating tumor cell test by the Research Genetic Cancer Center (RGCC).

JM: Before we discuss that – that was my next question for you, actually.

LC: Okay. Sure.

JM: Most people don't understand this. You can make a comment and it would go over their heads. But most people don't realize that the vast majority, maybe 90 to 95 percent of the reasons why people are dying from cancer, at least at a pathway level, has to do with these circulating cancer stem cells. That's what kills people. You definitely want to have a test that screens for those to see if the strategy or the compilation of clinical therapies that you decided to use is being effective. With that framework, why don't you discuss how you can test for those?

LC: Okay. If you've ever had cancer before and the lumps and bumps are gone by surgery and/or chemo in the other strategy that you've used, the next thing you want to do is you want to check for circulating tumor cells and stem cells.

Why is that so important? If something is a millimeter in size, it is producing circulating tumor cells and stem cells. Even if you have surgery, chemo or radiation, it will not eradicate or eliminate circulating tumor cells. Even though you may have already had the surgery, the chemo, the radiation, and the doctor has told you that you are cured and I will see you in three or six months a year or whatever the timeframe may be, the biggest cause of reoccurrence is the circulating tumor cells and stem cells. Like you said, Dr. Mercola, these circulating tumor cells and stem cells can be the eventual cause of death.

When I first started measuring circulating tumor cells, I had a laboratory. A Quest Laboratory came and said, “Oh. We can order circulating tumor cells. We have the laboratory testing that we can do it.” I started checking everybody’s circulating tumor cells. They were all zero. After 20, I said, “Okay. Something’s not right.”

Then I learned about RGCC Labs, which is a lab in Greece. Dr. Ioannis Papatiriou is the chairman. He’s a molecular geneticist, M.D, PhD. I started measuring circulating tumor cells. Anybody who’s had cancer, they must have their circulating tumor cells [or] stem cells checked quantitatively.

Now, RGCC is not the only lab in the universe that does it. But the reason why I used RGCC, they’re in 13 countries. They have the highest laboratory international certification you can have. It is, to me, probably the most accurate of all the testing that I have done, that I have sent to other labs.

The beauty about RGCC is they will do what they call Natural Substances Sensitivity Testing. Because, as I said, surgery, chemo and radiation will not eliminate or eradicate the circulating tumor cells; they will check the 49 to 50 agents that we know have effect on circulating tumor cells and stem cells, such as vitamin C, such as vitamin D, curcumin, agaricus and the other 49 other agents that you can test. They will test to see what is most efficacious on the cells in your system, very much like antibiotic testing when you have a urinary tract infection. You’ve used antibiotics, you’ve developed a resistance, so you do a culture to see what works best. This is also the same thing.

Now, combined with these specific natural agents – I don’t give all the natural agents at one time – I rotate the supplements because I don’t want the cell to get accustomed to what I’m doing.

Along with that – it’ll be four years in August – we started using something called supportive oligonucleotide technique (SOT) therapy, very similar to antisense therapy. In SOT, they take the circulating tumor cells. They reverse engineer a new messenger RNA to disrupt the DNA of the circulating tumor cell. That is given back as an intravenous (IV), and that IV has a 24-hour, seven day a week killing effect for about four and a half months to target the circulating tumor cells. We have to eradicate those. You have to. Regardless of the diagnosis and the elimination of the cancer, you must attack those circulating tumor cells and stem cells.

JM: Earlier, you had mentioned, with respect to supplements, the use of oral vitamin C on a regular basis. I would have to – at least I personally believe and don’t do that for myself. I like to get it from foods. I have access to certain types of berries that I grow, certain cherries, acerola

cherries that have about 80 milligrams. I'm taking maybe 5 or 6 grams of natural vitamin C a day through the food, but not as a supplement because it's a whole complex. It's just a minor disagreement.

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But I couldn't agree more forcefully with the recommendation to do intravenous vitamin C as an adjunct to cancer therapy. I'd like you to talk a little bit about this because most people don't realize it's not the vitamin C directly that works, but it increases hydrogen peroxide, which causes a really potent oxidative stress to these crippling cancer cells, especially if it would be crippled even further with good low-carb, high-fat diet. But you have an interesting tweak on that that I'd like you to discuss, which is vitamin K3, which is a synthetic form of vitamin K2, designed for tumors that have high catalase. That's an intriguing approach. I'm wondering if you could expand on it.

LC: Yeah. Let's go back to the vitamin C. Anything food based is better, because as you said, if you took a photograph of a synthetic vitamin C and a natural vitamin C, look what you're missing. I tell people it's like an artificial flower and real flowers. You'd much prefer real flowers than the artificial flowers. Anything, like you said, the cherry, the berry. When you take that vitamin C, it's much more potent than any synthetic vitamin C. You're right on that and I agree with you on that.

Now, vitamin C intravenously at all different dosages because I use all different dosages, 30, 50, 75, 100 grams. National Institute of Health, Dr. Levine did the original studies. There are lots of different studies on IV vitamin C going on, even as we speak about it, killing cancer, like you said, by creating the hydrogen peroxide and creating cancer cell death.

We don't use K3 on everyone. We always do a testing for the patient. We always tend to do a subcutaneous just to make sure that no one has an allergic reaction to the K3. The K3, like you said, is just an adjunct to the IV vitamin C protocol that we are doing. Of course, there is no "one size fits all" for our patients. You have to customize, individualize, personalize each patient. We may not use it, like I said, on everyone.

Like for example, curcumin. It may test very high on someone's testing but you have to be careful with curcumin, because people can have – I want to call it almost like an – allergic reaction. You have to start out very, very slowly with these substances and see how the individual will do and will respond to these.

JM: As far as herbal preparations like curcumin, which is an extract of turmeric, it seems, in my experience in connecting with many other cancer specialists, the one that's almost universally effective for all cancer types. Other supplements can actually make the cancer worse. That's why you really don't want to go into willy-nilly. Because when you're feeding your body with these nutrients and you're thinking you're doing good, you might be feeding the cancer cells. You might be accelerating the cancer growth unknowingly. You have to be careful.

LC: That's why when you do a workup, Dr. Mercola – Today we have this incredible laboratory testing where you can check every person where they are. I do just the nutritional testing, and it's

not just nutritional checking. It checks their gut. It checks their antioxidants. It checks everything. You know what you're dealing with more specifically. Believe it or not, the insurance companies pay for all these tests. It's not like it's financially unaffordable because all the insurance companies pretty much pay for all of these, whether it's blood testing and/or nutritional testing.

JM: That's good to hear.

LC: Yeah. I want people to know because people don't realize the testing that they can get done that's covered by their insurance.

JM: Great. I just want to head back to the vitamin C for a bit, because as we're doing this interview, last week or so, there was an emergency room physician, not really in an academic position, but he had done some reading and decided that he was going to use 1.5 grams, not 25 grams like most of us use, but 1.5 grams, essentially a dosage you could easily replicate, almost anyone could orally. He did that IV with a little bit of thiamine. He used it for patients who are dying of sepsis.

Most people may not realize that a million people a year die of sepsis in the United States. That's a big deal. There are more people dying from sepsis than a lot of other conditions combined. They recovered. It has many other uses. But imagine what would happen if people started getting 25 grams of vitamin C like most physicians like yourself use for cancer therapy.

LC: Right. I saw that same study. They used IV vitamin C with thiamine and hydrocortisone. There's a great book. You probably know Dr. William Jefferies' book, *Safe Uses of Cortisol*.

JM: Sure. Absolutely. It's been around for two decades.

LC: Yes. Exactly. It's amazing. Look at that. Just a couple of few little very inexpensive things can dramatically change the outcome of someone's life.

JM: Yeah. You're at one of the forefronts of integrating most of these strategies today. You've introduced some of these important cutting-edge cancer treatments, some of which we've discussed already, and strategies in your book. I'm wondering if you can comment on any other ones that you're aware of that hold promise for the future. That we may be able to see some significant improvements and certainly recognizing that almost all the cancer specialists, the oncologists, are beyond, and I mean seriously, beyond seriously confused about the true cause of cancer.

They believe, almost every one of them, that it's a genetic disease. We know it's not. The genetic damage that's almost invariably present in all of cancers is the downstream side effect from the mitochondrial dysfunction, which is related to some of the other things that we're talking about: the toxins, the EMF exposures, poor diets. That causes it, not some type of genetic aberration or genetic roulette, "Woe is me. I've got the cancer gene from my mom or my grandmother. I'm doomed." That's not the case. You don't have to have a bilateral mastectomy prophylactically. What are some of the exciting new strategies coming down the road?

LC: I will tell you that, as you know, the conventional treatment is surgery and/or chemo and/or radiation. Nature, May 2016, came out with an article that 90 percent of cancers are lifestyle and environment. How many doctors ask their patients about their lifestyle, about their environment? None.

In fact, I had a patient today. She was diagnosed with breast cancer in July 2016 by another doctor after implant surgery in April. Then she had breast cancer in her breast three months later and it was probably there, obviously, before. She went to two oncologists. I always ask the patients, “What did your oncologist say that would be the best avenue for you?” She said, “Well, they said, ‘Okay. This chemo and because you’re H’ER-2 positive, you get this HER2.’” And they go, “IV vitamin C? Forget it. Don’t do anything.” Coffee enemas – because she had been doing the Gerson protocol – he goes, “No. None of that matters.” It’s so sad to hear this in today’s world.

We’re in the era of information so we can get this information. I said, “If you just want to google yourself IV vitamin C in cancer, you will find an unlimited supply of information. That’s why they were here, because they already know that information.” But it’s sad, like you said, that we have disinformation and misinformation out there.

I want people to understand that this isn’t a one-two punch. When you’re unravelling a 10- or 12-year disease, I tell people it takes me about a year for you to understand everything that I’m doing and why we’re doing it. Because when you understand why you’re doing something, they’re more compelled.

Like for example, you live a model life because you understand intellectually everything you’re doing and what it’s actually doing to your cells. We want our patients to catch up where we are and what we study, and they are willing to do it. My patients, they’re all now passionate about regaining and restoring health. I tell people it takes me about a year.

We do a couple of things a little differently. I’ll tell you what we do. Let’s do a couple of scenarios, Dr. Mercola. Let’s say a patient has a lump or bump, let’s say in their breast. Let’s say it’s 2 or 3 centimeters. Before, you used to just go in and do a lumpectomy, as well as doing the thorough investigation. You kind of need to know the pathology because if its estrogen-receptor positive, you need to cut off the estrogen supply. There are lots of natural substances that cut off the supply of estrogen to the breasts. But the pathology guides how you’re going to treat a patient.

[----40:00----]

What I’ve been doing lately for the past six months is I work with an interventional radiologist. She has been doing cryotherapy. Cryo is freezing the cells. This is really, really new. This woman, she will cryo anything. A lot of the studies, if you go and read online, they’re really just on the breast. But I had a patient with a very large grapefruit on her right chest wall, a neural endocrine tumor. She had breast cancer on her left breast and a neuroendocrine tumor.

She's already been treated by all doctors. No doctor said that they could do anything. She came to see me. The neuroendocrine tumor is gone from the cryo procedure. The left is partially gone. She's going to go in and get another cryo procedure now, because I've only been doing this for about I think five months now.

If it's something small that we can approach, I will recommend cryo because surgery is a very intrusive procedure on someone from an emotional standpoint, physical. Neurologically, it's very, very daunting to have surgery.

In some patients, you do everything [to] get rid of the tumor burden because the tumor burden is immunosuppressant. Patients may need chemo. If I have patients who have cancer in multiple locations in the body, I will recommend them to IPT chemo. That's insulin potentiation therapy with chemo. That is using a low-dose chemo after I do the testing, the sensitivity testing with RGCC. It will tell me the ideal agents for these particular patients.

We will make a cocktail. We give insulin. It lowers the blood sugar to a therapeutic moment. We give the chemo drugs. The chemos have insulin-like growth receptor sites on their cells so they're ready to selectively take up the chemo, and then we drop a bag of sugar. We use that.

In combo, I got a machine from France called iTherm. I've been using iTherm machine on some of the cancers. When you get your RGCC testing it tells me do your cells respond to heat shock protein. It will tell me the three different proteins and the sensitivity. On specific cancers – like the breast is out so it's very easy to obtain and treat with the hyperthermia machine.

We trained with the doctor in France who only allows any kind of integrative treatments if you are stage 3 or 4 cancer. He spent a lot of time with us in conference calls, elaborating us on this particular treatment protocol. We've been doing that, I'd say probably also for the last six months. Then I will combine that with mistletoe.

Mistletoe is an immune-modulating natural substance. We combine all those things together. Because the first thing we have to do if we have lots of tumor burden is we've got to take this big problem and shrink it down to a very manageable problem. Then if it's easily accessible with a cryo or a surgical procedure, we will do that. I've had cases where a breast tumor of 9 centimeters with low-dose chemo with hypodermic mistletoe goes down to nothing in one month. In just a pinch, you deal with what you have to deal with.

Now, the SOT procedure that I was explaining earlier is not for masses. It is just to attack the circulating tumor cells, which we recall is what's responsible for 95 percent of metastasis and death.

We just started something new recently. Very, very new, only in the last month, so I don't have any results. I will talk about it because they're doing 60 clinical trials right now with glioblastoma with dendritic cell vaccine. There are multiple trials going on all over everywhere. But right now that's the biggest one, because glioblastoma, as you know, is not a cancer that's easily treatable at all. Those studies are looking very, very good because I'm following them. The scientist that is involved with them I know. I have a little inside look at that.

I'm not talking about vaccines, like hepatitis vaccine and flu vaccine. This is a vaccine made from your cells and don't have adjuvants like aluminum and all the other chemical compounds. It is to instruct your immune system to attack the cancer and its stem cells and hopefully give you immunity. Those are things that are on the horizon. I know a doctor who's already done it a little bit. They're doing it in Europe. They're doing it in multiple places all over the world.

But I think the most important thing is when you get anything. It's like I tell people, "If you're going to do stem cells, don't go into stem cells dirty." Optimize your eating, your detox, all of your hormones, inflammatory nutrient levels. Don't go spend 10,000 or 20,000 dollars on a stem cell procedure in a dirty body. Get your body prepared with whatever you're going to do. My patients for surgery, I prepare them two weeks before they even have a surgical procedure. Don't go have surgery when you don't have good nutrient levels, when you don't have a good immune system, when you have inflammation. Get the body ready. The outcome would be outrageously [inaudible 46:10].

JM: Thank you for outlining many of these advanced strategies that one can do. I just want to emphasize again something that virtually all of us could do is apply strategies from the food choices we're making to help our body burn fat as their primary fuel. Essentially, a modified ketogenic cyclical diet that I describe in my book *Fat for Fuel* in great detail. Even if you're choosing conventional therapy, it's a good strategy.

One of the items that we discussed is actually integrating – If you decide for whatever reason to choose conventional chemotherapy, you can choose a lower dose and fast the day before and the day of, and then eat after the administration of the chemotherapy. It radically reduces not only the side effects, which are quite notoriously severe, but also the effectiveness of the intervention. It's a really simple strategy. This is something everyone can do.

I recently interviewed Dr. Slocum who is a physician in Turkey, in an oncology group. He had basically applied Dr. Seyfried's strategies. Not even some of his newer ones, essentially the diet that we just referred to and some of these insulin-potentiated therapies – IPT, and some glycolytic inhibitors. These were on patients who have not done the strategies that you and I recommend. These were basically stage 4, going-to-die-in-a-few-weeks cancer patients. He was getting like 50 percent remission rates from this, who had done the detoxes and the important other supplementals. I think they have IV vitamin C too and hyperbaric oxygen. It was a stack therapy. The diet by itself will work sometimes, but it won't work at all the times.

Dr. Seyfried is actually advancing this technique, and we're funding some strategies to help on his research on really effective [inaudible 48:11] which is glioblastoma multiforme, the most aggressive metastatic cancer in animals that has been developed so far. We test these strategies and seize other interventions. Groups like Dr. Slocum's in Turkey are actually implementing it. It's pretty good.

With that being said, I just want everyone to take responsibility for their own health, which is choosing the food you're going to eat and the strategies that we discuss in the book. There are

many people who go do that and do all these other advance therapies and do them themselves. You can look it up on the internet.

But the problem is that when you get a diagnosis of cancer [or] someone you love is diagnosed with cancer, time is of the essence. You could be dead in a few weeks, a few months or certainly a few years. Even though you could potentially do it, you typically aren't going to drop everything and start becoming a cancer expert. That's why it's so useful to find people who've been studying this for many, many years with good clinical experience that can help you refine the treatment and accelerate your learning.

You had mentioned in your book that the challenges define these physicians. That's what I want you to discuss now. How would you identify someone who could integrate these types of therapies? It's important to understand, as you mentioned in your book, that you don't have to be there in person because many of these consultations can be done online through Skype or Google Hangouts. Why don't you discuss the strategies if someone is interested in the type of approaches that you've reviewed on how they would identify a clinician that they could work with?

LC: That's a very good question. Another area is Best Answer for Cancer. That is a good organization.

[-----50:00-----]

There's a big one in April in San Diego. They invite the public. You can go and listen to one doctor every hour discuss all different facets of cancer. I encourage patients. Like you said, Dr. Cowden's coming. The public is invited to be a part of this discussion and to learn so they know the things.

You go to and meet the doctor and you see if the doctor knows what effect emotions have, what is the eating, do you know about the circulating tumor cells, do you know about nutrition, do you know about recommendation for detox, do you know about IV vitamin C; these basic things that I bring up in my book that everyone knows I reference everything in the book. I think these are basic tenets, like you're eating.

It's not just for cancer. It's for other medical problems that your book is coming out. It's not just for cancer. It just happens to be a great tool for cancer. But it can be utilized in neurodegenerative and all kinds of other medical problems. But the doctor's got to be well-versed on all those platforms, all those healing platforms.

JM: Yes, indeed. I interviewed Annie Brandt recently, who was the founder of Best Answer for Cancer. On their site, they actually have a Find a Physician. [It's] Best Answer singular, BestAnswerForCancer.org. That's another way that someone could find them. You've done a great job on your book. That's another resource. There are many of them out there. One is not necessarily better than the other. Annie has written a book, *The Healing Platform*. That's the name of her book.

LC: Correct.

JM: That's another good strategy. When you compile a number of different resources, you'll find some overlapping commonalities that can be very useful. If you see it in more than one place, there's a high likelihood that it's going to be consistently valid for your approach and it will resonate with you. I would encourage you to read as many research as you can. This is something that can take you away prematurely, that does every day.

Sixteen-hundred people, close to 1,700 people, are dying every single day in the United States. This is something that will affect you if it hasn't already. We have to have effective strategies. In closing, what would you like to emphasize or perhaps even bring up a point that we haven't discussed yet?

LC: I think probably I'd tell people we can do all these blood testing and we can do all these investigative strategies and treatment strategies, but probably, the single greatest tool that costs no money is getting into the right frame of mind and right state of mind. You become what you think about most of the time. If you become the cancer victim, as opposed to the cancer victor, then your body and your immune system will succumb to that.

I don't necessarily do that the first visit, but at least the second visit. I am addressing there is no more powerful tool that you have than your own mind, changing the way the cells work and directing the DNA daily with your thoughts. You get what you expect. You've got to be in an attitude of gratitude 24/7. We are so blessed in the world today. We have a lot that we can work with. We have information. We have got to work on any unresolved emotional conflicts that we have. There are lots of tools.

They just came out with a study this February 15 at University of Jefferson. They actually now have MRI imaging studies of the brain under stress and the parahippocampus is the area of the brain. They've actually done the studies of a patient being diagnosed with cancer. If they went through a neural and emotional technique, resolve it, the whole parahippocampus [inaudible 54:34]. We now know this is opening new frontiers of how the mind affects our cells.

JM: You've done a magnificent job of putting it in a compilation of resource in your book, *The Cancer Revolution*. It's certainly a great one to pick up if this is a challenge for you personally or someone you love.

Also, again, I encourage you to consider attending the conference in Academy of Comprehensive Integrative Medicine (ACIM), which we'll put a link in this interview, where both Dr. Connealy and I will be presenting, along with Dr. Cowden and many, many other physicians who are going to be presenting strategies that will be useful in this intervention. These are all very high level strategies, clinicians who have been on the forefront in the battle lines for decades, most of them, in really implementing these therapies, getting the feedback, refining the approaches and essentially providing an effective strategy that you can personally use to address your situation.

I look forward to seeing you there in Orlando. Hopefully those of you watching who have an interest in this will also connect. It will be a very enlightening event.

[END]