



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

The final frontier in the war on cancer

by Paul Davies

This article is reprinted from our January 2016 Newsletter.

Frustrated by glacial progress, the US has turned to physicists to fight the disease, reveals Paul Davies.

Daily Telegraph (UK) 07 Feb 2012

When President Nixon declared war on cancer 40 years ago, he also sanctioned one of the biggest research programs in history. The budget of America's National Cancer Institute (NCI) is now \$5 billion a year, more than NASA spends on space exploration. Cancer accounts for a large slice of research funds in most other developed countries, too: Cancer Research UK, for example, has a budget of £500 million a year.

But despite this vast investment, the long-awaited "breakthrough" remains elusive. Although certain drugs (often very expensive) can prolong life, the brutal truth is that most patients diagnosed with metastatic cancer today fare little better than their counterparts did decades ago. And as life expectancy rises, more people will die of cancer. Given the escalating costs of treatment, the economic impact is unsustainable.

I became embroiled in this depressing story four years ago when I was called out of the blue by the deputy director of the NCI, Anna Barker. Dr Barker talked about the glacial pace of clinical progress and her frustration that, even with some of the world's finest minds involved, no light could be discerned at the end of the tunnel. Her question to me was: "Can physicists help?"

I explained that my career was focused on quantum mechanics, cosmology, black holes. "I know nothing about cancer," I said. "It doesn't matter!" was her response. Physicists, she pointed out, think about the world in a distinctive way. They have elucidated the secrets of the atom and probed the farthest reaches of the cosmos, and have a good track record at cracking



Paul Davies

tough, complex problems. It was not so much new technology that she was after, but insights from our problem-solving approach.

Two years later, in a bold attempt to exploit this untapped expertise, the NCI created 12 centres of physical science and oncology, and I found myself directing the one at Arizona State University. So, how are we getting on?

Well, one of the virtues of being unencumbered by much knowledge of a subject is the ability to come at it afresh, to see it through different eyes. The basic story of cancer is very simple.

Somewhere in the body, cells start to proliferate uncontrollably. If unchecked, they spread to other organs and colonise them. At that stage, the patient's prospects are grim. Yet nobody has a convincing explanation for why this happens. The individual steps can be partially explained in terms of changes in the cells. But precisely why a cell from, say, a breast duct or the prostate gland starts roaming the body to make a home in the liver or the lung – a process called metastasis – remains a mystery.

Most research has focused on cancer as a human disease. But tumours are also widespread among animals and plants, suggesting that they have deep evolutionary roots. Cancer is such a formidable adversary because it is a fundamental part of the story of life itself, and I believe it can be properly understood only by seeing the grand evolutionary picture.

The earliest traces of life on Earth date back 3.5 billion years, but only about a billion years ago did complex, multi-celled organisms begin to evolve. This was a profound transition. Single cells have but one imperative – to replicate. They are, in effect, immortal. But when cells first formed co-operative assemblages, a new deal was struck. Most organisms outsourced their immortality to specialised germ cells (e.g. sperm and ova), and in return accepted death for themselves. Thus a typical tissue cell might reproduce a handful of times and then die.

Organisms police this contract with a variety of regulatory systems, including specialised genes that suppress runaway growth. I believe that cancer is a breakdown in this contract, initiated when a common-or-garden cell refuses to die on cue and embarks on its own agenda.

It would be a mistake, however, to suppose that cancer merely represents a cell that has "gone wrong", and started running amok in the body. In fact, cancers possess a surprising degree of organisation. As they become more malignant, they deploy sophisticated tricks designed to evade the body's defences and enhance their own prospects. This pre-programmed box of tricks is what makes combating them such a challenge.

Together with Charles Lineweaver at the Australian National University, I have been developing a theory of cancer
(continued on page 4)

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IN THIS ISSUE

- P. 1 The final frontier in the war on cancer, by Paul Davies (reprinted from the January 2016 Newsletter)
P. 2 For Sale: Free Psych-K for members; Supplements for members; DVDs for sale.
P. 3 Overseas & Local New; Letter to the Editor from Naomi Groothoff
P. 5 More evidence for a chronic stress link to cancer and heart disease.
P. 6 Ivermectin proposed as an anti-cancer drug; The efficacy of vaccines
P. 7 Heart Attack Cholesterol—Fact, myth or both? by Roger French
P. 10 Letters to the Editor: Response to Naomi Groothoff.
P. 11 BOOK REVIEW: What really happened in Wuhan? By Sharri Markson
P.12 CISS Branches and Cancer Support groups
INSERT Membership Renewal Form

(continued from page 5)

by the endothelial progenitor cells during the repair process creating the new endothelial layer. A problem arises, however, when the blood clot is not fully eliminated and becomes a 'vulnerable' point, and another blood clot forms at the same point before the previous clot can be broken down. This incomplete repair process can gradually create a thickening inside the artery wall itself.

In almost everyone, the process of endothelial damage and blood clotting is an ongoing process. So problems only occur when the damage/blood clotting process occurs faster than the repair process, resulting in plaque build-up. This thickens the arterial wall, forcing blood flow through a nar-

rower gap. Over time this grows and becomes what's conventionally referred to as atherosclerotic plaque. When a large blood clot forms on top of an existing plaque in this already narrowed area you can end up with a heart attack or stroke.

Common causes of endothelial damage include such things as viral infections, high blood sugar levels, smoking, diabetes, heavy metals such as lead and aluminium, and high blood pressure.

Each of these factors can contribute to heart disease in different ways. For example smoking produces smoke particles that get out of your lungs and into your blood vessels as microparticles that cause damage to the endo-

thelial cells lining your blood vessels.

The protective glycocalyx layer is made of proteins and sugars. High blood sugar damages the glycoprotein layer, thinning it down in a measurable way. High blood sugar can reduce the glycocalyx layer by as much as two-thirds. This, in turn, exposes the endothelial cells to the blood and anything else damaging that might be in it.

High blood pressure puts stress on the endothelium. Atherosclerotic plaques (atherosclerosis) don't occur unless the pressure is raised, adding biomechanical stress.

Chronic stress raises both blood sugar and blood pressure, promotes blood clotting and impairs your repair sys-
(continued on page 3)

Non Sequitur by Wiley



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)
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CISS Seminar "Cancer & Hope - Survivors share their Lessons"
available for \$29.50 plus postage for members + postage

OVERSEAS & LOCAL NEWS

Overseas News

Gregg Braden interview

I apologise for devoting a very large proportion of the March/April Newsletter to one topic: an interview of Greg Braden by Nathan Crane. However after re-reading it several times and comparing it with the claims of Bruce Lipton, whose views Gregg Braden said he supported, I identified a very important difference in their claims. On the one hand, Gregg Braden says that current humans did not descend from earlier forms of life but appeared on earth about 200,000 years ago with brains roughly as they are now. Bruce Lipton says that humans evolved from more primitive forms of life on earth, multi-cell organisms, fish, reptiles, then mammals, apes and finally humans, with the brain being modified at each step.

There appears to be a basic disagreement about this important issue. I have asked our Research Assistant Gareth Fletcher to look at this claim and he does not find strong evidence for the modern human brain 200,000 years ago. I will contact Gregg Braden to ask for his source for this information.

What causes heart attacks?

Heart attack is often claimed be caused by a blockage of an artery leading to the heart, in turn caused by high cholesterol in the diet. Many have questioned this claim. A good up-to-



Don Benjamin, Editor

date example is from Roger French from the Natural Health Society whose article I include on page 7.

I include a related cartoon on page 2, reprinted from our January 2016 Newsletter.

Censorship of doctors

As mentioned on page 5 there is growing censorship of doctors in the Western world. Australia is not immune from this and many Australian doctors have lost their licence because they spoke out against the dogma of local medical authorities. The CISS Committee is investigating this to see if we can help any doctors.

(continued from page 2)
tems. Cortisol, a key stress hormone, reduces endothelial cell production.

So treatment of heart disease essentially involves treating any of the factors damaging the endothelial cells or the glycocalyx layer. Mercola discusses several of these in his interview with Kendrick.¹³

- Avoid unnecessary use of nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen, aspirin and naproxen — While they effectively inhibit inflammation, they can cause platelet aggregation by blocking COX-2. In other words, they activate your blood clotting system, making blood clots more likely;
 - Get plenty of sensible sun exposure — Sun exposure triggers nitric oxide (NO) that helps dilate your blood vessels, lowering your blood pressure. NO also protects your endothelium and increases mitochondrial melatonin to improve cellular energy production;
 - Avoid seed oils and processed foods — Seed oils are a primary source of the omega-6 fat called linoleic acid (LA), which he believes may be far more harmful than sugar. Excessive intake is associated with most all chronic diseases, including high blood pressure, obesity, insulin resistance and diabetes;
 - LA gets embedded in your cell membranes, causing oxidative stress, and can remain there for up to seven years. Oxidative linoleic acid metabolites (OXLAMs) are what's causing the primary damage, including endothelial damage;
 - Lower your insulin and blood sugar levels — Simple strategies to accomplish this include time-restricted eating, eating a diet high in healthy fats and low in refined carbohydrates, significantly restricting your LA intake and getting regular exercise.
- (continued on page 12)



See important notice on page 12

(continued from page 10)

occurrence where a Counsellor felt this was warranted.

Naomi also noted that, working as a *Naturopath*, she was required to ask patients diagnosed with cancer to sign a form to say that she was not treating their cancer but assisting to boost their immune system. This is consistent with the requirement that only medically approved therapists are permitted to treat cancer.

So I don't believe there is any disagreement about what counsellors do or don't do; only that there are two types of counselling roles. One sort has very different additional legal obligations from the others when he or she uses a particular therapy that is claimed to affect the course of cancer.

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(Continued from page 1)
 cer based on the concept that it is an evolutionary throwback to our earliest ancestors. About 600 million years ago, there appeared a riot of modern-looking metazoa (the multi-celled creatures that make up the bulk of the animal kingdom), with many specialised cell types and organs. But this explosion didn't happen in a vacuum. Hundreds of millions of years before, they – we – had precursors: clumps of semi-organised cells forming robust, tumour-like forms.

Our bodies are replete with ancestral genes that evolution has built on. These genes are retained because they are active in the early stages of embryo development, when the basic body plan is being laid down. Curiously, human embryos temporarily develop gills and tails, representing long-lost features of our evolutionary history.

Normally these ancient genes are silenced thereafter. But Lineweaver and I have proposed that cancer results from an accidental reawakening of the earliest metazoan genes, the ones programmed to build the sort of structures that inhabited Earth millions of years ago. Rather like a computer starting up in safe mode after an error

of some sort, cancer may be a reversion to a tried-and-tested ancestral lifestyle in response to a physical stress such as a carcinogen.

Connecting the dots of evolutionary, developmental and cancer biology, we have come to view cancer not so much as a disease to be cured as a condition to be controlled. Like ageing, cancer must be accepted as part of life. But by careful management, its effects can be mitigated. For example, 90 per cent of cancer deaths result from metastasis. Slowing or arresting this spread would make a big difference.

Even when cancer cells make a home in a remote organ, the micro-tumours often fail to progress, or may lie dormant. Many people who appear to have survived unscathed eventually succumb when the cancer returns years or even decades later, with enhanced malignancy. If we can understand how these micro-tumours remain in equilibrium with their environment, we could work to extend that quiescent phase. After all, a cancer that reappears after 50 years instead of five is not too serious a health risk.

The great advantage here is that such

improvements could come without requiring us to unravel fully the stupendously complex innards of cancer cells, with their myriad genetic and chemical pathways and survival mechanisms.

If Lineweaver and I are right, and a special cassette of ancient genes drives the basic behaviour of cancer, then we will have a well-defined target for therapy. The challenge is to find a way to seize control of the cassette's operating system and tweak it to do our bidding, by reducing the cancer cells' wanderlust or keeping the micro-tumours stable.

Cancer touches all of us. Public health programmes, such as the campaign against smoking, have had a big impact. And a handful of cancers are, in effect, curable. But headway against this scourge has stalled, and requires some radical new thinking, including concepts that cross subject boundaries and emphasise control over cure. The NCI's bold initiative of inviting perspectives from physical science needs to become an integral part of the next phase of cancer research.

Paul Davies is director of the Beyond Center for Fundamental Concepts in Science at Arizona State University.

Paul Davies questions the orthodox cancer paradigm by Don Benjamin

The visit to Australia by Paul Davies in 2015 set a cat among the pigeons for the local cancer authorities as what he had to say is almost identical to what CISS has been saying for years:

1. Cancer is a systemic disease and therefore unlikely to be affected by local treatments such as surgery or radiotherapy; and Chemotherapy is of little benefit and extends lives overall by very little;
2. Cancer is a natural condition that is not to be feared. Most people don't die from their cancer. In fact most people don't even know they have cancer because it rarely produces any symptoms.
3. Cancer screening is problematic because we all have cancer, and if you look for it you will usually find it. The problem is that, as most tumours are not life-threatening, and you feel obliged to treat all tumours found, there will be much overdiagnosis and overtreatment.
4. The cancer industry is driven essentially by money. There is usually no money to look at alternative paradigms of what cancer is. So existing funding arrangements will always favour the current unproven paradigm. The only reason his team has been funded by the US National

Cancer Institute is because a team within NCI has admitted that there has been no progress in the War on Cancer since it was funded in 1971 by Richard Nixon.

5. There is little evidence for the genetic theory of cancer.
6. Essentially cancer is a systemic condition resulting from a cell stressed by external influences as describe by epigenetic theories.

Based on the above and concepts such those proposed by Otto Warburg, cancer cell growth relies on three things:

- a lack of oxygen in the cell;
- a supply of glucose
- a lowered pH;

So treatment should recognise these facts. He speculated that treatment should include

- hyperbaric oxygen to increase the oxygen to the cells;
- reduced glucose to starve the tumour by fasting for a week;
- a change of diet to ensure an alkaline cell environment; and
- increased exercise.

He received good publicity in the Australian media despite the fact that he

was questioning the claims of the whole Australian cancer industry.

Their spokespersons were making predictable statements, including by misrepresenting what he had actually said. For example in an article in the Sydney Morning Herald of December 3 titled "Fighting cancer: have we got it wrong?" summarising Paul Davies' views Darren Saunders, a senior lecturer at University of NSW's school of medical science and a Visiting Fellow at the Garvan Institute of Medicine said Davies has "really only come up with some uncertain theoretical insights". He dismissed Davies' observation that "it is very difficult to do clinical trials for alternative treatments when there is little return for drug companies" as a "conspiracy theory" and is "offensive". Saunders says "it's a great idea to come in unencumbered by dogma but you can't also be unencumbered by evidence".....

The program rubbed salt into the wound to the local cancer authorities who were still having to deal with the aftermath of the ABC Program "Wasted" in September 2015 that questioned the benefits of many medical interventions, including cancer screening.

Increasing censorship of doctors

I am concerned about increasing attempts in Western societies by medical and state authorities to prevent doctors from presenting alternative views to dogmatic statements by medical authorities. The two most recent examples were in Britain and the US. In Britain Dr Sam White, who had spoken out about the risks of Covid vaccinations and the ignoring of effective alternative treatments, had his licence to practise revoked. He took the case against the "Responsible Office" of the UK General Medical Council to the UK's High Court and won. The court found the action in denying him freedom of speech had been in breach of the Human Rights Act of 1998.

Meanwhile in the US, California's state assembly is trying to have a law passed that would strip doctors of their medical licences if they expressed medical views that the state does not agree with. (e.g. California Assembly Bill 2098 designates "the dissemination

or promotion of misinformation or disinformation related to the SARS-CoV-2 coronavirus, or 'COVID-19,' as unprofessional conduct" warranting "disciplinary action" that could result in the loss of their medical license".

Misinformation related to SARS-CoV-2 includes "false or misleading information regarding the nature and risks of the virus, its prevention and treatment; and the development, safety and effectiveness of COVID-19 vaccines." But as far as what might constitute "misinformation" or "disinformation" is unclear and basically left open for interpretation by the state.

Doctors have an ethical obligation to treat each patient as an individual, and to ensure each patient receives the safest and best care. Bill 2098 will turn doctors into government agents, leaving no one to advocate for patients' health

California has also introduced six other bills seeking to enshrine tyranny into law, including bills to:

- criminalise "amplification of harmful content",
- create a centralised vaccination registry,
- strip funding from law enforcement that refuses to follow public health orders,
- mandate COVID jabs for school children,
- authorise minors to consent to vaccination, and
- require school districts to conduct routine COVID testing.

It is to be hoped that none of these 7 authoritarian diktats get passed. If they do this will be the first sign that a US state government has abandoned the medical and personal freedoms outlined in the US Constitution.

It looks like the "woke" folk are trying to turn California into a police state, by making it a criminal offence to criticise the government.

CISS is investigating the situation in Australia. (See page 3)

More evidence for a chronic stress link to cancer and heart disease by Don Benjamin

One of the controversial areas of medicine is the cause(s) and treatment of heart disease and cancer.

The links in the puzzle are beginning to fall into place in relation to **cancer**: Among other contributory factors to cancer, chronic stress has been established as a being involved in

- Suppression of the immune system
- Shortening of telomeres
- Toxic damage to cells

These links are essentially correlation, not proof of cause and effect.

These potentially causative links are explored in the work by Candace Pert¹ and Elizabeth Blackburn and Elisa Epel^{2,3}, Ronald Grossarth-Maticek and Hans Eysenck^{4,5} whereas the efficacy of treatment based on the chronic stress hypothesis is also explored and evaluated by Ronald Grossarth-Maticek and Hans Eysenck^{6,7}. There are several other trials showing benefits from psychosocial intervention for cancer, but none that have shown as large an effect as the randomised controlled trials by Grossarth-Maticek and Eysenck⁴.

In contrast, in the case of **heart disease**, its causes and treatments, this has essentially been driven by arguments for and against the high saturated fat/high cholesterol hypothesis propounded by Ancel Keys in the 1960s – see page 7- and essentially disproven

by randomised controlled trials in recent years evaluating the elimination of high fat diets and the use of cholesterol-lowering drugs in preventing heart disease in the general population^{8,9}.

The Cochrane review in 2011 of trials evaluating reducing high fats in diets concluded that there were no clear effects of dietary fat reductions on total mortality or cardiovascular mortality⁸. Similarly the Cochrane review of the benefits of statins appeared to be confined to the beneficial effects of reduction in low-density lipoproteins (LDLs), rather than total cholesterol. The authors concluded that "Only limited evidence showed that primary prevention with statins may be cost effective and improve patient quality of life. Caution should be taken in prescribing statins for primary prevention among people at low cardiovascular risk."

However a new hypothesis has been proposed by Scottish doctor Malcolm Kendrick, first in his book "Great Cholesterol Con: The Truth about What Really Causes Heart Disease and How to Avoid It" in 2008¹⁰ where he debunks the cholesterol myth. Other doctors confirmed this new hypothesis at the time including Dr Dwight Lundell from Arizona whose book in 2007 "The Cure for Heart Disease: Truth Will Save a Nation"¹¹ resulted in his medical licence being revoked in 2008.

More recently Kendrick expanded upon it in his book, "The Clot Thickens: The Enduring Mystery of Heart Disease" 2021¹³.

During a recent interview of Dr Kendrick by Dr Joseph Mercola¹⁴, Kendrick summarised his "thrombogenic" hypothesis (that blood clotting is the basic underlying pathological process that causes all heart disease) as follows:

Your blood vessels are lined with endothelial cells, a bit like tiles on a wall. Endothelial cells are themselves also covered in a thing called glycocalyx that is incredibly slippery. It's nature's Teflon.

So the glycocalyx lines the inside of our blood vessels to allow the blood to travel through without it sticking, without damage occurring. So there is a kind of damage-repellent layer on top of the endothelial cells.

If that layer is damaged, and then the endothelial cell itself underneath is damaged causing bleeding, then the body will produce a blood clot there to stop the bleeding.

The blood clot will then be repaired or removed by endothelial progenitor cells, which float around in your bloodstream at all times. When a blood clot forms on your artery wall, it will typically be covered over and broken down

(continued on page 2)

CANCER and other NEWS

Ivermectin proposed as an anti-cancer drug

Dr Mercola reports that the much vilified anti-Covid-19 drug, Ivermectin has notable antitumor effects, which include inhibiting proliferation, metastasis and angiogenic activity in cancer cells.

Ivermectin may target cancer in multiple ways, including inducing apoptosis and autophagy while also inhibiting tumour stem cells and reversing multi-drug resistance.

Along with direct cytotoxic effects, it's believed that Ivermectin regulates the tumour microenvironment, mediating immunogenic cell death.

The development of an injectable form of Ivermectin, or liposomal Ivermectin, could help overcome some of its limitations regarding solubility, and open its use to a broader range of cancers.

Considering that the "war against cancer" has been on-going for decades, with little to show in terms of lives saved, repurposing existing drugs with favourable safety profiles and notable anticancer effects — like Ivermectin — makes sense.

Although not yet tested for cancer in humans it has shown positive effects in *in vitro* and *in vivo* experiments. These include in particular breast, gastric, kidney, ovarian, brain and lung cancer cell lines as well as leukemia.

This is not surprising in the sense that several researchers, such as Hulda Clark, have claimed that other antiparasitic drugs are effective against cancer.

Similarly Gaston Naessens concluded from his research findings that when stress or some other environmental factor initiates a particular macrocycle,

organisms that include bacteria, viruses and parasites (that he referred to generically as 'somatids') start to secrete "toxic" substances and growth hormones. He states that these substances disrupt normal cell metabolism and incapacitate immune cells, allowing many diseases to progress more rapidly.

He believes that they also disrupt cell division and result in the proliferation of cells that are more primitive. Such cells, he reports, derive their energy anaerobically, act as "nitrogen traps" to deplete the rest of the body of nitrogen and may become cancerous over time.

[Is Ivermectin a Cancer Solution? \(mercola.com\)](https://www.mercola.com)
12 May 2022

The efficacy of vaccines

The COVID-19 pandemic has raised an interest in the efficacy of vaccines.

We have reported on the claims that the various accepted vaccines for Covid-19 cause more harm than good, including more deaths than in those who have not received these vaccines.

Several reports related to Covid-19 have mentioned that vaccines have been increasing in number such as in the US where very young children might receive as many as 24 injections during their early childhood years.

The nine most common ones are DTP (diphtheria, tetanus, pertussis (whooping cough)), hepatitis B, polio, haemophilus influenza type B, measles, mumps and rubella (MMR).

It is often claimed that these vaccines are all effective and in fact save lives. In contrast many researchers question most of these claims.

For example The Tetanus vaccine is claimed to be effective, yet as shown in the figure below the incidence of tetanus fell sharply during the 20th century

due mainly to improved hygiene, so that 80% of this reduction occurred before the tetanus vaccine was introduced in the late 1940s.

The only clear case of efficacy was shown with the oral Sabin vaccine that was discontinued and replaced by the less effective Salk vaccine. It has since been claimed that the Sabin vaccine was more effective mainly because it was taken orally, thus activating the body's main initial immune response, whereas the other injected vaccines by-passed this critical area and relied on blood circulating immune components that made up only part of the body's immune response.

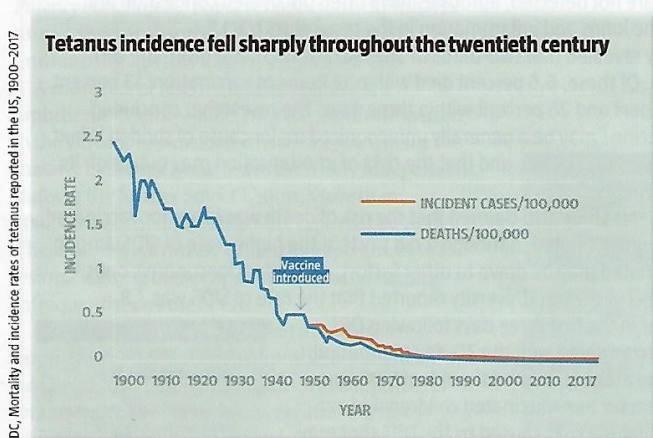
This history of falsely claiming efficacy for medical interventions includes the repeated claim that the Pap test saves lives by preventing uterine cancer whereas, as shown by the second figure below, the reduction in the death rate from cervical cancer began in the late 1930s and had fallen by a third by the time of the introduction of the Pap test, that had no observable effect on the continued falling mortality rate of cervical cancer.

Hopeful Quotes

"The secret of health for both mind and body is not to mourn for the past, worry about the future, or anticipate troubles, but to live in the present moment wisely and earnestly." - Buddha

"Cancer didn't bring me to my knees, it brought me to my feet." -Michael Douglas

Visualise yourself as having recovered. Your body will fit in with this new reality.



Thanks to improvements in wound hygiene, deaths from tetanus were rapidly declining long before the vaccine was introduced

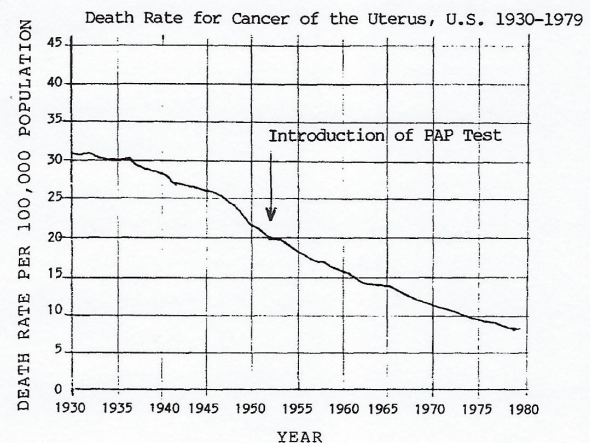
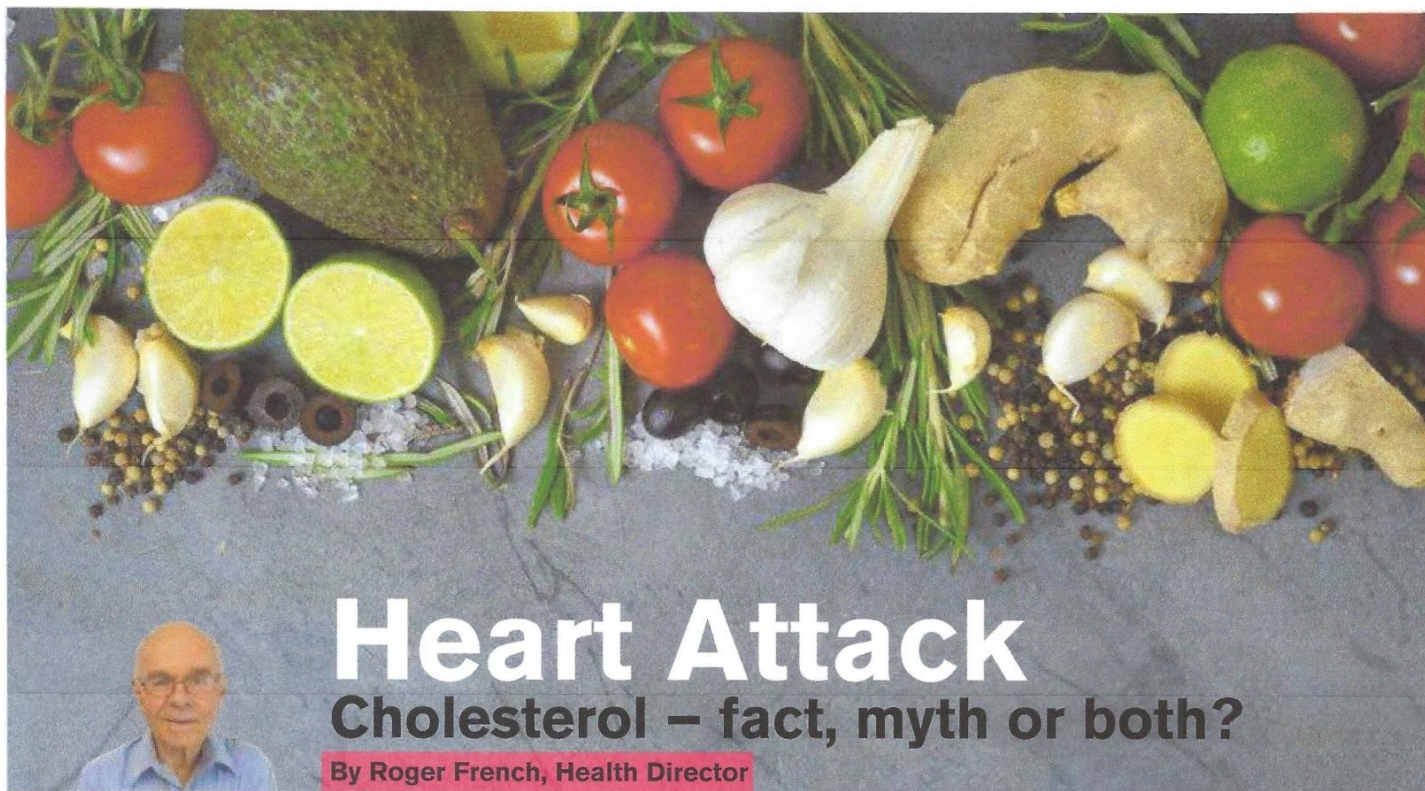


Fig. 6 Earlier surgical treatment of uterine cancer following the widespread introduction of the PAP test has been claimed to be the cause of the observed fall in the mortality rate. However there have been other claims that the fall began before the introduction of the PAP smear. Source: Cancer Facts and Figures, 1984, American Cancer Society.



Heart Attack

Cholesterol – fact, myth or both?

By Roger French, Health Director

In stark contrast to the standard dogma about the dangers of high cholesterol, older people with high cholesterol are likely to live longer than older people with low cholesterol. This was the finding of a study published in the prestigious *British Medical Journal Open* in 2016.¹ They discovered that 80 percent of the participants who lived the longest had the highest levels of the so-called 'bad' LDL cholesterol. Conversely, those with the lowest levels were far more likely to die prematurely.

This puzzle of cholesterol in relation to heart attack is one of the great health paradoxes of modern times.

JUST WHAT IS CHOLESTEROL AND WHAT DOES IT DO?

Is cholesterol a bad substance? No, it is absolutely essential, and in its pure form is a solid, white, waxy lipid. Cholesterol is produced by the liver which typically manufactures approximately three grams daily.

Cholesterol has many functions. Being the foundation for all our steroid compounds, it is required for the production of sex hormones, stress hormones (insulin, adrenalin, cortisol, etc.), the structure and repair of cell walls, the manufacture of vitamin D and the proper functioning of nerve tissue, including the brain. In fact, the brain is approximately 7% cholesterol (on a dry weight basis). Unless it is unnaturally high due to wrong diet, forcing the body's cholesterol level below its natural level could be an unwise thing to do.

The liver can make all the cholesterol the body needs, and if some is consumed in food (it occurs only in animal products), the liver compensates by eventually making less. But if large amounts of cholesterol, refined sugar or saturated fat are eaten, the balance can be upset.

The transport of cholesterol in the bloodstream is in two forms:

- *low-density lipoprotein* (LDL) and
- *high-density lipoprotein* (HDL).

LDL cholesterol travels to the tissues where cholesterol is needed, but may be deposited in the walls of arteries and capillaries to form plaque, hence its reputation as 'bad' cholesterol. The so-called 'good' HDL cholesterol travels to the liver for breakdown into bile salts and elimination via the bowel, carried by dietary fibre.

Probably of greater significance than cholesterol is the blood level of *triglycerides*, 'triglyceride' being simply the technical name for fat. These are carried in the bloodstream in *very-low-density lipoprotein* (VLDL). High triglyceride levels are potentially dangerous because the fat thickens the blood, it may be deposited in plaque, and saturated fat stimulates the liver to make excessive cholesterol.

IS THERE A CONNECTION BETWEEN CHOLESTEROL AND HEART ATTACK?

Numerous recent discoveries have tended to shatter the cholesterol theory. The Lowering cholesterol levels through dietary intervention does not reduce the risk of death from coronary heart disease. This was the finding of the Minnesota Coronary Experiment which was pub-

lished in the *British Medical Journal* in 2016. The researchers found that for every 0.8-point drop (Australian units) in total cholesterol, there was a 22 percent increase in the risk of death from cardiac disease.²

A classic example is quoted by Beverly Teter, lipid biochemist at the University of Maryland. Her mother had very high cholesterol - between 10 and 10.8 - and lived to age 97.²

Instead of being the cause of atherosclerosis, cholesterol is now being seen as a response mechanism activated by our body when a blood vessel is injured through an inflammatory process. Once the lesion occurs, the body sends cholesterol-based plaque to cover the area and prevent further damage, much like a scab after a cut on our skin. It is inflammation that first triggers injury to our arterial walls. No matter how low cholesterol levels go, the body will still use its cholesterol to repair the arterial wall.²

This view was reinforced in 2009 by Dwight Lundell, MD, former chief heart surgeon at Banner Heart Hospital, Mesa, Arizona, who had performed over 5,000 open-heart surgeries during his 25 years of experience.³

Dr Lundell says that mainstream medicine made a terrible mistake
(continued on page 9)

when it advised people to favour foods high in *extracted* omega-6 fats, including polyunsaturated margarine. We now have an epidemic of arterial inflammation leading to heart disease and other silent killers.

The discovery that inflammation in the artery wall is the real cause of heart disease is slowly leading to a paradigm shift in how heart disease and other chronic ailments need to be treated.

Without inflammation, there is no way that cholesterol-rich plaque would accumulate in the walls of blood vessels and cause heart disease and strokes. Without inflammation, cholesterol would move freely throughout the body as nature intended. It is inflammation that causes cholesterol to become trapped.

The biggest culprits causing chronic inflammation, concludes Dr Lundell, are an overload of highly processed carbohydrates, (white sugar, white flour and products made from them) and the excessive consumption of *refined* omega-6 *extracted* vegetable oils, including soya bean, corn, sunflower and safflower oils, that are in many processed foods. These cause repeated injury to blood vessels, creating chronic inflammation leading to obesity, diabetes, heart disease and stroke.

Early studies were first reviewed in *The Cholesterol Myth* written by the Sydney nutritional biochemist, Dr Robert Buist.⁴

A 1989 French study of elderly women found that a woman with a cholesterol level of 4 mmol/l had three times greater risk of heart disease compared to a woman with a level of 8 mmol/l - the exact opposite of what would be expected.

The European Working Party On High Blood Pressure In the Elderly reported that in elderly people with high blood pressure and *moderately* high cholesterol levels, ranging from 6.07 to 6.46 mmol/l, the higher the cholesterol level, the lower the death rate. Again, the opposite of what would be expected.

A 1991 Finnish study of business executives that had spanned 15 years found that those on diets carefully controlled to lower cholesterol and triglycerides were more than twice as likely to die of heart disease as those who continued on their normal diets.

Perhaps the most revealing of all such studies reported by Dr Buist was of 194 autopsies where the health data were known before death. Conducted at Providence Medical Center in the USA, it found that:

- Two-thirds of those with severe atherosclerosis had none of the *major* risk factors;
- Of those with moderate to severe

atherosclerosis, an extraordinary 72% had cholesterol below the USA recommended 5.2 mmol/l;

- In those who died of severe atherosclerosis, 27% had cholesterol between 5.2 and 6.5, and only 7% were greater than 6.5 mmol/l. In other words, only one third were above 5.2, and only one in 14 were at a so-called 'high-risk' level above 6.5.

In short, the large majority of the people with atherosclerosis did not have high cholesterol.

It is clear that cholesterol and fat are related to artery disease, but the connection is inconsistent. Something is missing in the cholesterol theory.

What is missing is consideration of the condition of the cholesterol and fat.

OXIDISED FAT AND CHOLESTEROL

The view is consolidating that, as far as lipids are concerned, oxidised fats (*rancid fats*) and oxidised cholesterol (*oxycholesterol*) are the real culprits in atherosclerosis, not fresh fats and fresh cholesterol. However, *excess* fresh lipids can cause major problems in other ways, so they are still potentially harmful food constituents that need to be kept to safe levels.

Atherosclerosis can be caused by oxidised fat, oxidised cholesterol and free radicals. Free radicals are very destructive molecules generated by cigarette smoke, air pollutants, chlorine, benzene (especially in petrol), pesticides, other toxic chemicals, radiation, excessive iron and some other factors.

The oxidation of fat and cholesterol occurs when *unsaturated* fat and cholesterol are exposed to heat, air, light, free radical attack or certain other factors.

In addition, the unsaturated fats and cholesterol inside our bodies can be oxidised if there are large numbers of free radicals combined with deficiency of the antioxidant nutrients - mainly vitamins A, C and E, the carotenoids and the minerals zinc and selenium. If these are plentiful, the lipids should be protected.

It appears that cholesterol is not so bad for artery walls unless it is oxidised, and then it can be very bad.

This is why cholesterol is an issue of both myth and fact.

A Sydney businessman, and now winemaker, at the age of 25 had a high level of cholesterol of 13 mmol/l. A cardiologist gave him a 50/50 chance of reaching 50 years of age. Being a thorough investigator, this

former company CEO, Frank Cooper, made a detailed study of cholesterol and heart disease which resulted in his writing a book entitled, *Cholesterol and the French Paradox*.⁵ Frank, who is now over 60, consulted doctors and medical researchers to ensure that the contents of the book are accurate.

The remainder of this section is abridged from Cholesterol and the French Paradox with the generous permission of the author and the publisher.

To his surprise, Frank found that many medical scientists who had done research on cholesterol *and were independent of drug companies* were of the view that cholesterol does not cause heart disease.

HOW DID THE CHOLESTEROL MYTH COME ABOUT?

In 1953 when the heart disease epidemic in the Western world was approaching its peak, an American researcher, Ancel Keys, PhD, was convinced that a high consumption of fat and cholesterol resulted in heart disease. He used six leading countries to produce a graph showing that the higher the levels of fat and cholesterol, the higher the rate of heart disease. These findings were widely accepted, right up to the US Congress.

However, it went unnoticed that Keys' charts had ignored 20 other countries that he had assessed because they didn't provide the clear result he wanted. If he had included the other 20 countries, including France, Italy, Spain, Sweden and Holland, his graph would have been all over the place and any link between high-fat/high-cholesterol diets and heart disease would have been much less compelling. It took 25 years before anyone discovered the missing data, but by then the major food conglomerates and pharmaceutical companies were making vast profits selling low-fat/low-cholesterol foods and cholesterol lowering drugs.

One of the most significant recent contributions has come from Dr Uffe Ravnskov, a Swedish medical doctor and researcher, who is an expert on cholesterol [and who addressed a seminar in Sydney, New South Wales, in August 2006].

After reviewing a vast number of cholesterol studies and trials, Dr Ravnskov found flaws and inconsistencies that few medical researchers had ever bothered to look

for. He discovered that *people with elevated cholesterol were only slightly more at risk of developing heart disease, and the difference was so slight that it wasn't worth worrying about.*

Dr Ravnskov re-calculated the data from the trials and concluded that:

- Elevated cholesterol does not result in heart disease;
- Lowering your cholesterol will not lengthen your life;
- Older women with high cholesterol live longer than older women with low cholesterol;
- The prudent diet, low in saturated fat and cholesterol, will not lower your cholesterol.

And what about the so-called 'bad' LDL and 'good' HDL forms of cholesterol? Dr Ravnskov found no association between either LDL or HDL cholesterol and heart disease. For 99.5% of the population, cholesterol levels, including LDL and HDL levels, are simply not indicators for heart disease, he concluded.

Dr Ravnskov published his findings in a book entitled, *The Cholesterol Myths*. His website is www.ravnskov.nu/myth1.htm.

Unfortunately, few family doctors or cardiologists get to read about this kind of research because it is simply impossible for a busy doctor to keep up with the mountain of medical research published every day.

Many other medical researchers have come to similar conclusions, and some have banded together to form The International Network of Cholesterol Sceptics, which in 2018 had 109 members, including nine heart specialists. Their website, www.thinics.org, lists their names and is a virtual treasure chest of clinical studies, medical papers and books on cholesterol, all written by doctors.

WHAT LEVEL OF CHOLESTEROL IS NORMAL?

Since French people have low levels of heart disease, it makes sense to use their cholesterol levels as a guide. The average level for males in the 46 to 64 age group is 6.1 mmol/l. The range would be typically between 5.1 and 7.1, so that anyone within that range could be considered normal.

These levels are about the same for males in the UK. In both countries people consume similar amounts of saturated fats, yet a male in the UK is three times more likely to have a heart attack. This 'French Paradox' is a good example of the evidence that cholesterol and heart disease are not significantly linked.

It needs to be known that cholesterol tests are highly inaccurate. When two British reporters went for cholesterol checks at different clinics over two consecutive days, they were presented with some staggering results. The first reporter had four tests, the readings being 4.77, 5.42, 5.01 and 6.44 mmol/l. The second reporter had three tests, 3.8, 4.1 and 6.1.

So if only one test had been conducted, as is usual, and the figure was 3.8, the doctor would have been happy. But if the 6.1 figure had been on the pathology report, cholesterol-lowering drugs would normally have been prescribed.

It also needs to be known that the United States 'magic' safe upper limit of 5.1 mmol/l was set by the Expert Panel for High Blood Cholesterol within the US Department of Health and Human Services. However, most of the doctors on the Panel had links to US pharmaceutical companies. As was stated in the magazine, *USA Today*, 16 October 2004 issue, "When these famous doctors advised the government on new cholesterol guidelines for the public, something they had in common wasn't revealed. Eight of the nine were making money from the very companies whose cholesterol-lowering drugs they were urging upon millions more Americans."

Their report made little mention of the side effects of cholesterol-lowering drugs. And it failed to mention that in France the people have the same average cholesterol levels as in the US, but much less heart disease.

Also, there was no reference to the 10-year Nurses Study which demonstrated a huge 40% drop in heart disease by consuming 450 grams of raw nuts per week.

The latest thinking is that cholesterol still does have a role in artery disease. If damage to the artery wall *has already occurred*, the body repairs it with a special filler called *plaque*, which is a fatty material composed of fat, cholesterol, protein, lecithin, other compounds and later on calcium.

"The conclusion from all this," states Frank Cooper, "is that cholesterol is a very important substance for your mind and body. If you are eating a healthy diet and your natural cholesterol level is, say, 5 or 7 - or 10 like mine - then accept that as your normal level." [Note that many cardiologists would be shocked at this advice.

Clearly there is a need to keep an open mind on this issue.]

WOMEN AND CHOLESTEROL

Dr Uffe Ravnskov was unable to find any notable association between cholesterol and heart disease in women, and was surprised to discover that older women with elevated cholesterol live longer.

In fact, research is now showing that cholesterol is of benefit to women, and that women with very low cholesterol may be worse off. But this has not been highlighted by the pharmaceutical companies in the product information given to doctors or to the public.

No study has ever demonstrated that statin drugs extend life for women, says Dr Beatrice Golomb, Assistant Professor of Medicine at the University of California, who has researched cholesterol and statins.

For pregnant women there is a special risk in taking statins. Researchers at the US National Institute of Health found that statin use during the first trimester of pregnancy is associated with severe central nervous system defects and limb deformities in the foetus. Their findings, published in the *New England Journal of Medicine*, 8 April 2004, were that 20 out of 52 babies exposed to statins in the womb were born with malformations....

The bottom line regarding cholesterol and heart disease is that the issue is both fable and fact. Normally cholesterol at typical levels in the Australian population is not dangerous, so putting the primary focus on cholesterol is fable. But if the cholesterol is oxidised, it becomes the opposite - very dangerous - and this is fact.

Over-riding these situations is the fact that if the body has high levels of those factors which oxidise cholesterol, then the more cholesterol, whether fresh or not, the more dangerous.

Prevention of heart attack requires attending to all the factors involved. Then cholesterol, unless exceptionally high, need not be dangerous.

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FROM: True Natural Health, Autumn

LETTERS TO THE EDITOR

Response to Naomi Groothoff

In the November/December 2021 CISS newsletter on page 6 I had an article about CISS' charitable status having been revoked by the Australian Charities & Not-for profits Commission (ACNC) and how CISS operates. It mentioned that "our counsellor is forbidden by our governing board to give advice. She only provides information about options, including conventional ones, and explains there are pros and cons of each treatment. This is referred to as providing 'informed consent', something rarely provided by conventional "approved" counsellors who rarely mention any options except the conventional ones, and then normally only the advantages...."

Naomi's response was "Having a Diploma in Counselling, I take umbrage at your judgement of counsellors without you providing evidence/references to back up your claim; which counsellors have you spoken to? In which settings? Did they state they were unable to give options to clients? Did they provide examples? Or did you use other research?" These are very good points and raise some very important issues about counselling people with cancer and CISS' role in this.

Essentially what I was saying is that, unlike CISS' Information & Support Counsellor, counsellors do not generally provide what I referred to as 'informed consent' by providing options for people with cancer *because they are not required to do so*. Rather they see their task as helping people with cancer come to terms with their situation. The alternative approach sometimes mentioned by CISS would see cancer as a condition that can be treated using psychologically-based techniques to help remove the cause.

In this sense the CISS Counsellor could be seen as supporting a "therapy", something not permitted by the medical profession. Australian legislation requires that all cancer therapists provide informed consent; so this would become a requirement for cancer counsellors under this paradigm. In contrast with this approach, normal counsellors would generally not see their work as having an impact on the cancer process or condition; rather they are helping people come to terms with and deal with the many problems involved with what many see as a life-threatening condition.

So I believe there are several issues involved here that have been raised by Naomi's letter:

1. Can counsellors be considered to be therapists who can affect cancer survival?
2. If so, would they be required to give informed consent to people with cancer?
3. If so, how would they do this? and
4. Who decides the answers to 1 - 3?

1. Can cancer counsellors be considered to be therapists, i.e. someone who could affect the course of a condition such as cancer? CISS would say Yes, sometimes. Most cancer counsellors would say No.
2. So the CISS Counsellor would be required to provide "informed consent" when using a technique believed to affect the course of cancer, whereas other cancer counsellors would not.
3. How would the CISS Counsellor provide informed consent? What is "Informed Consent" if you are diagnosed with cancer and have agreed to a treatment that has been recommended?

Informed Consent includes ensuring your consent is properly informed - You must be properly informed about your particular medical treatment plan and any potential risks. To obtain your informed consent, your doctor or medical professional is under an obligation to assist your understanding by discussing a combination of the following:

- The diagnosis;
- A recommended course of treatment or a range of treatments;
- The possible risks (in percentage terms) that are associated with the recommended medical treatment or surgery. This includes the nature of your condition, the proposed approach to the treatment, the risks associated with other possible medical options, the likelihood of success, the risks involved with taking no course of action at all, and time frames and costs; and
- Any significant risks to you as an individual, factoring in your relative health, fitness, age and other underlying medical conditions.

It is important to remember that you have a legal right to refuse medical treatment.

So what options would the CISS Counsellor provide? There are several including:

- Normal counselling as described above to help the person deal with the emotional/psychological stresses resulting from a cancer diagnosis;
- Helping the person find a therapist who might be able to help with a par-

ticular problem caused by the chosen treatment; e.g. removal of lymph nodes under the arm can lead to pain and swelling that can sometimes be relieved by lymph drainage;

- Suggesting a naturopath, osteopath, craniosacral therapist, physiotherapist, etc. who might be able to help with a particular physical or emotional problem;
- Describing a range of psychologically-based therapies that have been found useful by others with cancer: Psych-K, Emotional Freedom Technique (EFT), Emotion Code, writing The Letter, Mind Language, Behaviour Therapy, etc. – Some of these, such as the first four, can be provided free of charge by the CISS Counsellor; others might need the Counsellor to provide a contact for the client to follow up; The last, Behaviour Therapy, is the only one claimed to affect the course of cancer and would normally need a referral to a psychologist familiar with this technique.
- Helping the person with cancer put together a cancer control program.

Once the person with cancer has chosen a treatment option (e.g. a woman with breast cancer might have chosen a lumpectomy plus radiation plus lymph node removal), the counsellor supports her in whatever decision she makes and refers any technical questions to our researchers. The CISS Counsellor can then outline the various additional options listed above.

As with conventional cancer treatments, there is very little known about the benefits of the various alternative therapies because very few, apart from Behaviour Therapy, have been evaluated in a properly-run randomised controlled trial comparing the results to those from a matched group receiving no treatment.

So informed consent could include providing this information about the lack of data about relative risks.

4. CISS has provided the research that shows that psychologically-based therapies can affect the course of cancer. So only those who accept this evidence would agree that such therapies could affect the course of cancer. Only these "therapists" would be required to give informed consent. And informed consent would only be required if the counsellor planned to, and was trained to use one of them.

So as Naomi says a good counsellor would not normally provide options unless asked for same, or in a rare

(continued on page 3)

What really happened in Wuhan?

By Sharri Markson

BOOK REVIEW

What Really Happened In Wuhan: A Virus Like No Other, Countless Infections, Millions of Deaths. Harper Collins 2021

Reviewed on Nov 07, 2021 by Grant Patterson.

This review is the short version of a longer article. For the whole article, please see:

<https://grantpattersonbooks.com/2021/> ...

The Truth Hurts: A Review of Sharri Markson's What Really Happened in Wuhan

The Australian investigative journalist's exhaustively researched account is a troubling read, but a necessary one.

We are now entering the third year of the global pandemic. Three years of lost lives (five million and counting; likely many more concealed by dictatorial regimes), three years of lost opportunities, and three years of lost trust, between people and institutions, and people with each other.

The COVID-19 Pandemic is the single greatest disaster of the 21st Century. And Sharri Markson makes a very convincing case that it is not a natural disaster, but the result of criminal negligence by human beings.

From the beginning, it was apparent to all but the most ardent China-lovers that the PRC was playing its usual lie/deny/hide routine. Initial cases were downplayed. People who tried to report on the dire conditions in Wuhan were intimidated, locked up, or simply disappeared. Chinese authorities gave out incorrect information on the virus, crucially denying that it was transmissible by asymptomatic carriers.

Markson details the early days of the outbreak, and a lot of it is stuff we already know. China's reflexive secrecy and stubborn pride denied her own people and us the chance to effectively respond. By the time the West woke up to the threat in the spring of 2020, it was far too late to stop the spread. But we knew that already.

China's duplicity was matched by our own cupidity. The World Health Organization, headed by the Chinese-backed Director General

Tedros Ghebreyesus, tamely accepted the PRCs accounts, and health authorities worldwide tamely accepted the WHO's information.

Where Markson's book gets really interesting is when we start seeing the behind-the-scenes struggle, in China, in the UN, and in the White House, over information and response. Her sources are amazing, going right up to the former Secretary of State, and top Trump advisors.

The overall picture? One of a world completely unprepared for what was coming, and a China unwilling to admit its role in the looming disaster. Too many opportunities to enact travel bans that would have stopped the rapid spread of COVID were frustrated by people like Dr Anthony Fauci, who kept repeating "Travel bans don't work," with no supporting arguments. Now we wear masks everywhere and can't travel anymore. Guess that's a travel ban after all.

But the most interesting part of Markson's book is the last half, which zeroes in on the origin of the virus. This is where the real bombshells are. Almost from the beginning, we were told, authoritatively, yet without supporting research, that the virus had jumped naturally from an animal source into us. Arguing anything else was a "conspiracy theory," and the mainstream press, along with social media, actively suppressed any speculation to the contrary.

Now, where are we? There's a curious silence settling on the whole subject. The truth, it seems, will be too painful. The media, the scientific establishment, and the political class have too much to lose; they argued vociferously against lab-leak, and stigmatized anyone who disagreed, far past the point of any rational debate. And the revelation of an experiment gone wrong jumping out of a lab and killing millions would open the king of all cans of worms. So, we are treated to a great silence

Sharri Markson's book is of tremendous importance in ending this silence. The establishment does not want you to read it. That alone, is reason enough to go right out and buy it. But prepare to get angry.

Comments from the Editor

It is interesting to read the other reviews of this book. They show how polarised readers have become. The book is admired by one group who

shows a great deal of respect for the author's skills as a journalist; the other group shows a closed-mindset based on the fact that Sharri Markson works for The Australian and Fox News – both right wing organisations that they suggest supported the Trump presidency – so she must be wrong.

One even criticised Sharri Markson for omitting the full stop after the title Doctor, e.g. Dr rather than Dr. For someone to be so dogmatic one would think they would first check up on the rules of the English language that state that full stops are used in titles to show they have been abbreviated, except where the last letter of the abbreviation is the same as the last letter of the origin title. So Dr Fauci is the correct spelling, not Dr. Fauci.

Unfortunately, like many "woke" folk, evidence is no longer a requirement in debate. Opinion has been replaced by dogma – a term normally associated with religion.

However these are among a small minority with 75% rating the book with 5 stars and another 15% 4 stars, many describing it as "amazing"

I agree with the criticism that the author has not included an Index. Instead she has included Notes expanding on the individual chapters. For a book with so many excellent references from reliable sources, an Index would have been of great benefit. I did not discern any of the bias observed by many who criticised the book. In fact the author does not draw any conclusions from the evidence presented; rather she leaves it up to the reader.

The three main options analysed were:

1. The virus evolved naturally from bats or other animals, possibly at the wet markets in Wuhan;
2. The virus leaked accidentally from the Institute of Virology laboratory in Wuhan; or
3. It was intentionally leaked from one of the Chinese virology labs as part of a chemical/biological warfare plan.

Another not spelled out is that the virus research was part of a Chinese biological warfare plan funded by the US and the virus leaked out by mistake.

What's Available from the CISS Office?

DVD: CISS 2007 Seminar: Cancer & Hope \$29.50
Enema Kits: \$16.50

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.

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.

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.

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 Krolak.

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/stgscg/>

SUTHERLAND SHIRE CANCER SUPPORT GROUP

Meets every Tuesday morning from 10.30-12.30 at the Parish Centre of the Catholic Church, 50 Kiara 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.

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.

(continued from page 3)

- Address chronic stress, which raises both blood sugar and blood pressure, promotes blood clotting and impairs your repair systems. Cortisol, a key stress hormone, reduces endothelial cell production; and
- Quit smoking.

I believe that the above scenario describing how the various factors contribute to heart disease help us to develop the alternative paradigms related to the cause and treatment of cancer and heart disease. It also suggests how we might provide linkages be-

tween the various factors believed to be causing cancer as it has for heart disease. It also provides an opportunity to explain Grossarth-Maticck's and Eysenck's hypothesis of the two different cancer-prone and heart disease-prone personality types.

For example it might be easier to identify how the two different personality types process the same or similar contributory factors into the two distinctively different diseases or conditions. For example, why is

it the blood vessels that are attacked first in those who get heart disease; and what are the vessels that are attacked first that lead to cancer? and what are the different factors?

References available from the CISS office.

Important Notice

This is a request from the CISS Committee for members to join the Committee to help decide priorities. We are down to 4 and we need another 5. You only need to attend once a month, by Skype or just by phone if you are out of Sydney.