

**CENTER FOR MIND-BODY MEDICINE
COMPREHENSIVE CANCER CARE 2000**

CONCURRENT: National Foundation for Alternative Medicine Best Case Series

PRESENTERS: Wolfgang Woepfel, MD; Michael Gnatt, MD

MODERATOR: Honorable Berkley Bedell

COMMENTATOR: Robert Wittes, MD

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P R O C E E D I N G S

MR BEDELL: Millions of dollars on laboratory cancer research, and as far as we know, no one, except this little foundation reform, is out visiting clinics, and in a scientific manner, trying to determine whether or not they have found things that enable us to more effectively treat cancer.

So that two years ago, my wife and I said, well, if we can't get the government to do it, we'll try and do it ourselves. So we formed the National Foundation for Alternative Medicine, wherein we're doing exactly that. We're sending teams with a medical doctor around the world to visit cancer clinics.

Two of the doctors that go on these visits are here -- Michael Gnatt is one of them here, and Arnold Eggers is here in the second row, and another one of them -- there's medical doctors.

We're visiting these cancer clinics, and going in and checking their patient records to see what sort of success they're having. Then we're using a protocol, which was mentioned this morning, in which the NIH uses in a best case series to sort out some of their best cases.

We're in the process of having those translated in English; and those translations will be furnished to oncologists here in the United States. If oncologists agree with our medical doctors, we would hope to get that published.

Regardless of that, our real goal is to get information, so that people -- either of two people, certainly, one of which those people are sent home to die because the doctor said they couldn't do anything for them. They were told that there was a place for, at least, some people in their condition that had been successfully treated.

Secondly, for people who did not want to go through the toxic problems of chemotherapy and radiation. They were told there's a place they can go to try a non-toxic treatment first, at least to see whether it would solve their problem or not.

So that's our goal; that's what we're trying to do. Of course, our ultimate goal is to try to bring better and better cancer treatments to people in the world.

In our efforts, there are two doctors and one clinic that are here. There are two German clinics that we believe have records that are sufficiently impressive that we are in the

process of having them translate. One of them is here with us this afternoon, Dr. Woeppel. They are going to present what they have found in some of their cases.

First of all, I'd like to introduce our doctor, Dr. Michael Gnatt, who's going to talk a few minutes about his impression of what he has seen as he's visited some of these alternative medicine clinics.

Dr. Gnatt?

DR. GNATT: Thank you very much. I'd like to share with you some of the process that we're using in visiting the clinics, the methodology we're using. So I will share with you our process, and tell you how we're going about our work.

First, let me introduce myself. I'm a conventionally trained internist. I have a primary care practice in New York City. I have an interest in alternative medicine, I've studied herbal medicine; but I really was quite skeptical when I was approached by the staff of the National Foundation, and they described to me what they were planning to do.

I really did not expect to find -- when they proposed that we go to clinics around the world that were using unconventional and alternative medicine to treat cancer, I said I'd be happy to come, but I really didn't expect to find anything. I think, in retrospect, the work that we've done has been very astonishing to me, and impressive; and I think that it needs to be brought out.

So, first, let me explain how we do our site visits. There have been others before us that have visited clinics around the world that are doing this kind of work -- John Fink published a book that gives some information about the clinics -- but the work that we're doing with the National Foundation goes really beyond this because in all of our visits the team is led by a medical doctor.

So, that gives us the opportunity to interview the practitioners in a more revealing way. We can go on rounds with the doctor, and see patients together, and see how they treat patients there.

In addition, we are challenging all of these clinics to submit cases to show evidence that the treatment that they do there really works. It's not enough to just explain why something should work; we're looking for outcomes.

So far, we have visited 56 clinics around the world in 11 countries. Personally, I've been to 22 of these, and it's very revealing to make the visits because it makes quite an impression. Several of these clinics have submitted best cases, although not all of them have. So far, we have six of the clinics' reports on our website, and we are adding more currently.

The method that we're using to study outcomes as a best case series you've heard about. Now, this methodology has evolved over time, originally proposed by the Office of Technology Assessment in 1990. NCI proposed their first official methodology for a best case series program in 1991. Then in 1993, Wayne Jonas, who was director at that time of the Office of Alternative Medicine, wrote a guideline for screening cases for a best case series. And this is the methodology that we're using in our work. Let me explain how that works.

There's three inclusion criteria. First, and obviously, the diagnosis of cancer must be well documented, including the tumor type and the extent of the disease. The second criteria is very important. Cancer has to be present at the time the alternative treatment starts.

What this means, is that adjuvant therapy would not be acceptable as a criteria for a best case because sometimes when patients have surgery and the tumor is removed, there's no recurrence, and patients are sometimes cured with surgery. So cancer must be present at the time of diagnosis.

I'm just going to share a case with you to show how sometimes that makes very impressive cases not acceptable as best cases.

One of Dr. Woepfel's cases was a woman who is years old, when she was diagnosed with a very large colon cancer. It was metastatic to the liver, and this was in 1991. The tumor was removed, and the liver metastasis was also removed. But in 1993, this woman had a recurrence in the liver, so the surgeon went in again and removed the metastasis. She was okay until 1995, and had another recurrence in the liver. Again, the surgeon went in and removed this.

She had no chemotherapy. But this time she went to Dr. Woepfel at the Hufeland Klinik afterwards, and began this program, which involves no conventional therapy in this case. She's remained well, which I think is quite impressive; but it's not a best case because there was no cancer present at the time treatment was started.

The third criteria is that there must be no concurrent therapy, which is known to affect the cancer, or no treatment immediately preceding. So, this would eliminate conventionally-treated patients, patients who are treated conventionally at the same time.

So, many of the patients that were seen at other clinics as well, but certainly at the Hufeland Klinik, are simultaneously treated with conventional therapy in some cases. For example, in breast cancer, they have many patients who have done very well, or have gone into remission, Stage 4 breast cancer, but also treated with hormone therapy, so we can't include those cases either -- cannot include those, because some could argue that it was a conventional treatment, the hormonal therapy that may have been responsible for their remission. So you can't make a claim about the unconventional part.

The next three criteria are outcome criteria. First, complete tumor remission, which is obvious that would be a best case. Next is partial tumor response. And this is the criteria that is emphasized by the NCI best case series. They're looking for 50 percent reduction in tumor size -- at least 50 percent -- and at the same time no new tumor occurring elsewhere.

Then, the third criteria that was proposed by Wayne Jonas was prolonged quality of life expectancy, which is defined as a survival extremely longer than would be expected for that person's stage and tumor type, and also evidence of improved quality of survival.

This is not one of the criteria, as I understand it, for the NCI best case series, but I think that it's important to emphasize the importance of this criteria because a partial tumor response and the options of improved survival, and the options of prolonged survival or

improved quality of life, to me, is not necessarily impressive. As many of the chemotherapy trials show, the tumor may respond, but the patient doesn't live longer or feel better. I'm not sure how impressive that is.

On the other hand, certainly, there may be certain indolent tumors, or tumors with very variable clinical courses, where prolonged quality of life may not be impressive.

These are guidelines. Our criteria is, when all is said and done, are the cases impressive when reviewed by our reviewing oncologist?

So what would a series of best cases mean? One case, perhaps, might not mean that much; but a whole series of cases at one institution would be very suggestive that the treatments that they're using may be efficacious, and is worthy of further study.

I think, though, that it's important to emphasize the limitations of this kind of study. It does not give an indication of tumor response -- of the response rate, I should say -- so it's difficult to compare to other treatments. And also, it's impossible to study an integrative treatment program where conventional agents are used for the reasons I've mentioned.

What are we finding when we're visiting these clinics? First of all, the most striking thing is, the treatment philosophy is very different in these alternative cancer treatment centers. In general, conventional medical oncology has a different philosophy than these clinics, and tends to have an anti-tumor approach; where, if the tumor can't be removed surgically, the approach is to try to destroy the tumor cells, to eradicate the tumor with chemotherapy or radiation therapy. Unfortunately, these approaches are toxic kinds of treatment, and sometimes can injure the patient's immune system or detoxification systems.

The approach used by most of the unconventional clinics that we've seen is more of a host supportive approach, where the treatment seeks to improve the patient's own ability to heal in various ways. I'm going to let Dr. Woepfel, in a minute, describe their treatment in much more detail.

Finally, best cases alone, without validation, would, I think, be brushed off as anecdotal reports. So we recognize it's extremely important to validate the findings. Already we've taken steps to have the pathology slides and radiology imaging studies reviewed.

Columbia University is working with us to do this work. Already, the slides are being transferred to the pathology department there. Unfortunately, this is a work in progress; we don't have all of these validation steps completed, but the slides are in review.

So the question is, do these unconventional treatments work? So we're going to switch to this projector. And while you're doing that, I'm going to introduce Dr. Woepfel.

I have some simple slides that describe the cases. The advantage of the computer is we also have computer images of the x-ray studies, and that sort of thing. So hopefully, we'll be able to get this going.

Let me introduce Dr. Woepfel. It's really a privilege to be able to present these cases and work -- Dr. Woepfel, after completing his training in internal medicine, took a position at

a hospital near Heidelberg as the assistant chief of service, and his responsibilities included managing the intensive care unit. So he had experience after his residency in conventional medicine.

Then in 1982, he took a position working with Dr. Joseph Issels. I don't know how many of you know of Dr. Issels. He's one of the great figures of this century in the holistic treatment of cancer. I'm also delighted to see his wife. Mrs. Issels is here with us today.

So Dr. Issels developed a program, which has been continued by Dr. Woepfel. Dr. Woepfel began working with Dr. Issels in 1982; and then in 1985, he left to begin his own clinic, the Hufeland Klinik in Bad Mergentheim. It was my pleasure to visit there last year, and see how Dr. Woepfel treats patients.

So I'm going to present the first patient, while they're working on this. So that's a picture of the Hufeland Klinik. The clinic is dedicated to treatment of cancer. Ninety-nine percent or so of the patients there are there because of advance cancer.

Why don't we go ahead? I'll present the first case; and then you can tell about the clinic and how you treat patients. So this first patient was a man who found blood in his urine in April of 1989. And you can see on this intravenous pyelogram (IVP), he presented immediately to his doctor, and the urologic investigation revealed that he had a bladder tumor.

You can see on the right side of the hydronephrosis the dilated ureter, as well as the base of the bladder. On the right side, you can see a routing image that shows the tumor. There's a CT scan that was done that shows the tumor was 6.5 x 2 centimeters. He had a diagnostic transurethral biopsy, which showed that it was a transitional cell bladder carcinoma, grade 3.

So the doctors treating him recommended that he have chemotherapy first, followed by radical cystectomy. Because of the quality-of-life concerns that the patient had, he adamantly refused to have any of these treatments. And instead, he went to see Dr. Woepfel at the Hufeland Klinik. Dr. Woepfel also recommended that he have the surgery, but the patient continued to refuse.

So he began in July of 1989 the immunobiological treatment, and he was an inpatient for seven weeks receiving treatment for this tumor. Then in October, he was improved, and he had an ultrasound and a CT scan, which showed resolution of the obstruction.

Now, I'm showing a close up of the bladder so you can see the tumor. There's an hydronephrosis on the right side. Here on the CT scan, you can see the dilated ureter on the right, as well as the indentation of the tumor on the surface of the bladder -- well, the appearance of the bladder.

Now, here's the follow up. In October, just several months later, showing that the bladder now is round and full, and you can't see the appearance of the tumor there that was there before, and the hydronephrosis has resolved on the right. And here's a picture of this patient. Both pictures are in 1998, where he is well with his wife.

The follow up of this patient was quite close. He continued to see his urologist every year, and had follow-up examinations, cytology, ultrasound, and continued to be a continuous debate to be in remission.

DR. WOEPPEL: Perhaps, I will explain to you a little bit of my treatment so that you'll know what we do.

In principle, we think that a cancer can only develop if the body is severely disturbed by a lot of influences. I'll mention, the left side, we have influences by the genes. We have external influences physically and chemically. We have very important internal influences, a wrong diet. Very important is emotional influences. Long-lasting emotional influences from the childhood, from marriage, from drug.

All these different influences -- also called causal factors -- damage the body within years, and they cause organ disorders, secondary damage to organs and cells. The detoxification is impaired, the environment disrupted, regulation disturbed, and all this causes a lowered resistance.

So lowered resistance in our sense does not mean a weakness of immunity. A weakness of immunity is only a very small part of this problem. It is much more a whole breakdown of regulation mechanisms in the body; and we often find that the patients tell us, oh, we've never had fever the last 5 or 10 years, we are very healthy.

I always say to my patients, if you are really healthy, you must be once a year sick with a cough or something like that, so that you know that your body's just reacting.

So the regulation disturbance is really a severe problem, and you don't notice it; it doesn't hurt. It's the same as if you have high blood pressure. Most patients do not notice that the blood pressure is high until they get a stroke or a heart infarction.

Insofar these damages are not noticed neither by the doctor, nor by the patient. When you now get a normal cell transferred into a cancer cell, for example, by toxins or by radiation, or by viruses, then this cancer cell finds the environment which it needs to grow up to a tumor.

If you follow this opinion, then it must be clear that it's not enough only to remove a tumor. When I only remove the tumor, I cut them out; I did nothing to change this lowered resistance. Some tumor cells survive; they found a good environment to grow again, and to make a relapse.

Insofar, in our opinion, one must not only remove the tumor, or fight against the tumor; one must do a lot of things to change this lowered resistance. Of course, you can give immune stimulators that helps immune system to get better.

But the negative influences which come from these causal factors are still working. Insofar you don't change anything in the long term -- that means if you make a biological treatment without removing causal factors -- the chances of the patient's are not so good to get healthy because of the negative influences work during the whole time.

So we must seize a tumor, we must fight against the tumor, and we must urgently do everything to help the law of resistance, and this means to reduce as much of these causal factors as possible.

The second problem is psychology. Here, I listed the scientifically known and the defense mechanisms. We know that each cell has a lot of repair systems. When the genetic material is destroyed by radiation or whatever, there are a lot of possibilities to repair it.

With the extra cellular environment -- that means the fluid around the cell is very important for the function of the cell membrane, and the cell membrane determines which substances can come into the cell, and which can come out. If this environment is disturbed, or the function of the cell membrane is disturbed, insofar, the cell is disturbed. The third is an immune system, which is our defense against microbes and pathological cells.

So this systems function, we need a autonomic nervous system, which regulates all these mechanisms. Now, autonomic nervous system is dependent from our psychological stage. That means, if we are depressed, the depression blocks our autonomic nervous system.

If we are very nervous, we have a high activity of the autonomic nervous system, so that these mechanisms don't function the regular way, and insofar the psychological treatments are very important to influence the autonomic nervous system, and these very important defense mechanisms of our body.

That's why we have these components of our therapy. The most important treatment which each cancer patient should have is a basic therapy. That means eliminating harmful factors. All causal factors which we know should be removed. That is why the biological treatment is a very individual treatment.

Each patient has different causal factors, and we must find out is this patient much more disturbed by a foci, or is he much more disturbed by psychological problems. And insofar, we must exactly diagnose which patient they have come from.

We have to treat the secondary damages. We have to help the patient and to support the detoxification of the body. The patient has, perhaps, to change his lifestyle, and he has to do exercises activate, or to regulate his autonomic nervous system, which is so important.

Of course, we look at which of the specific tumor therapies are necessary. Must I perform an operation, is it possible to operate, or is it better to begin hormone therapy, or chemotherapy, or radiation? In this concept, conventional therapy adds an important position.

Next important is the post-treatments, i.e., psychotherapy, with counseling, with exercises, or hypnosis. There are a lot of possibilities to influence psychological intervention.

Then we have the immune therapy, but the immune therapy is not the first step. The immune therapy will not work when the regulation systems are disturbed. The body will

not react on immune stimulators. We see that when we perform, for example, chemotherapy. A healthy person which reacts with 40 or 41 degrees Celsius fever, a cancer patient will not react with this example just because the immune system cannot stimulate.

So this is the principle and the theory of our treatment, which these patients which we show you now are treated with.

DR. GNATT: So we'll go on with the cases. Just yesterday, Dr. Woepfel had the opportunity to explain his treatment protocols in extensive detail, I'm sure that at the end there will be time for questions, if you have additional questions about how he treats patients.

The next patient I wanted to present is in striking contrast to the first. The first patient had never been treated with any conventional agents prior to treatment. This patient was exhaustively pre-treated with conventional agents before coming to the Hufeland Klinik, and still was able to recover.

When this patient was diagnosed with ovarian cancer, she was only 25 years old. In 1968, she had carcinomatosis of the peritoneum with her diagnosis, at which time she had a hysterectomy, followed by 10 cycles of chemotherapy with a single agent, cyclophosphamide.

She did very well. She was okay until 1981, when she had a recurrence of carcinomatosis, with ascites. Again, she was treated with the same agent. She did fairly well, until in 1984, when she had a metastasis of the abdominal lymph node, and this time, she was treated with a different chemotherapy, with PAC, and received seven cycles.

However, just half a year later, she had recurrence with, again, carcinomatosis. So this time, she was treated with whole abdominal radiation therapy. Then just a little over a year later, there was, again, new evidence of recurrence in the abdomen.

She had exploratory laparoscopy and biopsy, which showed definite recurrence of the ovarian cancer. This time the patient refused any additional chemotherapy. She came to the Hufeland Klinik shortly thereafter. In March of 1987, she began treatment.

So this fills all the criteria of the best case series. Although she was pre-treated with conventional agents, there's a long time that lapsed, and biopsy-proven recurrence, with no intervening treatment.

At the Hufeland Klinik she started, and four months later a laparoscopy showed a complete resolution, complete remission of the cancer. She continued to be quite well. She had a remission that lasted 12 years.

In 1998, she had had several laparoscopies, CT scans, and continued to feel very well. Then she had a colostomy, at which time the surgeon was able to look, and see by operation there was still no evidence of cancer.

This is her in 1989, just two years after starting treatment at Hufeland, and she's well. Unfortunately, last year, she developed new problems. In January of '99, she developed a

cancer in the left kidney, and shortly thereafter and advance cancer of the pancreas, and died last year.

The next patient is a man, who was 43 years old when he developed a brain tumor. It was not resectable, but at surgery, two-thirds of the tumor was removed. It was a glioblastoma, grade 4. He was treated with radiation therapy and monotherapy, with chemotherapy 1-3-bis(2-chloroethyl)-1-nitrosourea (BCNU).

Here's the picture of the tumor, typical appearance of a glioblastoma before surgery -- again, before the operation.

After surgery and chemotherapy, the patient had a relapse. It was not completely excised, as you saw; and CT scan was suspicious of recurrence in March of '88. Then in August, he had surgery for a second time, where again, it was not resectable, but a subtotal extirpation removed as much of the tumor as possible. This time the histology was read as, an anaplastic astrocytoma, grade 3. He had a shunt placed, and then, two months after surgery, began treatment at the Hufeland Clinic.

Here's a picture of -- this is March. This is before the second operation, with the suspicion of recurrence, and then we'll show you pictures later. So then, after starting treatment at Hufeland, the follow-up CT scan showed either edema or progression, in the post-operative area. He continued treatment at Hufeland, and his clinical and neurological symptoms were improving steadily. The follow-up CT scan showed that this area that was in question of progression was resolving. In fact, in January of 1990, there was no evidence of tumor progression.

In March of 1990, the CT scan showed a hygroma, which was large; and so, he had surgery to drain the hygroma. Unfortunately, there were a lot of complications with infection. The patient survived these, however, and recovered, and continued to do very well. There were follow-up CT scans regularly. In 1990, see the large effect where the tumor had been removed, but there's no evidence of tumor recurrence.

In 1992, we have a letter from his doctor showing complete remission of the tumor disease. He was last treated in Hufeland in January of '93, and remained in stable condition until he had a stroke in March of '96. He was admitted to the hospital with a stroke, and at that time, the CT scans and imaging studies showed, again, no evidence of tumor recurrence. And that's the most recent CT we have to show.

The next patient was a woman who was 63 years old when she presented with brain tumor. She was first treated preoperatively with radiation therapy, and unfortunately had a pulmonary embolus, so surgery was delayed for few months. But then in May of '83, she had a resection of the tumor surgically, and then five cycles of chemotherapy.

In November of '83, there was evidence of tumor recurrence, 4.3 centimeters, and there was also new neurologic symptoms that developed. This is the tumor before surgery, and this is a relapse.

All right. We have reviewed this with our radiologist working with the Foundation, and it's impossible to be a hundred percent certain that this is a relapse, but it's possible that it's edema, but it probably is relapse; and it was not fully resected by the operative report.

So we began immunobiological therapy at the Hufeland Klinik. Oh, yes. That's right. This was not the Hufeland. This was actually treated at Dr. Issels' clinic, and Dr. Woepfel was taking care of this patient.

So her neurologic symptoms resolved, and follow-up CT scan showed a reduction in tumor size, which persisted on subsequent CTs. But then much later, three years later, the CT scan showed complete remission.

The patient did quite well until 1988, when she started to have focal seizures, and then finally, in November of '89, was admitted for somnolence, and the evaluation included a CT scan and MRI. There was no evidence of tumor recurrence by MRI, and the diagnosis was that she had a process involving the myelin, which was damaged by the preceding radiation therapy, which was leading to her seizure disorder, and she died of a myelin condition.

But no evidence of tumor recurrence at death. So these are the most recent films that do not show any recurrence. Most are no evidence of recurrent tumor.

The next patient is a young man who developed a melanoma. He found a mole on his thigh, was excised, and was a deep ulcerated malignant melanoma. Although it was resected, he shortly thereafter, one month later, developed a new lesion on the skin of the thigh; and then every month, or every other month, for the next six months turned up again with a new skin lesion. Each time removed and resected was showing melanoma recurrent to the skin.

Then finally, he developed a large inguinal node, which was removed; and that showed melanoma. Then subsequently presented to the Hufeland Klinik.

When he came to the Hufeland Klinik, he began immunobiological therapy, but one month later, he developed there subcutaneous metastasis in the thigh, which had to be removed. It was not completely removed, but the pathology report showed the melanoma in lymph node and in fat.

Subsequently, this nodular area continued to grow, despite the treatment that was being given at Hufeland. There was a follow-up MRI, which shows in April of 1992 that the tumor had increased in size to 4 centimeters.

This patient was not treated with any conventional agents. He did not receive Interleuken 2 or Interferon, and no chemotherapy. So Dr. Woepfel changed his treatment on this patient because he was continuing to have enlargement; and subsequently, the tumor began to regress.

In May of '93, the MRI shows that the nodule had reduced in size to only 1 centimeter; and subsequently, it resolved completely. This patient is still alive and well within full remission, no evidence of disease. This just shows the MRI finding of the metastasis, the nodule.

Now, this is another melanoma patient. This is a woman who in 1985 discovered a melanoma on her arm. First, when it was removed, the doctors saw that she had findings in the lung that were pulmonary fibrosis. They were concerned that it was metastasis, but in fact, it was not.

She did well for several years, until she developed an acute abdomen with obstruction, and when the surgeons operated, they found a very large tumor and this was resected. There were, unfortunately, many metastatic lymph nodes in the mesentery.

Then, a year and four months later, she had a second intestinal metastasis with obstruction, and this time it was an 8 centimeter mass, and the pathology showed melanoma.

Then subsequently, just a few months later in March of 1991, she developed in stools, and on the proctoscopy and CT scan, she was found to have a very large tumor, a 7 centimeter tumor in the pelvis. This was stenosing the ureter and causing hydronephrosis.

This is the large tumor in the pelvis, and I'm not sure I see the hydronephrosis. Here's the hydronephrosis.

So she was told by her doctors that there's really nothing they can do for her. She went to the Hufeland Clinic, and began the standard immunobiological therapy, receiving no conventional agent. Three months later, the patient was feeling quite a bit better. She was having normal bowel movements, and the pain had resolved. A follow up CT scan and ultrasound showed an obvious reduction in the tumor mass.

This shows the rectum and bladder, and there's no intervening tumor that had been present before. This shows reduction of tumor, and the resolution of the hydronephrosis.

This patient remained in complete remission, without any evidence of recurrence or lymph node metastasis, and follow up CT scan. She did have some other medical problems. She had glomerulonephritis, which led to deterioration of her kidney function, and continued to have pulmonary problems, but remained essentially well, and no evidence of melanoma.

She eventually died in 1997 with acute presentation to the hospital with headache. The MRI showed metastasis.

This is the most recent CT scan, showing complete resolution of the abdominal pelvic tumor. You're going to present the last two.

DR. WOEPPEL: The last two patients which I want to present are no complete remissions, but I want to demonstrate that you can even live with a tumor which is not curable, even if it's not possible to resect this tumor, or to destroy it by chemotherapy.

This patient had in '91 the diagnosis of a mixed tumor in the mediastinal area. You can see, perhaps, it is a very big tumor -- and compressed by this tumor. The patient had difficulty with his breathing. In 1992 he had emphysema. But after his radiation, the tumor grow again. Then he came to us for the treatment. And this is a picture on February of this year, and this was a patient this year.

You see the difference in the clinical stage, but the difference in the x-ray stage is not so important. One can see that here this phase is quite bigger than this phase. So the tumor

is still there, but the patient is still alive; he's in a very good condition, and he has no problems with his tumor. He has normal breathing, and everything's okay with him.

I thank you. That is all I wanted to show you.

MR. BEDELL: We'll now hear from Dr. Robert Wittes.

DR. WITTES: Since I'm not a politician, I'm not very good at speaking in a loud voice, especially not this late in the afternoon, so I will use the microphone, if that's okay.

I think what you just saw, to me -- I'm actually seeing this data for the first time, just the way you are; and so, I'm just going to give you my kind of off-the-cuff reactions to what I've just seen, and in that context, maybe say some things about the best case series process. In fact, why don't I start with that, and then work back to the cases.

I think Dr. Gnatt actually outlined very nicely a bit about the history of this, and a bit about the philosophy of doing it, and also the circumstances under which it's most appropriate to do this. So, let me just reemphasize some of those points.

You'll notice that the cases that you just saw all emphasized objective findings. And when we set the NCI's best case series process up, in '91, I guess, the people who were responsible for doing that -- mainly Mike Hawkins with some of his associates at that time -- emphasized tumor shrinkage as "the" major endpoint that they were interested in.

Now the reason for that was not that tumor shrinkage is the "be all" and "end all" of oncology. It really had nothing to do with that. It wasn't that survival isn't important, it wasn't that quality of life isn't important, it wasn't that freedom from progression isn't important; it was simply that tumor shrinkage, whether or an X-ray, or an MRI, or a CT scan, or anything else, is objective, if it is of a certain degree.

Certainly, if you have a big lump, and it goes away, that's something that most people can agree has occurred. If you have a big lump, and it mostly goes away -- so called partial response -- that's something also that isn't likely to be mistaken for the kind of change that actually might have been due to something else besides tumor cell killing.

If you have minor responses -- if you have just minor shrinkages in the size of tumors that you can measure or see on an image, that's a problem. That's why partial response was considered the floor for this process. Minor responses, maybe interesting, maybe not; but the key thing about them is, you often can't tell whether you've even seen something that's a phenomenon or not.

Even if it's on an X-ray, it's sometimes hard because the positioning of various X-rays is different, and the shots are done somewhat differently, and technique can account for a certain amount of apparent change and the way images appear.

So that's one important element, the objectiveness of the endpoint, and that's why that particular endpoint was chosen. The second thing about was chronology -- what events have occurred, and in what temporal sequence.

So if you are alleging that intervention X has caused tumor shrinkage, it's pretty important to be sure that you know when intervention X started and stopped, with

respect to the observed change in the tumor. It's also pretty important to know that there wasn't something else given at the same time, or prior to intervention X that could have caused it and confounded it.

It seems to me that you've done a very good job in the analysis of these cases in clarifying the temporal sequence, and sitting listening to Dr. Woepfel's presentation for the first time, and also Dr. Gnatt's narration of the cases that he did, the people who did this were obviously sensitive to these issues -- they were careful -- and what they produced was a sequence of cases that made me interested in what the treatment was.

We were calling it immunobiological treatment throughout. Actually, I'm glad you did that, rather than spending a lot of time talking about the details of the treatment. Because what we're talking about here is a methodology for finding out whether there's any reason to be interested in what Dr. Woepfel is doing.

If these cases actually were not convincing, you might be very interested in his regimen, you might be very interested in his philosophy of treatment; but after seeing cases that didn't show very much, you would leave the room, scratch your head, and say, okay, his philosophy is interesting, but what's the bottom line, what does it actually do?

So I think what I've seen today are several cases that interest me, that whet my appetite to learn more about what's going on in his clinic, what the treatment consists of, and so on. There were several of those cases in particular that I found striking; there were others that I found a little harder to understand in terms of the temporal sequence. But that's because I was seeing these complicated cases for the first time, and they were complicated.

Those of you who do this kind of medicine routinely know that the presentation of individual cases like this usually triggers a lot of questions about details. But that really isn't the point of the exercise today, and I'm thankful that presentations were actually -- given the complexities, that they were really so clear.

So the interesting question now is, what does one do with a best case series result like this? Because it's important to sort of be aware what data like this does for you, and what it doesn't do for you.

The first thing, what don't you know? A best case series is a best case series. It's an invitation to people to present the very best of their experience. And the reason to do it is to develop a sense of plausibility on the part of skeptics. I consider myself a professional skeptic, not just for CAM, but for everything.

It's good to be a skeptic. People who allege things should have to convince you that they're right, it doesn't matter what it is. So the idea is to try to convince professional skeptics that something that you're doing is interesting.

Then the whole series of other questions follows. So it's interesting. How common is it? Has Dr. Woepfel shown us a treatment that cures cancer left and right? Well, we don't that, and he hasn't alleged that today; that hasn't been the purpose of this exercise. So the frequency, how often does this happen.

Is there some kind of discrimination between the kinds of patients that are likely to respond to what he does and the kinds of patients that do not? How does this compare to other kinds of intervention that are either standard or not standard, but are alleged to work by other investigators, people that have reported in the literature, or whatever.

But those are all the kinds of questions that follow the determination that there is, in fact, something to be interested in. I think, as best I can tell from what's been presented here, this is a very good process, and it's going to be a very useful thing.

I can tell you that we at the Cancer Institute would be very interested in sitting down with people from your organization, Mr. Bedell, you, Dr. Gnatt, or others who are doing this process, and to sit down with the finished product after you've done this, and take a look at it with you, and to really spend some time looking over the details, then to consider what the regimen actually represents, and where we ought to go from here.

Now, Mr. Bedell is right. The Cancer Institute hasn't up to present mounted field investigations of this kind in similar circumstances, although we're actually currently contemplating one in India at a homeopathy clinic that was brought to our attention at our best case series process at the so called CAP CAM, the evaluation group that we and the NCCAM together empaneled to do best case series, to do exactly this. Only, it's true, we don't go to the clinics and collect the information; we ask the people who are in the clinic to come to us.

In the case of the Indian homeopathy physicians, they did that. They brought slides, they brought X-rays. The slides were reviewed by NIH pathologists, the X-rays were reviewed by NIH radiologists participating in the CAP CAM process. The physicians presented data to the CAP CAM, and each case was discussed.

I think there was something like 14 or 17 cases presented at the session. There were a number of cases that were interesting along these lines. There are a number of cases that seem to show objective shrinkage of tumor that one could not explain on any other basis.

This whetted our appetite for more. And we're currently seeing whether we can work out a field investigation, basically, at the clinic in India; it's near Calcutta. This is not so easy to do all the way around the world -- I have to tell you -- and Jeff White has been spending a fair amount of time trying to figure out exactly how to do this in a way that would actually work.

So that's actually one consequence of the best case series process that we, the Cancer Institute, have put in with the NCCAM together. Jeff has also written lots of letters to many people in the CAM community. I think he sent out about 150 letters so far to various people to try to make them aware of the process, and invite their submission of information to it.

So I think that's about all I have to say. These approaches in a way are complementary, aren't they? You go out into the field -- but there's every reason to expect -- and the reason we decided to do it the way we are, there's every reason to expect, I think, that if you create a process that is perceived to be fair by people, in which they can expect that if they go there and they present their experience, they will be treated with respect, their

information will be looked at seriously by experts; and above all, they will be treated fairly.

I think there's every reason to think that people will come forward to a process like that, not everybody, but I think enough people to make it very much worth doing.

Now in closing, let me just say one huge thing that the best case series process doesn't do. We've been talking about objective response all this time, which is the ultimate endpoint. There's an enormous amount of intervention that's going on in the CAM community right now that may be of tremendous value -- is of tremendous value to people who are ill -- that is not really subject to this kind of evaluation.

It's very hard, for example, to come to a group of skeptics sitting around the table, and allege that you have a pain medicine, for example, that causes pain relief with a series of cases like this, unless the pain relief is so stunning that no knowledgeable medical person in his or her right mind would doubt that there's a huge effect going on. And we don't have too many interventions like that in medicine, any kind of medicine, huge effects. We generally deal in moderate effects.

So, for example, somebody on tons of morphine, for example, for intractable bone pain for metastasis, and you do intervention X, whatever it is, and their morphine requirement goes down to nothing, and they get up, and they have no pain anymore.

We've had magical discoveries like that; we don't very much. But unless you have enormous effects like that, then a best case series process isn't likely to be very revealing -- so quality of life issues, for example, psychosocial adjustment.

So we're struggling right now with the question of how you do the same kind of solicitation, to ask people who practice complimentary and alternative approaches in chronic disease -- well, cancer specifically, that's what this is about -- how we can approach the question of finding regimens that work that don't have these objective endpoints associated with them, at least not that you can hold up to a light, and look at, and measure. I'd invite your comments about that when we get to the discussion session. Thank you very much.

MR. BEDELL: Thank you. We now have an opportunity for some questions and answers by our panel.

First of all, we do have a doctor from a German clinic here in the audience. Do you want to say anything, Dr. Eggers?

DR. EGGERS: You said that tumor shrinkage is the most important factor in cancer therapy. I think it was for decades of years that tumor shrinkage was the number one in complication about efficacy of chemotherapeutical tracks. In 95 percent of the publications, only partial remissions and complete remissions have been published.

Nevertheless, we have seen in the last year that not always the partial remission and its relation to survivor. Even in treatments, in chemotherapeutic treatments, which have been used with partial and complete remissions, even the patients lived shorter times compared to also treatments with less percentages of partial and complete remissions.

So the question I think for the cancer patient is, at first, the quality of life and how long the patient survives. It's not a question about, in many cases at least, the percentage of partial and complete remissions. Beside the cases when the tumor is inducing pain by the size that's a different question.

But just in the last years, we have seen immunotherapeutic regimens. They are prolonging survival, improving quality of life, and prolonging freedom of disease and all these things, without changing the tumor size itself.

So, in your opinion, wouldn't we change a little bit the meaning of the percentage of partial and complete remissions with respect to the discussion about complementary medicine?

DR. WITTES: I thought I was careful to say that we don't concentrate on shrinkage of tumor in the best case series process because it's the most important. It isn't the most important; I agree with you. It's simply the most verifiable externally, so that's why we look at it. It's a little bit like looking under the lamp post rather than everywhere else, because under the lamp post is where the light is.

But you're absolutely right that survival -- the quantity and quality of survival together, I think everybody in the field that I know would agree that those are the most important things. You actually raise a very important point also, in that it is entirely possible that the therapies of the future will not necessarily involve tumor shrinkage; they will simply involve inducing a kind of a static state in which the tumor merely doesn't progress; it just sits there.

Maybe some immunotherapies do that now, but it's entirely possible that other kinds of therapies that directly attack the tumor will do that as well in the future and if that happens, a best case series is going to be a big problem; it's not going to be a good way to do this analysis. We're going to have to figure out other ways to do it.

So, basically, you're right. But I didn't say what you said I said.

MR. BEDELL: Did you want to add something to that?

SPEAKER: If I could just have a follow-up on that, in terms of a best case series -- I'm going to address this to Dr. Wittes.

Would you consider it a best case if a patient had a pancreatic, adenocarcinoma, that received an unconventional cancer therapy, and then lived eight years. There was absolutely no reduction in tumor size, but the patient's quality of life seemed better, reduced pain, improved function -- lived eight years, and he was hit by a truck, and died.

Would that be a best case? There's no reduction of tumor.

DR. WITTES: When I hear examples like that, my first reaction is to doubt the diagnosis, my second reaction is to doubt the diagnosis, and my third reaction is to.

So what you're assuming is that I have the slides, and I've reviewed them with a pathologist that I really trust. The diagnosis is, indeed, garden variety adenocarcinoma of the pancreas, the kind that kills people usually within the first year; and that there's no

peculiarity. It isn't an islet cell tumor masquerading as it, it's not some sort of indolent lymphoma.

It's not one of the very uncommon adenocarcinoma varieties that's known to be indolent; it is just plain, the usual kind of pancreas cancer.

In that case, cases like that, if you have long survival several fold greater than you would expect, yeah, I'd be very interested in it. The trick is to know how long is long enough to be interested.

MR. BEDELL: Now the purpose here is not to have a debate between me and Dr. Wittes, but I do have to say, Doctor, that I doubt that Dr. Woepel would have come to the National Cancer Institute. I'm pretty sure that not very many practitioners in the United States, if they had a cure for cancer, would come to the National Cancer Institute, because you may be doing things differently now, but the experience that Dr. Burzynski had and that other people have had in the past, I think most American practitioners would say, the last thing I want to do is get near the NIH, or the FDA, or any of those government regulatory agencies.

I'm not upset about that now, because we're out doing it. But I really think that it's very important, if we're going to really look for alternative practitioners that may be doing things, that the only real way to do it, is to go out in the field and try to hunt them down, and not depend upon them coming to a government agency to try to interest the government agency in what they're doing.

DR. WITTES: Right. So my reaction to that is, if people don't want to come and see us, they sure as heck aren't going to want us to come and see them.

MR. BEDELL: Maybe that's why it's a good thing we've got our foundation, because our people are able to go see people without that.

DR. WITTES: That's right. It may actually be that the data that you collect -- your intermediation in this process will actually be acceptable to the great majority of people to whom we would not be acceptable, for the reasons that you give. I'm hoping you're wrong about that.

MR. BEDELL: I think Mary Ann Richardson can go visit a lot of these people.

DR. RICHARDSON: Can I say something?

MR. BEDELL: Sure, that's why they're here for.

DR. RICHARDSON: I just want to say that I think what you've been doing, Berkeley, is great. I just want to acknowledge Dr. Wittes for his leadership.

We are really -- there's been a lot of garbage, a lot of baggage that we've been dealing with for a long time. I think this is a real opportunity for us to start to move forward, and just let's go forward. We've got people from Germany and the United States. We've got a great guide in Seattle. We've got Dr. Wittes behind us.

It's really an opportunity to move forward, and I think this is a great opportunity, and I think we should capitalize on it. We've never had an opportunity. It's a window right now; the FDA's willing to work with practitioners.

So on a positive note, I just want to say this is a great opportunity. I think we should focus on these chances now, and move forward, and kind of let the history go, Berk.

MR. BEDELL: That's probably particularly good advice to me; and that is, forget the past, and let's go forward into the future with where we are now. I think that's probably a very, very good statement.

Yes, sir?

SPEAKER: I'd just like to thank Dr. Woepfel for coming all this way and showing us your work.

I would tend to put more importance on the third objective for your best case scenario, and that would be the quality of life and the functionality of the patient.

I'm not so sure I'm impressed with the tumor regression of those patients that had died three months later with an extension of the disease, which several of the patients did. I thought they had regressed, the tumors, at the site that was treated; but they then proceeded to die of a stroke, or of an extension of the disease. I'm not sure I'm impressed with that.

But I'd like to have seen what the patients went through during the treatment, and how they reacted to it, and their functionality, and their improvement in the quality of life.

MR. BEDELL: I think I can answer that a little bit. I visited some of these clinics. The difference between Dr. Woepfel's clinic and these other clinics and the American hospital, is about as different as you can imagine.

These are really spas, where you all go together down for your lunch, and you are there living as a family, so to speak. The cost of his clinic, I am told, including the doctor, the medicine, the stay in the clinic -- room, board, and everything -- is approximately \$250 a day. Here it would be four to eight, ten times that much.

But part of it is, in my opinion -- if I can speak my opinion -- it's partly that you're in a healing atmosphere, and I would argue that an awful lot of our American hospitals are not particularly healing atmospheres, if you spend time in them.

SPEAKER: I thought actually -- the data went by a little quickly. But I thought that some of those remissions that didn't last still lasted a number of years. So, that's pretty valuable, I think.

I mean, if we had conventional therapy that could take patients with visceral melanoma, and reproducibly cause extensive visceral melanoma to go away, for what, four years before it came back, I'd be pretty happy with that. I mean, I wouldn't be ecstatic about it, but it'd be a heck of a lot better than what we've got now. Now, the question is whether this does it reproducibly or not, but the case I thought was really pretty impressive.

MR. BEDELL: Do you have a website, Dr. Woepfel?

DR. WOEPPEL: Yes.

MR. BEDELL: She'd like to know it.

DR. WOEPPEL: www.hufeland.com.

SPEAKER: If I could just have a follow-up on Mary Ann Richardson's comments, I also support her urging everyone to be moving forward. But as far as our ultimate goal of being able to bring home to the United States treatments that do prove to be effective, there's a long way to go.

Because many of the treatments that are used here in this clinic, for example, are not available in the United States; in fact, they're illegal, including hyperthermia, autologous vaccines, Coley's toxins, a lot of the infused herbal medicines that are used in this protocol.

So there's a lot of reform in the regulatory structure, as well as the FDA, that needs to be done in order to make these treatments available. And one additional thing to say about them is, that they're all, by and large, extremely safe therapies.

As far as quality of life, I spoke with many of the patients there when I visited, and one in particular stuck in my mind. It was a woman who had breast cancer that had been removed, and then spread to the lungs. She was only in her thirties. She went through two cycles of chemotherapy of different protocols, did not respond. And then she was recommended a stem cell transplant with high dose chemotherapy, and refused. Having gone through the chemotherapy, she said I won't do heavier.

Then came to the Hufeland Clinic, and she was treated with hormonal therapy, as well as the complete immunobiological program. So we didn't include her case as one of the best cases, because it isn't because of the hormonal therapy, which contributed to her recovery.

But she was in full remission, and remains so to this time. In asking her, she felt better during the stay at Hufeland. By the time she left, she felt better, as opposed to the conventional therapy.

She said that the most difficult thing that she had to go through was the fever therapy. It's quite difficult to have a fever up to 104 degrees. But she said it was nothing like the chemotherapy.

So it's not just a spa, but people as they leave the clinic are already feeling better.

SPEAKER: Why do you feel that those processes are against the law in this country?

SPEAKER: It has to do with many things. One thing is, the FDA approval process is geared for single substance pharmaceutical medications. And a lot of these procedures like herbal medicines don't fit their paradigm for review, and there is no pharmaceutical company who's going to try to get a patent on intravenous Echinacea, or whatever else it

is. So that there isn't a process or an incentive. It really requires reform of the whole FDA approval process, and there's many other reasons as well.

SPEAKER: There is an important issue with substantives that are mixtures, natural extracts. If you don't have a pure chemical, then if you're going to give them to a human being -- just forget about the FDA for a minute. If you're going to give them to a human being, and you want to give it to the person with therapeutic intent, you need to know something about the production of it, and the lot to lot variation, and the strength of whatever it is that you think you're giving to somebody.

This is actually an issue in this country all the time in the marketing of herbal products, and so on, which, I believe, largely are currently unregulated.

The question for the society to settle is whether it wants to let down regulatory vigilance for assuring purity, or if you know that you don't have a pure substance, the extent to which the various components in it that you want to be there, are, in fact, there.

I said that in a very complicated way. This comes up actually when we think about Chinese herbal medicine all the time. You're giving herbal mixtures to people. There's no quality assurance associated with that manufacturer when it's done in China, and it's sent here. In fact, there have been instances of gross contamination with toxic substances of certain Chinese herbal preparations.

But even leaving that aside for the minute, if you have a place with competent people who care about the product that they're making, there still have to be some sort of QA and QC on the process of manufacture. Even if we didn't have an FDA that cared about that in a regulatory sense, any clinician that cared about the patients that he or she was treating, would care about its medical reasons.

MR. BEDELL: I would argue, that's not the major problem. You're talking about the quality, and I think most people would agree you've got to assure good quality. I'd say the big problem is the efficacy requirement that some bureaucrat at the FDA has to decide that this is effective, as compared to letting the marketplace determine whether or not it's effective. I think that's a terrible mistake.

It's what Congress has passed, I know, but it's the efficacy that is cause of a large part of that tremendous cost of going through the FDA approval process.

SPEAKER: For marketing.

MR. BEDELL: Yeah.

SPEAKER: I'm actually talking about to bring it into the country for study.

MR. BEDELL: Same deal though. I can't bring in one of their medications for mistletoe. I can't bring it in no matter how well we know that it's not going to be damaging to anyone or harmful to anyone. No doctor can bring it in and administer it because it has not gone through the FDA approval process.

SPEAKER: That's right. You have to file an Investigational New Drug Application (IND).

MR. BEDELL: That's an efficacy issue, which in Germany a large number of the clinics, as I understand it, use it, where there's never ever been, as I understand it, any problem with it in terms of safety is concerned. Yet, we have regulations here that say Dr. Woeppel can use it, but that Sloan-Kettering cannot use it.

SPEAKER: But no one needs to tell you, that's the law.

MR. BEDELL: I understand, and I think it's terrible. It's partly the law, but it's partly how the law is enforced. It's partly up to the regulatory agency as to how they handle that requirement. They could easily, if they wish to, say that if there's an education from the efficacy that's been shown in foreign countries, that we're going to let it be used here; they could do that.

As I understand it in the law, their only requirement is that they make sure that things are safe and efficacious. They could say that we're going to accept the fact that if something's been shown to be efficacious in foreign trials, that it can be used here. Certainly, they could say that it could be used in trials here, if they wished to do it.

My opinion is, we've got a double problem. We've got a problem with the law; but I would argue that we've also got a problem with the FDA, and that they do things that, I think, are not in the best interest of trying to have better treatments available to people.

SPEAKER: I actually do classic drug developments at a university center, and I understand the frustration -- because I think we all share it -- that we're not doing better for people with cancer. However, before people start talking about decreasing regulations or increasing access, or limiting the efficacy data required, I would remind people of two things.

One, is that every time you say to a patient, I have another treatment option for you, you're potentially creating hope, and you want to make sure -- at least, I would want to make sure as a clinician -- that there's enough information to say to that person, commit yourself to that therapy.

We can talk about therapies all we want that have little side effects, or actually made people feel better, but ultimately, you've created an alternative for somebody, and they're now going to invest themselves, no matter what that takes.

Secondly, every time somebody currently is on a clinical trial in the United States of America, they have the assurance that this has gone through multiple levels of review, and there's nothing capricious or arbitrary about that process. And that's very important, because I think we would all agree that public trust in what's happening in clinical research in America is at a low.

That if we're going to apply new alternatives or new conventional agents, trust is going to have to be restored.

So I think, in fact, drug development in the United States actually goes very well. It's slow, but at least safety and trust is in tact in that process.

MR. BEDELL: You know, we can all have our own opinion, and I appreciate that. I'm talking too much. But I would have to say that I think hope is terribly, terribly important to anyone who is ill.

Let me finish, if I might. I think that there are a lot of people who when they submit themselves to chemotherapy do not necessarily have a great deal of hope, if they've studied things very much. Therefore, it is my belief -- and everybody should have their own beliefs. It is my belief that everyone would benefit if it was easier for these possible, potential improvements in treatment to be tried on some people, particularly, if there's no evidence that they're going to be of harm to them.

But, you know, we've all got different opinions, and that's the great thing about being in America, and that's the great thing about why we're having this meeting here, and that's the great thing about some of us that figure we ought to say what we think, whether it's going to be popular or not among people.

In interfered here a little bit with Michael.

DR. GNATT: Quite all right. Actually, I think it's a legitimate concern that when best cases are assembled in this way, that some patients may opt for treatments that are not as well studied as conventional that may, in fact, do better with conventional. We don't have the comparative trials yet.

But on the other hand, there are many patients that were illustrated here that had no conventional treatment that could have been offered for them -- some of the brain malignancies, the women with melanoma in the pelvis. Actually, perhaps there is some conventional therapy for her, but many of these patients don't really have any useful conventional alternative. Many patients with solid, epithelial tumors in this country have limited options. So to expand the options, I think, is useful.

One more comment about the herbal medicines. The standard of regulation in Germany, as I understand it, is a very high standard for safety, and a lower standard for efficacy in those types of herbal medicines that have a very long historical track record of use that's safe, where experience have shown benefit.

In fact, by virtue of having the government involved and regulating these products on that standard, there's a better system of insurance of quality standards; whereas, in this country these products are all being sold and marketed by health food vendors as food supplements, and I don't think that's advisable either.

MR. BEDELL: Thank you, folks. Should we give a hand to the panel here?

(Whereupon, the PROCEEDINGS were adjourned.)

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