

# Linitis Plastica Gastric Cancer: A Case Report

by Linda L. Isaacs, MD

I worked with the late Nicholas J. Gonzalez, MD, in New York City for more than 20 years, offering an intensive nutritional approach for patients with cancer. The regimen involves dietary changes, oral nutritional supplements with large amounts of pancreatic enzymes, and detoxification including coffee enemas. Dr. Gonzalez had originally investigated the work of William Donald Kelley, DDS, who pioneered this method, and had found a remarkable number of patients with documented terminal cancer who had thrived under Dr. Kelley's care.<sup>1</sup> From that point on, Dr. Gonzalez was driven to keep this treatment method alive and to collect preliminary data that would finally lead to the formal academic testing that we thought the method deserved.

In 1993, after 6 years in practice, Dr. Gonzalez presented a "Best Case Series" of 25 of his patients with exceptional outcomes at the National Cancer Institute (NCI). After the session, the NCI scientists suggested that we proceed with a pilot study evaluating this approach in the treatment of inoperable pancreatic cancer. The results were published in the peer reviewed journal *Nutrition and Cancer* in 1999, documenting outcomes well beyond what had previously been reported for the disease.<sup>2</sup> The NCI then agreed to support a controlled clinical trial, again evaluating our approach in the treatment of inoperable pancreatic adenocarcinoma. The trial was administered through a major academic medical center in New York City.

The controlled trial ended in discord, with publication by the academic researchers involved of what I believe to be meaningless data.<sup>3</sup> Dr. Gonzalez's book, *What Went Wrong: The Truth*

*Behind the Clinical Trial of the Enzyme Treatment of Cancer*, examines in detail the problems with the study.<sup>4</sup> In an article in *Integrative Medicine: A Clinician's Journal*, I discuss the failures in study design that, among other things, contributed to inclusion of a large number of noncompliant patients for our arm of the study – an issue described as a legitimate concern by a National Institute of Health scientist in a letter as the study progressed, but totally ignored in the published results.<sup>5,6</sup>

After the bitter disappointment of this venture, Dr. Gonzalez and I resolved to continue to collect and publish case reports, and he was working on a large collection of such cases at the time of his death on July 21, 2015.<sup>7</sup> Dr. Gonzalez's widow and a medical consultant are currently preparing his final project for publication. Over the years, Dr. Gonzalez and I had many discussions about which cases merited inclusion. The patients needed to have clear evidence of cancer being present – which may seem obvious, but the Internet is full of "testimonials" for various products or protocols by patients who never had tissue confirmation of disease in the first place. They needed to have had an unusual outcome: either regression of disease, or prolonged survival, preferably both. And they also needed to have undergone no other treatment that could explain their good outcomes. Here, I will give an example from my own practice of a case that Dr. Gonzalez rejected from the series that he was compiling – a patient who met the criteria above, but whose story was complicated by compliance issues.

In August 1993, after noting black stools for a few months, Ms. Doe (not her real name) sought medical attention

after vomiting blood. A stomach ulcer was noted on endoscopy; biopsy showed adenocarcinoma. A CT scan found no evidence of spread, and in late August 1993 she underwent subtotal gastrectomy. Pathology showed "transmurally infiltrating poorly differentiated adenocarcinoma of the stomach, predominantly linitis plastica type, with extensive intra-neural infiltration and spread, with microscopic involvement of both proximal and distal margins of resection, and with metastases to 0 of 4 lesser omental and 1 of 4 greater omental lymph nodes and with intra-neural invasion present within lesser omental fat. ..."

Ms. Doe recovered uneventfully from her operation. Chemotherapy and radiation were suggested, but after doing independent research she opted to refuse this and to pursue treatment with me. She began her nutritional protocol in November 1993.

At her first return visit in June 1994, Ms. Doe was feeling well and had gained weight. She had intermittent heartburn, for which she took cimetidine with relief. More than a year later, in September 1995, she reported that she was feeling very well, and had started to skip doses of pancreatic enzymes and eat foods that were not on her diet because she wanted to be able to meet her friends for lunch. She complained bitterly that the protocol was ruining her social life, and resisted any suggestions about ways she could manage to both comply with her treatment and spend time with her friends.

In November 1995, endoscopy was done and she was found to have distal esophagitis and a "surprisingly normal" gastric remnant. A nodular fold in the stomach was biopsied and pathology returned as "no evidence of malignancy

or of significant inflammation," remarkable considering that both the resection margins were positive more than two years previously.

After these good results, Ms. Doe had a hard time believing that she still needed to stick to the treatment plan, and in April 1996 she called to let me know that she intended to discontinue it altogether. Then in June 1996 she developed shortness of breath. Chest X-rays showed pulmonary infiltrates. She resumed her protocol, and during an office visit in July 1996, she reported that she felt better. She then continued with self-reported erratic compliance.

In September 1997, after her breathing worsened, a repeat CT scan showed a masslike consolidation in the right middle lobe with multiple indistinct pulmonary nodules, and a soft tissue mass around the right kidney. This mass was present and was biopsied at the time of her original operation, but the sample was reported to be fat necrosis by the pathologist. In November 1997 she underwent bronchoscopy; washings showed "atypical lymphoid cells suspicious for lymphoma." The slides from the 1993 biopsy of the tissue around the right kidney were looked at again, and thought to be consistent with low-grade lymphoma, present but not recognized when her adenocarcinoma of the stomach was diagnosed.

Ms. Doe came to the office again in November 1997, reporting that she was back on her protocol, but she continued to be frustrated by the lifestyle required for compliance. In March 1998 she called to say that she felt well, but that her local physicians thought she had a low-grade lymphoma and were recommending chemotherapy. After seeking further opinions she decided to start Cytoxan in June 1998, discontinuing her nutritional program a few months later.

A CT of the chest and abdomen in May 1999 was read as stable, and the Cytoxan was discontinued. She came to see me again in July 1999, with a complaint of some stomach irritation. She told me that a recent endoscopy showed irritation at the anastomosis of the stomach to the jejunum; 12 biopsies were done and none showed cancer.

She continued to be frustrated by the demands of the treatment protocol that I prescribed.

I did not hear from her again, but in March 2000 her husband called, very distraught. His wife had never resumed her program, and began to have pain in her abdomen in November 1999. He had pleaded with her to contact me, but she refused. In January 2000 she had a CT scan that showed carcinomatosis, and she subsequently developed intestinal blockage. Endoscopy showed recurrent stomach cancer with complete blockage of the stomach. In March 2000 she died.

In summary, this patient was originally diagnosed with a transmural poorly differentiated adenocarcinoma of the stomach, described as linitis plastica, with spread to a lymph node and with both surgical margins positive. All of these pathological findings indicate a poor prognosis, with expected early manifestations of the growth of residual disease. She also had a low-grade lymphoma retroactively diagnosed several years later. While she followed her nutritional protocol, she felt well; some time after she discontinued it, she had an explosive recurrence of her stomach cancer and expired, having survived 6.5 years from diagnosis.

A recent article describing the outcomes of patients with linitis plastica gastric cancer at a single institution illustrates the dismal prognosis of this disease.<sup>8</sup> Patients who had a complete resection of their cancer had a median survival of 17 months, while patients

such as Ms. Doe, with positive margins, had a median survival of only 6 months. Ms. Doe's prolonged survival is remarkable.

The protocol that we recommend is rigorous, but compliance is not impossible. Most of our patients can lead full and enjoyable lives while following their diet and supplement protocols. Unfortunately, Ms. Doe was never able to reconcile herself to the changes in her life brought about by her diagnosis and the treatment path she chose, and she resisted all attempts that I made to encourage her to reframe her situation.

For more case reports of successfully treated patients, please see our article from 2007, freely available from my website at [DrLindal.com/articles.html](http://DrLindal.com/articles.html), and keep an eye out for the upcoming case report book by Dr. Nicholas Gonzalez.

## Notes

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4. Gonzalez NJ. *What Went Wrong: The Truth Behind the Clinical Trial of the Enzyme Treatment of Cancer*. New York: New Spring Press; 2012.
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Linda L. Isaacs, MD, received her bachelor of science degree from the University of Kentucky, graduating with high distinction with a major in biochemistry. She was elected to Phi Beta Kappa. She subsequently received her medical degree from Vanderbilt University School of Medicine in 1985. She completed a residency in internal medicine at the Department of Veterans Affairs Medical Center at New York University Medical School. She is board certified in internal medicine, most recently completing recertification in 2011.

She worked with her colleague Nicholas J. Gonzalez, MD, for more than 20 years, using a nutritional approach for treating patients diagnosed with cancer and other serious degenerative illnesses. After his untimely death in July 2015, she has continued with the work that they shared. She has written papers published in the peer-reviewed journals *Nutrition and Cancer* and *Alternative Therapies in Health and Medicine*, and is the coauthor of the book *The Trophoblast and the Origins of Cancer*. Her website is [www.DrLindal.com](http://www.DrLindal.com).

