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A Novel Immuno-Chemotherapy: Inducing Long-term Remissions without Side Effects

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Summary

A novel therapy that combines immuno- and chemotherapy has been developed. Clinical data to date demonstrate the new therapy referred to as "Neutrophil-potentiated chemotherapy[sm]" or "Immuno-chemotherapy[sm]" is strongly effective across a broad spectrum of cancers including breast, lung, colon, pancreas, gynecologic, bladder, and prostate. The new therapy has near 100% response rate and has shown frequent ability to reverse cancer even in advanced stages without much toxicity. Where cancer is stage 3B or early stage 4 and the therapy induces long term-remissions, it does so without making patients feeling sick and without causing baldness. Patients remain able to work. Complete remissions were achieved where statistically there was no hope. For exemplary purpose of how we induce a complete remission with minimal side effects, a 49 years old patient with bladder cancer in early stage 4 is presented. He recently celebrated two and a half years of remission.

Introduction

The problem of cancer is that the treatment is worse than the disease. Most cancer drugs kill any cell in the body that is dividing. Killing stomach cells results in vomiting. Killing cells in the intestine results in diarrhea, and killing blood-making cells in the marrow subjects patients to pneumonia and other infections. In the seventies and early eighties, I tried to find ways to deliver cancer drugs only to cancer cells, without success.

Then quite by serendipity, I came up with the idea of delivering antidotes against chemo agents selectively to stomach, intestine, and marrow cells during chemotherapy, thereby eliminating the usual side effects. Most chemo agents already had FDA approved antidotes. When I protected the body's normal cells in this manner, I found that I could intensify chemotherapy doses without causing any side effects and achieve improved eradication of cancer. However, what was puzzling was that even without intensifying dosages, I was able to achieve higher response rates and faster eradication of tumors. Doubting my data, I continued research until it was irrefutable that I had made cancer drugs much more powerful simply by eliminating side effects and protecting normal body cells from chemo agents. It was clear I had made a major discovery, but the mechanism of empowering drugs in this manner remained to be elucidated.

It took over a year of thinking. Then I recalled back to my physiology classroom in medical school. I had learned that white blood neutrophils not only attacked invading bacteria, but had a remarkable role in what is called Neutrophil Cascade. The purpose of Neutrophil Cascade was to rid the body of sick, injured and aged cells.

There are three types of neutrophil cells. The first type circulates and when finding sick body cells marks them so that the second type can find so-marked cells and poke holes in them to kill them. The third type of neutrophil cells finds these disintegrating sick cells and digests them away.

Chemo agents never kill 100% of cancer cells when applied. Perhaps 60% of cancer cells are outright killed, but another 35% are merely injured. The injured cancer cells repair themselves to go onto kill the patient. In a typical chemotherapy, neutrophil cells are decimated and are not present to take part in the Neutrophil Cascade. When I sought and succeeded in preserving neutrophil cells, I enabled chemotherapy to not only kill the 60% outright, but via the neutrophil cells acting as immunotherapy eradicate additional 35% of the cancer cells.

If one does the math, starting with a billion cancer cells, ordinary chemotherapy killing 60% of cancer cells at a time requires 52 cycles for the number of cancer cells to become less than 0.5 cell, a cure. No wonder we tell patients with stage 4 cancer that chemotherapy will only be palliative, never curative, because no one willingly undergoes that many toxic chemo cycles.

On the other hand, with neutrophil cells preserved, and providing immunotherapy on top of chemotherapy to eliminate an additional 35% of cancer cells, a billion cancer cells become near zero after only 8 cycles.

Coincidentally, in our earliest patients treated with Neutrophil-potentiated chemotherapy, all four patients went into long term complete remission in eight or less cycles of carboplatin. These were two stage 3B lung cancer patients, one stage 4 breast cancer patient, and one myeloproliferative disorder in leukemic phase. The latter patient reached remission after only three weekly cycles of AUC1.6 carboplatin.

The addition of immunotherapy to chemotherapy has clearly created a powerful therapy that has little side effect. Because neutrophil levels are sensitive to emotional stresses, we have learned that ideally-conducted Neutrophil-potentiated chemotherapy should be provided with many hours of one-on-one support by physicians and nurses.

In the United States, medical care of patients today have drastically changed from the 1960s. Due to insurance dictates, where billing codes were eliminated for medical staff taking time to talk and spend time with patients, cancer patients now crave for staff attention. In order to provide emotional support to patients, I have had to divorce from insurances. When I am treating my cancer patient, I often spend hours talking with a patient, sometimes becoming involved in solving their non-medical problems. After all, cancer does not occur isolated from their lives. I do not find it surprising that patients given this much staff attention do better than typical patients in an ordinary chemotherapy practice.

It is a fact that today's insurance billing codes disallow physicians from seeing their chemotherapy patients more than once every three weeks! It is regrettable that we are unable to work with Medicare and insurances. Because our therapy is so much faster in achieving results and our patients are less likely to have recurrences, insurances can actually save money if patients choose my therapy over ordinary chemotherapy. It would behoove insurance companies to consider coverage. We are working to create appropriate billing codes that match our procedures so that our patients can eventually be covered by insurances and Medicare.

Even the environment that patients are placed in during a typical Immuno-chemotherapy cycle can effectuate a more successful and faster recovery from cancer. Two of our treatment centers are purposefully in travel resorts. One is in Lake Tahoe, Nevada, and the other is in the resort of Ensenada, an hour south of San Diego. Ensenada is the first port for all cruise ships from Los Angeles headed for Mexican resorts.

Lake Tahoe has arguably the most beautiful snow-capped mountain-scape in the world and Ensenada with its gorgeous Pacific sunsets is creating a loyal cadre of patients and their families with long term plan to return there annually in the future.

Over ten years of experience treating patients with Neutrophil-potentiated chemotherapy, we have learned to provide a tranquil and relaxing environment. Both our resort centers are located where our medical staffing derives from historic cultures that are more consonant with psycho-therapeutic requirements of our therapy.

The Lake Tahoe center is located inside the Washoe Nation, a Native American group. The Washoes lived peacefully and in tune with nature around Lake Tahoe until white settlers drove them out of their homes. About fifteen hundred survivors of this tribe maintain their old culture and offer to provide their knowledge in health care to others. I was offered collaboration and a facility. Because I have predicated that my revenue from cancer care be used for social justice, we married our advanced cutting edge medical technology with the tribe's holistic approach to healthcare.

I became involved with our Ensenada center when European patients who heard about my therapy were barred from coming to Berkeley due to America's terror fear after 9-11-2001. A prominent Mexican government oncologist and a member of the American Society for Clinical Oncology offered to treat patients from Norway, Greece, and Spain at a private hospital in Ensenada, with my therapy. As I began to work with him, his colleagues, and nurses there, I realized there was a considerable cultural difference about them. Over the ten plus years of observing patients at the Ensenada center, I appreciated the more patient-focused approach they brought to our therapy. Their approach delivered higher rates of success to our cancer patients. I am not stating that a historic culture automatically provides an improved milieu for patients to do better in, but the improved milieu that my Ensenada staff created for patients came about more naturally from their root in their historic culture. I credit my Ensenada staff members for making the discovery that patients did better when accorded certain respect and care. Such a discovery should not be a surprise but the fact that I even call it a “discovery” points to how far “modern” medicine has moved away from truly caring for our patients.

The practice of Neutrophil-potentiated chemotherapy has over 23 facets and we have learned that it takes 2 years of intense training for a practitioner to begin to master the therapy. Even how cancer responds under this completely new therapy is different how a practitioner monitors and reacts to events during a follow-up of a patient on Immuno-chemotherapy must be carefully guided. Sadly, we have learned, a typical response of seasoned but uninitiated oncologists can be the opposite response required for a patient undergoing Immuno-chemotherapy. So as to not jeopardize the life of a patient, every new physician to Immuno-chemotherapy must be proctored and guided. For example, tumors can actually swell initially when successfully treated by Imuno-chemotherapy because the initial attack on cancer cells by chemicals is followed by infiltration of tumors with white blood neutrophil cells. An untrained oncologist may interpret the swelling as a failure of the Immuno-chemotherapy and

choose to abandon the therapy altogether. Also, after our therapy begins, we sometimes find more metastases than observed in a pre-treatment CT imaging. An uninitiated interpretation may be that cancer is getting worse, but actually, we have learned that a CT imaging will identify only lesions that are large enough for x-rays to pick up. When we apply Immuno-chemotherapy and neutrophil cells infiltrate tiny metastases that were already present but too small to show up in x-rays, these small metastases swell and become large enough to be seen in a follow-up CT scan. We have to teach new medics to rejoice at times like this and not abandon the therapy.

For reason that an incomplete presentation of the methodology of the new therapy can do more harm than good, I have been advised to present the details in a monograph which is under preparation. We are developing credentialing to certify those who complete our academic and clinical training in Neutrophil-potentiated Immuno-chemotherapy.

The following case report will serve to provide a better description of how the new Immuno-chemotherapy is practiced. The achievement of eradicating cancer in a disease that is considered hopeless for ordinary chemotherapy and doing so with hardly any side effect is truly noteworthy. The case report is followed by brief descriptions of two other cases. In one, liver metastases were liquified, something that has never happened ever before. In the other, progression of late stage blood cancer was halted in just three weeks using very low doses of carboplatin. This case is presented because it is clear such a low chemical dosage alone could not achieve what we achieved and it is a testament to the power of the Immuno-chemotherapy.

Eradication of Bladder Cancer Achieved without Traditional Side effects: A Case Report

A 49 years old, recently married male patient applied to me to undergo Neutrophil-potentiated chemotherapy. A year before, on August 4, 2014, he had undergone resection at Stanford University for distal right ureteral carcinoma with ureteral re-implantation. A follow-up CT scan on June 5, 2015 revealed a 2 cm recurrence extrinsic to the bladder in the region of the distal right ureter. On July 29, his CT scan reported , "there is an enhancing soft tissue mass centered at the right UVJ partially protruding into the bladder lumen measuring 3.8 x 3.5 cm. The mass abuts the seminal vesicles with mildly prominent adjacent vasculature." On August 3, his urologist examined his bladder internally and remarked finding a "Huge right sided mass invading the bladder lumen" Pathology reported of this mass "multiple fragments of pink-gray rubberly soft tissue aggregating to 4 x 4 x 2 cm and weighing 8.3 g...High-grade urothelial carcinoma - which extensively involves the portions of muscularis propria and lamina propria present. In areas the carcinoma closely approaches nerves." His urologist, oncologist, and radiotherapist all recommended that the patient undergo neoadjuvant chemotherapy in an effort to make his disease operable because even with the bladder removal and chemotherapy, he was told his life expectancy was one to two years. On August 11, he underwent eight hours of cisplatin and gemcitabine chemotherapy. While receiving the ordinary chemotherapy which he was told would not save his life, he searched on the internet for an alternative therapy that might save his life. He came across our website at www.cancer-institute.com and contacted me.

When the patient arrived at my office on August 19, and I met him for over two hours, he complained that thanks to insurance billing codes which place priority on minimizing cost of care he was unable to meet with his oncologist more than briefly. My first complete blood count on August 24 revealed that his absolute neutrophil count had fallen due to his chemotherapy two weeks prior, down to 819 cells per mm^3 and his platelet count was only 66,000 per mcl. Since we rely on high neutrophil count to

provide our chemotherapy with an immunotherapeutic boost to kill cancer cells that are injured by carboplatin, I decided to wait for his neutrophil count to rise to at least 2000 cells per mm^3. When on September 2, his neutrophil count was not rising much, I gave him three daily doses of 300 mcg Neupogen subcutaneously. When on September 9, his neutrophil count was 5975 and his platelets were at 229,000, I began his neutrophil-potentiated chemotherapy using carboplatin as the sole chemo agent. His cycle used carboplatin dosage of AUC4.0.

The mechanical aspect of the Immuno-chemotherapy calls for administering daily varying amounts of intravenous mesna, which is a known antidote for alkylating agents, particularly ifosfamide. The dosages for each day is computed based on numerous data on the patient. On the second day, 21 hours after the first mesna administration, carboplatin infusion is initiated over a period of an hour. Mesna injection is continued daily for two more days after carboplatin. The patient keeps an extensive diary of food and liquids consumed, which is reviewed by my nurses and myself. Advice is given based on computation of the patient's idealized intake. The advice on intake is designed to optimize the blood level of carboplatin during the period of 120 to 144 hours from carboplatin infusion. On daily basis, the patient is interviewed to gather data about sources of his/her current worries and anxiety. Upon analyses by my nurses and myself of the gathered data, the treating staff decides what advice we provide the patient to reduce the patient's anxiety level. Studies have shown that the level of catecholamines resulting from anxiety will reduce neutrophil function. If neutrophil function is impaired, so will be the ability of the patient's own immune cells to destroy cancer cells that have sustained injury from carboplatin. We also counsel our patients to help them with any depression, because depression will suppress neutrophil function. The patient is discharged from our watchful outpatient care after four days, but is then monitored thereafter for any changes in symptomology. I provide patients with my personal cell number 24 hours a day, seven days a week to reduce any anxiety of not being able to reach me. I frequently provide ongoing advice on various health issues such as aches and pains, and constipation. Although it was not an issue with my bladder patient, those patients who have metastases in an organ like the liver could experience aches in the region and I have to be prepared to reassure the patient that such aches indicate that we are successfully killing cancer in the region of the pain. Such continual follow-up of a patient is essential in reducing anxiety level and in keeping optimum the neutrophil immune cell function. I think this type of care is missing in today's oncology practice. Certainly, insurance billing codes discourage doctors and nurses from acting like doctors and nurses. In effect, as one of my nurses pointed out, non-health professionals in insurance companies and the government are dictating how patients should be treated by the creation of insurance codes. Such a behavior is actually an illegal practice of medicine by those unlicensed to practice in a state or a jurisdiction.

During the immediate follow-up period after carboplatin, typically for three days, a patient can report mild anorexia or queaziness, which patients are almost always specific to say is not “nausea.” This bladder patient experienced virtually no gastrointestinal symptoms, which is the case in 75% of patients undergoing Immuno-chemotherapy. Ondansetron oral preparation 8 mg is provided patients to use as needed up to two or three times a day. Most patients are advised to take at least one ondansetron pill in the morning for three days after carboplatin regardless of how they feel. Patients who are experiencing anxiety from external causes like workplace or family issues will tend to have more GI complaints. We counsel against use of any non-steroidal anti-inflammatory agents like ibuprofen or naproxen because their quality to irritate the stomach can bring out more GI symptoms in patients undergoing Immuno-chemotherapy. This bladder patient reported feeling well and continued to work as a computer programmer.

The bladder patient reported at the start of his second cycle, on September 23, that he passed three chunks of partly black-partly pink tissue from his urethra. He continued to pass more such chunks over the following few days. Pathology report was non-committal although consistent with history of carcinoma.

The bladder patient's chemotherapy was performed on a biweekly schedule. At the beginning of his next cycle, I ordered a complete blood count and comprehensive chemistry to determine if his platelet count is at least 80,000 and his absolute neutrophil count is at least 1,600, in which case the new cycle is allowed to commence.

The bladder patient undertook eight continual biweekly cycles of Immuno-chemotherapy as described above. With the exception of the fifth and sixth cycles whose carboplatin doses were reduced to AUC3, other cycles were at AUC4. The reduction in doses for the fifth and sixth cycle was as a precaution due to slightly lower absolute neutrophil counts of 1552 and 1562 respectively, although these counts are considered laboratory normals. The patient successfully tolerated a cumulative total of AUC30 over a period of 16 weeks. Expressed in another way, he received over an eight weeks period, cumulative carboplatin dose of 954 mg per $m^{2.}$. Eisenhauer[1] studied the effect on the marrow of carboplatin alone without use of any antidote and found that a dose of 400 mg/ m^2/month resulted in median granulocyte count of only 1600 (80-4700) and six per cent of patients suffered granulocyte counts of less than 500. More remarkably, 24 per cent of patients experienced platelet count below 50,000 and 12 per cent of patients experienced platelet counts below 25,000. My bladder patient who received 477 mg per $m^{2.}$ in a month, which is nearly 20% more than Eisenhauer's patients, maintained his granulocyte counts no lower than 3100 in the first month, no lower than 2500 in the second month, no lower than 2600 in the third month, and no lower than 2100 in the fourth month of the patient receiving 477 mg carboplatin per m^2 monthly. Even more remarkably, platelets never fell below 137,000 in the first month, 117,000 in the second month, 122,000 in the third month and 57,000 in the fourth month.

The patient continued to be evaluated by his urologist on a 3 months schedule, which continues even to date. His CT urogram on January 6, 2016 revealed “normal upper urinary tracts. Right ureter reimplanted into Dome of bladder. No evidence of bladder mass or recurrence of bladder cancer.” His cystoscopy was reported, “Bladder: erythematous patch with microcalcifications on the surface of the bladder in the area of the right hemitrigone, the region of the previous resection. There are no exophyte tumors in the bladder.” On his cystoscopy on July 14, 2016, the urologist concluded “complete resolution of urothelial carcinoma of the bladder... No evidence of recurrence.“

In March 2018, the patient underwent his routine quarter-annual complete urological evaluation and he was found to remain in complete remission from his bladder cancer. He underwent complete MRI scan also of his pelvic regions as well as of his spine and he was found to be completely free of any bony metastases. His urologist expressed his amazement at his complete long term remission (now two and a half years) from his high grade urothelial cancer in stage 4.

Eradication of Liver Metastases by Liquifying:
How Immuno-Chemotherapy Works Completely Differently

A 57 years old female with extensive liver metastases from estrogen and progesterone positive breast

cancer continued to worsen and was placed in December 2002 on five weekly chemotherapy alternating between Immuno-chemotherapy and ordinary gemcitabine chemotherapy.

Her cancer history began in August of 1989 when she underwent left breast lumpectomy during which 12 of 13 axillary lymph nodes were positive for malignancy and she was given 3 years to live. She had a six and a three years old and I supervised a modified CMF adjuvant radio- chemotherapy which enabled her to remain free of cancer for ten years. She then developed a mass in the contralateral breast which was treated by another physician with a mix of chemotherapies including doxorubicin which were largely ineffective. By the end of 2002, she suffered hundreds of hepatic metastases along with metastases to the bones.

In December 2002, I had her start Neutrophil-potentiated carboplatin chemotherapy at a dosage of AUC1.6 followed a week later by intravenous gemcitabine at a dosage of 200 mg per M^2. These two cycles were repeated once and followed by another weekly cycle of Neutrophil-potentiated carboplatin chemotherapy at a dosage of AUC1.6. At this point, we observed a rise in bilirubin and deterioration of hepatic enzymes. A CT scan of the liver revealed extensive liquifying of liver metastases that has never before been seen in any patient undergoing other therapies (I can provide images of the CT of the liver before and after Immuno-chemotherapy). Proving that the deterioration of liver function was caused by the disruption of the liver architecture when liver metastases suddenly collapsed, the patient's bilirubin peaked at 10.5 mg% and then began to improve. Unfortunately, a mistake was made by one of the physicians treating her and she died of morphine overdosage.

Long-term Suppression of Leukemia Induced in Three Weeks with Immuno-Chemotherapy

A 62 years old female with pulmonary hypertension and myeloproliferative disease was treated in September of 2006 with weekly Neutrophil-potentiated carboplatin chemotherapy when her myelocytic leukemia began to take over her marrow requiring her to have weekly blood transfusions. Her carboplatin dosage was AUC1.6. Unfortunately, the patient's pulmonary doctor increased dosage of her diuretics causing her to become anuric shortly after she was given her third dosage of carboplatin. Obviously, coordination between her pulmonary doctor and myself was inadequate. Because carboplatin is eliminated from the bloodstream purely by the kidney, the patient's anuria inadvertently caused extended retention of carboplatin as if we had given her AUC10. The patient experienced serious lowering of her neutrophil count because I was not aware of carboplatin retention and I did not sustain protection of the neutrophil marrow with mesna. Her case was early on during the development of our extensive monitoring techniques and we were not measuring her urine specific gravity as it is customary to do so today. Although in the animals, I have been able to cure cancer with but two “lethal” doses of a chemo agent given a week apart without making animals sick at all by using antidote delivery to the gastrointestional tract and to the marrow, I have not had the courage to try injecting such high “lethal” doses in humans. The inadvertent super-high effective dose of carboplatin (caused by retention of carboplatin due to anuria) induced complete remission of this patient's leukemia because she stopped requiring blood transfusion after we gave her only three cycles of weekly Immuno-chemotherapy. She remained free of any problems from her marrow disease for 18 months when she succumbed to pulmonary hypertension.

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Search terms: Kenneth Matsumura; cancer; cancer chemotherapy; cancer immunotherapy; cancer therapy response rate; cancer Immuno-chemotherapy; neutrophil-potentiated chemotherapy; cancer therapy remission; therapy side effects; bladder cancer; urothelial carcinoma; breast cancer; myeloproliferative disease; carboplatin.