

CASE REPORT

An Enzyme-Based Nutritional Protocol In Metastatic Cancer: Case Reports Of A Patient With Colon Cancer And A Patient With Lung Cancer

Linda L Isaacs, MD

ABSTRACT

Context • The author and others have previously published case reports demonstrating positive results in patients with cancer utilizing lifestyle modification which includes high doses of a product rich in pancreatic enzymes.

Objective • The study reports on outcomes of two patients utilizing this nutritional protocol, one with colon cancer metastatic to the liver and lung, another with lung cancer metastatic to the brain.

Design • Retrospective case studies.

Setting: The patients were seen in an outpatient clinic in New York City, and implemented their protocols in their homes in the United States of America.

Participants • The patients in these case reports are two men in their 60s.

Intervention • The patients were instructed in the self-administration of a nutritional protocol consisting of

dietary modifications, a supplement protocol including high doses of a pancreas product naturally rich in enzymes, and detoxification including the use of coffee enemas.

Outcome Measures • Records were reviewed for evidence of prolonged survival and/or improvement or resolution of radiographically apparent disease.

Results • The patients experienced both prolongation of life and resolution of radiographically apparent disease.

Conclusions • While case reports cannot be considered as proof of efficacy, these cases added to others of patients treated with the same method would suggest that this is a viable option for those patients whose disease cannot be treated successfully with other modalities. (*Altern Ther Health Med.* 2019;25(4):16-19).

Linda L. Isaacs, MD, is in private practice in Austin, TX.

Corresponding author: Linda L Isaacs, MD

INTRODUCTION

For more than twenty years, I worked with Nicholas Gonzalez, MD, (1947-2015), offering an enzyme-based nutritional protocol to patients with cancer and other degenerative diseases. The method is based on the work of William Donald Kelley, DDS; Gonzalez had reviewed Kelley's records and found many remarkable patient outcomes.¹ Gonzalez and I previously published case reports in *Alternative Therapies in Health and Medicine* in 2007.² Gonzalez was working on a collection of case reports from his practice and mine at the time of his death, which were posthumously published.^{3,4} I have continued to utilize this treatment in my medical practice. Here I report on two cases not included in any of the above works.

Patient 1: Metastatic Colon Cancer

Patient 1 is a 62-year-old man who was in excellent health until May 2014, when he noticed blood in his stool. After colon cancer was found on colonoscopy, later that month he underwent right colectomy. Pathology showed "Invasive adenocarcinoma (4.5 cm), moderately differentiated" with "Metastatic carcinoma involving two of thirty-two lymph nodes." A CT scan in July 2014 showed three hepatic hemangiomas.

Chemotherapy was suggested, but instead Patient 1 followed a self-designed nutritional plan. A CT scan in December 2014 showed the three hepatic lesions seen previously, and a low-attenuation lesion that was described as unchanged from previous exams. PET scan in early January 2015 was negative, but since his CEA was steadily rising, he began chemotherapy with FOLFOX. On this regimen, he developed peripheral neuropathy causing difficulty walking, and a right subclavian vein thrombosis. A CT scan in June 2015 showed, in addition to the three enhancing lesions, a new 0.8 × 0.9 cm low attenuation lesion in the liver. He discontinued chemotherapy at that time.

A follow-up scan in late December 2015 showed that the low attenuation lesion in the liver had grown to 1.7×1.5 cm. In early February 2016 the lesion was biopsied and found to be “Metastatic adenocarcinoma consistent with origin from a colonic primary.” PET/CT was positive only for a “solitary posterior right hepatic mass.” In late February, he underwent partial resection of the right lobe of the liver. The pathology report stated: “RIGHT LOBE OF LIVER (PARTIAL RESECTION): METASTATIC ADENOCARCINOMA, CONSISTENT WITH COLONIC PRIMARY, EXTENDING FOCALLY TO MARGIN OF RESECTION.”

In early April 2016, he began a nutritional program under my direction. A scan around the same time showed “Enlarging low attenuation lesion within the right lobe of the liver suspicious for metastatic disease. 0.8 cm area of mild decreased attenuation within the right lobe of the liver not appreciated previously may also represent a metastatic lesion.”

In late June 2016, after about two months on his protocol, an abdominal CT scan showed a “Low attenuation hepatic mass ... may be metastatic disease or the sequela of locally treated hepatic metastasis.” In July 2016, a CT scan of the chest showed a new finding, a “slight lobulated nodule in the right apex measuring 0.9×0.8 cm.” His oncologist strongly recommended resection of the lung nodule and the liver mass, as well as resumption of chemotherapy.

In mid-July, he underwent resection of the right lobe of the liver which contained a $1.5 \times 4.0 \times 2.7$ cm well-circumscribed lesion. Microscopic examination showed “Metastatic nodule of colorectal-type adenocarcinoma with no residual viable tumor identified.” The finding of necrotic tissue, rather than viable cancer, is interesting since he had not been receiving chemotherapy for more than a year.

Refusing both the resection of the lung mass and chemotherapy, he continued on the protocol I prescribed. In December 2016, abdominal CT showed “no recurrent or residual mass.” Subsequent CTs in March and June, 2017, showed no evidence for recurrence in the liver, and steady shrinkage of the pulmonary nodule. CT August 2018 showed only a 2 mm nodule in the lung, and no evidence for disease in the liver.

Throughout this time, his oncologist strongly recommended resuming chemotherapy, but Patient 1 told me that the side effects of the FOLFOX treatment made him determined never to go that route again. But as the pulmonary nodule shrank, he reported his oncologist told him, “You are proving us all wrong.” He has continued to work full time at a demanding job while continuing his protocol, with the support of his spouse.

In summary, this patient developed a lesion in the liver while receiving FOLFOX chemotherapy. This was resected and confirmed to be metastatic colon cancer. He began an enzyme-based nutritional program roughly 10 weeks after surgery; ten weeks later, scans demonstrated a recurrent liver lesion and a new lung lesion. The liver lesion was resected and “no residual viable tumor” was seen; he had received no orthodox treatment that could account for this finding. Over

the following two years, the patient has had gradual resolution of the lung lesion, and no evidence for recurrence in the liver, while pursuing only the prescribed nutritional protocol.

In a systematic review and meta-analysis of palliative chemotherapy for colon cancer, median survival was estimated to be 8.0 months for untreated patients and 11.7 months for the chemotherapy group.⁵ Patient 1 is now 40 months out from the discovery of metastatic disease. His prolonged survival, clinical improvement and excellent performance status are remarkable.

Patient 2: Metastatic Non-Small Cell Lung Cancer

Patient 2 is a 65-year-old man who was in excellent health until October 2013, when he noticed a change in his eyesight, followed by vertigo and headaches. He sought medical attention; scans demonstrated masses in his brain and lung.

At Vanderbilt University Medical Center in February 2014, an MRI of the brain showed a “large rim-enhancing mass in the right parietal, occipital and temporal lobes with extensive vasogenic edema,” measuring up to 5.6 cm. The mass was resected in mid-February 2014. Pathology demonstrated “metastatic adenocarcinoma, most consistent with a non-small cell lung primary.”

In early March 2014, PET/CT revealed: subcentimeter 7 mm noncalcified pulmonary nodule in the right upper lobe anteriorly demonstrates intense uptake and is suspicious. ... There is focal intense activity in the right hilum presumably related to a right hilar lymph node which is concerning as well.

An MRI of the head in mid-March showed “Progression of marginal enhancement along the right parietal occipital/temporal resection cavity.” He then underwent radiation to the brain. Chemotherapy was suggested, but he was told that he would most likely be dead in six months regardless of treatment.

Instead of chemotherapy, he began a self-designed nutritional plan. In August 2014, chest CT showed a 1.5 cm mass in the right upper lobe of the lung, a 2.5 cm right hilar node, and several new small nodules felt suspicious for metastatic disease. An MRI of the brain in September 2014 showed a new 1 cm tumor in the frontal lobe, and in early December, MRI showed that the frontal lobe mass had grown to 1.7 centimeters with increased vasogenic edema, while a new mass had developed in the cerebellum.

I first saw Patient 2 in late December 2014. At that time, he felt reasonably well, though he did comment on visual changes caused by his original brain surgery. He had no symptoms from his pulmonary disease.

He started on the protocol I prescribed in January 2015. Because of concerns about impending herniation, he also proceeded with glucocorticoids followed by radiation to both tumors in his brain. After completing radiation, he was hospitalized because of excruciating headaches and was found to have extensive vasogenic edema with midline shift. He contacted me in June 2015 to let me know that despite all these issues, he had stayed on the prescribed nutritional program. A CT of the chest in early August 2015 stated that

“right upper lobe and right hilar abnormalities described on the previously [sic] CT are no longer evident.” An MRI of the brain September 2015 was unchanged from a previous study in June, and the glucocorticoids were stopped. In March 2016, he called to let me know that a recent MRI of the brain showed a slight decrease of enhancement in the resection bed, to the amazement of his neurologist.

During 2017 and 2018, he continued in his usual state of health, with visual problems felt due to his brain surgery and radiation. An MRI of the brain in April 2018, compared to a scan from June 2016, was read as “persistent right cerebral masses, slightly enlarged.” Then in late June 2018, he called me to report episodes of left-sided weakness and shaking of his left arm. I told him to go the emergency room immediately.

In the hospital, CT of the thorax in early July 2018 showed “No evidence of metastatic disease or primary neoplasm involving the thorax.” An MRI of the brain, compared with the April 2018 study, showed “Interval increase in size of right frontal mass with signs of recent hemorrhage ... with increased surrounding vasogenic edema ... stable right parietotemporal mass with surrounding vasogenic edema.” The final conclusion by his physicians was that the brain masses represented post-radiation changes, with the acute clinical change due to hemorrhage, and he was discharged on a glucocorticoid taper and levetiracetam. He is handicapped by poor vision and by residual weakness in his foot, but is living independently and continuing on the prescribed protocol.

In summary, this patient with non-small cell lung cancer had one brain metastasis removed, then radiation to recurrent brain lesions, but had no systemic treatment and no treatment of any kind to the lung lesion or the hilar nodes. At his recent hospitalization, there was no evidence of disease in the thorax.

In a review of cases of non-small cell lung cancer metastatic to the brain at M.D. Anderson, median survival was about 10 months.⁶ Patient 2’s 4.5 year survival is remarkable, as is the resolution of the lung tumor without orthodox therapy of any kind.

DISCUSSION

The treatment protocol used with these patients involves three components: diet, nutritional supplementation including large doses of a pancreas product naturally rich in enzymes, and detoxification with several modalities including coffee enemas. All three aspects, in my clinical experience, are vitally necessary for success.

The theoretical mechanisms behind the use of pancreatic enzymes against cancer have been reviewed elsewhere.⁷ Dietary advice for all patients includes organic food, unprocessed and unrefined, with no white flour, white sugar, or inflammatory oils. Beyond that, the diets can vary from patient to patient, since in this model, different patients need different diets, from nearly vegetarian to a diet replete with animal protein and fat. A detailed explanation of this can be found in Gonzalez’ book *Nutrition and the Autonomic Nervous System*.⁸

Detoxification, primarily with the use of coffee enemas, is perhaps the most controversial recommendation. Coffee enemas were part of mainstream medicine in the nineteenth and the first half of the twentieth century, used extensively in the treatment of poisoning and in postoperative care.⁹⁻¹⁵ Theoretically, coffee enemas stimulate bile flow from the liver and gallbladder, thereby assisting removal of wastes. Support for this comes from a 2014 article describing their use in clearing bile prior to capsule endoscopy.¹⁶ On a practical level, Gonzalez and I have had patients decide that the enemas were unnecessary, and none have done well. Fortunately, most patients feel much better with the enemas, so compliance with this aspect of the protocol is generally quite good.

Ideally, case reports such as this would be springboards for the development of more rigorous studies such as a randomized clinical trial.¹⁷ Gonzalez and I tried our best to move this methodology in that direction, with a pilot study in pancreatic cancer published in 1999.¹⁸

Unfortunately, the clinical trial that followed was marred by problems in study design, mismanagement, and poor compliance on the part of the majority of the patients enrolled.^{19,20} The issues with compliance were not mentioned in the report of the trial published by the academic researchers involved, despite having been discussed extensively as the trial progressed.^{21,22} I believe that the almost universal negativity of other physicians towards the treatment choice of the patients in the trial affected their compliance with the intensive lifestyle modification that we recommend.

The two remarkable patients described here have both faced the same negativity, but have nonetheless been diligent in putting the protocols I gave them into practice. My goal in publishing these two case reports is to add to our previously published case reports in the medical literature, keeping this work alive to help interested patients with no curative options. It is my hope that one day the orthodox medical world will be more receptive and willing to fairly investigate the results.

Author Contact Information

Visit www.drindai.com for contact information.

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