The Vietnam war looks like a huge success compared to the "war on cancer." And the failure of conventional medical therapy to stem the onslaught of this properly feared disease parallels the failure of the conventional Maginot line to halt the German panzer divisions. Indeed, the documentation of hidden truths disclosed in this newsletter provides the strongest arguments for consideration of unorthodox, guerrilla, alternative military maneuvers against this versatile enemy.

The traditional doctors' litany—"You should have come sooner," "Don't waste time on Laetrile, megavitamins, nutritional therapy, detoxification," "The quacks are trying to rip you off"--rings as hollow as the 1940 French marshal's "Our Line will hold."

Indeed, in recent months, there have been signs that the rigid posturing of cancer orthodoxy is crumbling. The AMA has come out against the ritualistic routine annual exam, and the American Cancer Society, stung by the discovery that mammography can cause breast cancer, now correctly opposes the routine annual chest x-ray. This staid organization also just came out against the sacred routine annual Pap smear. And last year, my own organization, The American Academy of Pediatrics, finally endorsed breastfeeding—a major step in the battle against breast cancer.

Now, these breaks in the wall may be unknown to your doctor. Or, knowing about them, he may be stuck in his habitual behavior. In either case, these 8 pages will provide powerful information to help you turn away from the weaponry that has failed for half a century. This is a necessary first step in the successful conquest of cancer—in our own lifetime.

For more than 100 years, doctors have known that cancer of the cervix hardly ever occurs among nuns. More recent studies have confirmed the link between cervical cancer and the number of men with whom a woman has sexual intercourse. However, modern sexual mores being what they are, it is not fashionable to counsel against promiscuity. And we cannot depend on a marked return to the cloister. Instead, a recent issue of the New England Journal of Medicine reports on a study at a California Kaiser-Permanente Medical Center which shows that the incidence of cervical cancer is much lower in women whose sexual partners have had vasectomies. Of course, while the studies on women are reported, results of long-term studies to determine the ill effects on men of blocking the exit of sperm are not available. A typically modern solution to a typically modern problem.
I have been fond of using a 10-year-old reference, "Presymptomatic Detection and Early Diagnosis," by C. L. Sharp and Harry Keen (Williams and Wilkins) to question the worth of the highly-touted Pap smear. As Sharp and Keen so sharply and keenly point out, "Several studies have shown declining death rates from cancer of the cervix, but since these were evident even before cytologic detection (Pap smear) was commonly in use, there is as yet no conclusive evidence that this type of detection method has played a definite part in reducing mortality... In none of the areas where cervical cytology has been in use for a considerable period has there been a significant fall in the death rate for the condition."

Now, ten years later, two researchers, Dr. Anne-Marie Foltz of New York University and Jennifer L. Kelsey, PhD, an epidemiologist at Yale University School of Medicine, once again have pointed out that it has not been well established that the screening of large numbers of women has any effect on the death rate from cervical cancer. Questioning the current (until 1980) medical practice of yearly Pap smears on all adult women, these researchers state that there is a 20 to 30 per cent incidence of false negatives in performing the Pap test. They point not only to the questionable accuracy of this test, but also to the fact that it became standard recommended policy without ever having been subjected to controlled trials to determine its efficacy.

I commend Drs. Foltz and Kelsey, and I hope that the appearance of more female researchers may lead to better research on females.

In the Fall 1979 issue of Cancer News for Physicians, Francis H. Straus II, M.D., Professor of Pathology at the University of Chicago Pritzker School of Medicine, details the technical problems associated with biopsies. This information is important enough that I quote it at length!

"Once the biopsy sample has been delicately removed from the patient, it [the sample] is not out of danger. It is all too easy to lay the biopsy down on the sterile prep tray and become engrossed in repairing the surgical defect while the tiny tissue morsel desiccates into a hard unrecoverable shadow of its former self. Compressive distortion by repeated picking up between forceps' teeth or squeezing between fingertips should also be discouraged....

"One important but often overlooked aspect of biopsying is the cleanliness and sharpness of the biopsy instrument. Frequently the biopsy tool retains tissue fragments from a previous biopsy which dry on and later are autoclaved with the instrument. Such desiccated particles impair the function of the instrument and can confuse the pathologist when mixed with the current specimen. Many cup forceps biopsies are torn off because the cutting edge of the instrument has been allowed to become blunted from continual use."

I regret that this information is buried in a professional publication. This excellent statement of Dr. Straus might well be distributed to all patients, particularly those who, for any reason, suspect the accuracy of their biopsy report.

Medical x-rays as a cause of cancer

In an article entitled "The Cancer and Leukemia Consequences of Medical X-Rays" (Insight Publishing Co., N.Y., 1975), eminent scientist, John W. Gofman, M.D., PhD, stated, "The use of x-rays is appropriately justified when the threat of the disease to the patient is far greater than the cancer-leukemia risk induced by their use in the diagnosis or treatment of that disease." Gofman, Professor Emeritus, Division of Medical Physics, University of California at Berkeley, pre-
sents evidence that cancer and leukemia induction is related linearly
to the dose of x-rays—the more radiation, the greater the risk.
Furthermore, he points out that young people are more sensitive to x-ray
induced cancer than adults, and he proceeds to give quantitative predic-
tions of the cancer risk, beginning with a consideration of one age
group—25-year-olds. Gofman's statistics lead to the conclusion that,
considering only adults, each year medical and dental diagnostic x-rays
are responsible for 12,000 extra fatal cancers. He wisely recommends,
"There should be a good indication for every x-ray taken if avoidance
of unnecessary cancer fatalities is our goal." In considering the best
technique, Gofman insists that x-ray technicians be taught and retaught
"that errors in procedure are not easily corrected by simply taking
another film. Every such additional film adds to cancer risks. Some
centers have indicated that as many as one extra film per three taken
is commonplace to correct for errors in procedure. This is a regrettable
state of affairs."

The September-October 1979 issue of Journal of the American Cancer Society,
which carries in large letters on its cover the words, "CAUTION: LOW
LEVEL RADIATION," contains an interview with Dr. Arthur C. Upton, Director
of the National Cancer Institute, which I wish every American could read.
In this interview, Dr. Upton points out the risk of x-rays to radiologists,
including a strong association with leukemia and skin cancer and a "mean-
ingful but less striking association" with lymphoma (including multiple
myeloma) and cancer of the brain. Upton shows that x-ray treatment for
arthritis of the spine produces an increased risk of cancer of the
pancreas, leukemia, and other neoplasms, and he emphasizes the danger of
x-rays administered to pregnant women. He states, "Prenatal exposure to
an x-ray examination, involving a dose on the order of one rad, is
associated with a 50 per cent increase in the risk of childhood leukemia."
(One rad is the dose a person receives from one chest x-ray or a dental
x-ray.) Leukemia becomes evident within two to four years of exposure
and reaches a peak within the first 10 years of life. (Perhaps this kind
of information explains the dramatic rise in childhood leukemia over the
past few decades.)

Upton further points out that "Cancer of the thyroid may result
from irradiation of an enlarged thymus in infancy. Other forms of
cancer, including tumors of the brain and kidney, are also possible in
irradiated children. In irradiated adults, there is the possibility of
cancer of the lung, gastrointestinal tract, bone and skin. The tissue
most sensitive to radiation is apparently the female breast. These
are the major human cancers that may result from irradiation."

After making these frightening revelations, Dr. Upton was asked
if we doctors can still use radiation in spite of the Hippocratic oath
to do no harm to our patients. His response was, "If one wishes to be
100 per cent safe, one should not enter the field of medicine." Even
though this caveat appears in a publication meant only for the eyes of
physicians, it seems to me that it applies even more to patients.

A report in the British Medical Journal reveals that children born to
hospital anesthetists are 60 times more likely to suffer from cancer
than are other children. In addition, the incidence of breast cancer
among women anesthetists is 50 times higher than normal. According to
Dr. P. J. Tomlin of Birmingham (England) University, several anesthetics
are capable of causing cancer, and all anesthetics can induce fetal abnormalities. Chronic exposure to such agents can affect the genetic system of both male and female anesthetists in such a way that birth defects can develop in their unborn, and maybe unconceived, children.

Dr. Tomlin reported that problems attributed to repeated exposure to anesthetics ranged from cleft lips and cleft palates to severe neurologic difficulties, bone and muscle disorders, impaired intellectual development, low birth weight, and miscarriages. Thirty per cent of the anesthetists had problems becoming pregnant, and there was "an excess of cancer" among male anesthetists.

Looks like anesthetists and anesthesiologists are exposed to risks from their own tools just as radiologists suffer from their own x-rays.

Is cancer contagious, and if so, how contagious is it? If someone with cancer were to write me a letter while he was still in the hospital, I would fear contamination from the letter and everything it touched (such as contaminated bandages). And if a person with cancer visited me in the home, I'd have the same concerns. Can you answer my questions?--W.C.

The easiest way for me to answer your question would be to chide you for suggesting a notion as ridiculous as cancer being contagious. Yet, your letter prods me into more deeply examining this not uncommon idea, and I can think of a number of reasons why people might have such thoughts. For example, leukemia outbreaks often occur within neighborhoods, medically referred to as "clusters." Breast cancer tends to run in certain families, and is more common in certain population groups, e.g., nuns. Workers in certain factories and industries often develop the same kind of cancers. One certainly might object to labeling the above instances as "contagious," since a variety of other epidemiologic factors are obviously at work. Yet, we often tend to use the word in rather loose fashion--psychiatrists may refer to the contagiousness of mental illness, a condition in which everyone agrees no germs are involved. Cancer patients perhaps acquire a reputation for contagiousness from the particular antibiotic-resistant germs they may pick up in hospitals and then transmit to others in the community.

If you consider the type of cancer and the method of treatment, I predict you will conclude that cancer is not contagious in the usual sense, even though it often appears to strike people close to the victim himself. Once this semantic problem is overcome, you may more easily delve into the various environmental factors that make cancer seem to be contagious.

My 74-year-old sister has an inoperable carcinoma of the right breast and right lung which has metastasized into the right rib cage and lower backbone. She was prescribed an oral chemotherapy medication, Nolvadex 10 mg. (brand name), tamoxifen citrate (generic name). I tried to find out about the medication from our local pharmacist who filled the prescription, but he came up with the standard reply that medications have to have seven years of research before they are put on the market. So why isn't it listed in the 1978 PDR? Neither our local cancer office nor our local social security office have heard of it. The medication costs $73.20 for 100 tablets which will last only 25 days. My sister's social security check is her only income. Please help.--Concerned Nurse

You are indeed correct in stating that these drugs were not listed in any of the standard references, not in the 1978 PDR, not even in the authoritative book published in 1978, "Conquering Cancer," by Lucien Israel, M.D. (Random House, $10). However, Nolvadex (tamoxifen) is listed in the
latest PDR. This non-steroidal anti-estrogen, used for the palliative treatment of certain types of advanced breast cancer in postmenopausal women, carries this unusual statement, "there are no known contraindications to the use of Nolvadex." However, this drug "may produce oncogenic [cancer-producing] activity in animals" and "is teratogenic [produces congenital deformities] in rats and rabbits with evidence of skeletal abnormalities."

Changes in the eyes (retinal, corneal, visual acuity) have been reported in some patients treated with unusually high doses for over a year, and high levels of blood calcium, as well as other adverse effects, have been described.

Should your doctor select any other new drug not listed in the standard references, ask him to get for you all the data directly from the manufacturer, since without full information, no one is in a position to give informed consent.

(From an article in The Lancet, March 15, 1980, entitled "Failure of Chemotherapy to Prolong Survival in a Group of Patients with Metastatic Breast Cancer."

"Overall survival of patients with primary breast cancer has not improved in the past 10 years, despite increasing use of multiple-drug chemotherapy for treatment of metastases. Furthermore, there has been no improvement in survival from first metastasis, and survival may even have been shortened in some patients given chemotherapy...Actuarial survival analysis...reveals no prolongation in overall survival, despite the increased use of multiple-drug chemotherapy for metastatic disease....The survival of the 78 patients who received chemotherapy from first detection of metastases (including single-agent chemotherapy) was no better than that of the 80 who did not receive chemotherapy. There was also no improvement in survival for those who received multiple-drug chemotherapy (66 patients)....The fact that regressions of breast cancer had no influence on overall survival must reflect the inadequacy of present-day chemotherapy."

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**Interferon**

Much fanfare has heralded the latest new cancer drug—Interferon. Although I would dearly love to be as wildly enthusiastic about Interferon as everyone else seems to be, commonsense (and the almost total lack of solid medical information) dictates that someone "interfere" with the hoopla surrounding this drug.

What do we know so far? First, we know it is very expensive. Second, we know it is hard to get. Third, we know that some drug companies have placed it in a top-priority production position. Fourth, we know that it seems to work in some cases. We also know that it has some side effects which already have been identified. Fifth and last, from the phone calls and mail I am receiving, we know that lots of people have heard about it. Therefore, I venture the following predictions:

1) Interferon soon will become available to patients and physicians outside the giant cancer centers.

2) It will be used as quickly as possible (as are all new drugs) before the side effects become known.

3) Interferon researchers will point out the advantages of this new drug over surgery, radiation and chemotherapy.
4) Serious, sometimes fatal, side effects eventually will be identified, and Interferon finally will end up in the pages of cancer treatment history, just as its successor (which will have a similar Madison Avenue name) appears on the scene.

So, for all of you sufferers from everything from the common cold to cancer (the indications for Interferon qualify it as the ultimate panacea of the 20th century), I recommend that you do not trust your doctor's verbal assurances about the safety of this insufficiently-tested powerful drug. If he wants you to take it, even experimentally, insist that he provide you with some of the scientific references for you to read. If you cannot easily understand the medical jargon, ask your own family doctor for help. A family physician is more likely to adopt a conservative, safe attitude than is the enthusiastic oncology [tumor] specialist who is eager to find any ray of hope within an area marked by depression and pessimism.

While some scientists are enthusiastically beating the drum for Interferon, others are more restrained. However, neither group is telling the whole truth about this anti-viral, anti-cancer drug--namely that it can cause cancer.

Searle Laboratories' news release dated March 1980 describes at least four types of Interferon--leukocyte, lymphoblastoid, fibroblast, and immune. After stating that fibroblast Interferon is the type which Searle is producing, the release continues, "Lymphoblastoid Interferon is produced from cells derived from human lymphoblasts. These cells contain a potentially oncogenic [Greek for cancer-producing] virus. If not removed, these may be transmitted to the patient during the treatment."

This statement in and of itself might have passed with little comment from me were it not for the American Red Cross's "Your Health," Winter 1980 (page 12). This publication states "...the National Cancer Institute will support the production of a like number of units of lymphoblast and fibroblast Interferons. Thus far, patient treatment with lymphoblast and fibroblast Interferons has been on a much smaller scale than leukocyte."

The Searle promotional material lists the advantages of fibroblast Interferon, including "it does not cause cancers in test animals." This also might have passed without comment from me were it not for Searle's recent history of fudging on animal experimentation test results, particularly in regard to tumor production. FDA investigations of Searle's questionable research practices on Flagyl, Aldactone and Aldactazide were turned over to the Justice Department.

Searle has entered into an agreement with Mochida, a Japanese manufacturer, in which, among other conditions, Mochida agrees to, "If requested, manufacture fibroblast AND LYMPHOBLASTOID [emphasis mine] on behalf of Searle." Searle's fact sheet reassures us that "Lymphoblastoid cells contain an oncogenic virus, thus limiting the use of Interferon derived from them." Notice that the word "preclude" is not used--only the word "limiting."

If you are a candidate for Interferon therapy, it seems to me it would be wise to ask your doctor a few questions before rushing into "treatment":

1) Have you carefully read the Searle press kit?
2) Just what kind of Interferon am I getting?
3) Are you satisfied that Searle's testing techniques for Interferon are any better than those they used when testing other drugs just a few years ago?

And, after your doctor gives you the answers to these questions, consider the answers in the light of a recent statement made by the officers and directors of the American Society of Clinical Oncology:
"There is no evidence or even remote suggestion yet to indicate Interferon may cure advanced cancer, and no 'acceptable evidence' that it can extend patients' lives regardless of the type or stage of cancer they have."

"Preventing" cancer

The field of preventive medicine has taken a bizarre turn. A report from the prestigious Beth Israel Hospital in Boston, appearing in the equally prestigious New England Journal of Medicine, described one single family with an unusually high frequency of cancer of the kidney. Geneticists who studied this family found a defect in some of their chromosomes which they claim is responsible for the tumors. On this basis, the researchers state that amniocentesis (the drawing of fluid from membranes surrounding the fetus within the mother's uterus) will enable them to determine before birth whether future family members will be predisposed to having kidney cancer. While they admit that inheritance of this kind of cancer is rare and thus far only one affected family has been discovered, the doctors hypothesize that someday similar techniques will enable them to find the seeds of other kinds of cancer in the unborn. Thus, once these "tainted" babies are identified, abortion can be carried out.

I am particularly interested in this latest method of cancer prevention since my own university medical appointment is as Associate Professor of Preventive Medicine. I began to become somewhat concerned years ago when geneticists began practicing preventive medicine by identifying and aborting infants presumably affected with mongolism and Tay-Sachs disease, since mistakes occurred frequently enough so that normal babies were also destroyed.

I became even more concerned when some cancer surgeons proposed preventing breast cancer by performing bilateral mastectomies on healthy young women whose families had a history of breast cancer. And my alarm level became even higher recently when prestigious medical centers around the country began to abort fetuses of the "wrong" sex. Now, this latest macabre achievement, aborting fetuses who may someday develop cancer, makes me suspect that the field of preventive medicine is now becoming one of the most dangerous specialties of modern medicine. As a matter of fact, the term "preventive medicine" is rapidly becoming a codeword for abortion. I used to think it was a good idea to tell your doctor as much as possible about your family history. But now, I'm not so sure.

Dr. Mendelsohn's new book, "Confessions of a Medical Heretic" (Contemporary Books, $9.95) is now available at bookstores throughout the country.

Your questions about the medical problems that trouble you most will be answered by Dr. Mendelsohn. Please send your questions to: The People's Doctor, P.O. Box 982, Evanston, Illinois 60204

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Caring for a seriously ill person at home can be an exhausting, worrisome, and occasionally frightening experience. When my friend, Mary Fran, learned her mother was dying, she was aware of these things but she still elected to bring her mother home where she could be cared for in familiar surroundings by people who loved her. Yet within weeks, Mary Fran began suffering from severe pains in her jaw. It seems she was clenching her teeth most of the day.

Many of the difficulties with home care, I believe, would be greatly alleviated with the right kind of support system. My model for this is found in the book, "A Death with Dignity--When the Chinese Came" (Random House, 1975). Written by Lois Wheeler Snow, it described the last illness of her husband, Edgar Snow, famed journalist and authority on China. Snow suffered from cancer of the pancreas, and while no one mentioned until later that it probably was too late for surgery to be of any benefit, he was operated on. He spent an initial period of time in the hospital during which both the Snows experienced many of the familiar frustrations of hospital care. There was the nurse who dealt with Snow's cries as though he were a naughty child: "Mr. Snow, behave yourself!"

And there was the surgeon who could allocate only as much time to answer Mrs. Snow's questions as it took him to walk from the patient's hospital room to the elevator. One day, that surgeon exploded in irritation as he cried, "Madam, if I gave everybody in the hospital as much time as I give you, I would have no time for anybody."

Worried and wondering what to do next, Mrs. Snow wrote to physician friends in New York, Paris, London and Peking seeking their advice. To her great surprise, the Chinese government responded by sending a team of six doctors and nurses to help their friend. While they originally had planned to take the Snows back to Peking with them, the members of the medical team saw that Snow was too ill to travel, so they set about arranging for him to be cared for entirely at home.

"From that point on," said Lois Snow, "I was never alone or afraid." The medical team, the patient, and the patient's family worked and consulted together on every step of the integrated treatment from diet, to the relief of pain, to the eventual confrontation of death and bereavement. There were no agonizing periods to be endured while a helpless nurse, dependent on an absent doctor or supervisor to change instructions, held back an urgently needed analgesic until a precisely scheduled hour. Dividing the days into two shifts, there always were team members in the house, yet they made their presence as unobtrusive as possible. Nails were put into ceiling beams so that intravenous drip attachments could be hung from spots above the day bed or over the couch where Snow liked to be when he felt like getting out of bed. Care was based on the needs of the patient and was aimed at helping him to maintain a dignified way of life and death.

How about some brainstorming on how we might adapt this system for us!