



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

Coronavirus – half the story is being missed by Roger French

The following is a Blog by Roger French, Health Director, of The Natural Health Society April 26 2020

The Federal Government's medical advisers appear to have forgotten some of their elementary training, and this is that our bodies have powerful defences against pathogenic micro-organisms – our immune systems.

However, our immune systems are only fully effective if they are strong. If they are weak, then we may well be susceptible to some nasty infectious disease.

For the immune system to be strong, the body as a whole needs to be strong, that is, healthy.

Orthodox medicine knows this. Harvard Medical School states:

“Following general good-health guidelines is the single best step you can take toward naturally keeping your immune system strong and healthy (Harvard Health Publishing, Sept. 2014)”

A strong immune system

A healthy body and mind – and therefore immune system – depend on the usual factors with which we are so familiar. Namely:

- An abundant intake of minerals, vitamins, antioxidants and phytonutrients. Adequate, but not excessive, protein, abundant fibre, and a balance between acid-forming and alkali-forming foods. In short, a diet high in fresh vegetables and fruits (in that order), to the extent of about three-quarters of total food intake.
- Regular exercise, both aerobic and strength exercise.
- Fresh air and sunshine. Sunshine in small doses daily, and never sunburn.
- Adequate sleep, rest and relaxation.



Roger French

- Minimising exposure to toxic man-made chemicals

Especially nutrition

Nutrition is especially significant for the immune system. As Harvard Health Publishing says:

“Scientists have long recognised that people who live in poverty and are mal-nourished are more vulnerable to infectious diseases”.

The inevitable deficiencies in at least some essential vitamins and trace minerals is known as ‘micronutrient malnutrition’. It tends to be more common in elderly people, partly because such deficiencies have accumulated over decades.

The Harvard Medical School also endorses the role of exercise in immunity:

“Just like a healthy diet, exercise can contribute to general good health and therefore to a healthy immune system.”

Similarly with stress, Harvard states that modern medicine recognises the close relationship between mind and

body, and that a wide variety of illnesses are linked to emotional stress.

Ignoring the above aspects of a healthy lifestyle means that not only can we expect to have impaired immunity, but also ‘toxaemia’ at some level. A state of toxaemia is the result of a build-up of metabolic wastes (from food) and an accumulation of toxic chemicals.

The puzzle essentially solved

Applying these requirements to the COVID 19 pandemic, it is easy to see why some people become seriously ill and a tiny proportion die. It is extremely significant that a large majority of infected people have only mild symptoms or none at all. In other words, this situation which puzzles people, including many doctors, is readily explained when we understand the full picture instead of being focussed solely on avoiding the potentially dangerous virus.

Most Australians eat nothing like enough fruit and vegetables and eat disproportionate quantities of the acid-forming foods – those rich in protein, refined carbohydrates and fat.

Worse still, some people consume a lot of junk foods which exacerbate the tox-aemia and the compromised immunity.

For most of us now, with or without the above problems, there is the stress caused by the Government's ‘draconian’ restrictions. Severe financial hardship and a huge amount of worry can be caused by losing your job. It can be even worse for small businesses. Imagine having spent, say, \$50,000 in fitting out a new shop only to find that suddenly there are no customers.

We are all being told that we must stay
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Tests by the radiation dose

	Procedure	Radiation dose (millisievert) 1, 2	Comparable exposure from natural sources such as radon	Should you get it?
Minimal dose: Less than 0.1 millisievert	X-ray of teeth (bitewing)	0.005	less than 1 day	Most people need one only every 24 to 36 months.
	X-ray of teeth (full mouth)	0.01	about 1 day	Many people can go a decade between exams.
	Cone-beam CT of jaw and teeth	0.06	7 days	Rarely needed for most orthodontic procedures.
Low dose: 0.1 to 1 millisievert	X-ray of chest (two views)	0.1	12 days	Presurgery X-rays needed only for people with a history of lung or heart disease (or those at risk) or before chest surgery.
	Mammogram	0.4	7 weeks	Needed every two years for women ages 50 to 74.
Medium dose: 1 to 10 millisievert	X-ray of spine	1.5	6 months	Rarely needed in first month back pain.
	CT of head	2	8 months	Not needed for most head injuries. CTs usually aren't needed for a concussion.
	CT of spine	6	2 years	Rarely needed in first month of back pain.
High dose: 10 millisievert and over	CT colonoscopy	10	3 years	Not as accurate as standard colonoscopy.
	CT of abdomen and pelvis	10	3 years	For possible appendicitis or kidney stone, ask whether ultrasound can be used.
	CT angiography (of the heart)	12	4 years	1 in every 1,300 60-year-olds may get cancer as a result, so it probably shouldn't be used for screening.
	CT of abdomen and pelvis repeated with and without contrast	20	7 years	"Double scans" are rarely necessary; fewer than 5 percent of patients should receive one.
	PET with CT	25	8 years	It exposes patients to very high radiation doses, so make sure that it is really necessary.

REFERENCES: 1. Doses are typical values for an average-sized adult. The actual dose can vary substantially depending on a person's size as well as on differences in imaging. 2. For every 2,000 people exposed to 10 millisieverts of radiation from a ct scan, one will develop cancer.

Free Psych-K & Emotion Code for CISS members

CISS members can receive Psych-K and Emotion Code to identify and change negative belief systems—free of charge. Ring the Office to try it.

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

New Members: June: Robert Lucas

Donations to CISS:

June: LA \$30; NB \$20; SG \$50; AM \$20; BP \$50; WR \$20; HW \$20.

July: MA \$50; RC \$100; HF \$30; CM \$50; DN \$50; SO \$20.

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 NEWS

Nothing special to report

LOCAL NEWS

CISS to get a large bequest

Earlier in the year we were notified that CISS is a beneficiary of a bequest by the late Jessie Barrie Speight of Bonnells Bay on the Central Coast who died on 16 November last year.

All we knew was that CISS had a 15% share of the estate. We were recently told that the estate was worth about \$4.8 million so CISS' share is \$720,000. This is a welcome boost to our survival after the serious financial setback we received in the early part of last year that cost us nearly \$100,000 to regain control of the Society. We should start receiving the funds by the end of the year.

The Immune system

In the last issue of our Newsletter we had several articles about how the immune system works. It is possibly the most important factor in determining if someone gets cancer and, if so, if they are likely to recover from it. Many factors affect the immune system, including acute and chronic stress.

An important part of understanding the immune system is how we can strengthen it, to protect us not only from cancer but also colds, flu and other infections such as the COVID-19 virus.

So in this issue we are featuring how to build up the immune system. Roger French from The Natural Health Society had a recent blog that does just this. See page 1.

Fasting and Vitamin C for COVID-19

The COVID-19 virus continues to take its toll although the death rate is still only 167 out of 15,304 confirmed cases. This is a death rate of ~1.1%, much lower than in most other countries. Also much lower than the average annual 'flu deaths of ~1,500.

On page 4 we have an article showing

CISS Committee positions

Members of CISS are invited to nominate for one of the three vacant positions on CISS' governing Committee.

The three positions are ordinary Committee members who advise on how the Society can best promote its message among the general public. Meetings are monthly, typically on a Monday at 7pm.

For further details contact Don Benjamin, General Manager, on 0416 121 140.



Don Benjamin, Editor

how well critically ill COVID-19 patients respond to high dose Vitamin C.

On page 5 Bryan Hubbard describes how fasting and high dose Vitamin C can improve survival with many types of cancer that do not respond to chemotherapy. As I comment after his article, he implies that chemotherapy can effectively treat the other types of cancer. A treatment that can extend life by a few months is not something I would call an effective treatment.

The hazards of X-rays

Many people assume that when a doctor organises an X-ray or CT scan to help with a diagnosis, the scan is usually justified and safe. According to US Consumer Reports both of these assumptions are untrue. On the first point, about one-third of those scans serve little if any medical purpose. On the second point, researchers estimate that at least two percent of all future cancers in the US are caused by CT scans alone – that's Approximately 29,000 cases and 15,000 deaths each year. See page 6.

Cancer overdiagnosis in Australia

That figure of 29,000 cancer cases caused by X-rays each year in the US is the same number of cancers that are overdiagnosed each year in Australia, resulting in much overtreatment causing much harm. These cases include 18,000 in men (24% of diagnoses) and 11,000 in women (18% of diagnoses). These are the figures referred to by Professor Alexandra Barratt, Professor of Public Health at Sydney University and her colleagues at SU and other Australian universities in a paper published in the Medical Journal of Australia on 27 January this year. See interview page 9.

Paul P Glasziou¹, Mark A Jones¹, Thanya Pathirana², Alexandra L Barratt³ and Katy

JL Bell³. Estimating the magnitude of cancer overdiagnosis in Australia Med J Aust 2020; 212 (4): 163-168. || doi: 10.5694/mja2.50455 Published online: 27 January 2020

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Surgeons stymie surgery reform

In the last issue we featured Professor Ian Harris and his campaign to bring surgery into the area of evidence based medicine in an article *Raising the Bar for Surgery* and referred to his book "*Surgery, The Ultimate Placebo — A Surgeon Cuts Through the Evidence*".

Another subject we have featured in the past is chronic back pain—its causes and possible treatments. So in this issue we feature the particular issue of spinal fusion—used to treat chronic back pain—that Ian Harris has criticised in his book and in several of his published papers.

When the government accepted Choosing Wisely's recommendations to cut back government subsidies for spinal fusion, surgeons fought back and stopped the reform. Ian Harris says "doctors and surgeons have too much power, and the government is scared of them and happy to take the path of least resistance". See page 11.

Gardasil fails risk/benefit claims

Readers of this Newsletter might recall that Professor Peter Gotzsche was sacked in 2018 from the Nordic Cochrane Group after he revealed that the Cochrane human papillomavirus (HPV) vaccine review missed nearly half of the eligible trials and the review was influenced by reporting bias and biased trial designs. Nine years before this, researchers were already claiming the vaccine was ineffective. See page 12.

(Continued from page 12)

Dr Ratner says she'd have been better off getting cervical cancer than the vaccination. "My daughter went from a varsity lacrosse player at Choate to a chronically ill, steroid-dependent patient with autoimmune myofasciitis. ...

"The risks of serious adverse events including death reported after Gardasil use in (the JAMA article by CDC's Dr. Barbara Slade) were 3.4/100,000 doses distributed. The rate of serious adverse events is on par with the death rate of cervical cancer.

(continued from page 1)

in our homes except for going out to buy food or other goods, going to work or visiting a doctor or for certain other needs. For people living alone, this can be akin to solitary confinement. For families, it can still be extremely frustrating. A vast number of studies have shown that loneliness and social isolation can have very destructive consequences. In fact, some researchers consider that prolonged social isolation can be as harmful as smoking.

Wow – that's bad!

Creating a strong immune system through a healthy lifestyle can be supported by supplements and herbs.

Critical vitamins and minerals

Vitamins and minerals that are critical for the immune system to function at its best include vitamins A, C, D and E, and the minerals zinc, selenium and magnesium.

A former Centers for Disease Control chief recognises the usefulness of vitamin D from sun exposure and/or supplementation in reducing the risk of COVID-19 infection through strengthening immune function. (*Mercola.com, 7th April 2020*)

Even in the conventional treatment of existing disease, the value of vitamins C and D are being recognised. Dr Mercola reports that seriously ill coronavirus patients in New York State's largest hospital system receive 1,500 milligrams of intravenous vitamin C three to four times a day, in conjunction with other conventional treatments. He adds that vitamin C at extremely high doses kills pathogens including viruses.

Helpful herbs

To boost your immune system, the following are seven of the most powerful herbs and spices. The list is taken from 'Healing Herbs and Spices to Boost the Immune System' by Kendra Lady.

(<https://www.onegreenplanet.org/natural-health/seven-healing-herbs-spices-boost-immune-system/>)

When considering taking herbal remedies, it is wise to consult a trained naturopath or herbalist.

Echinacea

It helps encourage healthy cell growth, promotes a strong upper respiratory system and provides numerous antioxidants that boost the immune system. Echinacea works by stimulating the immune system to produce natural killer cells. It can be consumed in the form of a capsule, liquid or tea.

Ginger

This rhizome contains chemicals called sesquiterpenes which target cold viruses and soothes a sore and scratchy throat. It has powerful pain relieving properties. It's pretty safe, but pregnant women shouldn't ingest more than two grams of dried ginger per day.

Turmeric

This rhizome, closely related to ginger, contains the active ingredient curcumin, which provides its characteristic orange-yellow colour. Curcumin eases inflammation, resists infections and improves overall health including that of the immune system.

Elderberry

It is important to note that the seeds, stems, leaves and roots can be toxic to humans, but the berries contain anthocyanidins which support a healthy immune system. It can be consumed as a tea, syrup or supplement.

Garlic

When this pungent bulb is cut or crushed, a compound called allicin is released. This has potent anti-bacterial, anti-viral and anti-fungal properties. It is thought to stimulate the immune system and boost the efficacy of white blood cells. Garlic can help prevent chest infections, particularly when eaten raw. Dietary doses of garlic are pretty safe.

Ginseng

Ginseng, specifically Panax ginseng, contains high levels of antioxidants that can boost the immune system and also promote a healthy respiratory system. There are a variety of ginseng supplements on the market.

Ashwagandha

This stimulates infection fighting white blood cells and is good for immune system support.

Cinnamon

This eighth spice (from another source) contains an active ingredient, cinnamaldehyde, that has anti-bacterial and anti-viral properties. Cinnamon is also high in immune-boosting antioxidants.

NOTE THAT no supplement or herb is a replacement for a healthy life-style. These can help, but they won't fix us.

Critical patients 'successfully' treated with high-dose vitamin C

A group of hospitals in New York have treated its most critical COVID-19 patients with high doses of vitamin C.

"The patients who received vitamin C did significantly better than those who did not get vitamin C," said Dr Andrew G Weber, a pulmonologist and critical care specialist with Northwell Health, which runs 23 hospitals in New York State including Lenox Hill Hospital in Manhattan.

His patients are being given doses of 1,500 mg three to four times a day, which is 16 times the recommended daily allowance (RDA) of 90 mg for men and 75 mg for women. He said the positive results coming out of hospitals in China - where the

coronavirus epidemic started - inspired him to trial the same therapy and dose on his critical patients. "It helps a tremendous amount, but it is not highlighted because it's not a sexy drug," Dr Weber added.

Dr Enqian Mao, chief of emergency medicine at Ruijin Hospital in Shanghai, treated

359 COVID-19 patients in critical care units with high-dose vitamin C ranging from 10,000 to 20,000 mg a day for seven to 10 days. None died.

Dr Mao has used high-dose vitamin C for 10 years to treat a range of health problems including sepsis, pancreatitis and surgical wound healing.

Dr Weber is not the only doctor at Northwell administering high-dose vitamin C. A spokesman said it is being used widely, although the exact dose is decided by each clinician.

New York Post, March 24, 2020; Chinese Journal of Infectious Diseases 2020;38; doi:10.3760/cma.j.issn.1000-6680.2020.0016'



Treating the untreatable cancers

by Bryan Hubbard

Around a quarter of all cancers are untreatable because of a gene mutation. But a new therapy, bringing together high-dose vitamin C and fasting, is producing some exciting results.

It's a secret oncologists rarely share with their patients: around 25 percent of all cancers are untreatable, and the prognosis is worse for colon (colorectal) and lung cancers, with half of cases immune to chemotherapy.

But the untreatable may soon be very treatable with a new therapy that blends two approaches that have always been relegated to the fringes of medicine: fasting and high-dose vitamin C, given intravenously. Both have had hit-and-miss research results when used independently, but combining the two seems to have a super-charging effect that kills these hard-to-treat cancer cells without affecting the surrounding healthy cells.

The therapy is still in its early stages. It's been tested on lines of colorectal cancer cells in the laboratory with "remarkable effects," says lead researcher Valter Longo at the University of Southern California's Longevity Institute. Each therapy killed some of the cancer cells on its own, "but when used together, they had a dramatic effect, killing almost all cancerous cells."¹

Longo and his team then tested the combined therapy on laboratory mice and saw the same positive results: their cancers started to reverse. Thanks to these exciting findings, five clinical trials on breast cancer and prostate cancer patients are now underway.

Although a variety of cancer cells were used in the experiment, the team discovered that the vitamin C/fasting combination was especially effective against cells that had a special mutation, one that makes cancer untreatable. This mutation protects the cancer cells from even the most powerful and toxic chemotherapy drugs - and when the mutation is detected, oncologists are told not to treat, as it will probably destroy the patient's quality of life for no good reason.

The mutation is on a gene called KRAS (**K**irsten **r**at **s**arcoma viral oncogene homolog), but aside from smoking, researchers aren't sure why it happens. KRAS is responsible for signalling cells to grow and divide, but when it mutates, those signals can start the process of cancer.

If a diagnosis of cancer isn't bad enough, one that has a KRAS mutation

is far worse. In one study, 63 percent of lung cancer patients who had a KRAS mutation died compared with 32 percent who didn't have it.² In another looking at 116 lung cancer patients, the five-year survival rate for those with the mutation was just 11 percent, but 64 percent of those without the mutation reached the five-year mark.³

The mutation creates a protect shield around the cancer cell. Chemotherapy drugs—such as panitumumab, cetuximab and erlotinib—have had no effect whatsoever in patients with KRAS-mutated colorectal and lung cancers.

Until Longo's discovery, oncologists have been at a loss as to how to treat around a quarter of all cancers they see. Fasting and vitamin C have been tantalizing options for years, but the research hasn't been consistent, with a positive finding soon being overtaken by a negative one and, as a result, both have been added to the growing list of unproven cancer therapies.

Not so fast

There's a good scientific basis for fasting as a cancer therapy. While the American Cancer Society advises cancer patients to eat plenty of calories and protein, especially during chemotherapy, it's also known the diet feeds the cancer. In 1931, German doctor Otto Warburg noticed that cancer cells were relying on sugar rather than oxygen for their energy, a process known as the "Warburg effect".

Starve the body of sugars, and the cancer cell will also die, or so the theory goes, and the process has been witnessed in laboratory tests. In one, 17 lines of cancer cells including samples of melanoma, glioma and breast cancer were "starved" and the researchers said the results were as successful as anything achieved by chemotherapy.

The cancer cells stopped growing and, more significantly, the ones normally resistant to cancer drugs—possibly because of KRAS mutation—suddenly became sensitive to them. Fasting made the untreatable cancers treatable.⁴

A five-day fast can produce a 50 percent fall in glucose—the sugar in the blood—that is feeding the cancer and helping it grow, Longo estimates. The fast, followed by resumption of a normal diet, could also protect cancer patients against the worst ravages of chemotherapy without the same weight loss.⁵

But to really see a turnaround in the

cancer, the patient would need to follow a strict diet, with a 40 percent reduction in protein, for months, and this is where the theory hits up against the hard wall of pragmatics. No oncologist would allow his patient to be on such a strict diet for so long during chemotherapy, indeed his ethical code would prevent him from even suggesting it, and so the fasting approach ran out of road.

A strict fast is just that: no food whatsoever other than regular sips of water, and this is extreme for even a healthy person, let alone someone with cancer. Seeing the dilemma, Longo has developed his own version of the fast, the fasting-mimicking diet (FMD), which he says delivers all the health benefits of a true fast without starving the patient. (see box next page).

Let's C

While fasting has been on the outer fringes of cancer treatment, vitamin C has at least flirted with the mainstream. Touted by American biochemist Linus Pauling more than 40 years ago, high-dose vitamin C (ascorbic acid) therapy was claimed to reverse end-stage cancers.

The way the vitamin was delivered didn't seem to matter, according to early researchers; patients given the vitamin orally or intravenously were improving⁶. But the therapy was quickly abandoned when two clinical trials of oral vitamin C couldn't replicate the results⁷.

This could have been because it does matter how the vitamin is administered: it has to be done intravenously. One study reported that cancer patients on a vitamin C drip, given an average of 10 g a day, saw a benefit,⁸ but a later trial that followed the exact same protocols failed to see any improvement in a small group of patients with advanced cancer⁹.

Why were the researchers coming up with such different results? High doses of the vitamin can trigger a biological process in KRAS-mutated cancer cells that makes them produce ferritin, a protein that binds iron. Iron, in turn, is associated with cancer growth, especially colorectal cancer. There's a direct correlation between iron levels and survival in colon cancer; the higher the iron, the lower the survival rate.

And this could be why Longo's two-

punch approach of fasting and vitamin C is working. Fasting reduces levels of ferritin in the body, and this allows the vitamin C into the cancer cell to kill it.

The approach could also make chemotherapy more effective, but that's a short-term gain. Longo sees the day when milder drugs without the neutron-bomb effects of chemo will be given to cancer patients. And, possibly, the day will come when cancer isn't treated with any drugs at all, but just with a short fast and vitamin C.

Bryan Hubbard

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A Fast of sorts

A true fast—no food and just sips of water—is extreme, and few can stay on it for very long, but it could be very good for us. Seeing the dilemma, Valter Longo at the University of Southern California's Longevity Institute has devised a five-day fast that delivers the benefits but avoids the agony.

He has developed his own commercially available fasting plan, L-Nutra, which he claims mimics a true fast, and consists of vegetable soups eaten twice a day, olives, vegetable chips, nuts and bars made of nuts. He's also developed supplements as well as drinks and teas to keep the body hydrated.

He recommends people fast for five days every six months or so, but there are some key dietary changes that he advocates everyone should follow most of the time.

Reduce your protein. Eat just 0.31 grams of protein per pound of body weight a day, meaning a person weighing 140 lb (63.5 Kg) would be allowed 43 grams a day.

Cut down on fish. Eat just one to two servings a week. Replace with plant-based food such as vegetables.

Reduce sugars. An essential part of any diet, reduce your sugar intake to almost zero and cut back on pasta and bread.

Take vitamins. The essential vitamins include omega-3 and -6 fatty acids and vitamin C.

Eat good fats. Get your fats from olive oil, nuts and fish.

Cut back on the booze. Try to eliminate alcohol as much as possible.

While fasting is good for almost everyone, Longo cautions that people over the age of 70 should check with their doctor before fasting.

How Much C?

Longo recommends going on a vitamin C "feast" for a few weeks every six months when up to 6 g should be taken every day, or up to the level of bowel tolerance. Beyond that the vitamin can cause diarrhea.

But therapeutic doses for treating cancer and other chronic problems can be higher still. Doses given in clinical trials

have ranged from 0.15 g to 0.7 g per kg of body weight every day. At the upper level a person weighing 140 lb (63.5 kg) would be taking nearly 10 gm a day.

That's 50 times the highest recommended dose of 200 mg and a far cry from the recommended daily allowance of just 95 mg.

WDDTY JULY/AUGUST 2020

Editor's comments: The above article makes a lot of sense about the benefits of fasting and vitamin C. But some of the statements about genes, gene mutation and cancers being *treatable* need to be questioned.

For example the claim that 25% of cancers cannot be treated (with chemotherapy?) implies that 75% can. This ignores the fact that most types of cancer do not *respond* to chemo; for those that do, chemo generally adds only a few months to survival; and for a very small number,

such as acute childhood leukemia, chemo can add years to survival. But there are no cures. Overall chemotherapy increases 5-year survival from about 65% to 67%.

Regarding the role of genes there is little evidence that genes or gene mutations cause or affect cancer. The main role of genes appears to be related to reproduction, ie cell division.

For example the **KRAS** gene provides instructions for making a

protein called K-Ras, that relays signals from outside the cell to the cell's nucleus. These signals instruct the cell to grow and divide (proliferate) or to mature and take on specialised functions (differentiate).

The claim that a mutated KRAS gene disrupts the signals that instructs the cell to differentiate (ie remain non-malignant) or proliferate (and possibly become malignant) assumes that this is the only signal required to make a dividing cell malignant. There could be many other interfering signals required.

The surprising dangers of CT scans and X-rays

Patients are often exposed to cancer-causing radiation for little medical reason, a Consumer Reports investigation finds Published: January 27 2015

When James Duncan, M.D., a radiologist at Washington University in St. Louis, experienced intense pain in his abdomen in 2010, he rushed to a local emergency room. His doctors suspected kidney stones but they wanted to be sure, so they ordered a CT scan. Duncan remained motionless as the machine captured a

detailed 3D image of his abdomen. He knew that the test was done when the machine stopped whirring. So he was surprised when the scanner kicked back on after a few seconds.

"I later learned that the technician running the CT mistakenly believed that the first scan didn't include the top of my kidneys, and decided to acquire more images 'just to be sure,'" Duncan says. "The irony: I was getting ready to give a lecture

on reducing radiation exposure from medical imaging. And there I was, reluctantly agreeing to a CT scan and then getting overexposed."

Duncan will never know whether that specific scan caused any long-term harm, because it's almost impossible to link radiation exposure from any one medical test to a future illness. But like other researchers, he knows that doctors today order millions of radiation-based imaging tests each year; that many of
(continued next page)

them are unnecessary, and that the more radiation people are exposed to, the greater their lifetime risk of cancer.

X-rays have been used for almost 120 years, but the introduction of computed tomography, or CT scans, in the 1970s, was revolutionary. The new tests, which use multiple X-ray images, allowed doctors to see with unprecedented precision the inner workings of the human body, and earned the inventors of the device the 1979 Nobel Prize in medicine.

Use of the tests grew quickly, rising from fewer than 3 million per year in 1980 to more than 80 million now. But recent research shows that about one-third of those scans serve little if any medical purpose. And even when CT scans or other radiology tests are necessary, doctors and technicians don't always take steps to limit radiation exposure.

All of that exposure poses serious health threats. Researchers estimate that at least 2 percent of all future cancers in the U.S.—approximately 29,000 cases and 15,000 deaths per year—will stem from CT scans alone. Even some standard X-rays, which expose you to much smaller amounts of radiation, can pose risks if you undergo multiple ones.

“No one says that you should avoid a CT scan or other imaging test if you really need it, and the risk posed by any single scan is very small,” says Marvin M. Lipman, M.D., Consumer Reports' chief medical adviser. “But the effect of radiation is cumulative, and the more you're exposed, the greater your cancer risk. So it's essential that you always ask your doctors why they are ordering an imaging test and whether your problem could be managed without it.”

Given those risks, why are we—and our doctors—so scan-happy?

For one thing, patients aren't necessarily aware of the danger. A new Consumer Reports survey of 1,019 U.S. adults found that people are seldom told by their doctors about the risks of CT scans and other radiology tests. It's no surprise, then, that only 7 percent of those who had a nondental X-ray and 2 percent of those who had a CT scan thought they might have received the tests unnecessarily. And only 4 percent ever told their doctor they did not want a CT scan. “That's worrisome,” says Lipman's colleague at Consumer Reports, Orly Avitzur, M.D. “Patients need to take the lead on

this because their doctor may not.”

Other studies show that doctors themselves often underestimate the dangers CT scans pose. Moreover, some doctors may actually have a financial incentive to order the tests.

“Health care professionals shouldn't have the right to image children or adults unless they first show that they can do it safely and appropriately, and most of the time in this country, that's not happening,” says Stephen J. Swensen, M.D., medical director at the Mayo Clinic in Rochester, Minnesota. “If the scan isn't necessary or emits the wrong dose of radiation, the risks far outweigh the benefits.”

Radiation risk 101

CT scans can expose you to as much radiation as 200 chest X-rays.

A CT emits a powerful dose of radiation, in some cases equivalent to about 200 chest X-rays, or the amount most people would be exposed to from natural sources over seven years. That dose can alter the makeup of human tissue and create free radicals, molecules that can wreak havoc on human cells. Your body can often repair that damage—but not always. And when it doesn't, the damage can lead to cancer.

Cancers from medical radiation can take anywhere from five to 60 years to develop, and risk also depends on age and lifestyle. That's why scientists struggled in early attempts to quantify the danger of medical radiation. Until recently, researchers often relied on evidence from the atomic bomb attacks on Hiroshima and Nagasaki. But now research shows that today's medical patients are being harmed, too.

New evidence comes from a 2013 Australian study that looked at more than 680,000 people who had CT scans as children and compared them with some 10 million children who did not have a CT scan. The researchers determined that for every 10,000 young people scanned, 45 would develop cancer over the next 10 years, compared with 39 cancers among 10,000 people not screened. Overall, people scanned had a 24 percent increased cancer risk, and each additional scan boosted risk an additional 16 percent. Children who had one before the age of 5 faced a 35 percent spike in cancer risk, reflecting the fact that young bodies are more

vulnerable to radiation.

Other researchers estimate that for every 1,000 children who have an abdominal CT scan, one will develop cancer as a result. And a 2012 study that looked at almost 180,000 British children linked CT scans to higher rates of leukemia and brain cancer.

“All too often children are receiving adult-sized doses of radiation, which is many times the amount they need,” Swensen says. “The dose directly increases the risk of leukemia or a solid tumor. And that's not regulated today.”

Radiation poses a smaller risk to older people, in part because there is less time for cancer to develop in them, explains David Brenner, Ph.D., director of the Center for Radiological Research at Columbia University. But, he points out, adults actually receive far more scans than children do, “so the bigger issue is actually with adults.” Research also suggests that, contrary to expectations, the risk of radiation-induced cancer, notably of the lungs, doesn't decline as we age.

One scan leads to another

One of the insidious ways that unnecessary CT scans increase risk is that a single CT test often leads to another, then another. A disturbing example of that dangerous cascade was featured in an article in the September 2014 issue of the *Journal of Patient Safety*, co-authored by John Santa, M.D., medical director of the Consumer Reports Health Ratings Center.

An 11-year-old girl received a CT scan because of possible appendicitis. That was the first mistake: An ultrasound, which does not emit radiation, is the best initial test in such situations. The second error occurred when her CT showed a normal appendix but her doctors noted a spot on one lung and decided that it warranted a follow-up CT. Such incidental findings are so common doctors have a name for them: *incidentalomas*.

Expert advice is to ignore the vast majority of those results because slight abnormalities seen on scans are very common but rarely harmful. Yet many doctors find the urge to order follow-up tests irresistible. For the 11-year-old girl, the CT didn't reveal a tumor or any other problem, but over the next two years her doctors recommended repeat scans of her lungs, all of which would further increase her cancer risk.

“Stories like this occur every day in the United States,” Santa and his co-authors wrote. “This unfortunate sequence of patient harm, waste, and needless anxiety could have been completely avoided with an ultrasound. None of this had to happen. None of this has to happen.”

(Continued on page 8)

Why there's so much overuse

The main reasons for excessive scanning are:

Financial incentives. Overuse is caused "not just by greed and money, but that's part of it," says Swensen of the Mayo Clinic. Most doctors are paid by volume, he notes, so they have an incentive to order lots of tests. And many doctors have invested in radiology equipment or clinics. Such physicians order far more CT scans and other imaging tests, research shows.

Fear of lawsuits. Almost 35 percent of imaging tests are ordered mainly as a defense against lawsuits, not because of true medical need, according to a study presented at the 2011 meeting of the American Academy of Orthopaedic Surgeons.

Uninformed physicians. In a 2012 study of 67 doctors and medical providers caring for patients undergoing abdominal CT, fewer than half knew that the scans could cause cancer. In another study, only 9 percent of 45 emergency-room physicians said they knew that CT scans increased cancer risk.

Misinformed patients. Fewer than one in six patients in our survey said their doctors had warned them about the radiation risks of medical imaging. It's not surprising, then, that many patients have mistaken assumptions about the dangers of medical radiation. For example, almost as many people in our survey (17 percent) were very concerned about magnetic resonance imaging (MRI), which doesn't emit radiation, as were concerned about CT scans (19 percent).

Patient demand. When you or your child is in pain, it's normal to want an imaging test to find out the cause. But that's often not necessary or wise. Many back-pain sufferers, for example, ask their doctor for an X-ray or CT scan (and many doctors acquiesce) even though expert guidelines say that such tests are usually warranted only if the pain lasts a month or longer.

Lack of regulation. About one-third of the people in our survey assumed that laws strictly limit how much radiation a person can be exposed to during a CT scan. In fact, unlike mammography, there are no federal radiation limits for any kind of CT imaging.

There are also no national standards for the training or certification of technologists (professionals who operate the imaging machines). Some states allow almost anyone to work the equipment. The government relies on

three outside accrediting organizations—the American College of Radiology, the Intersocietal Accreditation Commission, and The Joint Commission—to ensure the safety of advanced imaging facilities. But each group has different quality and safety standards.

"As you go around the country, you see all this variation in how medical imaging is being used and adherence to best practices," Duncan says. Starting in 2016, the Centers for Medicare and Medicaid Services (CMS) plans to cut reimbursement rates if CT machines don't have the most recent safety features. It has been reported that about one-third of the scanners now used across the country won't meet those new CMS standards.

What you can do

Here's our advice on what to do before you get any radiation-based imaging test:

Ask why the test is necessary. Of course, don't turn down a test if it's really needed. But they're often not. So ask why the test is being done, how the results will be used, what will happen if you don't get the test, how much radiation you will be exposed to, and whether there is a radiation-free alternative like MRI or ultrasound that could be substituted. For more, read our report "When to Question CT scans and X-rays."

Check credentials. There's no guarantee that the equipment will work or that the providers are skilled. But there are some indicators. Ask whether the facility is accredited by the American College of Radiology, whether the CT technologists are credentialed by the American Registry of Radiologic Technologists, and whether the person interpreting the scans is a board-certified radiologist or pediatric radiologist. Also check online to see whether the radiology professional, imaging facility, or referring physician has joined efforts to reduce the overuse of medical imaging, such as Image Gently, which focuses on children, and Image Wisely for adults.

Get the right dose for your size. The smaller or thinner you are, the lower the radiation dose you need. The circumference of your chest, hips, thigh, or waist can also change the dose. So before you get scanned, ask the person taking the test whether they've factored all of that into your scan.

Ask for the lowest effective dose. The strength of the radiation dose used during a CT scan can vary tremendously, even when done in the same

institution and for the same medical purpose. Avoiding the highest of those doses could almost cut in half the number of future radiation-related cancers, according to a 2013 study in the journal *JAMA Pediatrics*.

Avoid unnecessary repeat scans.

The Institute of Medicine reports that \$8 billion is spent annually on repeat testing, much of it unnecessary. That often happens because doctors may prefer to get a new test rather than look at a previous one. So let your doctor know if you recently had an imaging test. To track your scans, jot down the date, facility, and ordering physician in a journal. And ask for copies of your scans to be put on a CD so that you can show them to new doctors.

Get a second opinion if . . .

1. Your doctor owns a CT scanner or has a financial interest in an imaging center

An in-office CT might seem convenient, but it carries an inherent financial conflict of interest. And studies have found that physicians who own scanners or are part owners of radiology clinics use imaging substantially more than others. If your doctor owns a scanner, ask why you need the CT or whether another test might be an option. And if he is sending you to a radiology clinic, ask whether he is financially affiliated with it.

2. Your doctor recommends a "whole-body" CT scan

Those scans are often touted as a way to detect early signs of cancer and heart disease. But most scans—and up to 80 percent in older people—have at least one abnormality that shows up on the exam. Almost all of the abnormalities are harmless, yet about one-third of patients are referred to follow-up imaging, according to a 2013 study. And whole-body CT scans expose you to much more radiation than regular CT scans. One study determined that for every 1,250 45-year-old adults who have the exam, one will die of cancer as a result. Yet it's unknown how many lives the scans might save.

3. Your dentist recommends a 3D dental shot

The CT technique, called cone-beam CT, exposes children to about six times more radiation than traditional dental X-rays. The American Dental Association says that children rarely need them before orthodontic procedures. And several studies have shown that for any given dose of radiation, children are three to four times more likely than adults to develop malignancies, in part

(Continued on page 10)

Wiser Health Care Submission to Medical Board of Australia

The following is the *Wiser Health-care submission to the Medical Board of Australia's Public Consultation Paper on the draft revised Good medical practice: A Code of Conduct for doctors in Australia*.

We support the Board's proposal to revise the code of conduct (Option 2).

Specifically addressing Q4: *What is missing?*

The code should include the risks to patients of overdiagnosis and overtreatment when doctors request, report and interpret screening and diagnostic tests.

Overdiagnosis and overtreatment are now widespread in healthcare.^{1,2,3}

A national statement calling for action to address overdiagnosis and overtreatment has been endorsed by leading healthcare organisations including the Royal Australasian College of Physicians, Consumers Health Forum of Australia, Australian Commission on Safety and Quality in Healthcare, Royal Australian College of General Practitioners, Royal Australian and New Zealand College of Radiologists, Royal Australasian College of Surgeons and Cancer Council Australia. A full statement and list of endorsements is available here:

<http://wiserhealthcare.org.au/national-action-plan/>

Doctors have a critically important role

in addressing overdiagnosis and overtreatment, and this role should be addressed in the revised Code of Conduct.⁴ Doctors have a responsibility to be aware of the growing evidence of overdiagnosis and overtreatment in healthcare, and a responsibility to ensure that they inform their patients about these risks.

A new sub-section should be added to **Section 3.2 Good patient care**

Ensuring they are aware of the risks of overdiagnosis when requesting, reporting and interpreting the results of screening and diagnostic tests

A new subsection should be added to **Section 3.3 Shared decision making**

Ensuring patients are aware of the risks of tests, including the risks of overdiagnosis and overtreatment, when considering their healthcare options

A new subsection should be added to **Section 4.5 Informed consent**

When requesting a screening or diagnostic test, advising the patient of the risks of overdiagnosis and subsequent overtreatment that may occur as a result of the test

Overdiagnosis and overtreatment not only cause harm to patients and their families, but also divert resources from addressing underdiagnosis and undertreatment.

A new subsection should be added to **Section 7.2 Wise use of healthcare**

resources

Understanding that over-investigation of your patients can divert financial and human resources inappropriately in the health system, resulting in a risk of underdiagnosis and undertreatment to other patients, and waste of healthcare resources.

Professor Alexandra Barratt
Dr Ray Moynihan
Professor Paul Glasziou
Professor Rachelle Buchbinder
Professor Chris Maher
Professor Kirsten McCaffery
Professor Stacy Carter

Wiser Healthcare
www.wiserhealthcare.org.au

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29,000 cancers overdiagnosed in Australia in a single year by Alex Barratt

The Conversation January 27, 2020

Almost one in four cancers detected in men were overdiagnosed in 2012, according to our new research, published today in the *Medical Journal of Australia*.

In the same year, we found that approximately one in five cancers in women were overdiagnosed. Overdiagnosis is when a person is diagnosed with a "harmless" cancer that either never grows or grows very slowly. These cancers are sometimes called low or ultra-low-risk cancers and wouldn't have spread or caused any problems even if left untreated.

Is it time to remove the cancer label from low-risk conditions? August 13, 2018

Over the past few decades, our understanding of cancer has changed. We now know some cancers don't grow or grow so slowly that they'll never cause medical problems.

But the way we label disease can harm. The use of more medicalised labels, including cancer, can increase levels of anxiety and the desire for more invasive treatments.

Given this growing evidence, my colleagues and I argue in *The BMJ* today that it may be time to stop telling people with very low-risk conditions that they have "cancer" if they're unlikely to be harmed by it.

Our understanding of cancer has changed

Cancer screening for people who have no symptoms and the use of increasingly sensitive technologies can lead to overdiagnosis – a diagnosis that causes more harm than good. Overdiagnosis is most common in breast, prostate and thyroid cancer.

Most people want to know risk of overdiagnosis, but aren't told May 21, 2015

This level of overdiagnosis means

Australian men are 17% more likely to be diagnosed with cancer in their lifetime than they were 30 years ago, while women are 10% more likely.

Cancer overdiagnosis can result in people having unnecessary treatments, such as surgery, radiotherapy and hormone therapy. Being diagnosed with cancer and having cancer treatments can cause physical, psychological and financial harms.

How many cancers were overdiagnosed?

In 2012, 77,000 cancers were diagnosed among Australian men. We estimated that 24% of these (or 18,000 in total) were overdiagnosed, including:

- 8,600 prostate cancers
- 8,300 melanomas
- 860 kidney cancers
- 500 thyroid cancers.

Some 55,000 cancers were diagnosed in women; 18% of them (11,000) were overdiagnosed. This includes:

- 4,000 breast cancers
- 5,600 melanomas
- 850 thyroid cancers
- 660 kidney cancers.

These calculations are based on changes since 1982 in the lifetime risk of cancers, after adjusting for other causes of death and changing risk factors.

Mammograms sometimes detect cancers that wouldn't grow, spread, or cause the woman any harm.

Because they are more common, prostate and breast cancer and melanoma accounted for the greatest number of overdiagnosed cancers, even though larger percentages of thyroid cancers were overdiagnosed.

In women, for example, 73% of thyroid cancers were overdiagnosed, while 22% of breast cancers were overdiagnosed.

The harms to patients come from the unnecessary surgery, and other treatments, as well as the anxiety and expenses.

Three in four patients with thyroid "cancers" that are overdiagnosed, for example, will almost all have their thyroid completely removed, risk complications, and have to take replacement thyroid medication for the rest of their life.

In addition, there are substantial costs to the health system, and delays in necessary surgery.

Some "good news" is that overdiagnosis appears to be largely confined to the five main cancers mentioned above.

What causes cancer overdiagnosis?

The cause of overdiagnosis differs for each cancer.

For prostate cancer, the cause is the quest for early detection of prostate cancer using the prostate specific antigen (PSA) blood test. A downside of PSA testing is the risk of detecting large numbers of low-risk prostate cancers which may be overtreated.

For breast cancer, the cause is also early detection, through mammography screening which can detect low-risk cancers.

Five warning signs of overdiagnosis February 5, 2019

We've had it drummed into us over decades that early detection is key to treating diseases early, before they have a chance to turn into something really nasty.

But we've since learnt the flip-side of this is overdiagnosis, where people are diagnosed with diseases that won't harm them. Overdiagnosis is often followed by overtreatment where procedures or other therapies are offered that won't benefit the patient and may cause harm.

The chance discovery of a small thyroid cancer in someone's neck, for instance, is likely to result in a total thyroidectomy (removal) and lifelong thyroid hormone replacement. But this cancer is very unlikely to have caused harm had it been left alone. And studies have found dramatic increases in thyroid cancer world-wide, without changes in death rates.

Likewise, detection of low-risk melanoma accounted for most of the melanoma overdiagnosis we observed.

Early detection activities again are the likely cause, with many times more skin biopsies being done today than 30 years ago.

Overdiagnosis of kidney and thyroid cancer is due largely to "incidentalomas" – abnormalities found incidentally on imaging done for other reasons – or through over-investigation of mild thyroid problems.

What can we do about it?

Some level of overdiagnosis is unavoidable in a modern health-care system committed to screening to reduce the disease and death burden from cancer.

We want to maximise the timely detection of high-risk cancers that allows the best chance of cure through early surgery and other treatments.

But this is still possible while taking measures to prevent overdiagnosis

and overtreatment of low-risk cancers that are better left undetected.

Take South Korea, for example. Following the introduction of a screening program for thyroid cancer, the country saw a 15-fold increase in small, low-risk thyroid cancers. Then it cut back on early detection. This led to a major drop in thyroid cancer rates without any change in death rates.

Rates of PSA testing are comparatively high in Australia. Rates of PSA testing in Australia are among the highest in the world. (Feletto E et al. An examination of prostate cancer trends in Australia, England, Canada and USA: Is the Australian death rate too high? World J Urol DOI 10.1007/s00345-015-1514-7)

Countries where there is less PSA testing, such as the United Kingdom, detect less low-risk prostate cancer, and therefore have less overtreatment.

Rather than simply accepting PSA testing, a wiser strategy is to make an informed decision whether to go ahead with it or not. Tools to help you choose are available from:

psatesting.org.au/info_utm_source=pcfa&utm_medium=redirect&utm_campaign=pcam19 and [prostate-cancer-screening-infosheetpdf\(2\).](http://prostate-cancer-screening-infosheetpdf(2).)

A decision aid is also available for Australian women to consider whether to go ahead with mammogram screening or not.

Trials to wind back treatment of low-risk prostate cancer have resulted in clinical practice guidelines that recommend men with low-risk prostate cancer be offered active surveillance as an alternative to immediate surgery or radiation therapy.

Trials to evaluate less treatment for low-risk breast cancer are now under way and should help wind back breast cancer overtreatment one day.

New screening tests that identify clinically important cancers, while leaving slow- and never-growing cancers undetected, are the holy grail. But they could be some time coming.

In the meantime, health services need to be vigilant in monitoring new areas of overdiagnosis, particularly when investing in new technologies with potential to further increase overdiagnosis.

(Continued from page 8)

because their cells are more sensitive to radiation.

Where the rays are—and aren't

The following describes different radiation forms:

Ultrasound

High-frequency sound waves sent through the body create echoes as they bounce off organs and tissues. Echoes are then turned into real-time images called sonograms. Produces fairly good images of soft-tissue disease, but they're not very detailed, especially in obese patients.

Radiation exposure: none.

MRI

Magnetic resonance imaging uses magnets and radio waves to create detailed images that can help spot cancers and soft-tissue problems. Patients are enclosed in the machine for 45 minutes to 2 hours before the image is captured.

Radiation exposure: none. ➡ To p. 11

The government tried to stop this surgery. Then surgeons got involved by Liam Mannix

After lobbying from surgeons, the federal government has reversed plans to stop funding a back pain operation critics say is expensive, dangerous and ineffective.

Last year, the government announced plans to stop surgeons billing Medicare for spinal fusions to treat uncomplicated chronic low back pain.

The changes followed a recommendation from pain specialists that there was no evidence spinal fusions helped people with lower back pain. Spinal fusion involves the joining of two or more vertebrae.

But surgeons say they were never consulted on the changes, which they say were driven by people with no expertise in spinal surgery and not backed by evidence. They say spinal fusions can help some people with back pain when all other treatments have failed.

Orthopedic surgeon Professor Ian Harris, who has published several studies critical of fusions, said the government's reversal showed that "doctors and surgeons have too much power, and the government is scared of them and happy to take the path of least resistance".

Spinal fusions are Australia's fourth-most costly surgical procedure. Between 1997 and 2006, the number of private operations increased by 175 per cent. But evidence suggests one in five patients experiences a complication.

Last year, following a recommendation from Choosing Wisely – the organisation that works to eliminate wasteful and unnecessary surgery – and with support from the chair of the government's Medicare Benefits Schedule Review, the federal government announced plans to ban Medicare funding for the "treatment of uncomplicated axial chronic lower back pain".

This is in line with British clinical guidelines that recommend against



Spinal fusion involves the joining of two or more vertebrae offering the procedure for lower back pain.

At the same time, the government proposed changes that meant spinal fusion was only covered by the most expensive tier of private health insurance.

But, following a backlash and lobbying from surgeons, both those changes have been quietly dropped, The Age and The Sydney Morning Herald can reveal.

Instead, spinal fusion will receive broad private health insurance coverage. And surgeons will only be restricted for claiming Medicare benefits for spinal fusion for "chronic low back pain for which a diagnosis has not been made".

The Health Department says it is "monitoring the use of the new spine surgery items and will continue to consult with the profession regarding appropriate use of all items introduced through this review".

Dr Michael Johnson, president of the Spine Society of Australia, said the original changes were made without consulting spine surgeons.

He was broadly critical of the Choosing Wisely process. Their recommendations came from pain physicians, not spinal surgeons – and they typically only saw patients who had failed back surgery, he said.

In some cases, often when conservative management had failed, spinal

fusion could help people with lower back pain, he said.

"I might operate on one person a year for low back pain. So the usage of spinal fusion is extremely limited, but it does have a place," Dr Johnson said.

He said some of the evidence Choosing Wisely relied on actually supported the use of spinal fusions in some patients.

He pointed to published evidence indicating spinal fusion did help "a small, carefully selected group" who had failed conservative rehab programs.

Dr Stephen Duckett, a health economist with the Grattan Institute (which receives sponsorship from private health insurers), said the policy reversal would drive up private health insurance premiums and public hospital bills.

Surgeons were trying to protect their own hip pockets, he said.

"Always, when the medical profession is acting in its own interest, they dress it up as acting in the patient's interest," he said.

"What we're seeing here is a triumph of politics over a patient's long-term interests.

"The overwhelming evidence is that on average spinal fusion does not help people."

Associate Professor Mick Vagg, vice-dean of the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists, was part of the team that drew up the Choosing Wisely recommendations.

He maintained lumbar fusions should only be offered when conservative treatment had failed.

"No new evidence has emerged since that would alter this view," he said.

FROM The Sydney Morning Herald and The Age, December 29, 2019

(Continued from page 10)

Mammogram

Uses low-dose X-rays to spot masses and mineral deposits that could indicate breast cancer.

Radiation exposure: low.

X-ray

The standard scan emits a broad beam that passes through the body before landing on film, casting shadowlike images. Fluoroscopy produces a continuous image, or X-ray movie. X-ray is excellent for bones.

Radiation exposure: minimal to medium.

CT

Computed tomography uses a pencil-thin X-ray beam to create a series of images from multiple angles, which are then transferred to a computer, creating a 3D image that can be enlarged and rotated onscreen. Excellent for looking at soft tissue.

Radiation exposure: minimal to high.

PET

Positron emission tomography requires the patient to ingest a

radioactive tracer, usually through injection, that lands in cells, especially cancer cells. Some machines that are used combine PET and CT scans.

Radiation exposure: medium to high.

Tests by the radiation dose

Just one CT scan of the abdomen and pelvis equals about 10 millisieverts, more radiation than most residents of Fukushima, Japan, absorbed after the Fukushima Daiichi nuclear power plant accident in 2011.

See Table on page 2.

What's Available from the CISS Office?

Branches of CISS

NSW

CISS CENTRAL COAST

The Central Coast Branch is in RECESS over December & January. From February to May and October to November the Branch holds a general meeting on the third MONDAY of the month from 7pm - 9:30pm at the Arts & Craft Centre, Henry Kendall Gardens, Bellbird Drive (off Maidens Brush Rd), Wyoming. A Guest Speaker or Sharing of Information and Common Experiences is the agenda. (In Winter months (June-September) meetings are held at 2pm-4:30pm on the third Saturday of the month.)

An excellent library is available to members. ALL WELCOME. Information Mary Sponberg-Macready 02 4322 8767

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

CANHELP CANCER SUPPORT GROUP

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

HILLVIEW COMMUNITY SUPPORT GROUP

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

NAMBUCCA VALLEY SUPPORT GROUP

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

CHAMPION Juicer - \$575 (\$615 non-members)

OSCAR Juicer - \$485

Enema Kits: \$12.00

Water Purifier: Reverse Osmosis - \$495. Other models avail.

DVD: CISS 2007 Seminar : Cancer & Hope

\$29.50 plus \$5 postage

Prices are subject to change. Items can be posted to you. There is a \$15.00 postage/packing fee for standard articles, \$16-\$18 for country and interstate, \$18 Express Post. CISS Handbooks \$13.50, \$15 including postage.

NSW (Continued)

NEWCASTLE CANCER SUPPORT GROUP

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

QUEST FOR LIFE FOUNDATION

Based on 30 years of delivering exceptional retreat experiences for people living with cancer, our 5 day residential retreats deliver the latest research on health, healing and neuroscience. Contact 02 4883 6599 or visit www.questforlife.com.au

SYDNEY ADVENTIST HOSPITAL CANCER SUPPORT CENTRE

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

VICTORIA

CANCER NATURAL THERAPY FOUNDATION

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 (Continued)

GAWLER FOUNDATION

Learn how to create wellness in the face of cancer at our 5-day and 10-day Cancer Retreats in Victoria's beautiful Yarra Valley. Call 1300 651 211 or visit www.gawler.org to learn more.

WESTERN AUSTRALIA

Solaris Cancer Care (formerly 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 is 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. Emphasis on self-help and development, teaching life skills that enable individuals to better cope with the fear and uncertainty of a cancer diagnosis. Website: <https://solariscancercare.org.au/page/support/support-services>

Gardasil Researcher Speaks Out

FROM: CBS, AUGUST 19, 2009

Amid questions about the safety of the HPV vaccine Gardasil one of the lead researchers for the Merck drug is speaking out about its risks, benefits and aggressive marketing.

Dr Diane Harper says young girls and their parents should receive more complete warnings before receiving the vaccine to prevent cervical cancer. Dr Harper helped design and carry out the Phase II and Phase III safety and effectiveness studies to get Gardasil approved, and authored many of the published, scholarly papers about it.

She has been a paid speaker and consultant to Merck. It's highly unusual for a researcher to publicly criticize a medicine or vaccine she helped get approved.

Dr Harper joins a number of consumer watchdogs, vaccine safety advocates, and parents who question the vaccine's risk-versus-benefit profile. She says data available for Gardasil shows that it lasts five years; there is no data showing that it remains effective beyond five years.

This raises questions about the CDC's recommendation that the series of shots be given to girls as young as 11-years old. "If we vaccinate 11 year olds and the protection doesn't last... we've put them at harm from side effects, small but real, for no benefit," says Dr Harper. "The benefit to public health is nothing, there is no reduction

in cervical cancers, they are just postponed, unless the protection lasts for at least 15 years, and over 70% of all sexually active females of all ages are vaccinated." She also says that enough serious side effects have been reported after Gardasil use that the vaccine could prove riskier than the cervical cancer it purports to prevent.

Cervical cancer is usually entirely curable when detected early through normal Pap screenings.

Dr Scott Ratner and his wife, who's also a physician, expressed similar concerns as Dr Harper in an interview with CBS News last year. One of their teenage daughters became severely ill after her first dose of Gardasil.

(continued on page 3)