NEW BEGINNINGS
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... let us be the light at the beginning of your journey

Desperate Measures

We're forever reading about "advances" in cancer drugs, and Big Pharma grows fat on the profits, yet cancer mortality rates have changed little over time. Just what is the truth about conventional treatments like chemotherapy? **Fenella Souter** reports

This story is reprinted from the CISS Newsletter of January/February 2006. It was accompanied by my comments at the time so I have updated the comments. See page 7.

On a late autumn afternoon earlier this year I found myself walking with a friend among the tilting headstones and mossy memorials of a neighbourhood churchyard. A handful of famous locals are buried there, but for the most part it is like any other cemetery, full of reminders of death's indiscriminate embrace. Here an unsuspecting 46-year-old taken midstream, there, an infant's melancholy yard of ground; grass growing over the infirm, the old, the unready.

As we wandered in the warmth of the sunshine, alive to time and tide, talk turned to a mutual friend – let's call her Lyn - who had been diagnosed with breast cancer some weeks before. Lyn had had a mastectomy, cancer cells had been found in one of her lymph glands and now she was to prepare for chemotherapy.

"The doctor told her it would probably only improve her survival chances by about 5 or 10 per cent, but she decided to have it anyway," my friend told me. "There's a possibility it might help."

I was startled. A chance it might, help? Five or 10 per cent? Was the benefit really so small, the outcome so uncertain? Weren't we always reading about the great strides being made in cancer treatments? The drug breakthroughs?

In the weeks that followed, I canvassed the issue with friends and acquaintances. What did they know about conventional cancer treatments — not only chemo, but also surgery and radiotherapy?

Most seemed to think everything was immeasurably better these days. Naturally, they dreaded being diagnosed with cancer but they felt reasonably optimistic about the outcome. You went in for treatment, often punishing, you survived it, you got on with your life.

On the other hand, they kept hearing of

Fenella Souter

friends and acquaintances newly diagnosed with cancer; they had wept at the funerals of many lost to it, despite having everything medical science - or alternative medicine - could offer. In some cases, their friends had died of the toxicity of the treatment, pushed beyond what's sometimes called, delicately, "the vital frontier".

So what was the truth here? How far had we come? Was the constant barrage of "good news" media stories justified or misleading? Was the "war" against cancer being waged on the wrong front? Were we being told everything we needed to know? Was there another way?

Even to ask such questions is to invite trouble. There are few subjects as painful and sensitive as cancer.

Patients and their families want the truth about their prognosis but they also want hope. Cancer professionals need to believe in their branch of medicine, and somehow reconcile that with watching many of their patients die in a few brief years, months or sometimes weeks. Governments want to be seen to be making inroads.

And cancer is big business. Stocks rise on the announcement of "breakthrough" drugs barely beyond trials on the first laboratory mouse. Cancer treatment is one of the fastest-growing areas for pharmaceutical companies, and worldwide sales of cancer drugs look like hitting $US45 billion by 2010. Tellingly, drug companies fund an estimated 80 per cent of medical research - and they prefer positive results.

All in all, then, there is much invested in maintaining the faith in modern cancer therapies. But is that faith misplaced?

The challengers

Dr John Bailar III is not used to being called a "murderer". Mostly, he's known as an American epidemiologist with impeccable credentials. He worked at the National Cancer Institute for 22 years, as well as at Harvard and McGill universities. He's now a University of Chicago emeritus professor.

But that was the word hurled at him when he spoke at a public meeting of 700 or 800 people a few years ago. He was accused, he says, "of dissuading people from using the most effective cancer treatments", because he had questioned the progress made against cancer.

Bailar made himself unpopular with many in the establishment after two of his papers appeared in *The New England Journal of Medicine,* the first in the mid-1980s, another in 1997. (A third is under way.)

The 1997 paper was called "Cancer Undefeated" and its very title flew in the face of mountains of upbeat press releases from pharmaceutical companies and government cancer bodies, and streams of sensational media stories.

In it, Bailar concluded that "the war against cancer" was far from over. "The effect, of new treatments for cancer on mortality has been largely disappointing," he wrote.

There was a flurry of furious letters to the *NEJM* challenging Bailar's analysis, but none, as he pointed out, questioned his finding that cancer-related mortality, adjusted for

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such as AAP to claim otherwise is pure pro-government propaganda.

In addition to the petition against mandatory vaccination, Tony Nikolic, Director of Ashley, Francina, Leonard & Associates has lodged a 29 page submission to State Parliament: ***RE: Informed Consent—Vaccine Rollout—State Orders*** Dated 7 July in which he requests the government to set up a consultation with a range of experts to review the actual evidence on which government decisions restricting people's freedom are being based.

How do the COVID-19 vaccines work?

First it is important to understand that most of the so-called vaccines aren't vaccines at all. A virus vaccine is supposed to have parts of the virus in it, or attenuated, so that the body recognises it as foreign and mounts an immune reaction to destroy it. If the body experiences it in the future the body keeps a memory of it and is ready for it next time.

The SARS-CoV-2 virus that causes COVID-19 has what are referred to as "spike proteins" on it that it uses to latch onto body cells and then enter the cells.

the Novavax vaccine contains the same spike protein as the virus has, so the body mounts a reaction to it in the normal way. The AstraZeneca vaccine is a viral vector vaccine made from a weakened form of a common cold virus from chimpanzees. The genetic code of the SARS-CoV-2 spike protein is produced once inside the body.

The immune system then responds and produces antibodies to help equip the body against a real case of COVID-19 in the future.

Unlike these vaccines the Pfizer and Moderna vaccines instead work by injecting Messenger RNA to tell the cells how to make the spike protein. Once this is done the immune system recognises these spike proteins as foreign and mounts an immune response to it. The potential problem with this is that there has not been a lot of experience with the other possible effects that this technology might produce in the longer term. For example how much of the spike protein is produced in different people? Does this spike protein cause the same serious damage to the heart, lungs and brain observed from the spike protein in the COVID-19 virus itself, including endothelial damage leading to blood clots, inflammation and heart attack? Also, unlike normal vaccines, these new mRNA ones don't stop you getting the virus but only ensure that you get a milder version of it.

How dangerous are the Vaccines generally?

In 1990, the Vaccine Adverse Event Reporting Systems ("VAERS") was established as a national early warning system to detect possible safety problems in U.S. licensed vaccines." VAERS is a voluntary reporting system meaning it relies on individuals to send in reports of their experiences to the Centers for Disease Control and the FDA. VAERS is useful in detecting unusual or unexpected patterns of adverse event reporting that might indicate a possible safety problem with a vaccine. The total safety reports in VAERS all vaccines per year up to 2019 was 16,320. The total safety reports in VAERS for COVID Vaccines alone up to 25 June 2021 is 411,931.

People are dying and being hospitalised in record numbers in the days after vaccination. Based on VAERS as of 25 June 2021, there were 6,985 COVID-19 vaccine deaths reported and over 23,257 hospitalisations reported for the COVID-19 vaccines (Pfizer, Moderna, Johnson & Johnson). By comparison, from 1999, until 31 December 2019, VAERS received 3167 adult death reports (158 per year) for all vaccines combined. Thus, the COVID-19 mass vaccination is associated with at least 39-fold increase annualised vaccine deaths reported to VAERS.

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Supplements for CISS Members

Low Dose Naltrexone all strengths 1.5mg to 4.5mg
100 compounded capsules (Doctor's prescription needed)
Look up "Low Dose Naltrexone" Homepage
Stabilised electrolytes of oxygen 50ml—$15 (Chlorine Dioxide)
Visionary Health Compounding Chemist (02) 4969 5081

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CISS members can receive Psych-K to identify and change negative belief systems free of charge. Ring the Office if you want to try it.

DVDs for Sale from the CISS Office

CISS Seminar "Cancer & Hope - Survivors share their Lessons" are available for $29.50 plus postage for members or $39.50 + postage for non-members

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OVERSEAS & LOCAL NEWS

OVERSEAS NEWS

Fluoride issue to be decided soon

Dr Mercola reports that a court case in the US will soon decide if adding fluoride to the water is likely to result in a measurable lowering of the IQ of newborn babies.

LOCAL NEWS

NSW joins the COVID lockdown:
What happened to "Freedom"?

After more than a year of posturing about how NSW Liberals support "freedom of choice" over the severe and dictatorial lockdowns experienced in other Australian states, Premier Gladys Berejiklian finally allowed NSW to join the "mob" mentality encouraged by the politics driven medical profession exerting their influence through the State health departments.

These were the same "experts" that predicted that if Australia does not act seriously to stop the COVID-19 spreading we would see 150,000 deaths; and if we acted responsibly we would see only 50,000 deaths.

This unscientific prediction designed to instil fear in the population provided the rationale for the most severe restrictions ever placed on Australians in its history—without the passing of any laws. It will be to Australia's ongoing shame if this giving in to authority on such flimsy evidence is allowed to continue.

Those like me who lived through the

Don Benjamin, Editor

Second World War ostensibly to fight against Nazi Germany and Imperial Japan, both run by dictators, in the cause of freedom are starting to wonder how this could have happened.

It has taken Prime Minister Scott Morrison 14 months to understand that restrictions on freedom of movement should be based on the number of deaths or serious hospitalisations each year, not on the basis of the number of "cases". The number of deaths from 'flu each year averages about 1,000, around the same number as Australia's death toll from COVID-19 in 2020 (909). Every life might be "precious" but no such restrictions are placed on people to avoid getting the 'flu or restricting the driving of cars to reduce the annual road toll—also currently around 1,000.

Only the medical profession could come up with such a ludicrous and hypocritical rationale while being responsible for more than 20,000 deaths every year resulting from wrong or unscientific medical interventions. It needs someone like cartoonist for The Australian Johannes Leak to make this point in the media. (see below)

This unprecedented restriction on people's freedom has inspired a parliamentary Petition expressing opposition to compulsory COVID-19 vaccinations that are currently under discussion for various situations in Australia—in breach of the Nuremberg Code.

Despite hardly any publicity this Petition EN2753 "No Mandatory Covid-19 vaccination" closed on 14 July with 309,831 signatories.

Media outlet AAP reported on 9 June that the claim that compulsory vaccination was in breach of the Nuremberg Code was invalid on the grounds that the Code only applied to such injections that were part of human experimentation. This is not "experimentation" because "the vaccines had been approved by health authorities".

No doubt the Jews and other minority groups in Germany at the time would have been happy and set their mind at ease to know that the experimental injections they were being given had been "approved by German Health Authorities".

It is accepted by vaccine authorities that the vaccine must be considered experimental until the results of the Phase 3 (safety) trials have been concluded. Approval for emergency use doesn't mean the trials are no longer considered experimental.

The US National Institute of Health clinical trials website lists studies with a start date, estimated primary completion date and estimated secondary completion date. For the Pfizer Covid-19 vaccine, for example the primary completion date is October 2021, and the estimated study completion date is April 2023. So all of the COVID-19 vaccines are still considered "experimental". For media outlets

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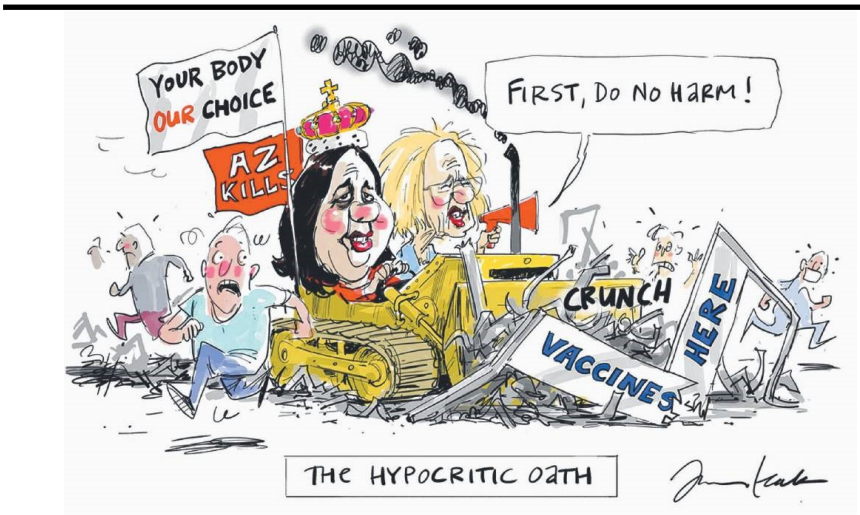

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age and population, was higher in 1994 than at the time of the National Cancer Act of 1971, the year Richard Nixon declared "war on cancer". It began to decline slightly in the mid-1990s and, as Bailar admits, appears to have plateaued. He's waiting to see if that trend continues, and as yet sees no reason to change his original view.

The figures are similar in Australia. Between 1991 and 2001, mortality rates for all cancers stayed about the same until the mid-1990s and then, through to 2001, decreased for males by an average of 1.8 per cent and for females by 1.4 per cent.

Bailar argues that the apparent drop in mortality was mostly due to early detection and prevention. Hence the drop in male lung cancer, apparently as a result of men giving up smoking (in Australia, incidence and mortality dropped by 2.1 per cent a year between 1991 and 2001), and the decline in cervical cancer, attributed to Pap smears (incidence fell by 6.2 per cent a year over that same decade and mortality by 5.2 per cent). Stomach cancer has declined, too, although no one is sure why. (All percentages here are averages, and all mortality rates age adjusted.)

Bailar's argument is that while prevention is having the best results overall, that's not where the money is going. "When I started doing research on cancer in about 1956," he says in his measured tones, on the line from Chicago, "there was as much emphasis on prevention as there was on treatment. That changed with the demonstration that some chemicals could wipe out cells of the lymphatic system.

"That eventually developed into treatments for some kinds of leukaemia. At that point, there was a general feeling that if we can do this for leukaemia, we can do it for all cancers. We just need to find the right chemicals.

"Back then, it [chemotherapy] looked really promising. The problem is, it hasn't worked. But while this has been happening, virtually all the leaders of research in cancer have grown up with the treatment model, and that's the way they think."

Medical literature is still full of trials of this drug versus that, combinations, tinkering around the edges with a model Bailar says has been spluttering for some time. "There have been a fairly large number of cancer types found to respond to [drug] treatment -whether chemical, hormonal, biological - after the cancer is established, but most of the cancers are in children and almost all of them are quite rare.

"We haven't made much progress against the big common cancers in adults, with a couple of exceptions. We've made virtually no progress in lung cancer treatment. Breast cancer, we have [the drug] Tamoxifen, which doesn't really cure it but does keep it in check. The picture as a whole has not much changed from 50 years ago."

Just how far we have come depends on how you analyse the numbers.

Increased survival rates are often cited as an example of success. The latest available figures from the Australian Institute of Health and Welfare show an improvement in five-year survival rates for all cancers — from about 50 per cent in the mid-1980s to 60 per cent in the mid-1990s.

But Bailar, among others, suspects these figures may be inflated by increased detection and overdiagnosis. That is, did some of the people who have been "cured" ever have cancer in the first place?

"Over several decades now, the means for detecting and diagnosing cancer has expanded," he says. "So has our concern about cancer. A lot of things that are borderline when you look at them under a microscope - and that in the old days would have been called borderline or undiagnosable — well, now nobody wants to make a mistake, so they get called cancer.

"It means cancer incidence rates are not really comparable with what they were 20 or 30 years ago. If what we get from cancer registers has been diluted by adding in things that were surely always there but you didn't know about them, and they weren't lethal, it will look like the incidence of cancer is going up and, at the same time, as if the survival rates are going up."

There are other things that can make survival statistics look better. The phenomenon called lead-time bias, for example. It works like this. Because of screening and better diagnostics, some cancers are now diagnosed earlier, which means that survival *from time of diagnosis* is longer, but the point of death is the same.

In other words, the person knows about the cancer for longer. Instead of, say, being diagnosed in 1990 and living until 2000, a 10-year survival, he or she may now have learnt about the cancer in 1985 but still die in 2000. The statistics will record that as a 15-year survival.

John Bailar isn't the only scientist to have put his head above the parapet in the cancer debate. In recent times, leading London oncologist Professor Michael Baum has infuriated the UK breast-screening establishment with his revised position on mammography.

In the late 1980s, Baum pushed for its introduction. Now, in the light of further large studies and along with a number of other researchers, he has raised serious questions about whether the potential benefits for a few women outweigh the downsides for the many others, particularly when it comes to screening women under 50. (Baum goes so far as to doubt that there are *any* benefits for women under 40.)

Screening is presented as reducing a woman's relative risk of dying from breast cancer by 30 per cent. What tends not to be mentioned is that the risk is very small to begin with, so, in turn, the absolute benefit is quite small. Another way of looking at it is that 1000 women over 50 have to be screened over a 10-year period in order to have two fewer deaths from breast cancer. A major Canadian study challenged even that benefit. Baum believes screening downsides include false diagnosis, overdiagnosis and overtreatment, from biopsies to unnecessary mastectomies.

In a 2002 interview, Baum said he resigned from Britain's National Screening Committee "because they were intentionally deceiving women [about the harms]. They went on record saying, 'We mustn't let women know this because it might deter them from coming to be screened.'"

The UK's Breast Screening Program has said that Baum's comments are inflammatory and out of date with current research.

Another scientist who has questioned cancer orthodoxy is the German biostatistician Professor Ulrich Abel, of the Heidelberg/Mannheim Tumour Centre.

In 1992, he analysed hundreds of clinical trials and publications around the world that had looked at the value of chemotherapy for advanced, solid-tumour cancers (such as bowel, breast and lung, as opposed to cancers of the bloodstream such as leukaemia). Abel's review was sober, methodical and damning.

One of the criticisms conventional medicine tends to make about complementary and alternative medicine is that there is no solid evidence of benefit. Here was a far-reaching survey that found the same to be true of conventional treatments frequently given to cancer patients. Indeed, some treatments risked *shortening* patients' lives.

(It's important to note that Abel was looking only at advanced cancers, where the tumour has metastasised - or spread - to other parts of the body. Chemotherapy, in these cases, is not an attempt to cure but to prolong life or palliate symptoms by shrinking tumours.)

Basically, Abel found no direct evidence that chemotherapy prolonged survival in patients with advanced carcinoma. In the case of ovarian and lung cancer, there was some evidence of benefit, but it was small at best, and more aggressive treatments weren't necessarily more effective. Nor was it clear, on the whole, that it even helped with quality of life, if the patients were symptom-free. Yet doctors had often administered it in all these circumstances - and perhaps patients often demanded it.

Has the situation changed since he did his survey in 1992?

"There has been some progress since the 1990s, but it is certainly smaller than the public assumes," he says in his impeccable English when I speak to him in Heidelberg. He's engaged in a different field of research now, but has kept a watching brief. He's aware of some advances - in the treatment of advanced colon cancer and a type of lung cancer, for example - but the improvements are in terms of extra weeks or months, not years.

The picture seems to be brighter in less advanced cancers. "In early breast cancer, the situation is rather clear. Chemotherapy can have an effect on survival."

Abel's survey also looked at the evidence for the widely held conviction that a "response" to chemotherapy - making a tumour shrink -is a good indicator of pro-

longed survival. It sounds logical that one follows the other, says Abel, but is it?

"Some patients don't have a response and you can't predict which ones will. If it's only a partial response, that probably won't be enough to change the prognosis. Even if some people have a complete response, what about those who don't? They will have only the toxic effects of chemotherapy. So they will not profit - on the contrary, their survival may be shortened. So there's an ethical problem.

"The second argument is that there may be some advantage to patients with a response, but that response might also help to single out cells which resist chemotherapy and remain in the body while the others are killed."

If that were the case, he says, life expectancy after a relapse - a recurrence of the cancer - might in fact be shortened because these cells are more aggressive….

...Associate Professor Michael Boyer, head of medical oncology at the Sydney Cancer Centre at Royal Prince Alfred Hospital (RPA) ...is convinced things are going in the right direction but admits the gains are incremental and the benefits far from universal. "It's a matter of whether you think any medical problem is solved overnight. It's not. The nature of these things is that occasionally you hit a home run and find a drug - or a procedure - that changes the nature of a disease. Mostly that's not what happens. Mostly you have a drug that improves survival by 2 or 3 per cent. Then five years later you find something that improves it by another two or three ... Sometimes it's not a drug, it's finding the disease early."

The difficulty is that there's no way of knowing who needs adjuvant chemotherapy or radiotherapy, or who will respond and who won't, which means that you have to treat everybody.

(Adjuvant chemotherapy is "protective chemotherapy", given as a follow-up to some other treatment, such as surgery, with the intention of reducing the risk of a recurrence. The intention is to kill any cancer cells that may still be in the body. In the process, it may also kill rapidly dividing cells found in bone marrow, hair and the lining of the mouth and stomach, hence the common side effects of hair loss, mouth ulcers, nausea and diminished immunity. Radiotherapy is given to a particular region to kill any cancer cells possibly missed by surgery or, in other cases, where surgery is not an option.)

As Boyer conceded in a recent interview on ABC Radio's *Health Report,* to save the life of one woman with early breast cancer, or give her a five- to 10-year survival, you would probably need to treat 20 to 25 women who wouldn't get that benefit or didn't need the treatment. They will have only the toxic effects of chemotherapy.

Infertility, sometimes reversible, sometimes not, is a common side effect of chemotherapy for both sexes. Depending on the drug, other long-term effects of chemotherapy and/or radiotherapy can range from heart disease, respiratory problems and bone damage to impaired cognitive function ("chemo brain") and secondary cancers such as leukaemia — although the risks are generally small.

Until 20 or 30 years ago, radiation for, say, breast cancer, was beamed straight onto and through the chest, and out the other side, often causing permanent damage to the heart. As Boyer says, in an observation less than reassuring for those treated in the past, "If you were treating the left-hand side, the heart was in the way. Now it's given tangentially so it goes across your chest wall." Doses are also lower than they used to be and practitioners more certain of the distribution of the radiation, he says….

...Statistics are pliable, as we know. On the *Health Report,* Boyer challenged a paper by associate professor Graeme Morgan, a radiotherapist at Sydney's Royal North Shore Hospital. It argued that if chemotherapy were to disappear, the five-year survival rate of all patients with cancer would drop by only about 2 per cent, from 62 per cent to 60 per cent.

Morgan, of course, is keen to beat the drum for radiotherapy, which he says is underused in Australia. Radiotherapy machines are expensive. He'd like to see less money directed towards chemotherapy and more towards other treatments, particularly his. "Chemotherapy is oversold," Morgan tells me bluntly. "It's sold in terms of reduction of risk, rather than absolute benefit [which makes the numbers sound better].

"Doctors don't appreciate when someone is not curable, and therefore what you're looking at is not survival but quality of life. So they might say, here's a drug that may give you two more months, why don't you try it? They don't say, well, in giving you this drug, you've only got a 15 or 20 per cent chance of having a response to it."

When I ask Michael Boyer about Morgan's paper, he gives a wry smile and rolls his eyes. For one thing, he says, Morgan lumped together all cancers, including those in which chemotherapy wouldn't be used, and left out those which respond well to chemo, such as the lymphatic cancers.

Even so, in the debate over the paper, Boyer was only able to increase the 2 per cent figure to 6 per cent, but that was using Morgan's methodology, which is not how he would choose to calculate it….

...Of course, many of the world's finest scientific minds are trained on coming up with new approaches to treating and understanding cancer. Many have high hopes for drugs such as Herceptin, which rely on molecular biology - a more finely tuned approach that aims to target characteristics of particular cancer cells. The drawback is that Herceptin only works for a. certain type of breast cancer and it can increase the risk of heart disease.

Immunotherapy and cancer vaccines are being explored, as well as lesser-known areas such as anti-angiogenic drugs - drugs that stop angiogenesis, the rapid growth of blood vessels. Angiogenesis is generally a good thing - the body's natural healing process, triggered in response to injuries as well as menstruation. With cancer, however, it may be a negative. One theory is that these new blood vessels may help "feed" tumours and also be a vehicle for cancer cells to travel to other organs and form new tumours.

Harvard Medical School researcher Michael Retsky, Michael Baum and others have speculated that surgery - or even needle biopsies - on the primary tumour may have two unwanted effects. First, by removing the tumour, surgery removes the tumour's own angiogenesis inhibitors. Two, by creating an injury, it may work as an "angiogenic switch", triggering angiogenesis in distant, dormant micro-metastases — tiny clusters of cancer cells elsewhere in the body.

That may explain the often rapid relapses in some cases of breast cancer in young women who haven't had chemotherapy, when the cancer comes racing back 12 to 18 months or so after surgery. Baum has hypothesised that it may be true for some other cancers, as well, when symptomless tumours are disturbed.

Retsky suggests the answer is more drugs - not cytotoxic chemotherapy drugs, which he says have probably reached their zenith, but perhaps anti-angiogenic methods. But how to control the side effects on normal healing?

At this stage it's only a theory, one of a great many. That's the thing with cancer – nothing is black and white.

Pride and prejudice

Lisa Whittaker was diagnosed with breast cancer in February 2000. Earlier this year, she briefly told her story in one of many submissions received by the 2005 Senate inquiry into cancer treatments. The inquiry was initiated by Senator Peter Cook, who became interested in both conventional and alternative methods of treating cancer after he was diagnosed last year with melanoma.

Whittaker wrote that although a "multidisciplinary tactic to my wellness was suggested ... when I inquired whom my naturopath, homeopath and Chinese herbalist would be, the silence was deafening".

In 2004, her cancer returned — it was now in her liver, lung, kidney, left breast, spine, pelvis. "This time I searched for practitioners willing to work together. Over the past 12 months my journey has been amazing. I was able to collaborate with four different practitioners."

They range from Professor Martin Tattersall, an oncologist at RPA, to Dr Qi Chen, a suburban doctor who practises traditional Chinese medicine.

"There is an urgent need for a place or centre where information of this nature is readily available," she pleaded, "with an integrated approach to wellness."

Remarkably, Whittaker is now in remission.

Between 20 and 50 per cent or more of cancer patients are thought to use one or more forms of complementary medicine. (Complementary medicine refers to uncon-

ventional treatments used in conjunction with conventional ones; alternative generally means those used *instead* of conventional treatments. The more popular umbrella term these days is integrative medicine, which combines multiple strands.)

If conventional cancer medicine had all the answers, argues Professor Avni Sali, former head of surgery at Melbourne's Heidelberg Hospital and now foundation head of the graduate school of integrative medicine at Swinburne, there wouldn't: be such a need to look elsewhere. "The Western model," he says, in his characteristic tumble of words and ideas, "has to do primarily with mopping the water, rather than looking for the cause. Well, okay, now, if you've got hypertension or diabetes, we've got good mops.

"With cancer, the results are unpredictable. Hence the necessity for looking at why this person has cancer and what else you can do apart from those three things [surgery, radiotherapy, chemotherapy]."

The very least, he says, is make the cancer patient as healthy as possible in order to cope with the rigours of the disease and the treatments. Psycho-social support (group therapy, psychotherapy, relaxation techniques such as meditation) to reduce stress, improved diet, exercise, and vitamins and minerals to improve the immune system are some of the things Sali claims can improve general health and survival, yet they tend to be overlooked. He stresses the importance of a strong immune system.

"In some cancers, such as melanoma, immunity is profoundly important - in others it doesn't seem to be that important. In breast cancer, women who get it early in life, pre-menopausally, are more likely to have immune depression.

"People in alternative medical centres were using immune stimulants and vaccines 50, 60, 70 years ago, but it's only in the last four or five years that the conventional cancer world has become exceptionally interested in vaccines [as immuno-stimulants] in melanoma. It's also important in bladder cancer."

Sali says orthodox medicine tends to ignore - or be ignorant of - research that doesn't fit the lucrative drug model. Still, change may be coming. In May this year, even the conservative American Cancer Society cautiously noted a study that suggested women with oestrogen-negative breast cancer (that is, cancer not stimulated by oestrogen) who followed a low-fat diet reduced the risk of recurrence by 42 per cent. "If this kind of reduction were found in a preventive chemotherapy study," an ACS statement read, "it would be cause for much excitement."

Avni Sali is not opposed to conventional treatments: "There's nothing wrong with drugs, used appropriately and at the right time." For instance, in the case of palliative chemotherapy, his view is that if there's a reasonable chance it may be of some value, people should try it, but over a short period. "Continue if it doesn't cause any problems," he says, "but if it does, then stop it. People don't have to keep having it. Many patients seem to think it's as if they've signed a contract, so they have to have it rain, hail or shine.

"In cases where there's only a small chance it could be valuable anyway and it's causing serious complications - for instance, you're so nauseated you can't eat for long periods of time – you'd have to have fairly good evidence to continue."

Sali says the patient would want to have some idea early on that it was having an effect, rather than waiting months for a scan. To that end, he would like to see wider use of blood markers, where possible. "They are not 100 per cent accurate but they can give a good guide to how you may be going. If the cancer marker is going up and you're still getting chemo, it's highly unlikely to be valuable."

Avni Sali is a convert but, as the Senate Inquiry found, Australia lags behind the rest of the world in responding to the popular demand for more research into integrative medicine.

In the US, the government and other sources provide $A400 million for research into complementary medicine. Here, says Sali, "the Australian government provides zero".

Well, not quite. In 2004, the NHMRC allocated $64 million for cancer research. In that same year, it allocated less than $1 million to research into complementary and alternative medicine (only one project was cancer-related). This year, the forecast is lower still.

A NHMRC spokesperson, John Rogers, noted that they do not receive many applications for such research. Sali laughs at that. He says it's because people know from past experience that they're going to be knocked back. "We've tried the NHMRC with the most brilliant ideas and got nowhere."

While the public appears eager to know what else is on offer, some of the medical establishment fear even being *seen* to show an interest in anything "unorthodox".

Last year, Germany's Ulrich Abel published a paper in the *Journal of Cancer Integrative Medicine,* suggesting 35 reasons there were so few well-designed clinical trials of unconventional cancer therapies. (Abel, by the way, says he is personally sceptical of the evidence for unconventional cancer treatments.)

Reason No 35 - that ethics committees may not approve the proposal - reads like something one might find among the dusty archives of the Politburo: "A study on the holistic treatment of women with breast cancer in Denmark was refused by the Scientific Ethics Committee on the grounds that 'participation of well-known specialists in the study as well as the acceptance by the Central Committee might give several people the impression that unproven methods are generally acceptable' "

Yet how else, one wonders, are "unproven methods" to be proved or disproved?

Everyone wants to understand cancer better and, if not cure it - that now seems an impossible task - at least reduce it to a chronic but manageable disease.

The question is, how do we get there? Honesty, independence and an open-minded exchange of knowledge seem at least a start.

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What astonishes Frank Hewstone, 68, isn't so much that he's alive when he ought to have been dead years ago, but that the medical profession has so little interest in his survival. [Frank died in November 2019, 30 years after his cancer diagnosis and 14 years after this article was written. Ed]

In 1989, he returned to Australia after living in Samoa, where he had contracted dengue fever. He'd been feeling unwell and losing weight. It turned out he had cancer in his bowel and liver. The prognosis was five years.

Three months after surgery to remove the tumour on his colon and a section of bowel, tests showed his liver cancer had progressed and his doctors recommended a further operation and chemotherapy. He declined.

Hewstone and 12-year terminal lung-cancer survivor Barbro Spike told their stories recently at a meeting of the Cancer Information & Support Society, a small group interested, says president Don Benjamin, in an honest assessment of conventional therapies and an open-minded approach to alternatives.

"They said I was going to die," Hewstone told his rapt audience of 16 or so cancer patients and their families. "I said, 'Like hell I am.' "

"I had a grandfather, a mother and a sister who died from cancer. All of them had chemotherapy and died anyway and that put me off. It didn't give them any quality of life and certainly didn't cure them. Chemo doesn't suit everyone."

Instead, Hewstone, a retired builder, read up on other approaches. He decided to radically change his diet. "I took up a combination of things. Lots of carrot juice, vitamin C, herbal teas and all pure and unprocessed food.

Wheatgrass juice - we grow our own wheatgrass - and lots of vegetables, everything raw or just lightly steamed."

Coffee enemas, no alcohol, no meat, positive thinking and affirmations were also part of the regimen.

Four months later, he went back to one of his doctors. "Without looking up from his desk, he said, 'I see you are on this "health kick". How do you feel?'

"I said I felt great. He said, 'Well, what did you come back here for then?' But he got me scanned anyway and it was completely clear. After that, he wasn't interested in what I'd done to get well. He said, 'That's your business.'"

Unfortunately, that sort of attitude means there is very little hard data on people like Hewstone - is he a statistical aberration, on to something, or just lucky?

He feels the bowel surgery was important - "otherwise the cancer might have been too much for my body" - but attributes the rest of his recovery to diet (somewhat more relaxed

these days after the very strict first year or so), his collection of imported vitamins, colloidal minerals and selenium - and to faith and state of mind.

"You have got to love life. [My wife] Maxine and I have got a caravan and we tour. You have got to think and plan for the future, picture it.

"When I had cancer, one woman came up to me and asked me how I was. I said I was well. She said, 'Well, don't get your hopes up.' You've got to avoid people like that."

****

Paul Kraus knew something was wrong when he woke from his "simple, less than an hour" operation for an umbilical hernia and glanced at the clock in the recovery room. It was 2pm. He had gone into theatre at 8 o'clock that morning.

Back in the ward, his grim-faced surgeon handed him a set of colour photos. They showed the inside of Kraus's stomach. It was "riddled" with tumours, the surgeon told him.

Kraus, then 52, had peritoneal mesothelioma - a rarer form of cancer than pleural mesothelioma but just as deadly. He was given a few months to live.

That was eight years ago. He's now possibly the world's longest-surviving mesothelioma patient who has not had conventional treatment.

Kraus was told nothing could be done - apart from drastic surgery or chemotherapy so intensive that the side effects would compromise his quality of life - but he and his wife Sue (pictured with him above) weren't prepared to give up.

"I want to stress that I didn't jump on the alternative bandwagon of my own free will," says Kraus. "At the time, conventional medicine had nothing to offer."

Three weeks after he was diagnosed, he and his wife went on a 10-day retreat at the Gawler Foundation in Victoria –"it was so therapeutic, so full of joy" - and radically changed their diet.

"Paul was juicing until he was yellow, we were doing everything to the letter," says Sue. "Then three months after the initial diagnosis he had a further scan that showed it had got worse. But these things take time. At six months, the radiologist believed it had not deteriorated and may have improved slightly.

"The oncologist disagreed. He said everything we were doing was a waste of time and told Paul, 'Oh, don't punish yourself. Go out and have a beer and steak and chips for lunch.'

"I was so mad. We were trying so hard. At least the cancer hadn't increased. That attitude made us all the more determined."

After that, they went to Fremantle to see a GP who had apparently had success with an experimental treatment:

Kraus underwent intravenous Ukrain therapy (a basic form of chemotherapy that combines Thiotepa, a cytotoxic drug, with a herb, greater celandine, and is claimed to kill cancer cells without such toxic effects on normal cells) and intravenous vitamin C treatment. Later he had intravenous ozone therapy, claimed by alternative practitioners to "saturate the body with oxygen".

He finished those treatments years ago but continues to rely on a domestic pharmacopoeia of vitamin and mineral supplements, including vitamins A, C and E, selenium, wheatgrass, barley green, aloe vera and chlorophyll, as well as vegetable and fruit juices. He and his wife eat fish but no red meat. They don't eat dairy, sugar or processed foods.

Kraus also meditates daily: "I used to be a shocking worrier." The couple estimate they now spend between. $6,000 and $7,000 a year on supplements, and have spent far more than that on the treatments. "The Ukrain was horrendously expensive. You had to commit yourself to at least 18 months of it and that was $25,000. The ozone therapy was between $100 and $200 a session.

"Still, the change in diet is free, the meditation is free. If you don't do that the rest is all a waste of time ... But I know some people find it all too hard, changing their life around. It's not for everybody."

Says Kraus, who wrote a book based on his experiences, *Faith, Hope, Love & Laughter: How They Heal:* "I've come to an awareness that we are made with incredible self-healing capacity, if we do the right thing by our body."

The Krauses admit they're not sure what has worked and what hasn't. All they know is, somehow, he's still alive. [and still alive in July 2021. Ed]

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The above extracts are from The Sydney Morning Herald's Good Weekend of October 15, 2005 by Fenella Souter

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Comments by Don Benjamin:

"Desperate measures" was the title of a long article on chemotherapy in the Sydney Morning Herald's Good Weekend magazine by Senior Writer Fenella Souter on 15 October 2005.

The main article starting on page 1 is made up of extracts from that article. Copies of the complete article are available from the CISS office.

The article was fairly objective.

It started off by pointing out that the claims of chemotherapy drugs (and also surgery and radiotherapy) were being oversold. Treatment is driven largely by vested interests (the profits for big drug companies) and the need for other cancer professionals (surgeons and radiotherapists) to believe in their branch of medicine.

It then presented interviews with four internationally respected cancer experts who questioned some of the current dogma about progress being made in cancer treatment:

- Professor John Bailar from the US – who questioned the claimed improvement in survival over the past 50 years, and attributes most of it to prevention (such as reduced smoking);
- Professor Michael Baum from the UK who after being an advocate of mammography screening in the 1980s now calls for it to be scrapped because it causes more harm than good, particularly by producing much unnecessary surgery for ductal carcinoma in situ;
- Professor Ulrich Abel from Germany, who claims that very few types of late stage cancer benefit from chemotherapy, despite the fact that it is widely used for other types of cancer;
- Professor Avni Sali from Melbourne who pointed out the need for including psycho-social support, improved diet, exercise and vitamins and minerals to improve the immune system and improve the health generally to help cope with the rigours of cancer and the conventional treatments.

It mentioned that chemotherapy only adds between 2% and 6% to the background percentage five-year survival rate (raising it from 56% or 60% to 62%)

It mentioned that there is no way of knowing who will respond to chemotherapy and who will only get the side effects (and possibly be killed by it).

It mentioned the hypothesis that surgery – even needle biopsies – on the primary tumour might switch on cancer growth elsewhere in the body;

It pointed out that between 20% and 50% of people with cancer use complementary or alternative therapies (and accurately describes the difference between the terms).

It gave a very good sympathetic summary of the long survivals of CISS members Frank Hewstone and Paul Kraus in two separate brief box articles and also mentioned Barbro Spike.

Where the article fell short of objectivity was in the area of what it didn't say. For example it didn't mention the following:

- the assumption that any type of cancer can be "cured" is not proven;
- the definition of "cure" used by cancer experts is misleading and refers not to eliminating the disease or saving any lives but to surviving for 5 years without symptoms after treatment;
- the number of "lives saved" does not refer to the number of people who don't die of their cancer but to the apparent number of years of life extended by treatment. For example if 100 women treated for breast cancer with chemotherapy each live one year longer this is technically an increase of 100 years of living or 100 life-years; but it is then described as a 'saving' of 100 life-years; or colloquially shortened to 100 'lives saved'.

  This is then misunderstood to mean that some women don't die of the breast cancer after treatment;
- the benefits from cancer screening are not proven. The article repeats the claim that breast cancer reduces the relative risk of dying by 30%. It mentions that a Canadian study challenged even that benefit. But it doesn't mention that the Nordic Cochrane Group (specialising in evidence based medicine) found that, in addition to the Canadian study, the other six studies evaluating breast cancer screening had shown no proven overall survival or mortality benefit. Also another research team had found that the same lack of proof also applied to other forms of cancer screening;
- chemotherapy is used in a majority of types of cancer despite the fact that benefits are only proven for a small number of types;
- the current overall 60% five year survival figure quoted for cancer has not been proven to be any better than survival without treatment;
- although it mentions the difficulty of knowing who will respond to chemotherapy it does not give the figure of 25% who respond to chemotherapy;
- although it questions the claim that 'response' is a good indicator of prolonged survival, it does not give any detail showing that there is no good evidence linking response with improved survival for any type of cancer.

Despite these shortcomings the article would appear to be the most critical of conventional therapies that has ever appeared in the mainstream press. Considering the strong editorial pressures at Fairfax newspapers it is surprising that it included so much that questions orthodox thinking and that appears open-minded, and even sympathetic to alternative cancer therapies.

LETTER TO THE EDITOR (The Australian—not published)

Andrew Bushnell's article "Ridd, reason and free speech at the crossroads", (June 19-20) raises what is probably the most important issue confronting scientific integrity today: the role of consensus versus the scientific method.

Medical history provides clear examples of the dangers of consensus in science. About 60 years ago about a dozen medical experts representing various health bodies in the US decided by an 80% consensus, after viewing the evidence, that the major cause of deaths from heart disease were high-fat diets and high cholesterol.

About 10 years ago the scientific method was applied to this earlier decision and randomised controlled trials (RCTs) found that both decisions had been invalid. High fat diets were not the major culprit and cholesterol-lowering drugs provided little benefit.

So this consensus-based medical paradigm was invalid when applied to the world's biggest killer.

A second medical example relates to the world's second major killer – cancer. It is the consensus view that cancer starts locally and often later spreads. So the mantra developed for treatment is "get it all, and get it early". About 12 years ago the US National Cancer Institute spent more than US$150 million to find out why this was not working.

The scientific method, using RCTs has found no significant reduction in overall deaths with "getting it all" (e.g. with more radical surgery with breast cancer) or "getting it early" with screening for breast, bowel, lung, prostate or ovarian cancer. So this second consensus-base paradigm must also be invalid.

It is perhaps relevant to mention that Peter Ridd was sacked for questioning the evidence related to a third consensus-based paradigm - that the observed global warming is caused mainly by CO_2, due mainly to human activity.

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Chatswood NSW 2067
0416 121 140

Don Benjamin is Research Director of the Cancer Information & Support Society in Sydney.

"The Journey", by Brandon Bays

This book describes a process whereby people can release deep-seated emotional blockages that are contributing to their ill-health, including cancer. It describes an emotional journey where you go deep into your being; and a physical journey where you identify all the physical factors involved.

For those interested in attending a session of "The Journey" as described in the book of the same name by Brandon Bays, Sydney therapist Sharon Turton is organising an online Session over the weekend of 11-12 September run by Brandon Bays and herself.

Those interested should contact Sharon on 0412 792 967.

We have a copy of "The Journey" for loan in the CISS library.

Farewell from CISS

We offer our loving thoughts to the family and friends of those members who have died in recent months

William Bruce
John Fleming

Alkalinity vs Acidity

There are several proponents for a diet high in alkaline-forming foods. This is because many functions in the body occur only at a certain level of acidity or alkalinity. For example, the skin, stomach, bladder, and vaginal area are highly acidic (pH<7) to protect us from outside invaders. Whereas most of our other organs and cells function best in an alkaline pH (pH>7).

Western diets typically leave our bodies very acidic because they are overloaded in poor fats, over consumption of protein, not enough fibre, and too much sugar. If the body becomes too acidic, it leads to inflammation and an increased risk for other diseases and disorders. Whereas an alkalizing diet helps to balance your pH level, ultimately reducing acidity. See page 10 for the foods needed to reduce acidity.

COVID-19 Update

from Dr Mercola

Inventor of mRNA vaccine technology's warning of risks censored.

STORY AT-A-GLANCE

- June 11, 2021, the inventor of the mRNA vaccine technology, Dr Robert Malone, spoke out on the Dark Horse podcast about the potential dangers of COVID-19 gene therapy injections. The podcast was quickly erased from YouTube
- Malone is concerned about government not being transparent about risks, and that people are being coerced into taking these experimental injections, which violates bioethics laws
- He believes the risks outweigh the benefits in children, teens and young adults, and that those who have recovered from natural SARS-CoV-2 infection should not get the injection
- Five days after his DarkHorse podcast appearance, Malone's scientific accomplishments and contributions were scrubbed from Wikipedia
- As recently as June 14, 2021, Malone's contributions were extensively included in the historical section on RNA vaccines' Wikipedia page. June 16, his name was removed and his accomplishments attributed to nameless researchers at the Salk Institute, the University of California, and the University of Wisconsin

See Dr Mercola July 6, 2021

Ivermectin criticised by WHO

STORY AT-A-GLANCE

- If the World Health Organization has been captured by Big Pharma and is putting out information that goes against medical science, then public health is at grave risk
- While the WHO insists large randomized controlled trials (RCTs) must be completed before ivermectin can be recommended, RCTs actually are not the gold standard in terms of scientific evidence. Meta-analyses are
- A meta-analysis of 24 RCTs clearly demonstrates that ivermectin produces large statistically significant reductions in mortality, time to clinical recovery, and time to viral clearance
- Ivermectin distribution campaigns have also resulted in rapid population-wide decreases in morbidity and mortality, which indicate that ivermectin is effective in all phases of COVID-19
- While the WHO and world governments are willing to roll the dice when it comes to the novel COVID shots, they insist on ridiculously high standards of safety and effectiveness when it comes to off-patent drugs that have decades of safe use

See Dr Mercola July 10, 2021

Science Journals Engaged in Massive Disinformation Campaign

- The Lancet's COVID-19 Commission included Peter Daszak, Ph.D., president of EcoHealth Alliance, a nonprofit organization that collaborated with various universities and organizations on research in China, including the Wuhan Institute of Virology (WIV). He was recently taken off the Commission due to controversy over his large number of conflicts of interest
- The Lancet's COVID-19 Commission also includes Danielle Anderson, an Australian WIV virologist who left Wuhan shortly before the pandemic broke out. Anderson says she "does not believe" the virus is manmade. Anderson's Commission biography does not mention that she worked at the WIV
- In January 2021, 14 global experts submitted a letter to The Lancet in which they argued that "the natural origin is not supported by conclusive arguments and that a lab origin cannot be formally discarded." The submission was rejected with the justification that the topic was "not a priority" for the journal
- Richard Horton, the editor-in-chief of The Lancet is now being criticized for his long defence and support of the Chinese regime, and is accused of using The Lancet to pursue political causes and stifle scientific debate

See Dr Mercola July 7, 2021

Proposal to change laws on charities

An article in the Saturday Paper titled Morrison's 'unconstitutional' crackdown on charities, May 22 – 28, 2021, explores community reaction to proposed changes to laws affecting charities. It highlights a submission to the government by Arnold Bloch Leibler's public interest practice.

Under the changes, registered charities could be held responsible for summary offences – minor legal breaches – committed by their members or supporters. They could lose their charitable status and consequent preferential tax treatment, have their board directors suspended, or be shut down.

The Saturday Paper's national correspondent, Mike Seccombe writes of ABL's submission: "What is being proposed", the firm said, was unjustified, ultra vires (that is, beyond legal power), unconstitutional, would have an unquantifiable negative impact on the sector, would add administrative burden to charities, did not address any uncertainty in legislation and was "fundamentally inconsistent with our democratic system of government". The changes "are a clear fetter on freedom of political communication and on dissent by civil society. They … must not be made law."

Also quoted in the article, Toby O'Connor, the chief executive of St Vincent de Paul, is particularly concerned about a proposal that would see organisations held responsible for how other groups use their reports or materials. Using the rallies that churches organise every Palm Sunday to advocate for Christian charity towards asylum seekers and refugees as an example, Mr O'Connor says: "If there are people who are branded with the Vinnies logo, for instance on a T-shirt, they're asked to move on and they don't move on, then that will be a summary offence. And that will provide an opportunity for the commissioner to review the charity."

Vitamin D and COVID-19

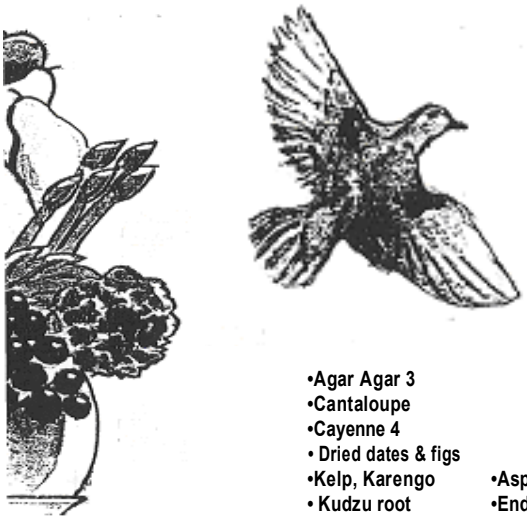
In a recent article by Dr Mercola about Ivermectin (see above) he gives information about Ivermectin and Vitamin D as both a prevention and treatment for COVID-19. In that article there is s link to an earlier article dated 22 February "Vitamin D Supplementation Reduces COVID-19 Deaths by 64%"

It tells about optimum Vitamin D levels to prevent and treat COVID-19. You just have to take sufficient to get the blood levels up to a particular value. It says: "Data from GrassrootsHealth's D*Action studies suggest the optimal level for health and disease prevention is between 60 ng/mL and 80 ng/mL, while the cut-off for sufficiency appears to be around 40 ng/mL.

I imagine that the dose recommended on bottles of Vitamin D3 is designed to do this. For example one supplier lists Vit D3 capsules as 1000 IU as cholecalciferol 25 micrograms. They recommend 1 each day with a meal. A blood test would find out if this is enough.

FOOD THEORY FOR HEALTHY LIVING

80% ALKALINE / 20% ACID



MEDITATION
PRAYER
PEACE
KINDNESS
LOVE
•Lemons 1
•Watermelon 2

7.5

•Agar Agar 3
•Cantaloupe
•Cayenne 4
• Dried dates & figs
•Kelp, Karengo
• Kudzu root
•Limes
•Mango
•Melons
•Papaya
•Parsley 5
•Seedless grapes; sweet
•Watercress
•Seaweeds

7.0

•Asparagus 6
•Endive
•Kiwifruit
•Fruit juices 7
•Grapes, sweet
•Passionfruit
•Pears, sweet
•Pineapple
•Raisins
•Umeboshi plum
•Vegetable juices 8

6.5

•Apples, sweel
•Apricots
•Alfalfa sprouts 9
•Arrowroot flour 10
• Bananas, ripe
•Berries
•Currants
• Dates & Figs, fresh
•Garlic 11
•Gooseberry
•Grapes, less sweet
•Grapefruit
•Guavas
•Herbs, leafy green
•Lettuce, leafy green
•Nectarine
•Peaches, sweet
•Pears, less sweet
•Peas- fresh, sweet
•Persimmon
•Pumpkin, sweet
•Sea salt, vegetable **12**

6.0

•Apples, sour
•Bamboo shoots
• Beans, fresh green
• Beets
•Bell pepper
•Broccoli
•Cabbage;Cauli
•Carob 13
•Ginger, fresh
•Grapes, sour
•Lettuce, pale green
•Oranges
•Parsnip
•Peaches, less sweet
•Peas, less sweet
•Potatoes & skin
•Pumpkin, less sweet
•Raspberry
•Sapote
•Strawberry
•Squash 14
•Sweet corn, fresh
•Tamari 15
•Turnip
•Vinegar, apple cider **16**

5.5

•Almonds 17
•Artichokes, Jerusalem
• Brown Rice Syrup
•Brussels Sprouts
•Cherries
•Coconut, fresh
•Cucumbers
•Egg plant
•Honey, raw
•Leeks
•Miso
•Mushrooms
•Okra
•Olives ripe **18**
•Onions
•Pickles, home made **19**
•Radish
•Sea salt 20
•Spices 21
•Tomatoes, sweet
•Vinegar, sweet brown rice

5.0

•Chestnuts, dry roasted
•Egg yolks, soft cooked
•Essene bread 22
•Goat's milk & whey, raw **23**
• Mayonaise, home-made
•Millet
•Olive oil
•Quinoa
•Sesame seeds, whole **24**
•Soy beans, dry
•Soy cheese
•Soy milk
•Sprouted grains 25
•Tempeh
•Tofu
•Tomatoes, less sweet
•Yeast, nutritional flakes

4.5

EXTREMELY ALKALINE FORMING……MODERATE……SLIGHTLY……

RULE: Eat 80% alkaline forming foods and drinks & 20%

NOTES

1 *Excellent for EMERGENCY SUPPORT for colds, coughs, sore throats, heartburn & gastro upsets. Quick alkalinizer! 1 teaspoon fresh juice in 4 oz water.*

2 *Good for a yearly fast. For several days eat whole melon, chew pips well & eat also. Super alkalinizing food.*

3 *Substitute, for gelatin, more nourishing*

4 *Stimulating non-irritating body healer. Good for endocrine system.*

5 *Purifies kidneys.*

6 *Powerful acid reducer detoxing to produce acid urine temporarily... causing alkalinity for the long term.*

7 *Natural sugars give alkalinity Added sugar causes juice to become acid-forming*

8 *Depends on vege's content & sweetness.*

9 *Enzyme rich, superior digestability.*

10 *High calcium content. Cornflour substitute.*

11 *Elevates acid food 0.5 in alkaline direction*

12 *Vegetable content raises alkalinity.*

13 *Substitute for cocoa; mineral rich.*

14 *Winter squash rates 5.0. Butternut & sweeter squash rates 6.0.*

15 *Genuine fermented for 1 ½ years otherwise 2.5*

16 *Raw unpasteurized is a digestive aid to increase HCL in the stomach. 1 tablespoon, plus honey & water before meals.*

17 *Soak 12 hours, peel skin to eat*

18 *Sundried, tree ripened, otherwise 3. 5*

19 *Using sea-salt & apple cider vinegar.*

ARTWORK :PELAGO CREATIVE SERVICES, NEW ZEALAND 0-9-834-7133

BASIC RULES FOR THE CHART

[A] Alkaline or acid forming describes ash residue after metabolism. Citrus tastes acidic but leaves an alkaline residue.

[B] The fresher & sweeter the food tastes the higher the alkalinity. Chewing each mouthful 40 times increases alkalinity of grains.

[C] Any food cooked, canned or frozen subtract 0.5.

[D] Food grown chemically, processed with preservatives or prepared with white sugar subtract 1.0. Organic is best, biodynamic is better, partly raw is essential.

[E] All values are approximate. Make diet changes gradually. Ask your body what it needs.

[F] Scale of 7.5 to 0.5 is an adjusted scale for easy reference and does not indicate actual alkaline-acid values.

[G] Read "Alkalize or Die" by Dr. Baroody- Eclectic Press U.S.A., phone 001-704-456-6231, or Harvest Wholefoods Auckland.

[H] Author accepts no responsibility for use of this information

4.0 NEUTRAL	3.5	3.0	2.5	2.0	1.5	1.0	0.5
			..... SLIGHTLY		..... MODERATE	..... EXTREMELY ACID FORMING	
Butter, fresh unsalted	•**Blueberries**	• **Barley malt syrup**	• **Bananas,** green	•**Cigarette tobacco,** roll your own	• **Beer 34**	•**Beef**	OVERWORK
Cream, fresh & raw	• **Brazil nuts**	• **Barley, rye**	• **Buckwheat**	•**Cream of wheat,** unrefined	•**Brown sugar 35**	•**Carbonated soft drinks & fizzy drinks 38**	ANGER
Margarine 26	• **Butter,** salted	• **Bran**	•**Cheeses,** sharp & tasty	•**Fish**	•**Chicken**	•**Cigarettes,** tailor-made	FEAR
Milk, raw cow's **27**	•**Cheeses,** mild & crumbly **28**	•**Cashews**	•**Corn & rice breads**	•**Fruit juices with sugar**	•**Deer**	•**Drugs**	JEALOUSY
Oils (except olive)	•**Crackers,** unrefined rye	•**Cereals,** unrefined with honey fruit or maple syrup	•**Egg,** whole (cooked hard)	•**Maple syrup,** processed	•**Chocolate**	•**Flour,** white wheat **39**	STRESS
Whey, cow's	•**Dried beans** mung, adzuki, pinto, kidney, garbanzo **29**	•**Cornmeal**	• **Ketchup**	•**Molasses,** sulphured	•**Coffee 36**	•**Goat**	•**Artificial sweeteners 41**
Yoghurt, plain	•**Dry coconut**	•**Cranberries 30**	•**Mayonaise**	•**Pickles,** commercial	•**Custard** with white sugar	•**Lamb**	
	• **Egg whites**	•**Fructose**	•**Oats**	• **Breads** (refined) of corn, oats, rice & rye	•**Jams**	•**Pastries & cakes** from white flour	
	•**Goats milk,** homogenised	•**Honey,** pasteurized	•**Oats,** rye (organic)	•**Cereals** (refined) eg weetbix, corn flakes .	•**Jellies**	•**Pork**	
	•**Olives,** pickled	•**Lentils**	• **Pasta,** whole grain	•**Shellfish**	• **Liquor 37**	•**Sugar,** white **40**	
	•**Pecans**	•**Macadamias**	• **Pastry,** wholegrain & honey	•**Wheatgerm**	•**Pasta,** white		
	• **Plums 30**	•**Maple syrup,** unprocessed	• **Peanuts**	•**Whole Wheat foods 32**	•**Rabbit**		
	• **Prunes 30**	•**Milk,** homogenized, **& most processed dairy products**	• **Potatoes,** with no skins	•**Wine 33**	•**Semolina**		
		• **Molasses, unsulph** -ered organic **31**	•**Popcorn** with salt & butter	•**Yoghurt,** sweetened	•**Table salt,** refined & iodised		
		•**Nutmeg**	•**Rice,** basmati		•**Tea,** black		
		•**Mustard**	•**Rice,** brown		•**Turkey**		
		•**Pistachios**	•**Soy sauce,** commercial		•**Wheat bread**		
		•**Popcorn & butter,** plain	•**Tapioca**		•**White rice**		
		• **Rice or wheat crackers,** unrefined	•**Wheatbread,** sprouted organic		•**White vinegar,** processed		
		•**Ryebread,** organic sprouted					
		•**Seeds,** pumpkin & sunflower					
		•**Walnuts**					

acid forming foods and drinks daily for good health and humour

20 *Contains sea minerals. Dried at low temperatures.*

21 *Range* from *4.5-6.0*

22 *Sprouted grains are more alkaline. Grains chewed well become more Alkaline.*

23 *High sodium to aid digestion.*

24 *High levels of utilizable calcium. Grind before eating.*

25 *Alkalinity and digestibility higher.*

26 *Heating causes fats to harden & become indigestible.*

27 *High mucous production.*

28 Mucous *forming & hard to digest*

29 *When sprouted dry beans rate 5.0*

30 *Contain acid-forming benzoic & quinic acids.*

31 *Full of iron.*

32 *Unrefined wheat is more alkaline.*

33 *High quality red wine. no more than 4 oz daily to build blood.*

34 *Good quality* well *brewed - up to 2.0. Fast brewed beers drop to 1.0*

35 *Most are white sugars with golden. syrup added.*

36 *Organic, fresh: ground - up to 2.0*

37 *Cheaper brands drop to 0.5, as an over-indulgence*

38 *Leaches minerals*

39 *Bleached - has Goodness*

40 *Poison! Avoid*

41 *Potential cancer agent. Over-indulgence*

se information given by Dr. Baroody

Branches of CISS

NSW

CISS CENTRAL COAST

The Central Coast Branch holds a meeting on the third Monday of the month at 7 pm, and on the third Saturday of the month from May to August at 2 pm. Meetings are held at Green Point Community Centre, 96 Koolang Road, Green Point. Informative speakers, extensive library, support and shared experiences. All are welcome. For further information contact Sue Johnston on 0410 696 458 or email cisscentralcoast@bigpond.com.

CISS HUNTER VALLEY

The Hunter Valley Branch is currently not meeting. For information contact PO Box 4057 Rathmines, NSW. 2283 .

CANCER SUPPORT GROUPS

NSW

ACTIVE WOMEN TOUCHED BY CANCER & CELEBRATING LIFE

Meets at Balgowlah RSL, Ethel St, Seaforth on 2nd Tuesday of the Month at 7pm. $5 donation. Guest speakers. Contact Robin 9938 6128 or Kate 8902 0196

BLUE MOUNTAINS CANCER HELP INC, KATOOMBA

Support groups and complementary therapies. Groups include the Gawler "Living Well" 12 week program at Katoomba and Springwood, and a Breast Cancer group. Regular support groups held twice a month. A not-for-profit charity supported by our op shops. Phone 4782 4866, www.cancerhelp.net.au.

CANDLES CANCER SUPPORT GROUP

Meets Fortnightly [Thursdays] 10-noon Kanwal Community Hall, Pearce Rd Kanwal [Central Coast] Provides information, support, empathy and understanding. Phone/email contact available if unable to attend meetings. Open to all types of cancers patients, male and female. Survivors and carers all welcome. Contact: 4393-5017 for details.

CANHELP CANCER SUPPORT GROUP

Based on the Ian Gawler approach. Meets 1st & 3rd Tuesday each month from 6.00-8.00pm at Level 1, 280 Pitt St. Enjoy meditation, sharing and support. Ring Sue Saxelby 0408 442 030 or just turn up.

NSW (Continued)

HILLVIEW COMMUNITY SUPPORT GROUP

Meets each Tuesday 1.30-3.30pm at 1334 Pacific Highway Turramurra. Includes a meditation. No charge. Phone 9449 9144 and ask for Patricia Krolik.

KEMPSEY CANCER SUPPORT GROUP

This group for cancer patients and their carers meets on the 1st and 3rd Wednesday of each month from 10 - noon at the Community Health Building. Contact Penny Snowden 6562-6066.

NAMBUCCA VALLEY SUPPORT GROUP

Meets every Wednesday, Agnes Grant Centre, Macksville & District Hospital, 11 am – 1 pm. Phone 6568 2677.

NEWCASTLE CANCER SUPPORT GROUP

For information contact Make Today Count, 44 Dudley Road, Charlestown, NSW 2290. Phone 4943 8462.

PARKES CANCER SUPPORT GROUP

Meets every 3rd Monday of the month at the Education Centre, Parkes District Hospital at 1.30pm. For further information contact Margaret Green, 6864-5123 or Mary McPhee, 6862-3814.

QUEST FOR LIFE FOUNDATION

Residential and day programs and webinars (on-line seminars) for people living with cancer, grief, loss or trauma. Contact (02) 4883 6599 or visit www.questforlife.com.au.

ST GEORGE CANCER SUPPORT GROUP

Meets every Monday morning at 10.30am at St George Community Hall, Premier St, Kogarah. For info contact Margaret on 9580 5061. See website https://sites.google.com/site/stgcsg/

SUTHERLAND SHIRE CANCER SUPPORT GROUP

Meets every Tuesday morning from 10.30-12.30 at the Parish Centre of the Catholic Church, 50 Kiora Road, Miranda. For further information contact Deborah Harrison, 9523 5200.

SYDNEY ADVENTIST HOSPITAL CANCER SUPPORT CENTRE

Meets each Wednesday 10-12 noon at Jacaranda Lodge, 185 Fox Valley Rd, Wahroonga. A discussion group for patients and carers of any cancer type. Also special support groups for different cancer types and for carers. Contact Nerolie on 9487 9061.

VICTORIA

CANCER NATURAL THERAPY FOUNDAT'N

Support group meets on Tuesday nights at 7pm at 531 Elizabeth Dr, Sunbury, Victoria 3429. Meeting includes discussion, relaxation therapy and Reiki Healing. Certified organic produce available these nights. The Foundation operates a resource library, workshops and guest speaker program. Personal Counselling available. Contact Sandra Givca Maqueda (03) 9740 9921; mobile 0411 100 947.

VICTORIA (cont'd)

GAWLER FOUNDATION

The Gawler Foundation has leased the property to the Brahma Kumaris group for two years. During this time the BKs will maintain the property and run their own meditation retreats there. The Gawler Foundation will still have access to the property to run some of their programs, and for 2021 intend to run 4 x 5 day Cancer Fundamental retreats over the next 12 months. But without any paid admin staff, this will depend on the initiative of the therapists. Anyone interested in these programs or in individual cancer coaching could contact Maia and Paul Bedson at paulandmaia1@gmail.com

QUEENSLAND

CANSURVIVE on the Sunshine Coast meets from 10am-12 noon, 2nd Tuesday of each month at Eve Wilkinson's home, 99 Maleny-Kenilworth Rd, Maleny. Ph (07) 5429 6598. Contact Cansurvive: PO Box 941 Maleny Qld 4552, Ph: 5499 9918. Books, tapes, counselling available.

Cairns CANSURVIVE support meetings offer support, information and self-help activities for people affected by cancer or any other debilitating illness. Emphasis on self-help & development to enable individuals to better cope with fears and uncertainties. Meets 1st Saturday of each month at Cominos House, Greenslopes Street, Cairns from 2 - 4 pm. Cost $10 per year + a coin donation on the meeting day. Afternoon tea provided. Books/videos available for loan for members. Contact Beulah 4051 5544 or Helga 4047 4812 (bh).

FRUITARIAN RAW FOOD NETWORK

Write to PO Box 293 Trinity Beach Qld 4879.

QUALITY OF LIFE CANCER SUPPORT GRP

Meets on the North Side of Brisbane. For details phone Alan on 3263 8390 or Michelle on 3269 9687.

WESTERN AUSTRALIA

CANCER SUPPORT ASSOCIATION of WA

Cancer Wellness Centre, 80 Railway St Cottesloe WA 6011. Counselling hours: Tues-Thurs. Phone (08) 9384 3544. The CSAWA Inc was a non profit organisation with the primary objective to provide support services, information and self-help activities in a safe and caring environment for people affected by cancer, to enhance their emotional, physical, spiritual and mental well being. **This group was taken over by Solaris Cancer Care in 2017. We understand that the above services are no longer provided.**

What's Available from the CISS Office?

CHAMPION Juicer - $575 ($615 non-members)
OSCAR Juicer - $485
DVD: CISS 2007 Seminar : Cancer & Hope $29.50 plus $5 postage
Enema Kits: $16.50
Water Purifier: Reverse Osmosis - $495. Other models available.
Xylitol: (sugar substitute) - 450gms - $6.75

Prices are subject to change. Items can be posted to you. There is a $8.50 postage/ packing fee for standard articles, $10-$14 for country and interstate, $15.00 Express Post.

CISS Handbooks $13.50, $15 including postage.

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Members needed for the Committee

There are 4 vacancies on the Committee including Vice Convenor and Treasurer. Minimum requirements are ability to attend monthly meetings, usually at 7.00pm on Mondays (by phone if necessary) and prepared to suggest ways of improving how CISS operates. If you would like to nominate to join the Committee please contact me on 0416 121 140.