the People's Doctor
A MEDICAL NEWSLETTER FOR CONSUMERS by Robert S. Mendelsohn, MD

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IN THIS ISSUE:

# Colon Cancer (and President Reagan) . . . Warnings on Hyperthermic Cancer Treatment

**Dr. Robert Mendelsohn**

As this Newsletter goes to press, we continue to receive news about Presidential cancers--this time, skin cancers. One skin cancer has been removed from President Reagan's nose, while another has been removed from behind the ear of former President Nixon. In both cases, we as individuals can learn some valuable lessons.

First, the dermatologists are trying to tell us that President Reagan's skin cancer is "unrelated" to his colon cancer (Detroit Free Press, August 6, 1985). Yet, Dr. Thomas Nigra, chairman of the dermatology department at Detroit's Washington Hospital Center, points out that one in seven patients who have a skin cancer removed develop another somewhere else on the body within 18 months. Furthermore, the President's remarks suggest that there was indeed a relationship between his colon cancer and his skin cancer. During the colon surgery, a naso-gastric tube was inserted through his nose to drain his stomach. (Was the President told about the pioneering work of surgeon Gerald Moss, professor of biomedical engineering at Troy, New York's Rensselaer Polytechnic Institute, who, instead of using the ordinary naso-gastric tube, has devised a tube which is inserted through the abdomen into the stomach? This method, now 20 years old, also is being used by surgeons in other parts of the country. It permits such post-surgical patients as gall-bladder cases to go home the day after surgery and to begin eating right away. Johns Hopkins Hospital now is applying to the National Institutes of Health for a grant to study the standard naso-gastric tube versus the Moss tube versus no tube at all.) The tube was held in place by adhesive tape placed over his nose. The President is allergic to adhesive tape, and so this caused an inflammation of a pimple with which he "had been bothered for some time." Maybe there was no relationship, but again, maybe there was.

The second lesson has to do with the honesty of doctors. White House physician T. Burton Smith told reporters that a biopsy was not performed on the tissue removed from President Reagan's nose. Several days later, both the President and the public learned that a biopsy indeed had been performed, and basal cell carcinoma was revealed.

The third lesson is about the reliability of skin cancer statistics. The doctors assure us that President Reagan's basal cell carcinoma is common (some 300,000 cases a year) and curable (more than 95 percent can be cured with the first treatment). Yet the Free Press informs us that basal cell carcinoma is "usually omitted from annual reports of cancer cases and deaths in the United States." That being the case, how reliable are these skin cancer statistics, either of incidence or of deaths?

Analogous to the "begats" in President Reagan's case (his colon polyp begat surgery which begat the feeding tube which begat the adhesive tape which begat the inflamed pimple which begat his nasal surgery) are the begats in President Nixon's case. Nixon has been receiving coumadin, a blood thinner used in the treatment of his phlebitis. Because coumadin could cause hemorrhage, removal of Nixon's basal cell carcinoma required cessation of this drug. But, when the doctors resumed coumadin, the surgical site began to bleed. Nixon's doctor "swathed Nixon's head in bandages..." and persuaded him not to go to Washington for a dinner in his honor.

The lesson we can learn from both these Presidential encounters is how complications can arise from even the most "simple" surgeries and from the most common medical procedures.

*President's colon treatment raises questions*

Last March, when President Reagan's stool examination on routine exam was discovered to be positive for blood, I criticized his doctors for failing to put him on the proper diet before giving him that test because there are many foods which can confound the tests, yielding misleading false-positive results. I warned against the danger of a falsely positive stool test leading to medical interventions such as proctoscopy, sigmoidoscopy and colonoscopy. These procedures, designed to explore the large bowel and rectum through the use of tubes carry a number of risks, including hemorrhage, infection and perforation of the bowel. At that time, I telephoned my good friend Edward Pinckney, M.D. who promptly sent the President a copy of his excellent book, "The Patient's Guide to Medical Testing."

The President's doctor did repeat the stool exam, this time after placing him on the necessary dietary restrictions, and sure enough, the stool blood test came back negative.

When the President decided to undergo colonoscopy to further explore the inside of his bowel and to snip off polyps (polypectomy), I had the opportunity to discuss the matter on radio and television. I raised some of the following questions, and I am adding additional ones for you to think about.

Why didn't the President's doctors place him on the right diet to begin with, thus avoiding the anxiety of an uncertain test result?

Why didn't the doctors, knowing about the polyp all those months ago, insist on immediate removal? Conversely, since the doctors admit that the large polyp that was finally removed had probably been there for years or even decades, why did they feel it necessary to remove it at all--and why now?

Since the President was given "painkillers and sedatives" before his colonoscopy, was he informed in advance of the adverse effects of these drugs? And, was he informed of the above-listed complications of that procedure?

Was the President informed that polypectomy and resection of the bowel, although time-honored surgical procedures, have never been subjected to controlled scientific study? That is, no-one has ever taken a group of candidates for this kind of operation, performed the procedure on half of them, left the other half alone, and then compared the results. In the absence of such a study, these operations remain unproven remedies, i.e., doctors don't really know for sure whether the operations save lives, increase your chance of dying or leave things pretty much the same. In other words, the only proven features of this kind of surgery are their complications. Was the President told that he faced operations of unproven effectiveness but of proven risks?

When doctors claim that bowel cancers begin as benign polyps which then turn malignant, do they tell patients of the considerable body of medical opinion stating that no-one knows for sure whether malignancy begins in the pre-existing polyp or in a perfectly normal segment of the intestine? In other words, the argument about progression from benign changes to malignancy in colon cancer has just as many chinks as the gynecologist's arguments that dysplasia of the cervix can turn into cervical cancer. The entire concept of "pre-cancerous changes" is just as controversial today as it has been for the past 50 years.

Since no controlled studies have been done, why don't doctors at least study the natural course of colon (and other) cancer in patients who reject modern cancer treatment? There are many thousands of such patients who have rejected modern cancer treatment in whole or in part. Cancer specialists have set up plenty of registries for patients who accept treatment. Isn't it time that they set up a registry for patients who reject their treatment so that we could have told the President knowledgeably, on the basis of evidence, what his chances were without treatment? In other words, today's doctors have no idea about the natural

course of colon cancer. They did not know whether the President's large polyp might grow even larger if it had not been removed, might stay the same, or might shrink into insignificance or even disappear. Nor did they know whether their surgical treatment reduced or increased or will not affect the chance of spread (metastasis).

When the President received pre-operative antibiotics at 5 o'clock the morning of surgery, was he told of the many scientific articles condemning this practice on the grounds that this kind of "preventive medicine" has never been shown to decrease the rate of subsequent infection and therefore needlessly exposes patients to the adverse effects of antibiotics?

The confusion surrounding the President's colon surgery existed right within the illustrious pages of the July 14, 1985 New York Times. White House spokesman Larry Speakes was asked, "Will they examine his [the President's] liver and his lymph nodes and other organs [during the operation]?" Speakes responded, "No. In their judgment, the CAT scan is conclusive in those areas..."

But in an adjoining article on the same page, reporter Lawrence Altman told us that the surgeons "looked at and felt lymph nodes in the area... The care doctors took in palpating, or feeling carefully with fingers, was one of several reasons why the surgery took as long as it did." Speakes also was asked "So this is not really exploratory surgery in any sense of the word," and he answered, "That's right...it's a surgery to remove a portion of the large intestine and to remove the large polyp that's there." Yet on the same page, Altman explained that the procedures which the surgeons performed are known technically as a right hemi-colectomy, the removal of all the ascending colon and about half the transverse colon, and an "exploratory laparotomy," in which surgeons look at the entire length of the intestines as well as the liver, spleen, etc.

How easily can one distinguish microscopically between a malignant and non-malignant tumor? Altman told us that "...the difference between some types of benign villous adenomas and a cancerous villous adenoma can be subtle."

Since the top leadership of Bethesda Naval Medical Center had been riddled by accusations of malpractice and negligence, the President was no safer in that hospital than in any civilian hospital. Therefore, I felt quite relieved that he was released at the earliest possible moment.

For every reader over the age of 40--or who expects to be over the age of 40--the President's tumor has important implications. I predict that tremendous pressures will be exerted to convince the 30,000,000 Americans (10 percent of the population) estimated to have intestinal polyps to immediately run to their doctors' offices for stool blood tests, colonoscopies, and, if necessary, surgery--and maybe even radiation and chemotherapy. Even if the first visit results in a clean bill of health, people will be pressured to have repeated follow-up examinations "just to be on the safe side." Keep this Newsletter with you if you decide to make that trip to the doctor's office.

Before you decide that the treatment given our present President must be the best there is, look back not too many years at the cancer treatments given to previous presidential and vice-presidential families. Both Happy Rockefeller and Betty Ford received the now largely discredited radical mastectomy for their breast cancers. Radical mastectomy was abandoned because both patients and doctors finally started to ask the right questions about that mutilating procedure. The right answers, including the much smaller operation of lumpectomy, resulted.

Make sure that, when it comes to colon cancer, you ask the right questions of your own doctor. Encourage him to ask questions of researchers and scientists. Perhaps all these legitimate questions can convert our present treatment of colon cancer based on guesswork to rational treatment based on evidence.

Q

I am a 40-year-old female who has had a life-long intestinal problem. I have severe intestinal spasms which occasionally block the passage of gas and fecal matter, thus causing severe bloating and pain. When I have these attacks, eating worsens the condition, so I have difficulty maintaining a suitable weight.

I have had more x-rays and barium enemas than you can shake a stick at. I've also had three proctoscopic exams which, like the x-rays and enemas, revealed nothing. I have been given prescriptions for such drugs as Triavil, Bentyl, Librax, and Combid, none of which I am taking now.

Six years ago, I had severe intestinal bleeding and was admitted to a hospital for more tests, one of which used a colonoscope. A polyp was removed, and a biopsy was performed. The doctors said I had a carcinoid which is possibly a forerunner to cancer. I thus became a high cancer risk, and not a year goes by without a doctor's office calling to see whether I have had an annual exam. During these six years, I have submitted to a proctoscopy and a colonoscopy, with no findings of disease.

Until now, I have blindly accepted all the doctors' recommendations for tests. Now, I'm beginning to wonder, especially since my current doctor is pressuring me to have another colonoscope at once (the last one was done two and-a-half years ago). I'm concerned about the forms I have to sign to release the doctor from liability if he should happen to perforate my intestine during the exam, and I'm concerned about the effect of all those x-rays. Frankly, I wonder whether all this is necessary.

What is your opinion?--V.O.

A

*Risks of testing for colon cancer*

I'm glad your eyes have been opened. It is dangerous to blindly accept all doctors' recommendations since, in their zeal to ferret out cancer, some doctors run the risk of testing the patient to death.

Challenge your doctor by first asking him to refer you to the articles and books that he claims will bear out his statistics. When he scares you about a 30 to 35 percent chance of survival with colon cancer, ask him about the evidence that symptomless patients with cancer of the large bowel have better than an 85 percent five-year survival rate. Second, ask him to quantitatively measure all the x-rays he has exposed you to so that you can find out whether or not they are in the cancer-producing range. And third, ask him why he has not told you about the importance of dietary change (low fats, high fiber) in decreasing the incidence of colon cancer.

Doctors claim that many people suffer from cancerphobia. While this may or may not be true, there is no question that doctors share a similar phobia, one which might be called "far of missing cancer." Since the danger of this phobia of doctors is manifesting itself frequently, patients must take this factor into consideration in deciding whether they should accept or reject a doctor's advice.

Q

As a longtime victim of ulcerative colitis, I have learned to be a suspicious patient. However, I do not know how to evaluate the tests I am told I need. Doctors have repeatedly "advised" me (in raised voices) to have a lower G.I. series and a colonoscopy whenever I have a flare-up of the disease (about once every three years), as well as annually when there is no flare-up. I am told there is a one-in-four chance I will develop cancer of the colon due to repeated irritation caused by attacks of colitis.

While this statistic may be correct, what about the effect of invasive tests? I had these tests when the disease was diagnosed 10 years ago, and I found the prep and tests to be extremely upsetting, both physically and emotionally. Since I tend to have attacks when I am under stress, these procedures might guarantee I'll get cancer by assuring I'll have at least one serious flare-up each year.

What are the risks of taking these tests?--R.B.

A While you probably know the risks from the many x-rays required for a lower G.I. series, have those doctors who are pressuring you to have colonoscopies informed you of the risks associated with that method of investigating the large bowel?

Colonoscopy requires passage of a flexible tube through the rectum all the way up to the beginning of the large bowel at its junction with the end of the small bowel. In preparation for this examination, patients must restrict their diet for the preceding three days, and an enema may be required several hours before the procedure.

Pre-medication with a sedative (which carries its own set of risks) is given intravenously just before the examination. While the patient lies on his left side with knees drawn up to the abdomen, the colonoscope is thoroughly greased and inserted with pressure through the anus into the rectum. Air is introduced through the instrument in order to distend the bowel so that the physician can take a better look. As the colonoscope is passed further into the bowel, most patients may experience some cramping abdominal pain as well as a feeling of fullness when the air is pumped in, even with local anesthesia. If there is marked discomfort, the patient should ask the physician for more sedation.

Since the patient may feel dizzy and disoriented when the procedure is completed, he should remain lying flat and should keep his head lowered until he feels re-oriented. Then, he should slowly stand up. If he still feels dizzy or unstable, he should lower his head immediately. Colonoscopy may take up to two hours.

In addition to the discomfort, there is always the risk of damage. Even though it is flexible, the colonoscope can be accidentally pushed through the wall of the digestive tract. The risk of perforation is increased when the colon wall is diseased or has become thin with inflammation, as in the case of ulcerative colitis.

According to a 1985 abstract published in Gastrointestinal Endoscopy, and cited in AMA News, August 2, 1985, the complication rate of diagnostic colonoscopy and colonoscopic polypectomy (removal of the polyp through a flexible tube) was 2.7 percent, including hemorrhage, perforation, cardiac arrhythmia, fainting, and "other major and minor conditions." In the 6,614 cases surveyed, there was one post-surgical death from a polypectomy-related perforation.

If the doctor wishes to take a biopsy specimen, there is a chance of digging too deeply into the wall of the bowel, resulting in perforation. The more appliances (biopsy cups, brushes, crushing clamps) that are attached to--or manipulated through--an endoscope, the greater the risks. Bleeding also may occur, and there is a possibility of infection because of the difficulty in sterilizing all endoscopes, colonoscopes included. Not only can infections be passed from one patient to another via these instruments, but bacteria are apt to multiply on endoscopes (this includes all tubes inserted into body passages) even when they are not in use.

If you want complete information on the risks of colonoscopy, read "The Patient's Guide to Medical Tests" by Cathey Pinckney and Edward R. Pinckney, M.D. (Facts on File Publications, New York, $7.95) and "A Patient's Guide to Medical Testing," by Marion Laffey Fox, R.N., and Truman G. Schnabel, M.D. (The Charles Press, Bowie, Maryland).

With the explosion of medical testing, patients run a risk of damage from examinations which is rapidly beginning to rival the risk they face from treatment. Therefore, reference books such as these (which give the dangers of hundreds of medical examinations) are just as important to include in your library as is the Physicians' Desk Reference.

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*Are newer cancer treatments better than old?*

While much of today's cancer therapy remains unproven (i.e., has never been subjected to controlled scientific study), every once in a while a sound study does appear. The New England Journal of Medicine of March 22,

1984 reported on a randomized trial (in which patients were not given a choice whether they would be assigned to the group that received treatment or to the control group) on patients with cancer of the colon. A large group of doctors and hospitals participated in the study in which 621 patients with carcinoma of the colon were randomly assigned to one of four treatment groups. Some patients were treated with two kinds of cancer chemotherapy, some with immunotherapy, and some with a combination of both; some received none of these treatments. After five and-a-half years of follow-up, there was no difference between either the recurrence rate or the survival rate among the four treatment programs; however, leukemia developed in seven of the patients who had received the cancer chemotherapeutic agents.

As a result of this study, the investigators conclude that the use of certain chemotherapeutic drugs or certain forms of immunotherapy, either alone or in combination, cannot be justified in patients who have a high risk for recurrence of their colon cancer. The researchers further point out that the only reason they were able to demonstrate the ineffectiveness of these treatments was because they had included a "prospectively (in advance) selected" nontreated control group.

This fact is important because many doctors tend to tell patients that, 50 years ago, everyone with certain kinds of cancer would die, but many people now survive those same cancers as a result of up-to-date treatment. Thus, such doctors attempt to use history rather than science in order to sell patients on their treatments. The investigators in this NEJM report emphasize that, if a historical population had been chosen to serve as a "control" group for the patients who were given chemotherapy or immunotherapy or both, a serious error would have occurred. The investigators then would have concluded that both chemotherapy and immunotherapy would be effective against colon cancer. Of course, such an erroneous conclusion "would most likely have altered the standard of medical practice and fostered the widespread use of inactive treatment in enormous numbers of patients. This would have been particularly unfortunate in light of the six cases of leukemia that had developed among the patients given chemotherapy." The investigators properly conclude that "historical controls" are inadequate. This crucial principle of science--taught to me 35 years ago in medical school and I hope still being taught to every medical student today--should be posted in every doctor's office.

What do we learn from this?

1) If you or anyone close to you is diagnosed as having cancer of the colon and is told to have either chemotherapy or immunotherapy, you now have plenty of questions to ask your doctor.

2) If you or anyone you know develops any form of cancer for which your doctor recommends any form of treatment, you must ask him one question in which you use the magic words: "Doctor, can you show me scientific studies in which patients were subjected to a prospectively randomized trial including an untreated control group to justify your advice?"

I predict that you--and perhaps even your doctor--are going to be surprised at how much of modern cancer therapy is guesswork and how little is science.

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Maybe those of you who live in small towns are a little suspicious of those big city-slicker cancer hospitals where you are told that the new cancer treatments are better than the old ones.

Well, one small-town doctor has rendered a dissenting opinion. As reported in the Antigo (Wisconsin) Daily Journal (April 10, 1985), Wausau oncologist Dr. David Jenkins spoke at a meeting in Antigo (which has the highest incidence of colon cancer per capita of any place in the world!) and reported, "New treatments are not necessarily better than old methods."

Perhaps those of you cancer patients who have received glowing reports of new therapies from places like Houston and New York and San Francisco might want to seek out a second opinion in the Antigos and Wausaus of our country.

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*Old cancer therapy comes back*

Every once in a while, an old medical treatment comes back in style. This phenomenon usually occurs when people begin to lose confidence in present treatment.

Take psychiatry, for example. The antidepressant lithium was used decades ago and was almost totally abandoned when Thorazine and other recent psychotropic drugs came along. At first, Thorazine had all the characteristics of a miracle drug. But, as time went on, its darker side (including the most dangerous adverse reaction in medicine--sudden death) became more and more obvious. As enthusiasm justifiably waned for the new psychotropics, psychiatrists hauled out lithium again, apparently hoping that both people and doctors had short memories. Now the same thing is happening with cancer treatment.

Hyperthermia--applying intense heat to patients with cancer--is an old treatment which never has been proven to be effective but which has caused plenty of deaths. When radiation, chemotherapy and surgery came along, hyperthermia was put on the back burner (if you'll pardon the pun). Now that surgery, radiation and chemotherapy have been around for quite a few decades, the ineffectiveness and toxicity of these stylish treatments is becoming more obvious to both doctors and patients.

So it's time to trot out hyperthermia again. Therefore, since this Newsletter is designed to serve as an early warning system, watch out for those doctors who are enthusiastic about heating up your cancer (or your relative's cancer) and your body. Ask your doctor what effect his new heat machine has on the noncancerous parts of the body. If he is honest, he will tell you that "additional studies are needed to determine what the toxic effect may be on normal cells" (Executive Health Report, June, 1985).

If your doctor tells you hyperthermia is safe, ask him about the 10 to 12 percent of patients who experience burns as well as the others who show an increase in heart rate and blood pressure, lightheadedness, breathing difficulties, flushing, profuse perspiration, fatigue, nausea, diarrhea and loss of appetite.

If he tells you that there are plenty of studies supporting the use of hyperthermia together with radiation, remind him that Carlos Perez, M.D., head of the Division of Radiation Oncology, Washington University School of Medicine, St. Louis, and one of the advocates for hyperthermia admits: "Most of the studies, however, have been nonrandomized--patients were not randomly selected for treatment."

Doctors will recognize that a nonrandomized study is next to worthless in medicine. The gold standard--indeed, the only standard--for proving a treatment effective and safe is a randomized controlled study.

So if your doctor recommends heating up to get rid of cancer, ask him whether a controlled study has ever been done on patients with that particular kind of cancer. Has he or any other doctor ever taken such patients, treated half of them with hyperthermia, left the other half cool, and then compared the results?

At the very least, this kind of questioning will lead to a heated discussion between you and your doctor.

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# Another View

by Marian Tompson

Last year the New England Journal of Medicine published the report of a five-year randomized double-blind study of people with colon cancer, comparing those who had been treated with surgery and chemotherapy to those who had only surgery. The results not only showed no evidence that the chemotherapy was effective, it also revealed that five percent of those treated with chemotherapy developed an additional cancer--leukemia.

Chemotherapy, a stepchild of the chemical weapons and biological warfare developed during World War II and the Korean War, has annual gross sales of one billion dollars worldwide. It has been used on many people, even though there is little solid research evidence of its value. The treatment is expensive and, while in some instances it may extend life for a few months, many people suffer severely from toxic side effects while undergoing treatment.

In New York City, Emanuel Revici, M.D., scientific director of the Institute of Applied Biology, has developed a method of treatment applicable to many pathologic conditions, including cancer. He uses non-toxic therapeutic agents which not only are non-invasive and safer than current standard chemotherapies, but which also appear to be more effective. Patients have never been charged for the medications, and no one has ever been denied treatment because of an inability to pay the standard fee per visit.

Dr. Revici has observed that, in nearly every aspect of health and disease, there are two opposing actions in nature which he terms "anabolic" and "catabolic." Good health results from a daily rhythmic fluctuation from one process to the other. In sickness, particularly chronic degenerative disease, there is always a predominance of one of these activities. Dr. Revici found a similar dualism in the pharmacological activity of different therapeutic agents. Subsequently, he developed an approach which uses the inbalance induced by medication to correct an opposite imbalance present in the disease. Grounded on a highly individualized form of treatment, the substances and dosages are chosen specifically for each patient and are even changed for that patient from one day to the next if analyses reveal a change in imbalance. Patients are encouraged to enhance the treatment by eating appropriate foods, as the nutrients act synergistically with the treatment.

In 1965, Dr. Revici asked Professor Maisin, considered among the foremost cancer experts in the world, to evaluate his treatment of a group of advanced cancer patients. Dr. Maisin wrote, "The result is so good that I can hardly believe it." About the same time, in the 1970's, medication sent by Revici to the Roswell Park Memorial Cancer Center animal laboratory elicited a letter from its director, Gerald Murphy, who stated that the medication had produced encouraging results. During the past three years, Revici's methods of cancer control have undergone numerous tests in Italy, with impressive results.

But in December, 1983, Dr. Revici, then 87 years old, had his medical license suspended, before any hearings were held, on charges which included claiming to cure cancer and keeping sloppy records. All the charges were disputed by Revici's patients and supporters. His license to practice has been temporarily restored, pending the verdict of the hearings which were attended by many patients who had been written off as dead years before by other doctors. Although two physicians did testify in Dr. Revici's behalf, other doctors feared exposure to what was described as a "kangaroo court" which would make them the next targets in what they feel is a conspiracy served by governmental agencies. "If they are correct," one supporter remarked, "then it is a conspiracy not only against non-conforming doctors but against the American people who suffer 444,000 deaths a year from cancer."

More information on Revici's work is contained in an insert entitled "Emanuel Revici: Evolution of Genius" in the Spring 1985 issue of Impact, a publication of Project Cure, 2020 K St., N.W., Suite 350, Washington, DC 20069.

Contributions to help cover legal fees can be sent to Samuel Abady, Esq., 535 5th Avenue, New York, NY 10017. Checks should be made out to Emanuel Revici, M.D., Legal Defense Fund.

With cancer touching all of our lives in some way, can we afford to overlook any clues to treatment that might work?

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