

[The Gonzalez Therapy: Pancreatic Enzymes in Cancer](#) (Full Version)

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Message

GONNIO1 -> *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/17/2004 11:39:55 AM)

Note: The following is an article written by Dr. Gonzalez which appeared in the June -July issue of totalhealth magazine. It is reprinted here with the permission of the publisher, Lyle Hurd.

As I've learned over the years, as Dr. Isaacs and I continue the battle to have our work appropriately studied, tested, and one day, hopefully, accepted into the canon of orthodox medicine, nothing is more frightening than a new idea - except, perhaps, a disturbing old truth, that simply won't behave and go away.

As many readers of Totalhealth know from prior articles about our work, in our office we offer an aggressive nutritional program for treatment of advanced cancer and a variety of other serious illnesses, ranging from chronic fatigue to multiple sclerosis. Whatever the underlying problem, our therapy involves three basic components: individualized diets, individualized supplement protocols and intensive detoxification. The diets we prescribe can range from vegetarian raw foods to an Atkins' type red meat extravaganza. The supplement programs are equally as varied, involving vitamins, minerals and trace elements in various forms and various doses, as well as glandular and enzyme products, each chosen to meet a particular need in each individual patient. The detoxification routines, often the most misunderstood component of our therapy, consist of coffee enemas and a variety of other procedures that we believe help the body neutralize and excrete the multitude of toxic waste products we produce ourselves every second during our routine metabolism, and that we take in from our increasingly poisoned environment.

Though we treat many diseases, we are perhaps best known for our work with advanced cancer. For patients suffering malignancy, we rely on large doses, spread through the day, of orally ingested pancreatic enzymes derived from a pig source. Though the diets, the vitamins, minerals and trace elements help a damaged body repair and rebuild from the ravages of any physiological assault, in our therapy it is the pancreatic enzymes that we believe specifically target and attack cancer cells. The pancreatic enzymes are the true essence of our cancer protocols.

I wish I could claim that I was the first human to have believed that humble pancreatic enzymes, particularly the proteolytic enzymes, have an anti-cancer effect, and represent the body's main defense against cancer. I wish I had realized that these commonly available, not genetically engineered, non-test tube created proteins might be a wonderful way to deal with this most insidious disease. I say this, not out of any need for glory or ego gratification, since my foray into enzyme therapy has led to all manner of attack and for long periods of professional isolation. So it certainly isn't the glory; I wish that I were the first because then I wouldn't feel so glum, when I think that the research community at large missed an opportunity a hundred years ago, that might have led to a true understanding of cancer, its control, perhaps even its defeat. Perhaps, had scientists behaved differently, much human suffering caused by this disease might have been averted.

As I discussed previously in Totalhealth, it was the eminent Scottish scientist Dr. John Beard, Professor at the renowned University of Edinburgh who in an article in Lancet in 1902 first proposed that the pancreatic proteolytic, protein digesting enzyme trypsin might represent a powerful anti-cancer tool, and might be the solution to this frightening illness. Beard did not pull this idea out of the air; rather it was the careful culmination of twenty years of meticulous laboratory investigation, that began with his own studies, of all things, the development of the fish embryo.

Beard was not a physician, nor in his early career, even vaguely interested in medical research, let alone cancer; he was an embryologist, and quite happy as an embryologist, devoted to unraveling the details of fetal growth and development in all manner of species, from shark to man.

After I first presented Dr. Beard to Totalhealth readers some years ago, I embarked upon an intensive study of Beard's work beginning at his beginning, with his Ph.D. thesis, presented to the faculty of science at the University of Freiburg, where he did much of his graduate work. I was able to find a copy from a second hand bookseller recommended by my friend, the scholar and writer Dr. Ralph Moss, that happened to have a full collection of Beard's somewhat esoteric early writings. His Ph.D work, for example, dealt with the development of the nervous system of an obscure fish. As his career evolved, he focused his attention on the nervous system of the mammalian embryo, as it grew and matured. Many of his pioneering findings from this period in his life have proven correct, and are standard fare in the embryology texts of our day.

It was his fascination with nerves, how they form and grow in the embryo, that through a most convoluted route led him to consider the development of the placenta, the tissue that anchors the mammalian fetus to the uterus and serves as the point of connection between the blood supply of the fetus and the blood vessels of the mother. Beard was the first to report that in many respects the placenta in its early stages behaves much like a tumor. It begins growing as a very undifferentiated offshoot from the earliest stage of the embryo. Very quickly, as Beard observed, the early placental cells invade the mother's uterus, much as a tumor infiltrates host tissue in any organ, the placenta grows initially almost without control, as tumors were known to do even in Beard's day, and it quite efficiently produced a dense blood supply – a requirement for any rapidly growing tumor, as angiogenesis research today has made very clear indeed.

But then of course, as normal development proceeds, there is a not very subtle change in direction, from a highly invasive, rapidly growing, blood vessel producing tumor-like tissue, to the mature non-invasive, non-proliferating life-sustaining placenta. The only difference between the placenta and a malignant tumor, thought Beard, was that the placenta knew just when to stop growing, and tumors don't.

Beard learned through years of late night hours in his laboratory that the key to the change lay in the embryonic pancreas. As witnessed in every species he studied, the very day the placenta stopped its relentless, cancer-like invasion of the mother, was the very day the embryonic pancreas became active and began pouring out enzymes.

Even in Beard's day, more than 100 years ago, the main categories of pancreatic enzymes had already been identified; the proteolytic, or protein digesting component, the lipases, that digest fat, and the amylases, responsible for cleaving complex carbohydrates into simple, easily usable sugars. The activity of all three groups was thought by physiologists of the time to be limited to the duodenum, the first part of the small intestine, where the enzymes continued the breakdown of food arriving from the stomach, where digestion begins. The enzymes were known to be important, in their way, necessary for digestion of course, but quite dull, with no other significant presumed purpose.

But Beard effectively provided the data to support his contention that above and beyond this function, trypsin, the main proteolytic enzyme, served to control placental growth and prevent the tissue from invading beyond the uterus as a true cancer might, destroying everything in its path.

Beard then made a leap of faith which might have changed the course of cancer medicine had he been taken more seriously. Logically, he assumed that since the early placenta behaves much as a tumor does, since under the microscope, its cells even look like undifferentiated, primitive neoplastic cells, and since pancreatic enzymes forcefully regulate its growth and development, these very same enzymes could be, in fact, must be the body's main defense against cancer, and would be useful as a cancer treatment.

Beard, careful scientist that he was, first tested his thesis in the one animal tumor model available at the time, the Jensen's mouse sarcoma. He injected an extract of trypsin into mice growing such cancers, and the tumors regressed – an extraordinary achievement. Subsequently, during the first decade of the twentieth century, a number of physicians interested in Beard's hypothesis began, under his direction, to use injectable pancreatic enzymes to treat their human cancer patients. The successes were published in the major medical journals of the day, including *Lancet* and *The British Medical Journal*. I have read as many of these documents as I have been able to track down, and they remain to me extraordinary reports of patients surviving advanced cancer – such as one with a fungating laryngeal cancer, well beyond any chance of surgical cure, whose tumor under enzyme therapy regressed, then fell off. The patient thereafter lived a normal, cancer-free life. Other articles described patients with metastatic colo-rectal and breast cancer, as deadly today as in Beard's time, evidently disease free after the enzyme treatment – all carefully documented, and appropriately presented in the scientific literature.

One would think that such reports would have quickly mobilized the power of the medical research community behind Beard, to help him advance his promising theory, but instead, the enzyme thesis, and the supporting animal and laboratory data, provoked an enormous and angry backlash against Beard and his few loyal followers. The Scotsman was vilified in editorials in medical journals, mocked in the newspapers, belittled at scientific conventions. But Beard stuck to his course, fought back in articles and letters to the editor, and never once wavered; in 1911, he published *The Enzyme Treatment of Cancer*, a monograph which outlined his decades of research, his impeccably thought out hypothesis, his promising and compelling results. However, despite such valiant efforts, interest in Beard's thesis gradually petered out, and when he died in 1924, he died frustrated, angry and ignored, his therapy already considered no more than an historical oddity.

I have often pondered the vitriolic – and irrational – response of so many eminent researchers and scientists to Beard's well-documented approach, reactions that nearly buried the treatment for good. He was trained impeccably as a scientist and behaved throughout his professional life as a true researcher, carefully documenting his laboratory and clinical results in the mainstream medical literature. But it made no difference, at all.

The rejection of enzyme therapy 100 years ago had really nothing to do with science, but everything to do with politics, psychology, and popularity. Beard was a very nerdy ivory tower scientist, who had little patience for his critics whom he saw as unacceptably ignorant. He didn't court the press, didn't care about fame, didn't seem at all interested in international acclaim. His refusal to play the political game, his refusal to court his colleagues and the media of the day I believe worked against him. I also think that his approach was just too simple, perhaps not mysterious enough to enchant his fellow researchers. And importantly, at the same time Beard intently pursued his own determined course, other scientists such as Madame Curie, more lauded, more media friendly, more adored, extolled the benefits of the newly discovered X-ray as a perfectly safe, effective, non-toxic treatment for all cancer. The press of the time, the scientific and medical community at large latched onto radiation as the final solution to this frightening and deadly plague. Of course, the enthusiasm for the mysterious invisible emanation was misplaced, but it wasn't until Beard was long gone that the medical community realized that few cancers responded to radiation, that it wasn't perfectly safe as originally thought but instead terribly toxic, in fact carcinogenic in and of itself. Madame Curie herself would die from cancer brought on by her exposure to radiation, as would many other X-ray enthusiasts.

After Beard's death, periodically other physicians and scientists rediscovered his work and kept the idea alive. During the 1920's and 1930's, a St. Louis physician, Dr. F.L. Morse, reported that he had successfully treated a number of advanced cancer patients with pancreatic enzymes. When he presented his well-documented findings to the St. Louis Medical Society in 1934 – a proceeding published in the Weekly Bulletin of the St. Louis Medical Society (Vol. 58: 1934) – his colleagues attacked him viciously and relentlessly. One physician at the session, a Dr. M.G. Seelig, remarked:

“While I heartily agree with Dr. Allen when he strikes the note of encouragement, I recoil at the idea of witlessly spreading the hope of a cancer cure which is implicit in the remarks of Dr. Morse this evening...”

During the 1960's, the eccentric dentist, Dr. William Kelley again rediscovered Beard's forgotten work, and developed his own variation of enzyme treatment. In addition to large doses of orally ingested pancreatic enzymes, Kelley's program included individualized diets and supplement protocols, and detoxification routines. Dr. Kelley came to fame at a time of great repression organized against alternative medicine in general, and particularly against anyone foolish enough to suggest a nutritional treatment might have benefit against deadly cancer. Kelley was at particular risk because as a dentist, he was not legally entitled to treat cancer in the first place. He was repeatedly attacked in the press, vilified as a “quack,” investigated by numerous government agencies. He was thrown in jail as a public menace, had his dental license revoked for five years for practicing medicine, spent his earnings defending himself against government assaults, and saw his family life fall apart. But he, like Beard, never relented, and continued seeing patients. He survived because his successes created an extraordinary word of mouth network, that brought an endless stream of patients to his Grapevine, Texas – and later his Winthrop, Washington offices.

I met Dr. Kelley by chance during the summer following my second year of medical school. At that time, he seemed completely modest and unassuming, seeking only to have his work properly evaluated so that if the approach had merit, it might become more widely accessible to patients in need. I was fortunate to have as a mentor at Cornell Medical College the late Robert A Good, M.D., Ph.D., who encouraged a review of Kelley's cases. Dr. Good, then President of the Sloan-Kettering Research Institute, was the most published author in the history of the biomedical scientists, the “Father of Immunology,” as the New York Times described him, the man who performed the first bone marrow transplant in history.

Under Dr. Good's direction, I began a student project evaluating Dr. Kelley's patients, his methods, his successes and failures. Dr. Good, wise teacher that he always was, told me that even if Kelley proved to be a fraud, I would learn much medicine from a project of my own choosing, developed out of my own enthusiasm.

Despite what was said then and is said today, despite the eccentricities in his behavior then and now, I quickly realized Kelley was not a fraud. During a rather extraordinary summer spent reading through Kelley's records in his main Dallas office, I quickly found evidence of what appeared to be patient after patient with appropriately diagnosed, biopsy proven advanced and even terminal cancer, who were alive five, even ten years since first beginning the enzyme therapy. What began as a mere student investigation evolved into a full-fledged research project, completed while I was a fellow in Dr. Good's group, which, after he was pushed out of Sloan, ended up in Florida.

I eventually interviewed and evaluated over 1000 of Kelley's patients, and concentrated on a group of some 455. From this population, I wrote up in detail 50 cases, representing 26 different types of cancer. Even today, twenty years later, when I review my earnest efforts, I am still impressed by Kelley's achievement. For example, one of these patients, a woman who ran a gas station with her husband in Wisconsin, was diagnosed with metastatic adenocarcinoma of the pancreas, the worst form, with metastases into the liver. The Mayo clinic confirmed the pathology, offered no treatment and told her she might live two months. When last heard from in the mid 1990's, when she referred a patient to my office, she was still alive and well, more than 15 years from diagnosis. Another patient, with metastatic uterine cancer that had recurred and metastasized within the pelvis and to the lungs in 1975 enjoyed a documented reversal of all her tumors under Dr. Kelley's

care. When last heard from in the early 1990's, nearly twenty years after her cancer explosion, she was in her mid eighties and perfectly well.

By 1986, I had put the results of my five-year investigation into monograph form, and was excited by the prospect of publishing such unusual case reports and presenting the documentation for this nutritional, non-toxic treatment. To my disappointment and surprise, despite my careful labors and serious intent, I could not get the book published, either in its entirety as a monograph, or as a summary journal article. The responses from editors ran the gamut from disbelief and accusations of fraud, to fear, that the book would generate so much controversy that publishing careers might be ruined. No editor, even those that accepted the data as real, had the courage to take on the project.

This disappointment, our inability to get the study published, had a very damaging effect on Dr. Kelley. It appeared to him once again that all doors had closed, that his work would never be accepted for what he believed it was, a promising answer to a deadly disease. In 1986, he closed down his office, and eventually disappeared from sight. I have not spoken with him since 1987. I myself, determined to keep the enzyme therapy alive, left Dr. Good's group when I finished my fellowship, and returned to New York in 1987. I then began seeing patients myself, always with the hope of obtaining proper research support from the academic world.

In retrospect, seventeen years later, I am somewhat amazed at how determined I was, and how sure that if I just kept trying, I would be able to win the battle, get the research support needed, prove the benefit of the treatment. I made serious professional choices; after coming back to New York, I was offered a position at Sloan-Kettering by one of my former professors who had remained in contact with me, and who seemed to think I had some promise as an academic scientist. But he wanted me to pursue more acceptable, more mainstream research projects, and give up such flagrantly controversial work. I was touched by his interest and concern, but turned the offer down; I simply could not walk away from the enzyme treatment. I just couldn't.

The work was initially very difficult since the patients who came to us invariably had very advanced disease. But with my colleague Dr. Linda Isaacs, we began having successes, there were victories that kept us going, patients who seemed to beat their cancer, many of whom are alive today. One of the first patients who consulted me after I opened up my practice, back in December of 1987, had been diagnosed with metastatic inflammatory breast cancer with multiple metastases to bone, that had developed while she was receiving aggressive chemotherapy. She is alive now more than sixteen years since her original diagnosis, and the most recent scans show total absence of her previous extensive disease. Then there is my patient Mort, with metastatic adenocarcinoma of the pancreas diagnosed in September of 1991 with multiple lesions in the liver, evidence of cancer in the adrenals, bone and lung, who now is alive more than twelve years with no sign of disease. He is 82 years old, and doing well, except that his wife complains he is absent-minded.

In July of 1993, the National Cancer Institute invited me down to present case reports from my own practice, detailing patients with appropriately diagnosed poor prognosis cancer who had enjoyed tumor regression or unusual survival while following my therapy. Dr. Isaacs and I put together 25 cases for the session, including the breast cancer patient and Mort, described above. The session, attended by a large group of NCI scientists, lasted three hours, and afterwards I was asked to pursue as a next step a pilot study, evaluating my approach in ten patients diagnosed with advanced adenocarcinoma of the pancreas. In such phase II studies, as they are technically called, a promising new therapy is administered to patients with an aggressive cancer for which there is no effective standard treatment. A pilot study involves no control group, but can still give important information about a treatment. Since inoperable pancreatic cancer has such a grim prognosis, with an average survival in the range of 5 months, the Associate Director who chaired the meeting suggested that if I could get three patients to live a year, that would be a significant success. From my experience with enzymes, I expected to do better.

We were fortunate to get funding for the study from Nestle, the giant international food conglomerate. The then Vice President of the company in charge of research, Dr. Pierre Guesry,

who had formerly been Medical Director of the Pasteur Institute in Paris, had learned of my work and become a supporter.

We finished the study and published the results in June 1999, in the peer-reviewed research journal *Nutrition and Cancer*. We had eventually included eleven subjects, adding a patient when one dropped out. Of the eleven, all had biopsy proven, inoperable disease, eight of the eleven had stage IV, most had been very sick prior to consulting with us. All the patients were approved by a consulting oncologist and a cancer epidemiologist. Of the eleven, nine lived more than one year, five lived more than two years, four lived more than three years, and two made it beyond four years. As a point of reference, in the clinical trial of Gemzar, the latest drug approved for the disease, of 126 patients treated with chemotherapy not one lived longer than 19 months. Ours were results that had not previously been reported for the disease.

As many of you know, that study would again generate considerable controversy. Scientists who had never spoken to me once about the project, who knew nothing of its origins, questioned the methodology, though it had been developed in consultation with the NCI and eminent researchers from other institutions. The results were questioned, one scientist from Harvard claiming – though again he had never once spoken to me – that the patients didn't have pancreatic cancer, even though they had all been extensively worked up before seeing me and approved for entry into the trial by consulting specialists.

But at least some seemed to take the results seriously, and shortly after publication of the article, the NCI approved funding for a large scale, phase III clinical trial, again testing our enzyme approach in patients with advanced pancreatic cancer, but this time against a control group that would receive the best available chemotherapy. Eventually, the protocol was approved by the FDA, and the National Center for Complementary and Alternative Medicine offered to put up the required funding, initially in the range of 1.4 million dollars. Columbia University, under the Chief of Oncology at the time, and the Chief of Surgical Oncology, became the supervising institution in New York, where the study would be run.

That clinical trial continues, slowly but steadily. I cannot comment on the data, since the study hasn't yet been completed, but I can say that it has been a wonderful experience finally, after so many years, to have this work tested and evaluated in an appropriate academic setting. It hasn't been easy, since this is the first time so many institutions have come together to evaluate a complex alternative treatment as a primary intervention, and not as a complementary adjunct given along with standard chemotherapy and radiation. But everyone involved at the NCI, NCCAM, FDA and Columbia seem determined to complete the study.

And as this project has moved along, my friend Dr. Guesry at Nestle provided funding for studies to test the enzyme treatment in animal models, to provide supportive data as the human trials continue. He interested a group at the Eppley Cancer Institute of the University of Nebraska known for their investigations into the molecular biology of pancreatic cancer, to take on the challenge. Dr. Parviz Pour, the supervisor of the animal work at Nebraska, has himself developed mouse models of pancreatic cancer that are used to test promising new treatments against the disease.

Just this May, 2004, the results of the experiments were published in the peer reviewed journal *Pancreas*. I (Dr. Gonzalez) am listed as a co-author. In these studies, the researchers evaluated the effect of our enzymes in nude mice injected with human pancreatic cancer cells of a particularly virulent strain. These mice lack a functional immune system, so normally the tumors grow very rapidly and kill quickly. In the first study, which measured survival, the mice were divided into two groups, one receiving our enzymes, the other given no therapy. The animals treated with our enzymes survived significantly longer than the untreated control group, and, additionally, the enzyme mice appeared to be healthy, happy mice, even well into the study, in sharp contrast to the controls, who were listless, inactive, bloated, and obviously quite ill. In fact, two of the mice in the treated group were doing so well they had to be sacrificed so the study could be brought to conclusion. I wonder how long they would have kept going.

In a second experiment, again the mice were divided into two groups, one administered our enzymes, the other an untreated control. This time, animals were periodically sacrificed and evaluated for tumor growth. The enzymes clearly reduced the proliferation of the tumors, which in the treated mice remained small and very localized. In the controls, tumors were considerably larger, more invasive. Though in this study, the rate of tumor growth was the primary endpoint, the treated animals again lived considerably longer.

I want to emphasize that to me, the results are particularly significant because we have never used the enzymes to treat animals before, and decided to start at the dose per kilogram that we would normally use in humans. Inbred laboratory mice, however, metabolize most drugs far differently than we humans, and normally doses much higher than what would be given humans must be administered to get an effect. And, the experiments only evaluated the enzyme component of the treatment, not the additional vitamins, minerals, trace elements, and nutritious food we prescribe for our human patients. The animal chow also contained a fair amount of soy, and soy isoflavones, however aggressively they may be pushed as health nutrients, are among the most potent natural trypsin inhibitors known.

So we believe the results are important. As the authors wrote in the "Discussion" section, "In summary, PPE (Porcine Pancreatic Extracts) is the first experimentally and clinically proven agent for the effective treatment of PC (Pancreatic Cancer). The significant advantages of PPE over any other currently available therapeutic modalities include its effects of physical condition, nutrition, and lack of toxicity." Note that these results validate only the specific enzymes we use in our therapy, and no other commercially available formulation.

I am starting to believe that finally, after one hundred years, Dr. Beard and his enzyme treatment will get some well deserved recognition, and finally, cancer research might at least to some extent be channeled toward a more hopeful, less toxic, more successful direction.

KY11043 -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/17/2004 8:58:32 PM)

Great read! Great doctor!

Does the fermentation of soy diminish its trypsin inhibition?

Guest -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/18/2004 5:42:54 AM)

Wow...I heard Dr. Gonzalez speak several years ago as he was finishing up the pilot project. I've referred patients to him since.

I am also wondering now about isoflavones. Does anyone know if red clover and kudzu also have trypsin inhibitors? Is it the isoflavones in soy alone, or other isoflavones? I would think this could have major implications on those people eating large amounts of soy, and also people taking isoflavone supplements.

Maybe we could have a soy discussion next...? My own conclusions/recommendations from reading the controversial literature is that my patients should eat soy no more than once per day, in general. Less if they have hypothyroidism or hormone related cancer. And no soy supplements. However, I have been using estrofactors, quite liberally, which has red clover and kudzu.

Any thoughts?

Susan

GONNIO1 -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/18/2004 1:00:11 PM)

Dear Kris:

Soy fermentation inactivates the trypsin inhibitors somewhat, but the molecules seem to be very tough and a good percentage survives the processing, the exact percentage varying from lot to lot. For that reason, we never recommend soy in any form to anybody.

Regards

Nick Gonzalez

GONNIO1 -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/18/2004 1:18:51 PM)

Dear Dr. Blum:

All legumes contain protease inhibitors to some extent, the amount varying from species to species. Soy appears to have by far the greatest concentration of trypsin inhibitors specifically, and the most powerful collection of enzyme blockers of any food. I have read no evidence that the isoflavones in red clover have any effect on proteolytic enzymes in general or trypsin in particular. Remember, that the isoflavones include a diverse number of molecules. The ones in soy seem to be the most problematic. In our therapy we do allow beans other than soy, but no soy, ever in any form for any reason.

Increasingly, researchers are concerned that the phytoestrogenic effect of the isoflavones, though for years proposed as "anti-cancer" may actually instead stimulate proliferation in hormone responsive tumors. Laboratory modeling and clinical results are beginning to support such a negative effect.

For us, soy is a serious problem because it so nicely and efficiently inactivates proteolytic pancreatic enzymes in general, and trypsin specifically, which we believe as a group represent the body's main defense against cancer, and which we use as the main anti-cancer element of our treatment.

I think the rush to embrace soy as an all purpose "health miracle" certainly needs to be completely re-examined. If our research continues to indicate that the proteolytic pancreatic enzymes do indeed represent the body's main defense against cancer, rather than the immune system, the regular use of soy could pose a potential public health problem.

I believe that the reduced levels of breast and prostate cancer reported in Japan occur not because of, but in spite of the use of soy. The Japanese diet is particularly high in selenium and iodine, both of which have an anti cancer effect that has been nicely documented. I suspect the higher trace minerals levels in the diet override the negative effect of soy. Even epidemiologists forget the correlation does not prove cause.

Regards

Nick Gonzalez

Guest -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/18/2004 5:53:11 PM)

Dr. Gonzalez,

I didn't realize you had started this thread yourself. Thank you for participating in the forum and for personally answering my questions. I've been very interested in your work since I saw you speak at the Center for Mind-Body Medicine Cancer Conference 4 or 5 years ago.

Can you describe some of the criteria you use to decide if someone is a good candidate for your protocol? For example, type of cancer or current/past treatment with chemo?

Thanks,
Susan

THOGE01 -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/19/2004 5:30:18 AM)

I THINK THE WORK BY THE WESTON PRICE FOUNDATION HAS ALSO DRAWN A GREAT DEAL OF ATTENTION TO THE HAZARDS OF SOY. JUST WONDERING IF THE PORCINE PANCREATIC ENZYMES ARE READILY AVAILABLE ? I USE SOME FOR INFLAMMATION ALL THE BST GEORDIE THOMSON, M.D.

GONNI01 -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/19/2004 2:27:10 PM)

Thanks for your kind words and your interest. A lot of things go into our assessment of prospective patients, and each case is evaluated individually. Certainly the type of cancer and the extent of previous treatment are factors. If the patient is so advanced they cannot eat, or are too weak to get out of bed, they will not be able to follow the program effectively. For some types of cancer, such as adenocarcinoma of the pancreas, we have generally not had good results with patients who have received aggressive orthodox therapy, because there is such a small window of opportunity to generate a response. However, we have many patients with breast cancer who have had prior chemotherapy and have done well, so we evaluate the issue of prior treatment on a case by case, cancer type by cancer type basis. We have found, regardless of the type of cancer, that if the liver is significantly compromised, no therapy, including ours, is going to work.

For patients with localized breast or early stage uterine cancer, we would recommend surgery since such treatment clearly has a proven track record of success. For the few cancers that do respond to chemotherapy, such as newly diagnosed Hodgkin's disease, we would recommend the patient pursue standard therapy.

We also assess the motivation and support level of the patient. The program we recommend is very rigorous and requires excellent compliance, and a willingness to take responsibility for the treatment. We find patients who are filled with doubts and need to be convinced never stick with the program, and only end up resenting us and the treatment. We want patients we will enjoy working with, of course - angry, hostile, suspicious patients need to go somewhere else.

For more details, see our website at www.dr-gonzalez.com.

My colleague, Dr. Isaacs, has written an article that was designed to help patients make decisions about pursuing alternative cancer treatments. It is available at:

http://www.townsendletter.com/June_2002/pursuealtcancer0602.htm

I hope that helps.

Nick Gonzalez

GONNIO1 -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/19/2004 2:31:46 PM)

The enzymes are great for any type of inflammatory condition. In Europe, proteolytic enzymes are routinely used to treat arthritis, athletic injuries, autoimmune diseases, post surgical edema, as well as cancer.

The specific enzymes we use were designed by us, are made for us, and at this time are available only to our patients. We run our office as a research effort, and feel it would be premature to commercialize the product until the clinical trials and laboratory research are completed. There are many brands currently available both over the counter and as prescription items, but I cannot vouch for their anti cancer effect.

Regards

Nick Gonzalez

AVDCND -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/21/2004 10:14:23 PM)

Dr Gonzalez

I feel privileged to have access to you in this Forum, as I employ much of your work in my own treatment approach for cancer, and I'd like to collaborate with or add to your work during my possible MD/PhD experience, for which I am interviewing next month.

In your article in Nutrition and Cancer, as I recall you mention the use of nutritional supplements, and I am wondering specifically if you use "high" doses or low doses, and specifically if you use alpha tocopherol.

Questions about Enemas:

Also, how much coffee and how many liters/enemas? (We are using 2 strong cups per 2-liter bag)

Decaf or caffeinated?

Morning or evening or does it matter?

What type of testing (if any) do you do in the preevaluation for enemas? Electrolytes? Adrenal function to decrease the risk of hyponatremia?

Thank you for your research and answers to my questions,
Alex Vasquez, D.C., N.D.

KY11043 -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/23/2004 1:42:31 PM)

Nick,

When you say that you advise NO soy for your patients, does that mean NO whole soy, or NOTHING that comes from a soy bean?

A patient of mine who designs nutritional products tells me that the soy protein isolate that he uses is tested to be trypsin-inhibitor negative. Would you advise against your patients using such protein? If so, why?

If trypsin inhibition is dangerous in individuals with cancer, when and how is it functional to evaluate trypsin activity in asymptomatic individuals?

SM11026 -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/24/2004 12:30:22 PM)

Thank-you Dr. Gonzalez for sharing your wisdom with us and for taking the time to outline such an interesting and courageous story. I was first made aware of your work through a patient/friend of mine whom you treated highly successfully for Chronic Fatigue (without mentioning names, you'll likely know her as the woman that flew around the world-she's recently taken her Aunt with ovarian cancer to see you too).

I'm wondering if you might comment on how the enzyme therapy works in fatigue and if there are specific fatigue populations which are better prospects. Do you always recommend coffee enemas? and what do you suggest for probiotic support-po? or po + enema flush? etc?

Your points about soy are extremely compelling-thank -you- and I now come down on the side of avoidance for my patients.

Would you be able to offer any generalizations on quantities of enzyme/activity to use and perhaps your take on the best ratio of proteolytic to carb/fat digesting enzymes? It would be interesting to know your thoughts on the role of gastric acidity in the "non-digestive" use of digestive enzymes.

Apologies for the # of questions-the whole topic is very exciting. A brief answer to any would be greatly appreciated.

thanking you for your interest in our on-line FM community,
Suzanne Mack, M.D.
Denton (just north of Dallas!), Texas

GONNIO1 -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/25/2004 10:02:44 AM)

Dear Dr. Mack -

Thank you for your kind words and thoughtful questions. Indeed our mutual patient is doing extremely well, and I have enjoyed reading of her adventures around the world over the years.

Regarding your specific questions:

1. Pancreatic enzymes are not the main therapeutic tool we use in chronic fatigue. There is no one specific approach, as each patient with chronic fatigue has a different history, often a different underlying cause, and requires always a very individualized treatment program. Though I did not get into the details at all in the article posted, in our work we evaluate each patient in terms of

autonomic balance and dominance; most commonly, though not always, patients with CFS are far too parasympathetic dominant with a correspondingly weak sympathetic system. Such patients need lots of fatty red meat, minimal fruits, usually lots of calcium but minimal magnesium - a program that we find stimulates the weak SNS into action while suppressing the overly active PNS. When the two autonomic branches are in balance, the problem usually resolves.

We do have "sympathetic dominants" who have chronic fatigue, but in their case usually the problem is adrenal exhaustion, which can contribute, despite the strong SNS, to low blood pressure and chronic low blood sugar. They need a more vegetarian diet, lots of magnesium, and usually powerful adrenal glandular support.

Balanced autonomic folks in our experience never get chronic fatigue.

2. We always recommend coffee enemas, daily, for all patients whatever the underlying problem. We all live in a toxic environment that gets only worse each year, our bodies are loaded with environmental toxins wherever we live and regardless of how we live. Stress, histories of poor diet choices, etc. all increase the production of endogenous metabolic wastes, and the combined onslaught of toxic crud usually is more than anyone's liver and kidneys can handle. Coffee enemas in our experience are the simplest most direct and most effective way of enhancing the detoxification function of the liver. All patients need to do them, nearly all feel better when they do them. I have done them myself for 23 years and intend to do an enema daily forever.

With coffee enemas, you're only going up a foot into the lower colon, such enemas do not deplete the normal flora fifteen feet higher. We have all our patients on probiotics anyway, but the enemas do not deplete the healthy bacteria; enemas facilitate the removal of colonic wastes, and help the liver work better through a neurologic reflex, but they do not drain the normal flora. You're not going high enough into the colon for that.

3. I believe soy is a disaster for everyone, and will someday be looked up with the same way we now look at refined grain products, which when introduced last century in a major way were seen as a great boon to good nutrition.

4. We have spent years working out the precise levels of enzyme activity in the product which we use. These enzymes were designed by us, made for us, and our specified by us down to the last molecule. The best proportions of enzymes are those found in the natural healthy pancreas.

Myths about orally ingested pancreatic enzymes; they are destroyed by stomach acid, are broken down into component amino acids and are not absorbed into the blood stream. In a study from the 1980's a group in Russia took pure trypsin, boiled it in hydrochloric acid, and there was to everyone's amazement no loss in activity. Secondly, professors Rothman and Liebow have spent the last 25 years carefully proving that there is a recirculation of pancreatic proteolytic enzymes in the intestinal track, that the enzymes are not broken down, but are absorbed through the small intestinal mucosa both by active and passive transport, then reused. In our recent animal studies, as a side study, we evaluated the absorption of the oral enzymes and found indeed they are absorbed, and certainly based on the significant anti-cancer results, clearly had an effect.

Dosing of enzymes needs to be very precise, and I hesitate to offer generalities in this type forum since the doses can vary from a few capsules a day to over a hundred depending on the specific problem. Unfortunately, which tends to aggravate a lot of people, I do not find most commercially available preparations all that useful. They tend to be overprocessed and many cofactors are lost.

I hope that helps.

Regards

Nick Gonzalez

GONNIO1 -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/25/2004 10:10:10 AM)

Dear KY -

When I say no soy I mean no soy, ever, for any reason under any circumstance. The one exception is soy lecithin which has never been a problem. But we have run into problems even with so-called "purified" products.

Oddly enough, the one sentence on soy in my article has generated the most questions. I know it is a controversial area.

Regards

Nick Gonzalez

AVDCND -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/25/2004 8:05:00 PM)

Dr Gonzalez

In your article in Nutrition and Cancer, as I recall you mention the use of nutritional supplements, and I am wondering specifically if you use "high" doses or low doses, and specifically if you use alpha tocopherol.

Question about Enemas: how much coffee and how many liters/enemas? (We are using 2 strong cups per 2-liter bag)

Alex Vasquez, D.C., N.D.

GONNIO1 -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/26/2004 9:19:42 AM)

Dear Dr. Vasquez:

Sorry for the delay in getting back to you. I somehow overlooked your first e-mail.

Thank you for your kind and supportive comments about our work. It's always encouraging to have the support of our colleagues. And good luck with your interview next month regarding your MD-PhD program. Hope it goes well for you.

In terms of your specific questions; as you probably already suspect, in general in our therapy the doses of the various vitamins, minerals, trace elements, anti oxidants vary quite significantly from patient to patient, the amounts dependent on the individual metabolic needs and the type of cancer. We find specifically in dealing with pancreatic cancer that patients with the disease usually do best with moderate levels of the B vitamins, in the range for example of 75-100 mgs total daily dose of thiamin, riboflavin, pyridoxine, somewhat lower daily doses of niacin, 800 mcgs of folate.

We use moderate doses of pantothenic acid and minimal doses of choline, inositol and B12 - such patients do not do well with large doses of these three nutrients. Panc patients require huge doses of magnesium, 1000 mgs a day or more, rarely get loose stool from such doses, and usually need minimal calcium - no more than 200 mgs a day. Panc patients tend to hold on to calcium like a magnet holds a nail, they just don't need much and large doses acts as a molecular metabolic poison to them.

These folks usually thrive on chromium, manganese, molybdenum, don't need so much selenium despite its popularity as an anti cancer nutrient.

Panc patients do require fairly large doses of vit C, usually in the 7-10 gram range, spread through the day. I rarely go higher than that. They do ok with the standard doses of vitamin E, 3-400 units daily. We tend to favor the succinate because in practice we find it has the strongest anti cancer effect. We are aware of all the literature on mixed tocopherols, gamma, delta, etc., and the tocotrienols, but nonetheless we emphasize because of the literature and our experience the alpha succinate for a specific therapeutic function.

Coffee enemas; the number of enemas required on a daily basis varies considerably from patient to patient. The starting strength is always two level tablespoons of organic high caffeine coffee per quart of water. The coffee must have the caffeine because it appears it is the caffeine that sets off the parasympathetic reflex that leads to improved liver detoxification function and excretion of toxins. Decaf just doesn't work effectively.

Each individual enema is always a pint, never more, most patients have trouble holding larger doses. Each pint is held for ten minutes, never longer than 15 minutes. After 15 minutes, the toxins released from the liver will start being reabsorbed through the intestinal mucosa, neutralizing the effect.

Patients start with two pints each morning, back to back, each held for ten minutes, and two pints each afternoon, again back to back, each held for ten minutes, for a total of four individual pint enemas daily.

Mid-afternoon is best for the second session, as between 2-5 PM there is a natural parasympathetic discharge (that's why people get tired at that time) and the liver is most amenable to working hard and dumping its stored wastes with a little nudging. Though little caffeine is actually absorbed systemically, we do find if a patient is highly sensitive to caffeine, enemas in the evening can at times interfere with sleep, though I also have many patients who report the enemas help them sleep, and in fact I routinely fall asleep while doing enemas myself. Interestingly, coffee when taken by mouth stimulates the sympathetic nervous system (well documented in the literature), a response that explains the alertness, and etc following ingestion of coffee. Coffee taken rectally as an enema activates the parasympathetic system, an action that explains the enhanced detoxification and relaxation that accompanies rectal use. The Gerson people get deep into the biochemistry of various coffee components, and their effect on the liver but in our experience the explanations are much simpler, more neurologic, and involve activation of parasympathetic reflexes (see Pottenger for such reflex details).

We do no testing routinely specifically for the enemas. I myself when I was in research did 12 pints of enemas a day for two weeks and found no change in electrolytes. With the enemas, the tube is inserted only 12 inches, in the lowest part of the colon, by that point, there aren't any electrolytes left to absorb. I have never seen a patient develop electrolyte disturbances in the seventeen years I have been treating patients myself, and among the thousands of patients I studied when reviewing Kelley's charts. I have read the several articles published over the past twenty four years hysterically warning about the terrible dangers inherent in coffee enemas; I have followed up these articles and the reported cases, found them to be less than half a dozen, the reports misleading and exaggerated, and some of the science not defensible. For example, one patient with widely metastatic breast cancer with mets into the liver and brain, having failed aggressive chemotherapy and radiation, went to a Mexican clinic, went home, did enemas, and died. The authors blamed the enemas for her death, not the aggressive deadly widely metastatic cancer, and the aggressive

previous therapy that had failed..

As far as I am concerned, there is no risk from the enemas if they are done properly. You must use the right equipment, know what you're doing, and there shouldn't be a problem. Occasionally a patient with a history of severe irritable bowel has problems with cramping (a too strong parasympathetic response) in which case we use less volume, and make the enemas weaker. In some patients with pelvic floor dysfunction, we find rare cramping as well. And of course if tumor has invaded the rectum and pelvis, there can be cramping - but never electrolyte disturbances.

Occasionally a patient does feel weak after an enema, but this is very rare. There is a belief in the nutritional underground that coffee enemas "weaken the adrenals." Nearly all our patients when they start with me are very sick people and all have weak adrenals and most feel terrific after the enemas (because of detox not because of a caffeine rush). Usually if a patient feels particularly sluggish after a coffee, I look at the ileocecal valve, which as you know in very debilitated patients can stay open at the most inopportune times. For such patients, we recommend an ice pack over the valve for ten minutes before each session of enemas. Perhaps once or twice in the past ten years have I used adrenal glandular supplements with a patient before their enemas. Usually not necessary. If you make the coffee too strong, the valve will tend to open, even in healthy people. Stronger is not best. That I believe explains the reports of "weakness" after the enemas - it's the ileocecal valve, not the adrenals.

I think that does it. Thanks for your questions.

Regards

Nick Gonzalez

KY11043 -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/26/2004 7:00:37 PM)

Nick,

I am not alone on this forum in my continued appreciation of your time and invaluable experience.

It is a great feeling, being educated.

GONNIO1 -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/27/2004 10:54:45 AM)

Kris -

Thanks again, I appreciate your comments. It's been fun so far, and clearly the Functional Medicine folks are a dedicated group of health professionals.

Regards

Nick

KY11043 -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/27/2004 1:00:15 PM)

So Nick,

What can you tell us regarding the most appropriate patients that we might consider referring for your treatment. And I ask that question as a doctor on the west coast.

3 months ago I had a patient with pancreatic CA that I tried to get to consult with you. No such luck. Any suggestions about how I might make the case for contacting you?

adria -> RE: *The Gonzalez Therapy: Pancreatic Enzymes in Cancer* (10/27/2004 5:12:52 PM)

Dear Dr. Gonzalez,

I'm going to miss my vanilla soy milk. I am clear about avoiding that, and I certainly understand your reluctance to discuss dosages of enzymes, since this is obviously very individualized therapy. However, I was hoping that since the enzymes you use are not commercially available, there could possibly be some source that you can recommend, not specifically for cancer treatment, but as part of an overall wellness/preventive medicine program. Isn't there one reputable source that retains activity for this type of purpose?

Thank you so much for your participation and time taken answering our questions.

Fondly,

Adria Rothfeld, DC, MS

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