

CENTER FOR MIND-BODY MEDICINE
COMPREHENSIVE CANCER CARE 2000

KEYNOTE/PLENART: Cancer Wars: Messages from the Front

PRESENTER: Nicholas Gonzalez, MD

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P R O C E E D I N G S

DR. GORDON: In several sessions, there have been issues of people wanting more specific advice. How much do I take of this substance? How much do I take of that? How do I use them together?

And, in some instances, I know you've gotten answers and, in some instances, I know some of the speakers have said, we don't know exactly, yet. We don't know exactly how good this substance or this combination is, we just haven't done the studies. This is what we know so far and I know that's been frustrating for some of you.

I think, at some level, it's a frustration we all share, that the state of the science is what it is. In some cases, it's pretty low-level. In some cases, it's significantly better. And we're presenting what's there.

We also realize that many of you want more specific guidelines and not only guidelines of a little bit about one subject here, and a little bit about another subject there. At the risk of, I suppose, hopefully, healthy self-promotion, I really would like to recommend this book. Most of the money for this book, whatever we get goes back into this work anyway, so you're supporting this work.

This book represents our distillation of the best of the first two cancer conferences, this Comprehensive Cancer Care book. There are, based on the best available science, recommendations for exactly which supplements to take, what kind of herbal remedies we know something about, what kinds we don't know something about; what kinds of mind-body approaches have studied, how they work, how group support feeds into this whole work; how Chinese herbs can be helpful; acupuncture.

The studies are in here, the recommendations are in here and then, also discussions of other therapies for which there is some evidence but not as much as we would like. And I think we're pretty frank in saying here what the state of the evidence is as best we, and all the people who've come here, all the commentators, all the presenters, have been able to help us do it.

So really, if you want specific recommendations, please read this. We will be updating it periodically and we will present them in as best form we possibly can.

We'll also have all the presentations on the Web site, within a few months, hopefully; have transcripts of them, they're all available free to everybody. So if you want -- and the first two years' transcripts are available free on the Web site. Transcripts of Year One and summaries of Year Two. And This year, we'll have transcripts of this year. It's all up there.

So, please, look at those and where you see gaps, where you see things that you would like us to do next year, please let us know. And we are planning a very specific tract. We tried to work on tracts and I don't know that we've all succeeded completely but we're going to have specific tracts for patients presenting the kinds of recommendations we do have here in this book and others that will be as up-to-date as we can make them, so that you can come and just go to those tracts, if that's your interest.

I also know that we're going to offer much more mind-body experience, next year, for people, and do it in a very organized way, so it'll be available to everyone. And we'll keep on evolving, and it's your comments that are helping us to evolve.

Two other things I want to quickly mention. One is, many of you have asked about how to get more training in the kind of work we do at the center. And our basic way of working with people, of teaching them how to heal themselves and how to help others to heal themselves, is this professional training program.

And we can have, maybe, somebody could put some more of these brochures, you got one in each of your packets, but we'll put some more at the back of the room. Please take them, give them to your colleagues or friends.

This is a very powerful program. It is a professional training program and the level is the level of professionals. But we also have people who are not health professionals who come, who are patient advocates. The criterion for coming into this program is that you're willing to work at a level of basic knowledge and experience and that you will take this out into the world.

Each time we do it, we have several people who are not professionals who are at that stage where they're ready to have this very deep experience and take it out and share it with their communities.

So that's also a possibility. And we also look at every application individually, so that's not a promise that everybody or anybody in particular can come into this program. We have to limit it to 120 people because that's all the space we have. We work very intensively both in large groups and in small groups and we teach what you need to know, and we open the door to the experience of self-healing. And it happens. And we can provide more information.

There's information on our Web site from people who've taken the program and there are some articles and some journals and magazines that have been written about the

program that we'll be putting up on the Web site, as well. And you can always call Nancy and ask about the program. Nancy, raise your hand.

The Integrative Care Counselor Program. Again, a number of people asked me last night and this morning about it. We are moving ahead as quickly as we are able. Basic limitation at this point is funding for the program. As soon as we have sufficient funding to know that we can move it ahead, we are going to move it ahead and we are going to do a pilot program within a year to 16, 18 months.

Some of you have asked if you can be in that. I don't know how long it's going to be, exactly, it'll be an intensive program, a residential program, but if you're interested and want to put your name on the list, it will be limited in size, get in touch with us and let us know. And in that program, we're going to integrate some of the mind-body approaches but focus on how to present the latest information. How to help people make choices about what kind of cancer care they should have; how to understand the scientific literature, et cetera, et cetera, et cetera. Will be very powerful and we will let you know, as well, as the program evolves.

You're all on our mailing list and so we will be in touch with you soon about what we're doing as well as about next year's conference and where it's going to be.

If you have suggestions for us and you think of it two weeks from now, three weeks from now, please just let us know, okay.

Speaking of scientific evidence, and of the state of the art of this work, we are going to have a presentation of an award named after Ernst Wynder, who was the first recipient of the award, which is given to someone who makes a major, and is making a major, advance in this field, opening up the doors, not only for that person's work but for all of our work and all of our healing. And to present this award, we have Ernst's wife, partner, widow, Sandra Wynder.

MS. WYNDER: Thank you Dr. Gordon. Eleven years ago, I had become very symptomatic with a severe immune deficiency brought on by radiation treatment to my thymus at the age of four for chronic ear infections.

Knowing what I was at risk for, and knowing the limitations in treatment offered by conventional medicine, I decided to look into the work of Dr. Nicholas Gonzalez. I had only recently heard about this physician who was treating patients with advanced cancer, with large doses of supplements, the now infamous coffee enemas, and a diet based on organic foods, much of it raw.

Being a product of the '60s, this all seemed perfectly logical to me, even though I knew it was widely regarded as unorthodox and even ludicrous. But the bottom line for me, as for any patient facing serious potential illness, for which conventional medicine has no successfully proven remedy is that we do not have the luxury of time.

We do not have the luxury of time to wait while the medical establishment debates the merits of these so-called alternative methodologies based on nutritional elements. So, I went for it and I'm still here to talk about it.

With great enthusiasm, I then presented my find to my husband, who responded with great skepticism and asked, where's the scientific evidence.? After all, the data I presented to him were purely anecdotal.

A number of cases of Stage 4 disease culled from Dr. Gonzalez's files. Patients who had failed conventional treatment and were not only surviving but getting their lives back. Impressive but not scientific.

My husband's healthy skepticism gradually yielded to his insatiable curiosity and keen sense of biological reasoning, which I always thought to be the hallmarks of a good scientist, after we read a book called Pottenger's Cats , recommended by Dr. Gonzalez.

This book documents the results of a controlled randomized trial done over ten years comparing cats on a diet of raw food versus cats eating the usual processed laboratory chow.

Cats on the processed diet suffered the degenerative disease processes that we see in our human population today. And they tended to occur earlier and with greater severity in each succeeding generation. Cats on the raw, enzyme-rich diet maintained their fitness throughout the study.

Now, from my point of view, this was compelling evidence that the methods employed by conventional oncology, which by and large seem to be only marginally effective for the most frequent adult cancers, should give way to this kind of do-it-yourself back-to-basics therapy that marshals the body's own forces to treat the problem.

I expected that other members of the medical community with whom I was in contact would be skeptical when I told them about this new therapy but I figured that the same sense of intellectual curiosity would kick in and compel them to want to know more. The responses, unfortunately, ranged between anger and apathy.

But Ernst felt that the evidence justified a clinical trial and being no stranger to controversy, rose to the challenge. After all, according to the Ernst Wynder law of statistics that guided him throughout his career, if something looks significant, it usually is significant.

Fortunately, the leadership of the National Cancer Institute and Dr. Karen Antman at Columbia University, concurred, convinced that the results of a pilot study done on 11 patients with adenocarcinoma of the pancreas were significant enough to support a clinical trial.

So while the critics remain vocal, science is moving ahead, hopefully now at a faster rate of speed because it is now some 30 years since the war on cancer was declared. And while early detection has improved cancer statistics overall, that statement, you have cancer, still has a terrifying ring to it, particularly if there is any evidence of spread.

To quote Ernst Wynder on one of this familiar themes, "Many today are engaged in molecular and genetic research with the hope that such efforts will lead to basic knowledge about the etiology and ultimately to the successful prevention and therapy of cancer. These endeavors are important, but we must not rely solely on them. Let us also accept a lesson from history and acknowledge that diseases can be prevented without knowing the precise mechanism of pathogenesis."

Dr. Gonzalez's work seems to indicate that an existing disease can also be treated without knowing its precise mechanism of pathogenesis. So, until we can fine tune mechanisms at the molecular level, we must address the issue where the patient does not have a luxury of time. And many of the patients who have found their way to Dr. Gonzalez, had exhausted conventional therapy and were running out of time.

But with strict adherence to his rigorous, nutrition-based, nontoxic self-empowering armamentarium, many got their lives back and in continuing on the program, appear to be preventing the recurrence of any other cancers. And all this at a fraction of the cost of conventional therapy, in terms of both money and morbidity.

It is therefore imperative that the clinical trials now underway have the full support of the scientific community as it is subjected to the rigors of scientific scrutiny. Because if there is an effective treatment out there now, science has a moral obligation to validate it and get the word out.

Without the support of science, this kind of therapy is slow to win favor in either the patient population or in the medical community, probably because it doesn't contain a magic bullet. The patient would prefer a magic bullet to the permanent commitment to the major lifestyle change that is required by this treatment. The pharmaceutical industry would prefer a magic patentable bullet for other reasons.

But, if we all learn to eat right at an early age, as Ernst Wynder preached in his Know Your Body health education program for children, nobody would need a magic bullet.

And so, it is particularly gratifying to me as friend, as grateful patient, and as avid, unwavering, sometimes overbearing, supporter to present this award to Dr. Gonzalez and I know my husband would be honored because, while Ernst must have been one of his most difficult patients, and that's understandable to anyone who's ever tried to tell Ernst Wynder what to do, he was one of Dr. Gonzalez's strongest supporters.

As Ernst said many times, when the evidence is strong, it will in due time, be accepted, because scientific truth in the long run always triumphs.

In this spirit and in Ernst Wynder's name, my beloved Ernst, please join me in congratulating Dr. Gonzalez and wish him fulfillment and personal gratification as he helps patients regain useful lives and his research paves the way for therapeutic as well as preventive strategies that are so urgently needed in our war against cancer.

Dr. Gonzalez.

DR. GONZELEZ: Well, thank you so much. Thank you, Dr. Gordon, and Sandy thank you for a very moving talk and, as you were speaking, I had visions of Ernst in various places at the house in Connecticut, at your apartment. The Wynders had a very beautiful apartment in UN Plaza and it had one of the most beautiful views in New York City, because it faced the UN, which has a big plaza and a park, and it faced south, so you got a lot of sunlight. It was a perfect place, because Ernst had a great appreciation for natural beauty.

I was having breakfast with Ralph Moss this morning and I said, you know, there's a danger in overexposure. This is the third talk I've given. I spoke for seven hours on Wednesday, I'm going to speak with Jeff White after this talk and I suddenly said to Ralph, I said, you know, I don't really have that many different things to say. I'm basically this dull guy that gives cancer patients carrot juice, pancreatic enzymes and has them do enemas.

No matter how many things I can think about, it always comes back to that, so for those of you who heard me talk for seven hours on Wednesday, some of this, of course, is going to be repetitive, because this is what I do, this is the work that I do.

I'm going to approach it a little bit differently, and talk so much, since this is, really, in honor of Ernst Wynder, not in so much in honor of me, but in honor of Ernst Wynder, I'm going to talk a little bit about mentoring and how the mentors in my life changed the course of my own research career.

My first mentor, although I never met him, would, of course, be John Beard. And, again, those of you who have heard me talk before know about John Beard. I know there are people in this audience who haven't heard me talk before.

John Beard was a very brilliant embryologist. He wasn't a physician. He wasn't trained in cancer research. He was a professor at the University of Edinburgh at the turn of the Century and he was very well recognized in his field. And, in fact, the embryological literature today still quotes a lot of his innovations. So he was a very, very brilliant man.

And like a lot of truly brilliant men, he had a lot of interests in a lot of different areas. His precise area of research activity over a period of several decades was actually the mammalian placenta and, as all of you know, the placenta is an organ produced by the growing embryo in utero and it serves two basic purposes.

It's the point of connection between the embryo and the uterus, so it doesn't physically fall out of the mother. And, secondly, it's the point of connection between the blood supply of the embryo and the blood supply of the mother.

You know, a baby growing inside the mother in a mammalian situation has a problem. It has to get all the nutrients it needs from the mother and it has to get rid of its waste materials, the carbon dioxide from respiration, the metabolic wastes, like urea into the mother's blood supply. And the uteral connection, the placenta, really serves that function.

Beard was a very brilliant man, as I've said so many times and one of the things he observed is, the placenta, as it grows, particularly in its early phases, is very much like a tumor.

Under the microscope, Beard first observed, it looks like a tumor, it's very primitive and undifferentiated. It invades the uterus, the way a tumor invades. Initially, it grows very uncontrollably, the way a cancer grows.

It has angiogenesis, although Beard, didn't use that word, that word is more of recent lineage. He was aware that the growing placenta had to produce a blood supply, just the way the tumor does.

Although immunology was in its infancy at the turn of the century, Beard also realized that the placenta wasn't rejected by the mother. Like the tumor, it's immunologically protected, so it looks microscopically like a tumor, invades like a tumor, initially grows like a tumor, has immunological protection like a tumor, and has angiogenesis, like a tumor. To him, it was a perfect tumor model.

He presented this information in basic form in 1902. Over the following years, he made several leaps of faith. He said, since the placenta looks like a tumor and behaves like a tumor, we should use this as a tumor model. But he was also aware that there was a difference, which is not an insignificance difference.

Of course, in most situations, the placenta looks like a tumor, behaves like a tumor, invades like a tumor, up to a point. And then it changes its appearance microscopically and its behavior very, very radically, where it becomes a less aggressive organ and becomes a very well-behaved, mature, nonaggressive, noninvading, nongrowing organ that really is necessary for supporting life.

So here you have this organ that initially looks and behaves like a tumor and then suddenly shifts over and behaves like a less aggressive organ that's responsible for and allows for the growth of the embryo.

Beard thought if he could figure out what caused this significant shift from a tumor-like organ, an invasive tumor-like organ into a noninvasive organ, he might have the answer to cancer. And he spent years of his life trying to figure out what the connection was.

He knew the signals could be coming from either the mother or the growing baby. And after years of research, the only conclusion he could come to that made any sense, is the signal that causes change in appearance and change in behavior in the growing placenta, was actually related to the fact that the day the placenta stopped growing aggressively, was the day the fetal pancreas became activated.

Now, it's very interesting; Beard figured out that the pancreas became activated in the growing embryo around day 56 of embryological development, which is very early on, when you consider you're talking about a 9-month gestation. And the fetus really doesn't need a pancreas, because it gets all the food it needs in a predigested form from the mother and the pancreatic enzymes are digestive enzymes and the fetus really doesn't have an active digestive tract, because it's getting all the food it needs already from the mother.

Yet it is activated early on. And recent embryological data, in fact, I pulled up some studies from the last couple of years confirmed that the fetal pancreas is, indeed, activated very early on in development.

Beard presented his data and a number of scientists got very interested in his work and suggested he continue and develop this as a cancer therapy and like a good scientist, the first thing he did, is he did animal studies. And at that time, there was an animal mouse model called Jensen's Mouse Model, which was a sarcoma, tumor model, that researchers all over the world were using to test new substances for cancer.

Beard developed a pancreatic enzyme preparation, which he used on these animals and he set up one of the first controlled trials for an anticancer element in an animal model. He had a control group that had this Jensen's mouse sarcoma that got no therapy. And then he had a second group that got the pancreatic enzymes. And the control group died, just as they should, right on schedule. The group that got the pancreatic enzymes had rejection of the tumors. The tumors would actually die. And he published this data.

A number of physicians, when they saw the animal data, got very interested in using this on their patients. Remember this is, we're talking about 1905, 1910. There really weren't any effective therapies for cancer at that time, other than surgery.

Beard developed an injectable form of pancreatic enzymes working with a very eminent pharmaceutical company called Fairchild. And a number of physicians began to use these enzymes with great success. These successes were documented in the medical literature.

Now, I realize time is limited but I thought I would read at least one case, a different case than the ones I read on Wednesday. My point in reading these, is that this is not something that's just word-of-mouth or somebody made up. They're actually case reports in very eminent medical journals going back to the turn of the century.

This is from the British Medical Journal, August 31, 1907. This was a physician who'd used the enzymes in a patient with widely metastatic, what appeared to be, pancreatic cancer. And there was a biopsy, and the physician is simply discussing the case. And I'll just read it to you.

"A gentleman, aged 65, of good physique and hitherto robust health came to see me in January last, with a rapidly growing abdominal tumor; a globulus swelling about the size of the fetal head, feeling like a cyst....."

"He complained of pain, loss of appetite, and strength, and said he was losing flesh. He went to a surgeon" (at one of the great English teaching hospitals), "who opened the abdomen and found a cystic growth, which he tapped, but was unable completely to remove it. It was attached to the pancreas."

"Mr. Dunn had no doubt of the malignant character, moreover he found secondary growths in the wall of the stomach and elsewhere." I mean, by anyone's estimation today, or a hundred years ago, this was a very aggressive type of situation.

"The patient returned home in March and very rapidly lost ground. The growth immediately began to increase in size and by the end of April, the whole epigastrium appeared to be full of solid tumor. He was, besides, wasting rapidly and had become extremely weak, suffered a great deal of pain, especially in the back and had nausea and vomiting, pain after food, sleepless nights. At the end of April, he was seen by Mr. Dunn, said nothing further could be done, surgically.

"On May 1, he began hypodermic injections of trypsin, which we recommended and introduced by Dr. Beard and very soon improvement set in and continued steadily. The vomiting --" And then he goes on in detail discussing the patient's improvement.

And, basically, you could consider this, if not a cure, in fact the physician says, "I do not say it has cured. But no one who has seen him can doubt the immense improvement that has taken place. And considering how rapidly he was deteriorating before treatment commenced, and how promptly and steadily the improvement took place after the treatment began, it is extremely difficult to believe that the trypsin was not the cause of that improvement."

This was a very impressive case. It's only a single case. It's an anecdotal case, but there were subsequent cases and I have, literally, dozens of such cases from the orthodox medical literature at that time documenting tumor regression. In fact, some of the physicians, as these patients survived longer, would start using the word cure.

There was a physician in America who used it and even uses the word cure for a laryngeal cancer. So these cases were very carefully documented in the orthodox medical literature.

The response of the majority of scientists at that time was total disbelief and ridicule. There was a well-known surgeon who said, well, the mouse model that Beard used wasn't a legitimate mouse model, that it's not really a tumor model that should be used; that these cases can't possibly have cancer.

About the same time, as I've said so many times, Madame Curie's radiation therapy came into vogue. The press picked up on it, showing the power of the media, Beard was forgotten, died in obscurity in 1923. Although, periodically, physicians would rediscover his work.

I have a very interesting article here from the proceedings of the St. Louis Medical Society from 1934, where a physician had rediscovered Beard's work and had actually started using pancreatic enzymes with enormous success. Now, I should be able to find that article. It's a wonderful article, because he documents some great cures.

Here it is, "Treatment of Cancer With Pancreatic Extract," Weekly Bulletin of the St. Louis Medical Society, 1934.

"It has been nearly nine years since our first encouraging results have been attained in the use of pancreatic extract in the treatment of cancer." Remember, Beard is long dead. "A local pathologist has been able to note the absence of evidence of cell division in these cases, made it the fifth month from the patient who previously had shown many mitotic figures. Strange processes of repair occur. A large metastatic growth on the..... portion of the head that included skin and bone, disappeared and the hair grew perfectly.

"Several pathological fractures of ribs healed so perfectly that we could not tell at postmortem that they had ever been involved. An X-ray of a spine case that I will show you tonight had only six injections and left the hospital, now refuses to have another X-ray.

"Another case referred to me was one with an enormous cancer of the bladder and prostate. He was under treatment for nine months and died of nephritis, autopsy showed no trace of cancer."

This particular physician, Dr. Morris, was treating terminal patients. Because when you're dealing with an experimental new therapy, even then, you would tend to take patients at the last stages of their disease.

He says, "I shall not go into the theory regarding cancer, nor its pathology. I know full well that this plan of treatment is far from perfect but considering the type of patients, their hopelessness and the fact that the tumors disappear in some and they have been restored to apparent health, justifies this presentation and hope that further investigation and experiment may develop."

Very reasoned approach. Here's a man who's not claiming he's curing cancer. He's simply saying, I've observed something that's very interesting and I need support and help in 1934, using pancreatic enzymes. This was at a conference, a presentation of the St. Louis Medical Society. And what's interesting is that his presentation of the case is two-thirds of a page and then the attacks go on for about six pages.

Dr. Hollis Allen was the first person who spoke during the discussion, as it was called, not attack, they just called it politely, a discussion, who says he "followed a few cases and that they did have biopsies, and they seemed, they looked like good cases. One I recall, was sent from Barnes Hospital, was an inoperable carcinoma." Barnes' Hospital is one of the great midwestern teaching hospitals associated with Washington University, where Dr. Wynder went to medical school.

"I have been rather amused at Dr. Morris's endeavor absolutely to clinch the diagnosis on certain of these cases." I don't know why he'd be amused by that, but you see, immediately, he's not taking Dr. Morris seriously, even though, he's seen the biopsies himself.

A second physician, I really kind of enjoy this, sounds like someone I might know. "Well, I heartily agree with Dr. Allen when he strikes this note of encouragement. I recoil at the idea of witlessly spreading the hope of cancer cure, which is implicit in the remarks of Dr. Morris this meeting. Please remember the tragedy" and then he starts talking about someone else who claimed he had a cancer cure.

Remember, Dr. Morris, never used the word cure, never said I'm curing cancer. He said I have some interesting cases, boy I wish you guys would look at it.

Then he says, "In perfect understanding of Dr. Morris's motivation, with a deep willingness to cooperate," it's amazing, this guy was really slick, "I say to you, in all frankness, not one thing he has said in his presentation ——— the fact that the patients he presented tonight are cancer sufferers."

Just like with Beard's critics where they said the mouse tumor really wasn't a mouse tumor, the patients that were cured, weren't cured. He says, well, they got well, but they didn't have cancer, so it doesn't count. Even though they had biopsies at places like Barnes' Hospital.

When you read the comments, and I could spend two hours reading them because some of them are so, if it weren't so tragic, they would be comical. And then, having attacked Dr. Morris for about three pages, he then says, to defend himself, "I'm speaking now, only in the spirit of generous and tolerant scientific criticism."

It's a very interesting approach. The end result of Dr. Morris's work is that when he died, it died and enzyme therapy was really lost until during the 1940s, as Dr. Ralph Moss has pointed out to me, always remember to mention the Krebs, father and son,

resurrected enzyme therapy in the '40s. Unfortunately, they went off on the laetрил tangent and kind of forgot about the enzymes.

It took my next mentor, Dr. Kelly, the eccentric controversial dentist out of Texas, to really bring enzyme therapy into the fore in the alternative world during the 1960s and '70s.

Under Kelly's direction, the enzyme therapy had evolved from purely a single agent enzyme therapy to a very complicated program that involved diet, supplements, and detoxification routines. And he had treated, literally, thousands of patients over a number of years.

I first met him in 1981, as a second-year medical student. I had already been working kind of informally in the laboratory of Dr. Robert Good, who was one of the preeminent research scientists of the time, and then president of Sloan-Kettering Cancer Center, again, as I discussed on Wednesday.

Dr. Good was a very controversial man. Ralph Moss worked under him when he was at Sloan-Kettering and he can tell you stories about Good, just as I can. He was a very, very dynamic fellow, a very controversial fellow. He was trained, initially, as a pediatrician, had a Ph.D. in neurophysiology. He had done work in a variety of fields.

When I first met him, as a medical student, he was then the most published author in the history of medicine, with over 1,400 papers to his credit. He had also been chairman of pathology at the University of Minnesota, even though he wasn't formally trained as a pathologist.

His main area of interest was immunology and he was one of the people that first figured out what the thymus does. And he did one of the first bone marrow transplants in history in 1969 at the University of Minnesota.

He was trained in immunology, pathology, pediatrics, neurophysiology. He was an excellent neurophysiologist. In 1972, when he came to Sloan-Kettering, he brought his whole group from Minnesota with him with great excitement. He actually ended up on the cover of Time magazine.

But he was a controversial figure and he had an interesting teaching style. He tended to trust the people who work under him. He later would do this with me. And in 1973, in that period, there was a big scandal at Sloan-Kettering; the painted mouse episode, which many of you may be aware of. When one of his fellows, simply faked results and claimed to have done research he didn't do.

Now, Good wasn't directly involved with that, but Good was largely blamed for that and it was a smirch on his career that, to this day, he still hasn't lived down.

And, knowing Good as I do, I knew it really wasn't his fault that this had happened, because what Good did, in terms of his teaching methods, and he was an extremely good mentor, is he tended to let his students and his fellows follow projects that interested them, and he'd leave them alone. He wasn't a tyrant or a dictator. When you worked under Good, you had a lot of responsibilities, in that you had to produce but you could go months at a time and not have to report to him.

Well, after meeting Dr. Kelly, quite serendipitously in 1981, I thought his work seemed kind of interesting and might be promising. He told me about some of these cases from Dr. Beard. I thought if anyone at the Cornell Medical Center, where I was a medical student, would know how to filter through all this information about Kelly, the controversies, the good and the bad, it would be Dr. Good.

Actually, the day I met Dr. Kelly, I went up to Dr. Good's office, his president's office at Sloan-Kettering without an appointment. And this is one of the unique things about Dr. Good. Here's a guy who's president of Sloan-Kettering, like, he has nothing else to do but talk to medical students. Just went up to his office, talked to his secretary, whom I knew, and he saw me. And we talked for about an hour about Dr. Kelly, this eccentric dentist that might be curing cancer with his intensive nutritional program, who was very controversial. And the one thing Kelly had said to me, was that he wanted his work properly evaluated.

I said this to Dr. Good. And Good didn't laugh or make fun, or say, you know, Kelly's a quack, he had just come off from the Steve McQueen fiasco, this was 1981. You're wasting your time, it's a pile of garbage, it's quackery, do some real science. Absolutely the opposite.

He said, well, it sounds kind of interesting. He said it's not the kind of thing that necessarily makes sense to me that you could cure cancer with nutrition, but he said, are you interested in following this up? And I said, yeah. Then you should do it.

That was part of Good's genius. You'll hear a lot of good and bad things about Dr. Good, just like you'll hear a lot of good things and bad things about me. But one of the really great things about Dr. Good, as a teacher, is he gave his students freedom to follow projects, however peculiar they might seem to the orthodox medical world.

What began as a simple case review of Kelly's work, developed in to a major research effort which I continued when I joined Robert Good's group as a full immunology fellow.

Quite unceremoniously, during my third-year of medical school, Robert Good was told to resign from Sloan-Kettering. He'd been there ten years, he was very controversial, he would support projects such as mine. He was told, really, to get another job. And then he spent a couple years at the University of Oklahoma, where I joined him after finishing my internship, and then the University of South Florida, where he moved to set up a cancer research group, and I finished my fellowship there.

During my two-year fellowship with Dr. Good, I had virtually, not total freedom, but virtually near complete freedom to investigate Kelly's work as much as I wanted. There were periods of time where I would just disappear and go to Kelly's house and go through his patient records.

And Dr. Good would give me total, absolute freedom and treated me with trust. I could have been off skiing, and he didn't know the difference. As long as I produced something and had some evidence.

What we found with Dr. Kelly is, indeed, there was a lot of evidence. You'll hear a lot of very good and a lot of very bad things about Dr. Kelly. All of them true, but all I cared about was the data and the documentation in the cases.

Now, Dr. Good was a wonderful research boss and when you faced a situation like Dr. Kelly, epidemiologically and in terms of methodology, it's a nightmare. You're facing a man who wasn't even a physician. He was a dentist who treated thousands of patients. He had two offices, one in Dallas, one in Washington state. He had records scattered in both places.

There were patients there who had been treated with a variety of different cancers, all stages, some of them didn't even have cancer. Patients that had other problems would come to him. And this was before there was an office at the National Cancer Institute, or at the National Institutes of Health, before there was a concept of the Best-case Series.

We were sort of going blindly, or I was going blindly because Dr. Good, in terms of science, was never blind. We had to develop a way of evaluating these thousands of case reports that to me was just kind of an overwhelming problem. But he very quickly put a structure to it. And he said, this is the way you approach this: First, this is a retrospective review. It's not a controlled clinical trial, you're going to be looking at patients treated in the past. But you can still get interesting information.

He referred to my Kelly study as an experiment in nature. It wasn't a controlled trial. We'd be looking at patients treated in the past. He said, what you have to do is try and find cases that were appropriately diagnosed at proper institutions, by certified pathologists, by anybody's standard. Standards had advanced cancer that were either poor prognosis cases or terminal, by anybody's standards.

He said, put a series of cases like that together. He said, that would be an interesting first step. But then, the second step is you need kind of a numerator/denominator study.

We ultimately decided that I should evaluate 50 patients with a variety of different cancer, appropriately diagnosed with poor prognosis and put that into one section of our study.

Then, he said, you need a numerator and a denominator, basically, a success-rate type study. He said, it's great if you can find 50 cases but the point is that 50 out of 50, 50 out

of 100, or 50 out of 50,000. If it's 50 out of 100, that's extraordinary, it's 50 out of 50,000, then I'm not that impressed. He said we have to get some idea what Kelly's success rate is. And this is a question that Good himself had raised.

In retrospect, it was a very good question to raise. Again, it wouldn't be a definitive clinical trial where you're treating patients from day-one and watching them carefully on the therapy. We were going backwards in time and looking at patients already treated; some of whom, may have disappeared off the face of the earth; some of whom may have died; some of whom may have been lost to follow-up.

But Good said, pick a cancer with a terrible prognosis. Pick a specified period of time, go through every patient's records from that time in Kelly's office, find every patient with that diagnosis, track them down and find out what happened to them. And you'll get some idea of his success rate. We eventually did that with pancreatic cancer.

Now, in terms of the first part of our study, we evaluated 50 patients and because time is so limited, I'm going to read just one. This is a case, I know Ralph Moss likes, and I like it, too. It's a lady with metastatic uterine cancer. Very interesting lady. When we did this study, Dr. Good was a very, very relentless scientist in terms of how this had to be done.

He said, you get legal permission to use their names, you get legal permission to print their records, their actual medical records, so there can be no ambiguity, the patients don't exist, they don't -- you don't have their records, you can't show them because it's protected by privacy.

So we actually got extensive release forms from each of these patients. So I can use their names publicly and show their medical records publicly.

These case reports that I wrote are actually quite long. Because time's limited, I'm going to skip through it, but it's an interesting case.

"Frances Thors is a 72-year," this was written in 1986, "72-year-old woman from Washington state, alive nearly 18 years since her initial diagnosis, uterine cancer. Prior to developing cancer had been in good health. Mid- September 1969, experienced episodes of vaginal bleeding.

"Six weeks later, consulted her gynecologist, did a biopsy, was cancer, Grade 3 adenocarcinoma. Then she had radiation implant therapy and then a month later, December 9, 1969, was readmitted for hysterectomy."

The reason I'm reading it to you not to sum it up, I think it gives it more verisimilitude, you see that this really exists.

"Then, suddenly, her health began to deteriorate. In the late fall of 1975, six years after her hysterectomy, she returned to her physician when abdominal pain became intolerable.

"On exam, a solid mass was noted in the left pelvic area. She admitted to group health in Seattle, November 23, 1975. Mass was there, chest X-ray revealed evidence of metastatic disease in both lungs, described as several bilatery pulmonary nodules, which have appeared since the last examination, measuring up to 1.3 centimeters in diameter.

"She went for exploratory surgery, and a large 5-by-5 by 4-by-5 by 3 biocentimeter tumor was excised. Just prophylactically because the tumor was impinging on her large intestine. So she was having trouble eating.

"But this was, clearly, terminal disease. She had no chemotherapy, no radiation, she went on progesterone for about six weeks, but quit it because it made her sick.

"Ended up in Dr. Kelly's office. Her physicians called him a quack," told her he was stealing her money -- this isn't written down, but anyway told her he was just going to steal her money.

She went on the program, disappeared from the orthodox world and didn't die. And she had a history of atrial fibrillation. In November of 1984, she finally returned to her internist, and I have the internists letter right here, a Dr. Carl Neugent, who was her primary care physician, who hadn't seen her for a number of years.

And it's quite interesting what his response is, November 16, 1984, "I almost dropped dead when she told me she wanted a chest X-ray." He was so surprised when she entered his office, in fact, she said, it was like he'd seen a ghost.

Then he did a chest x-ray. "Chest film, except for a rather large heart, which shows no sign of decompensation that I can see. Chest film is normal. Rib detail looks normal, specifically, I did not see any evidence of metastatic disease on either film, which is quite remarkable, in view of the fact that nine years ago, she had metastatic disease in both abdomen and lungs, as nearly as I can tell from the record."

Interesting case, she was still alive when I last heard from her. She must have been like 90 years old in 1995.

I put this work together in this enormous tome, which makes a good door jam, and thought, of course, that what we had to do was publish it. Now, Robert Good, at that point was professor of pediatrics at the University of South Florida, where he had gone from president of Sloan-Kettering and it was not a career-advancing move.

He was really, I can't say he was semi-retired, but, you know, Robert Good was a controversial figure and there were a lot of people in the medical world who didn't

particularly like him. And his involvement in projects such as this, which by 1986 was no longer a secret, started to generate a lot of hostility toward him and toward me.

I realized the writing was on the wall and after I finished my fellowship, I moved back to New York with about \$200 in my pocket, trying to decide what to do. And, of course, the first thing I did, I tried to get this published. And I figured, at least, though it was controversial with Dr. Good's name involved, we shouldn't have any trouble getting at least some of the case reports published.

Was I stupid? I spent the next two years trying to get parts of this book published, tried to get the whole thing published as a monograph. There were two universal responses: The people who didn't believe it or thought it was fraudulent; and usually, they would write to Dr. Good, "Dear Bob, how could you be involved with such quackery, don't you know it's going to jeopardize your chance to win the Nobel Prize"?

In fact, in that period, in 1986-87, he had been nominated for the prize. And they thought all he needed was another explosive scandal in his life.

The second response was from people who believed it, they said, but this is so controversial, even if it's real, we can't publish it.

With no other option, and at that point, Kelly had closed down his office, I started seeing patients myself in New York, and my sole intention of collecting data and having clinical trials done, because I believed this therapy was so promising, come hell or high water, it needed to be tested. And if it were valuable, just as Kelly said, it needed to become part of orthodox medicine, and saved from being on the fringes of the alternative health care field.

Well, it wasn't until 1993, when the NCI, as part of its growing effort to look into alternative therapies, invited me down to Washington to present my own Best-case Series of patients from my own practice.

It was very interesting. On the plane down, I had a companion that was none other than Ernst Wynder. Now, I had met Ernst Wynder in 1990 before there was a Best-case Series at the NCI, before I had my clinical trial, when I really didn't have anything other than a lot of name-calling and hostility from the physicians who knew what I was doing.

And Ernst was completely different. I remember the first time I had dinner with Dr. Wynder, was at his apartment with Sandy. As Sandy said, he was skeptical, but he was gracious. Never was he disparaging, never was he patronizing, never was he condescending.

Ernst was an interesting fellow and I've heard many, you know, you've heard the name several times, of course, this is the Ernst Wynder award. Some of you may not be aware who he was.

In 1950, Dr. Wynder had published the first study, when he was a fourth-year medical student, an epidemiological study showing that cigarette smoking is linked to lung cancer.

This was the first published article showing the connection. And if you think that was well received, let me remind you that, at that time, medical journals, such as the eminent Journal of the American Medical Association (JAMA), carried cigarette advertising. They would have full-page ads, with actors dressed as doctors talking about how cigarette helps them relax. And I remember seeing one ad, I had actually seen this, where the ad said cigarette smoking will help your patients' throats. Actually thought, and we're not talking about 1850, I'm talking about 1950.

Dr. Wynder always told the story that after this article came out, to his credit, I mean, it was such a well done article that JAMA was forced to publish it, I guess, against their better instincts.

But it received some publicity and he was asked to appear at conference on cancer, a big international conference. And Sandy and I, and Ernst used to laugh about this. And these esoteric sheep viruses were getting 45 minute periods to talk about their work, and Ernst's work, which was so extraordinary, where he looked at hundreds of patients who died of cigarette smoking and showed really rather dramatically that it was related, the occurrence of this lung cancer was related cigarette smoking, he was given five minutes, and told to make it very fast. So, it was a very fast five minutes.

The cigarette industry did not receive Dr. Ernst's work with great enthusiasm. But Ernst was really a bulldog and he didn't give up. He subsequently completed his residency training at Memorial. In those days Memorial Sloan-Kettering had its own residency program, which today is part of New York Hospital. And then he, after finishing his residency, he stayed on at Sloan-Kettering. And with Dr. Hoffman, his great colleague, they continued their work with cigarette smoking.

Now, at that time, in the '50s, the cigarette industry had a major budget to discredit Ernst Wynder. They literally had private investigators following him to see if whether there was some great sin in his life that they could use against him. They had campaigns to discredit his research, say it was biased, say it wasn't done. I mean, all of these documents came out much later. He was not well loved in certain parts of American industry. to say the least.

In 1964, the surgeon general came out with his report linking cigarette smoking to cancer. And Ernst felt at least somewhat vindicated. But the battles, as Sandy and I often talk about, were not over.

In 1969, he was confronted with his own crisis, when the then president of Memorial, who was a very heavy smoker and who was still largely funded by the tobacco industry, told Dr. Wynder that he had to give up his cigarette research or leave Sloan- Kettering. Ernst was very troubled by this and this is five years after the surgeon general report.

Now, Ernst was a very popular figure at that Cornell campus and Cornell, where I went to medical school, has the medical center and then the Rockefeller University, which used to be the Rockefeller Institute on one corner at 68th Street, and across the street, Memorial Hospital and the Sloan-Kettering Research Institute. And let me assure you Ernst knew a lot of people at that medical center.

He thought he'd generate support for him and generate kind of a rebellion among the scientists at these three institutions. And he went to all his friends at the Rockefeller, all his friends at New York Hospital, his many friends and colleagues at Memorial. And he could get exactly one person to write a letter in his support, a scientist at the Rockefeller Institute. And he always talked about this gentleman, kind of teary-eyed, because people are afraid of their careers. You're dealing with the president of Memorial Hospital, ironically, subsequently died of pancreatic cancer.

Ernst decided, rather than give up his cigarette smoking that he would quit Sloan-Kettering. And he was, like, 47 years old, and let me assure you that research scientists at Memorial, though it may seem like a very honorable and powerful position, are not overpaid. You know, you're on salary there. It's not like being, in those days, being a practicing physician. He had about \$200 in his pocket. He had an apartment on East End Avenue about 20 blocks north of Sloan-Kettering near the East River.

And what he did, it was an old building, and in the basement, they had maids rooms from days when rich people on the East Side had maids, and they had these rooms that were basically used as storage rooms.

He decided what he was going to do is set up his own institution. And this is so typical of Ernst Wynder, 47-years-old, with, you know, a couple thousand dollars in the bank, no career, basically forced out of Sloan-Kettering. What are you going to do?

He was going to set up his own institution, with no money, no possibility. He rents a maid's room in the basement of his apartment house and sets up the American Health Foundation, which he decided the first world's institution devoted and solely to preventative medicine.

Now, his interest came out of tobacco research, but in the late '60s, he was already getting interested in nutrition, far ahead of any of his colleagues. By the mid-1970s, the American Health Foundation, of course, was a premiere research institution. Currently, its president is a very eminent Dan Nixon, who is taking it into its next generation. And they're a very large institution, Ernst used to say over 270 employees, they're an official National Cancer Institute-related institution.

They do enormous amounts of research in the basic science of nutrition and prevention and trace mineral metabolism, as well as tobacco research. And they recently, I think it was a \$12 million grant, and I stand corrected if I'm wrong to look into the effect of diet

on prostate cancer, breast cancer. They've been getting these large grants dealing with nutrition and cancer, so it shows you how tenacity and perseverance can really win out.

Of course, Ernst was later made an adjunct scientist at Memorial and they were very happy to have him back and he would give grand rounds and lectures on a routine basis.

But when you hear about these eminent scientists, like Dr. Wynder, or Dr. Good, their lives were not easy. They were, Dr. Beard, particularly. Dr. Good, in his own way, was decades ahead of his time and he was punished for it. He was punished for his teaching technique, which was to trust his fellows, to trust his researchers, like myself.

Well, when I met Dr. Wynder in 1990, I didn't have much support, but he stuck by me. He was a very good scientist. He didn't care whether he liked me or didn't like me, whether I was weird or whether I wasn't weird, or whether people thought I was nuts. All he wanted to see was data. And he was relentless.

You know, I remember the first time I was invited up to his country home in Connecticut. A beautiful place, two acres, with a stream going down the middle, with ducks and trees, beautiful Connecticut countryside. And I thought, what a relaxing day, Saturday in Connecticut. Boy was I wrong, I was presenting cases from the time I arrived till the time I was put on the train and on the train home I breathed a great sigh of relief. That Saturday, required more work than the previous five work days.

But he wasn't fooling around. He wanted to know the cases, he wanted to know their names, their diagnoses, did I have biopsy reports, could I produce the biopsy reports. And this would happen about once a month. Once a month I would get the Connecticut venture.

I began to dread them because I would have to be in top form. This was like an oral exam for your Ph.D.

But Ernst was a relentless, impeccable scientist. That's how he survived the tobacco industry. And this is in the '50s, before television was on your side. Television lived off the tobacco advertising. The media was against him. The tobacco industry was against him. Sloan-Kettering turned against him.

He survived and built a preeminent research institution, simply on his integrity and his guts. And that integrity, I can see it coming through with me. He wasn't going to give me one inch. There wasn't one dinner that we had together and I probably had dinner with him 500 times, where I didn't have to present cases. And sometimes at 10:00 at night, when you've got 12 hours of patients the next day, you don't want to present cases.

But I loved him dearly. And when I was going down to present my own cases in 1993, Ernst Wynder was sitting right next to me. And believe me, he had better things to do

than going down to Washington for the day. And it was a long presentation, as some of you in the audience might have been there, people from the NCI.

I presented for about three and a half, four hours. And Ernst began the presentation with a five-minute talk, just telling the people, and there were some very eminent NCI scientists in that room, to take my work very seriously.

I had put together 25 cases in book form, which I have here, which I'll be talking about in the next session. And I'll just present one of the cases. I like this particular case, because he was actually on national TV Friday night, so I have permission to use his name, since he's gone on national TV to talk about his case.

Mort Schneider, Sandy and I always enjoy talking about Mort. He was diagnosed in 1991 with metastatic pancreatic cancer.

"Morton Schneider, at that time, 72-year-old white male, history of metastatic adenocarcinoma. Initially they thought it was lung primary, then changed it to pancreas when they saw a tumor on the pancreas. Had a history of smoking," again, I'll be very brief. "CAT scan of the chest, August 20, 1991, after a chest X-ray had shown a tumor, showed 6 millimeter nodule on the right upper lobe associated with mild and large mediastinal node.

"CAT scan of the brain was negative, but a CAT scan of the abdomen, September 18, revealed 4 lesions of the right lobe of the liver, a round enlargement of the right adrenal gland up to 2 centimeters, diffuse enlargement of the left adrenal and a 4.5 centimeter mass in the upper pancreatic ———."

"Ultrasound confirmed the tumor, on September 24, 1991, he underwent mediastinoscopy, and they took out this right upper lobe nodule. They thought that was the most easily accessible piece of tissue to get a biopsy. It showed infiltrative moderately differentiated adenocarcinoma, and they ultimately defined this as pancreatic cancer with metastases in the liver and the lung.

"They told him he was terminal, they told his wife that chemotherapy and radiation in a man that age was a waste of time, that he should just enjoy his life. Gave him two or three months to live. "Started with me that fall."

Now, it was interesting, he'd been with me about two years when I presented at the NCI, and before I went down to Washington, I had redone the CAT scans, and they showed no change in the tumors. Now, at that point, as I'll be discussing later, and as I discussed the other day at the Best-case Series presentation, NCI definition of a successful case was a 50 percent reduction in tumor size at four weeks.

Now, here's a guy who was out two years with metastatic pancreatic cancer, four tumors in the liver, obviously, terminal case, who was in excellent health, but still had all his tumors and they were still exactly the same size. Sometimes tumors go away,

sometimes they don't. Doesn't matter. It's like diabetes, you can live forever with diabetes if you follow your diet and take insulin.

On our program, we find patients can live very long times if they follow their diet and take their enzymes, even if the tumors don't vanish.

I presented that case and he was out two years later. About four years later, we repeated the CAT scans, Mort was not a fan of having CAT scans done, he felt, well, he didn't care what they showed. But I finally got him to agree to have some CAT scans and when we repeated them in 1998, the tumors were completely gone.

I actually have that report here, but since time is short, I'm not going to read it. But, basically, all the tumors were gone. And he's alive and well.

On ABC Friday night, they actually had the CAT scan reports in my office. Dr. Isaacs, my colleague, showed the tumor reduction. It was quite impressive. And he's alive and well, with no sign of disease.

I presented a series of cases like that. At the end of the session, Dr. Wynder, gave another talk and, basically, looked at his colleagues, all of whom knew him, because they knew who Dr. Wynder was, and he knew all of them personally on a first-name basis. And said you have to take this work seriously.

Well, they weren't ready to invest in a large-scale study but they did suggest the pilot study. With pancreatic cancer, a pilot study's just a simple introductory study to see whether a new therapy has any benefit at all. This we did. It was funded by Nestle's, completed in 1999 and published in Nutrition and Cancer, last year.

Now, we had tried to get it published in JAMA, and I think I know to whom they turned over my article. But what we got was not an evaluation of data but a personal attack against me that this is basically psychopathic scamming to steal money from unsuspecting cancer patients.

I showed the names are not on, when you get peer review response, the names aren't on it so you don't know who they are. But I had a feeling who it was. I showed this to Dr. Wynder. He said, we don't have time to waste, you have to get this article published. He made one phone call to the editor of Nutrition and Cancer, which is a very good peer-reviewed, orthodox research journal. We were able to get the article expedited through publication. It was published in July of 1999, with an introductory editorial by Ernst Wynder. And the editor of the journal at the time, Dr. Gorey, and it was a very laudatory editorial saying this work had to be taken seriously. And lauding us for at least putting our work to the test of clinical trials.

As a result of that pilot study, as most of you know, we were able to get funding, initially, it was going to come from the NCI, but then the National Center for Complimentary

Medicine agreed to pay for the study, a \$1.4 million controlled clinical trial, which is being run at Columbia University, which will also be done with pancreatic cancer.

Ernst was still alive when we got word that we were going to get this large-scale grant. And he had a simple term for something that was an important event in someone's life, he would refer to it as a "biggie." When we got the NCI grant, he said it was a biggie. When he got his \$10 million grant, he said it was a biggie.

Now, if there was something that wasn't significant, there wasn't a lesser word, what there was, was a shrug of the shoulders.

For example, I had some interest from a pharmaceutical company that wasn't particularly well known and when I discussed this with Dr. Wynder with great excitement, he kind of looked at me and gave me that shrug, which I immediately know, well, it kind of said that, if you're so dumb you want to do that, I'm not going to close the door and prevent you from leaving, but it's not something I would do.

When we got the NCI grant, he kind of nodded and said that's a biggie. And it was a characteristic Wynder expression for anything that was significant. And when he used that word, he said this was significant.

Now, we had one problem with the pancreatic control trial, we had the NCI and the NIH involved, but we needed a clinical site. That took exactly one phone call from Ernst Wynder. He called Karen Antman, the former president of American Society of Clinical Oncology, set up a meeting, dragged me up to Columbia, we met with Dr. Antman, I presented all the data from the pilot study, and that day, at that session, she said, we're going to get Columbia as the site. She thought the data was significant enough that it warranted Columbia involvement.

Dr. Wynder had an extraordinary influence in my career. If it weren't for him, I don't know that I would have ever gotten the pilot study published. If it weren't for him, I never would have gotten Columbia. If it weren't for him, I don't know that the NCI would have taken me seriously after the 1993 presentation.

I'm very saddened that he's not here to kind of enjoy the success that he helped generate, but I'm sure that he's up somewhere looking down at this and kind of has that smile on his face, that award's a biggie. Thank you very much. Thank you very much.

DR. GORDON: Thank you, Nick, so much.

Nick is, absolutely, as you can see, a worthy student of Ernst and a worthy recipient of this award. And it's so appropriate that he receive the award. He has the same kind of courage and persistence and refusal to take no for an answer, and willingness to face opposition and to come up with the science, with the evidence, with the work on behalf of people, as Ernst. So, I'm so delighted, Nick, with everything you're doing.

And now, before we break, I just want to present you, in addition to the award and we're going to have -- actually, the award, the final version of the award is on its way, it's a very big and elegant crystal.

And we also have, for both -- you have to come up again, both of you, Nick and Sandy. This is a very solemn occasion for us, as we welcome you into the family of the Center for Mind-Body Medicine, we have another biggie for you, a big T-shirt. Those are the sizes we have. Thank you for being here. Thanks for being with us.

You'll be able to hear about some of the details of Nick's work in the Best Case Series presentation that Jeff White is doing, the NCI NCCAM is doing. So, we look forward to seeing you back here at 12:15.

(Whereupon, the PROCEEDINGS were adjourned.)

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