Dr. H. Gordon Ainsleigh, D.C.—Meadow Vista Chiropractic

PO Box 1087—Meadow Vista CA 95722—(530) 878-1901—drgordon@suddenlink.net

U.V. Workshop Speaker on Cancer Prevention, U.S. Nat'l. Inst. of Health, Bethesda MD, 9/16-18/1998

Member of the Board of Directors, Auburn Area Recreation and Park District

Founder, Staff Doctor & 23-Times Finisher: Western States 100-Mile Run

Postgraduate WSCC-Certified Chiropractic Clinical Nutritionist

December, 2012

For persons facing cancer death, there are some new reasons to have hope.

As reported 4 years ago, Dr. Evangelos Michelakis and associates of the University of Alberta noticed that the cellular hyperproliferation in pulmonary arterial hypertension (PAH) closely resembled that of cancer, and therefore tried an old, well-known PAH-effective drug, dichloroacetate (DCA) on both cancer tissues and patients of the deadly cancer, glioblastoma multiforme (GBM), with some promising results. Patients and their doctors can read about their work at http://www.chrcrm.org/en/rotm/dr-evangelos-michelakis , at http://www.nature.com/bjc/journal/v99/n7/full/6604554a.html , and at http://www.brainlife.org/abstract/2010/Michelakis_ED100512.pdf . This last study included treatment of five GBM patients with DCA, three of whom had quite favorable results. So, although other studies suggest that DCA is effective against many other cancers (including breast, colon and prostate), it apparently doesn't save everyone.

For those kinds of results, patients would have to turn to a therapy model that requires a lot more from the patient. In 2005, Dr. Dean Ornish and 18 colleagues at University of California San Francisco Medical Center, University of California Los Angeles Medical Center, and Sloan-Kettering Cancer Institute in New York City reported that prostate cancer progression stopped and generally regressed in 100% of 43 patients with slow-growing prostate cancer (Gleason score less than 7), who had refused conventional treatment because they still had good quality of life, when they adopted his heart disease treatment program of stress management, walking, and a no-animal-products whole-foods very-low-fat diet. Their study is at http://www.abundantwellbeing.com/Nischala/CancerStudyOrnish.pdf .

Like the Michelakis program, the Ornish program should work on all cancers because it attacks a function that all cancers have in common: the structure of all cells in made of protein and fat, so cancer must have enough protein and fat to make abnormal amounts of new cells. It appears that the Ornish Program, which is quite low in protein and very low in fat, provides enough fat and protein for normal growth, but may not provide enough for abnormal growth. However, the Ornish program is probably only effective on cancers that grow as slowly as the Ornish patients' less-than-Gleason-7 prostate cancer.

To compensate for this probable drawback of the Ornish program, I have put together a list of foods and supplements, available at local stores and markets, that have scientific proof of effectiveness in slowing the growth of various cancers, and expect that a combination of these interventions will slow many fast-growing cancers down to a growth rate below Gleason 7, at which point the 100% effectiveness of the

Ornish program should take effect. Although my protocol is posted on Ainsleigh.com and available to anyone free of charge, I would appreciate if people who use it would contact me, and stay in contact for a few years, so that I can compile data for a publishable scientific study which will, I expect, document the effectiveness of this protocol. Initial results have been very encouraging.

Participants in my study would have to be persons whose prospects are sufficiently grim, and desire to continue living sufficiently high, that they are willing to follow the diet, which means giving up all animal foods (steaks, eggs, cheese, fish, seafood, chicken, etc.) and all fatty plant foods (nuts, seeds, avocados, olives, soy, etc.), buy a bunch of supplements and take them as directed, and eat nothing but whole grains, legumes, fruits and vegetables (with no oil or sugar in the salad dressing). There is no charge for participation, and this protocol is intended to be in addition to whatever treatment a person's treating doctors advise. If medical treatment required a diet other than the above, a person would not be eligible to participate in this study.

A fascinating aspect of Dr. Michelakis' research is that Viagra also is an effective treatment for PAH. Therefore, if the metabolic similarity between PAH and cancer holds true, Viagra, Levitra and Cialis might be helpful with many cancers. It turns out that I am not the only one who has pondered this. You can read about Viagra inhibiting colon cancer in mice at http://jem.rupress.org/content/203/12/2567.full.pdf , and Viagra and Levitra causing human lymphocytic leukemia cell death and clinical improvement at http://bloodjournal.hematologylibrary.org/content/101/1/265.full.pdf+html . Levitra showed greater effectiveness in leukemic tissue culture, and either drug should probably be taken three times a week, a common dose for erectile dysfunction. It Levitra may be more effective because its effects last for 12 hours instead of 4 hours.

Cancer patients with grim futures now have several promising paths to take if they desire to remain among the living for longer than predicted.

1. They can contact Dr. Michelakis at the University of Alberta in Edmonton, Alberta, Canada, and ask if they can be included in his human trials.
2. They can ask a local doctor to acquaint her/himself with the standard use of dichloroacetate for mitochondrial dysfunction, the disease for which it was patented more than 30 years ago, and prescribe it to them based on the well-known fact that most cancers have in common that cancer cell mitochondria are malfunctioning.
3. They can ask a local doctor to prescribe Viagra or Levitra for erectile dysfunction. This is available to women as well as men because the clitoris is an erectile organ, and loss of clitoral erectility dramatically decreases sexual response. Obviously, either male or female erections are not what most interests a cancer patient, but such a rationale is necessary to keep prescribing doctors out of trouble with their licensing boards.
4. They can read up on the Ornish program for treating heart disease (Ornish has authored or co-authored several books) and apply his program, along with the supplements he used in his 2005 prostate cancer study.

5. They can go to ainsleigh.com and print out (and follow) my protocol for slowing, stopping or reversing the progression of cancer. (Notice I didn't say "cure". Among the small number of people who have tried my protocol, one person has had to stay on a partial compliance with the diet and supplement protocol for several years now to prevent his PSA (prostate specific antigen) from rising again.)
6. They can pursue a combination of the above plans; i.e. doing the Ornish or Ainsleigh diet and supplement programs in combination with Viagra or Levitra or dichloroacetate. At this point, until more is known about interactions, combining Levitra or Viagra with dichloroacetate should be approached with guarded caution, and only if the other approaches listed here are unsuccessful.

Keep in mind that you won't be hearing about these cancer treatments through the normal channels. Drug companies are used to getting hundreds, or even thousands, of dollars per dose for cancer drugs. So even Viagra and Levitra, at $25 per dose, would spell disaster for the cancer industry. Dichloroacetate is even more of a financial disappointment at less than $1/dose. And, of course, the Ornish program, and my own food-and-supplement cancer-slowing addition to the Ornish diet, makes no money at all for the pharmaceutical industry. When there is no profit in a new prevention or treatment finding, it usually takes 20-30 years for science to trickle down to the treating doctor. Drug companies pay for a substantial portion of medical school education and for a majority of MDs' continuing education, so the chances of any particular doctor being educated on this in the next 20 years is quite slim. Doctors practice what they are taught, and there will be no money to pay doctors to teach other doctors something as financially unrewarding as any of these treatments.

As "Deep Throat" said during the Watergate scandal investigation of the early 1970s, "Follow the money", or, in this case, the lack of money. The reason you heard about Viagra curing erection problems is because there is big money in solving the ubiquitous erection problems of older men at $25.00 per dose, once or twice a week, for the rest of their lives. But there is nothing in the corporate business plan that would make anyone in the business of medicine want to switch a patient from a cancer drug at $600/dose to Viagra at $25.00 a dose. Worse still, the patent on Viagra just expired, and the price per dose will soon be so low that even the homeless can afford erections.

So it gets down to this: if cancer patients are going to exceed their doctors' expectations, they will have to take responsibility for their own health. This means hard questioning of one's doctor to break through the usual traditional "happy talk" about treating for a cure when the doctor knows the patient is going to die. It means pinning the doctor down on the percentage success rate of his treatment for particular cancers at particular levels of advancement, so the patient has time to try new and experimental/alternative treatments before he/she dies or is permanently damaged by treatment. And then the patient who wants to live will have to do a lot of searching through research.

Traditional doctors are forever accusing alternative practitioners of giving patients false hope. But I have known several patients who stopped progression or cured cancer through diet and supplements, and there are many good scientific studies documenting why such approaches and agents are effective. In my experience, it is the traditional doctors who continue with hopeless, damaging but profitable chemotherapy, radiation and surgery, while giving the "happy talk" about cure right up to the point

when the patient loses consciousness and dies, often from the treatment. Seeing this happen again and again has convinced me that it is the traditional cancer doctors who need to quit giving cancer patients false hope, and let them try new and/or alternative therapies that offer significant realistic science-documented hope for cure or a halt of progression, using agents that have a track record of usually being harmless.