An Update on Cancer for the New Millennium

The first decade of the new millennium continues to reveal the Bourbonic nature of the Cancer Establishment. Bourbons learn nothing, forget nothing. Cancer specialists world over continue to be quite aggressive in their claims and media coverage. A brief survey of the cancer scene in particular and modern medicine in general is presented below to buttress the main text. What is true for cancer is true for coronary artery disease (heart attack), stroke, high blood pressure, diabetes, arthritis and aging.

Perusal of media and medicalese reveals that both continue their crusade of grabbing headlines. The media-trivia, reportedly dependent on "scientific" studies, reflect the medical ploy of promise-to-prosper. The unceasing promises from the scientific-lobby keep on convincing donors and governments to dole out yet more funds. The labs, hospitals and doctors prosper and justify this prosperity by yet more papers and promises. All, except the cancer-patients themselves, are happy. The mood is upbeat, the truth missing. A brief survey of some headlines is educative.

The Joy of Cancer, (Rupa, 2002 and 2005) by Anup Kumar, a nuclear physicist describes his own sojourn through diagnostic and therapeutic oncology, highlighting the travails about the monetary cost. Kumar is one of the lucky ones (see below, about luck in cancer) to survive, a phenomenon more common to the untreated than the treated. *The Times of India,* Nov. 2005, reports Nano plans for battle against cancer, both for diagnosis and treatment. The *Scientific American* (July 2006) has a cover story posing a question – "DO STEM CELLS CAUSE CANCER?" and then goes on to epigraph the big article: "A dark side of stem cells – their potential to turn malignant – is at the root of a handful of cancers and may be the cause of many more." This formidable scare gets matched by many a sop. *Time* (Aug. 7, 2006) flashes a cover story on THE TRUTH ABOUT STEM CELLS and details on the governors and senators pouring a Niagara of dollars on stem cell-labs to conquer cancer, coronary and so on. *WiCell – The Journal of Stem cell Discovery,* (Spring 2007) gives a flashy account of this fledgling science to claim, on the cover, the plans of journeying "From the laboratory to the Marketplace." Stem-cells may fail to provide the wanted cells, but seem sure to provide financial bonanza.

More from 2007. *THE PHAROS* (Autumn 2007) published by California's Alpha Omega Alpha Honor Medical Society, being "Worthy to Serve the Suffering," editorially generalizes that "Americans expect the most advanced and effective diagnosis and therapies for disease, no matter the cost" a trait partly derived from "our obsession with 'fighting disease'." In

the same issue, there is the story of Abram, a successful lawyer 'who tried to cure his own cancer'. Abram got treated by James Holland, an oncologic luminary. "He (Abram) approvingly referred to the intense and strong-willed Holland as someone who 'attacked my illness as it were a personal enemy, as if the mere existence of leukaemia were an affront to his power." The foregoing is a brilliant testimony to the megalomania oncologists often suffer from, the world over. Abram's story is related to Lerner, a professor of Medicine at Columbia University, and is a part of his researched-book titled *When Illness Goes Public: Celebrity Patients and How We Look at Medicine.* Abram was treated, rather intensely, by a combination of immunotherapy, chemotherapy, and undaunted will. Lerner offers his observations on each of these, and his generalizations are applicable to any other patient of any other cancer. "Indeed, while immunotherapy is still a focus of leukemic research, no randomized controlled trials have even shown that MER (Methanol Extract Residue) or neuraminidase-treated leukemic cells prolong life." About chemotherapy given to Abram, one must read between the lines: "It is most likely that Abram's survival should be credited to the new 7+3 chemotherapy regimen that he received…. Of course, the chemotherapy does not alone explain Abram's case, as most patients treated for the disease still die. Why do some patients who have a given cancer and undergo a particular treatment survive, while others do not? According to growing evidence, specific cases of AML, like those of other cancers, are biologically different even though they carry the same name. Some are simply more treatable than others." Lerner resolves this dilemma by growing fatalistic: "This fact introduces another important element into Abram's story: luck. Whereas he was certainly unfortunate to get leukaemia, he was fortunate to get a treatable form of the disease." The foregoing takes you to oncoresearcher Fould's 1969 generalization that cancers are good, or bad, a retrospective judgment depending on how they behaved after treatment. This is in line with Kurtzke's generalization after a global study on stroke, namely, that survival depends not on who is treating or what the treatment, but who is being treated. Lerner, Foulds, and Kurtzke allow you to summarize that in cancer, coronary or stroke, treatment per se is irrelevant and what gets treated, now and again, is the dis-ease accompanying the diagnosis. The corollary is that, however grave the diagnosis, treatment is avoidable in the absence of dis-ease. Lerner's comments on Abram's will-to-live are worthy of note, especially for the atheists. "But Abram's belief that he had willed his way to survival is more problematic. As noted above, existing research does not support the idea that cancer patients who try harder are more likely to live. In addition, such a construct potentially blames those patients who do not survive. One woman who wrote to Abram after the *New York Times* article made this point, reminding him that many courageous people with cancer nevertheless died from the disease." Abram's story came from a top-notch USA society, and deserved wider description. A few more bits from 2007 follow.

A 27 Oct 2007 *The Times of India* headline informs of a 'smart' bra that will send audio-visual signals in detecting an early cancer, concluding on a caveat: "The life-saving undergarment will be manufactured within the next two years." The 22nd Oct headline is on India's 500-crore cancer-drug market coming of age to compete with global sales, a marketing fact highlighted by Jacky Law in her book *The Big Pharma* (Constable, London, 2006). It is a classical case of dollars from drugs that really never were. *Tehelka* of Dec 15, relates Guha Ray's account of his mother's cancer, the article being titled: 'I RECALL WHAT MY UNCLE SAID – CANCER, NO ANSWER.' *The Times of India* of 27th Dec, reports on 'A nuclear tool to fight cancer'. The details provide an insight into USA's determination, no matter what the cost and *what* and *who* the enemy. "But a 222-ton accelerator – and a building the size of a football field with walls up to 18-feet thick in which to house it – can cost more than $100 million. That makes a proton centre, in the words of one equipment vendor: 'the world's most expensive and complex medical device'. Some experts say the push reflects the best and the worst of the nation's market-based health care system, which tends to pursue the latest, most expensive treatments – without much evidence of improved health – even as souring costs add to the nation's economic burden." Significantly, 2007 ends with a sort of bang. Watson, the hero of *The Double Helix*, who in 1975, summed up cancerology as *scientifically bankrupt, therapeutically ineffective, and wasteful*, champions each one of us having a CD of one's own DNA. He got it made for himself at a modest cost of one million dollars, but he envisages a time when, a decade from now, it will be $1000 per genome. Given this you can, from almost very start of your life, start predicting (may be apprehending) Alzheimer's, so as to start working against it. Watson's advice is a classical play of *ruining one's journey of life, for, unpredictably, ending on a desired state of dis-easing.*

While some elitist eyebrows may be raised for quoting science from lay media (who in any case got it from learned medical men), it would be appropriate to cite here a very personal account of a British patient treated by modern cancerlogy. "To My Oncologist – an Open Letter from a patient at the End of Follow-up," in *Clinical Oncology*, 19: 746-747, 2007, under the aegis pf the Royal College of Radiologists, UK. The patient merits being quoted *in extenso*, as follows.

> *This letter has been produced by members of the Macmillan Late Effects Working Group to stimulate discussion and debate among oncologists.*
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> *Since 2005, a group of patients and carers, representing those affected by significant complications of cancer treatment, has been working with Macmillan. They include representatives of RAGE (Radiation Action Group Exposure), but the wide collective experience of the group extends across different*

cancer types and all age groups. Their aim is to increase awareness and recognition of late effects, and to improve the information and services that affected individuals receive.

Dear Doctor,

Everybody says how well I look, and I guess I am cured now. So, as your registrar says, I can put it all behind me. Funny, it feels a bit like when I was first diagnosed with endometrial cancer. First the hysterectomy, then the radiotherapy with internal treatments. 'Just get through the tiredness and diarrhoea, it's all to be expected, then everything will be normal again.' But, it's never been the same, never my 'normal' as I once was.

At first, I would ask how long I would be a bit loose, or having to rush to the loo. I didn't like to tell you I was having accidents, how embarrassing. You did ask me once if we were managing intercourse. I know I said yes, but I couldn't tell you how sore and uncomfortable it was. My husband gave up after a while, he could see he was hurting me. I used the dilator just as the nurse instructed, but it has never been the same. I wanted to know if everyone was like me, but I never had the courage to ask.

There's another thing, my bladder. In the first year I kept getting cystitis. After this, I couldn't last for more than an hour. Everything now needs careful planning. I kept going back to my GP who gave me antibiotics, but they made little difference. A couple of years later, I had some bleeding from the back passage – that really alarmed. You sent me to the specialist who carried out a colonoscopy. It was very uncomfortable, but at least he had an answer. He told me the radiotherapy had damaged the bowel and that surgery might be needed if the bleeding didn't stop. Fortunately, it did. I eventually understood that this was the problem with my bladder, too. It had just shrunk.

Perhaps you did tell me at the beginning, before the treatment. I don't think I took it in, and when I did learn about radiotherapy damage, it was hard to find answers. There is so much I still don't know. Will it get worse? What will happen to me?

I think I was quite angry with you at this time, but I eventually realised that my problems weren't caused by bad treatment, they just happen to some people. I just didn't understand, but that made it harder to keep bringing the subject up when you saw me in clinic. 'How was I?' you asked. On a good day uncomfortable, using pads, and planning carefully every time I went out of the house. On a bad day, I'd rather not eat than embarrass myself in front of family and friends and I sleep in a separate room now.

My GP says he has not seen anyone like me before. For a long time, he said he didn't know what was going on. He admits he has little experience in looking after people with different types of cancer and especially in dealing with the after effects. I often have thought that it would have made a difference to talk to other people who had similar experiences to me. That's been the worst thing – at times I have felt that I was making a fuss. Eventually, finding out that all this was late effects on my bowel and bladder almost came as a relief. At least there was an explanation.

I don't mean to grumble. I just want specialists like yourself to realise that it is not just the big problems like bleeding, it is all the little things put together that wear us down. We don't expect you to have the answers – by now I realise there aren't easy ones – but it helps to be able to talk about them without embarrassment. If you can put in our notes that there is no sign of cancer, isn't it important to write down what else we are living with, if only so that other doctors and nurses will understand too and we can judge if things are changing or getting worse.

With hindsight, I think I needed to be more prepared for this at the very beginning – that life would be different rather than expecting everything to be the same. More information. This would have helped, as well as getting information when problems begin. When they do happen, it is so important that our symptoms are recognised and acknowledged as part of the treatment effects. At least that gives them a label and an explanation. Even so, it is hard to qualify

for benefits, and GPs and other people simply don't understand what I am talking about.

Yours sincerely,
Your Patient

It must be noted that the above sad tale has the backing of UK institutions of impeccable authority and scientificness. And, reading between the lines, you realize that the patient swapped what was occasionally disturbing uterine bleeding, by a state of perpetual ill-health, ruined sex-life and social life. Earlier, we have cited the case of 3 women. Mrs. D, sister to one of us, had a large bulky endometrial carcinoma that allowed after diagnosis, a full 7 years of normal life, save occasional bleeding. Two other women, had advanced carcinoma cervix, spread to the sides of the uterus. One lived normal and well for nearly 5 years, the other for 19 months, the sole treatment being a few vaginal douches to manage the discharge. Allopathy has been officially defined as the art of curing one disease by causing another. In the letter above, oncology "cured" one by causing many a dis-ease. Prof. B.M. Hegde, physician-cardiologist-writer-vice chancellor has posed in *Bhavan's Journal,* Jan 2007, a question "Is Cancer a Disease? which is but exact equivalent of the German translation of our book titled *Ist krebs eine krankheit?* The corollaries are that cancer is evolutionarily and ontogenetically integral to humankind, that for long after its inception it is compassionately and discreetly silent, that as and when it dis-eaes, all that you can and should do is to ease the dis-ease, and that while doing so you should see that your easing does not turn into an adventure of making your treatment costlier than the patient's original dis-ease.

2008, while still very young, is full of breakthroughs. A research team at Utah, USA (*Hindustan Times* Jan 3) have traced back colonic cancer in the whole of USA to a couple who migrated from England to America in 1630. "Colon cancer traced back to 1630" so the headline proclaims and then goes on to explain the countrywide "hereditary" transmission of a gene and its mutation in face of the fact that as terms and concepts *gene, mutation*, and *hereditary* are all begging for a logicizable status. The thrust of the whole learned piece, colourfully showing the (long-out-dated) tumour stages, is a marketing gimmick to sell yet more check-ups, colonoscopies, biopsies, and surgeries. Feb 4 *The Times of India* announces the *nailing* of a "gene that tackles tumours." The launching text is bitter-sweet: "Paris: Scientists have identified a gene that helps protect mice against intestinal tumours, although it may also play a role in spreading cancer."

Jan 21, *The Times of India* arrives with a new Merkel Cell Virus (MCV) which is the first polyoma virus to be strongly associated with a particular

type of human tumour. In tandem is an announcement (*The Times of India* Feb 3) that "Oral sex can cause cancer in man." The box assertively declares: "The sexually transmitted virus, HPV, now causes as many cancers of the upper throat as tobacco and alcohol, probably due to both increase in oral sex and the decline in smoking." This study published in *Clinical Oncology* suggests that the Merck vaccine, "currently given only to girls and young women" can now directly benefit men busy with oral or anal sex. Surely, the vaccine is busy doubtfully preventing cervical, oral, anal cancers to positively promote Merck profits. The readers need to note the poorly-recognized open secret that Robert Gallo, of the AIDS virus-ill-fame, was working on HTLV – Human T-Lymphoma Virus, wherein persistent failure led him to suddenly announce the existence of, as yet unproven and unisolated, HIV – also called AIDS virus. Viral oncology had died long ago, but laboratories have resurrected it profitably. Next to the viral breakthrough, is a "New treatment for brain tumours" detailing the combination of *radiation seeds and chemotherapy wafers* after surgery as assuring longer survival in Glioblastoma Multiforme (GBM). Oncologists continue to believe in Borgia's law: Two poisons are better than one.

An avalanche of scary-information is let loose by media (*Bombay Mirror* Jan 19) with a grief-stricken young woman facing the intimidating question: "HAVE YOU TESTED 'TRIPLE NEGATIVE'?" The epigraph to the article reads: "Most people haven't even heard of triple negative breast cancer. What's more scary, it's harder to treat and more common in young women." The text reeks with media-malignancy passed on to the public as some latest knowledge. Ecclesiastes stands proved right: *He that increaseth knowledge, increaseth sorrow*, for as Lord Tennyson put it, *Knowledge comes, but wisdom lingers.* One of us has had a chance to attend a 'Grand-round' in a California hospital, which was a slide-show laced with breakfast. At the end, a person on next-chair asked how it was. "Good". "You see, we have some problem here. One moment I think A causes B, and press a button, and I get 100,000 references in its favour. A little later, I change my mind to say A does NOT cause B. And I get 100,000 references. You see we in the west are well-informed, a little too well, but we haven't grown wise." The magnificent tomes called *Controversies in Psychiatry/Medicine*/so on truly speak volumes about modern medicine's oceanic knowledge *sans* an island of wisdom.

February 13, 2008 brought flashes from *Health Screen – A magazine for pre-patient care* (Vol. 4, No. 38, Feb 2008). The intellectually–uncomfortable term *pre-patient* should tell you that it is a journalistic mouthpiece of "*Thyrocare* – world's largest thyroid testing laboratory." The first item is on Siemens' *Mammomat Inspiration* – "latest innovation in digital mammography." While mammography has yet to come out with a clean chit of beneficence, the announcement by Jochen Dick, the chief of Siemens Medical Solutions bristles with pecuniary illogic: "In an

environment with large screening volumes such as mammography, many patients have to be examined, and some of them are very nervous about the procedure, that's why the entire procedure has to be as fast and as comfortable as possible for the patient while speed, efficiency, and accuracy are the deciding factors for the hospital. For this reason, every work step, starting with the examination and ending in data distribution – has to be optimized so that more patients can be examined and diagnosed in a far shorter time than in the past. Additionally many functions and technical features provide for low radiation dose." More mammography, more surgeries/chemotherapy/radiation/hormones and misery.

The next item in the above is on the Nobel award, for 2007, to Capecchi, Smithies and Evans for their discoveries "that paved the way for an inestimably powerful gene technology referred to as gene-targeting in mice, or to use the more common dialect, gene knockout mice," leading to breakthroughs in ailments of aging, diabetes, and of course, cancer. While James Watson was a bit conservative in promising a utopia, the *Health Screen* goes too generous: "The avalanche of genome data is growing day-by-day encompassing studies in trascriptomics, proteomics, structural genomics, knockout studies and comparative genomics. The knowledge of DNA sequence may find relevance in almost any biological subjects and the application of genome sequence information to health benefits could revolutionize disease prevention measures, early disease interventions, and make the possibility of personalized therapies routine." Health-Heaven just round the corner!

The Times of India, March 14, 2008 has a headline, from where else but USA. "US scientists discover 'master' breast cancer gene." The report details geneticists having identified a super gene which causes breast cancer to metastasize. The master regulator SATB1 gene alters the behaviour of at least 1000 other gene within tumour cells, says the study published in the British journal *Nature.* SATB1, when overactivated, makes cancer cells proliferate, and when neutralized, the gene forces the insane cells into sanity. The report offers the carrot of cure: "The findings could not only pave the way to diagnostic tools that show likelihood of the disease spreading, but to drugs that could prevent or treat metastasis in breast cancer as well." Hope, you see, springs eternal in the human breast, especially if the breast belongs to a researching geneticist in the USA.

Breakthrough-Headlines over, we may descend to some ground-realities. Despite seeming Himalayan advances, modern medicine is essentially ignorant about the two basic elements that form the human body – namely, cell and collagen fiber. These two elements govern all the maladies we are prone to. Regardless, modern medicine continues to

“attack” with results no better than USA pounding Afghanistan or Iraq. The net outcome is iatrogeny – doctor-induced diseases. It has been predicted that by 2025 AD, 80% of human suffering will be attributable to doctors themselves.

This is best illustrated by USA, the world-leader for better or worse. As summed up in *Time* June 31, 2006, medical errors remain one of the leading causes of death and injury. The Institute of Medicine report indicated that as many as 44,000 to 98,000 people die in hospitals each year as the result of medical errors. Using the lower estimates, medical errors are the eighth leading cause of death in the USA - higher than vehicular accidents, breast cancer, or AIDS. These figures more than justify the warning that Edgar Berman, an American surgeon, put on the cover of his book, titled *The Solid Gold Stethoscope* – “Your Doctor May Be Hazardous to Your Health.”

If the above is true for ever-vigilant and always-litigant USA, what must be the state of doctor-caused disease/death in India or Africa?

No wonder that the media, traditionally given to praising the medical world, have started giving cover stories on the perils medical practice poses. The October 2004 issue of the famed *Economist* from UK featured a cover story on “Beating Cancer” wherein the launching line is: “There never will be a cure for cancer.” This pessimism of a prestigious British periodical finds a strong echo in *Nature* (London) August 2007, declaring *Cancer and* aging, as *two sides of the same coin,* and hence integral to human growing. The May 2006 issue of *Business Week* (USA) has the cover-title: “Medical Guesswork – from heart surgery to prostate care, the medical industry knows little about which treatments really work.” The *Reader’s Digest* (USA) (August 2006) went a shade further, declaring on its cover: “How Doctors Gamble with your Life – Seven ways to protect yourself.” The *Reader’s Digest* cover shows 2 dices as the main instruments that doctors employ to guess what they should do, when, and how.

So, it is high time we all, the lay and the learned, appreciate and adhere to the true meaning of some medical words. *Doctor* (from *digga = disha, diggdarshak, director, doctor)* is one whose chief role is not to give medicines or do surgeries, but to give directions along which to conduct one’s life in health and sickness. The much-used phrase *modern medicine* is a tautology. Both these words are traceable to *Skt. matra* and *L. modus* meaning measure. *Modern Medicine* is something that you do as a *measured* step and dosage, after taking all factors into account. So modern does NOT mean the latest/imported/sophisticated/ expensive, but a way of taking even the latest failure of medical practice into account before succumbing to any treatment. The much-celebrated word *investigation* is rooted in *vestige* or a trace. However costly it may be, any

"report" tells very little about any particular illness. Like our political bigwigs, an investigation can as much mislead you as it may lead you. So, beware, for in the best-intended "fight" between a doctor and your disease, the real battlefield is you, your body, your mind, your finance.

It may not be realized that a 5-star check up-clinic is a magical place where a person walks in, and a patient walks out. The check-up-clinic's motto as outlined by the *Wall Street Journal* on July 26, 2006 – You are sick, We are quick – is as seductive as a TV ad, and far more dangerous.

It cost USA billions of dollars to complete the Human Genome Project (HuGo). Blaire and Clinton eulogized the report as the language of God and the code of life. Soon, however, its limitations were realized so that it has been consigned to the dumps. The place of genetics has been usurped by proteomics. Yet this summary failure of genetics has not deterred the cancerologists from promising a molecular classification of cancers: "Cancer classification has been based primarily on morphological appearances, which have severe limitations." This learned judgment by RD Lele in *Journal of Physicians of India* in April 2003, throws the best microscope into the sea, and poses a serious new challenge: A new classification is based on global gene expression using DNA microarrays. All this, mind you, when science is still struggling with what really *gene* is, and how to define it.

As stated by RD Lele, "The National Cancer Institute and Food and Drug Administration in USA have since July 2001 joined in a separate effort to focus on using proteomics to develop more targeted treatment and more reliable diagnosis of cancer." No body could have said *mea culpa, mea culpa,* more loudly. The damming words declare that hitherto cancer-establishment has been wrong in diagnosis, as also in dishing out such breakthrough as *Herceptin*, and *Gleevec* (The *Wall Street Journal,* July 24, 2006). Why not, for once, should doctors declare that cancer never has had, not can have, any drug, for the simple reason that cancer cells refuse to accept that they are in any way abnormal to the human body.

What would you feel when a 11-year old girl is made to pose (*Time,* June 19, 2006)for the sale of a vaccine designed to prevent cancer of the cervix? The FDA, USA have approved *Gardasil,* an antiviral vaccine, costing $360 for 3 shots. The assumption is that cervical cancer – 233,000 deaths per year worldwide – is caused by HPV or Human Papilloma Virus. So give the vaccine, as a routine, to girls between 9 and 11 before they begin to be sexually active. "The Gates Foundation announced that it will spend $28 million over the next five years to determine whether a cervical cancer vaccine can be made more widely available."

While science is greatly uncertain whether HPV causes cervical cancer or genital warts, and whether antiviral vaccine could really work, the Gates Foundation and the *Wall Street Journal* (July 21, 2006) have decided that everything be done to make the vaccine available worldwide. Is this vaccine a way of reestablishing the long-defunct theory of the viral origin of cancer? It is interesting that Dr. Kirtee Shah at the Johns Hopkins has done "crucial" work to link cervical cancer to HPV.

While it is accepted that science has very poor idea of what a cell really is, it is now widely claiming *stem cells* as a panacea for a number of medical problems, cancer included. It is not clear how stem cells, basically designed to proliferate, will help protect/cure/modify cancer that is itself a disease of proliferation. India has been quick to board the stem-cell-bandwagon, regardless of the cost and the confusion involved: Singapore has the (2 million sq. ft.) stem-cell-centre, called the *Biopolis* that is supposed to have seduced the best brains from the USA and UK.

From the enormous data available, it is not difficult to generalize that stem-cells is a stunt designed to keep the medical research alive, and human hopes kicking. The *Time* (Aug 1 2006) has the cover titled: "The Truth about Stem Cells – The Hope, The Hype and what it means for You." The article begins with caution that speaks for itself: "The debate is so politically loaded that it's tough to tell who's being straight about the real areas of progress."

The witch-hunting of tobacco continues. The August 2006 issue of *Journal of Association of Physicians of India (JAPI)* is devoted to creating a "Tobacco Free India." The editorial declares that "Cigarette smoking is responsible for more than 400,000 deaths each year, or one in every five deaths." Surely, Lady Nicotine was never more condemned!

Our tobacco-phobia needs to be intellectually treated. If the doctors have been loftily wrong in the diagnosis and treatment of cancer (and all other diseases allegedly caused by tobacco), is it likely that they could be as grossly wrong in their statistical claims? How about the statistically established fact that the tobacco habit prevents Parkinsonism and Alzheimer's disease? The current epidemic of both these diseases could be the unavailability of a natural product called tobacco. Time alone will tell, but it suffices to say that all pronouncements so far have had more rhetoric than reason.

The continuing failure of cancer research, stemming from the verifiable fact that "Cancer is Unresearchable" (Ch. 10 of this book), has given a great boost to the phenomena of Foundations. A tycoon or his/her near-ones gets a particular cancer to die therefrom, and a Foundation-for-that-cancer springs up. "Early Detection: Ex-Executive Backs Big Push to Get

A Jump on Cancer" so goes the headline on the front page of the *Wall Street Journal* of July 12, 2006: "Multimillionaire Mr. Listwin's mother died of ovarian cancer. So there is now the *Canary* Foundation to detect cancer in its earliest stages by locating "the fingerprints of tumours." Mr. Listwin is in good company. "Following his diagnosis with prostate cancer in 1993, the former financier and convicted security-law violator Michael Milkan established the Prostate Cancer Foundation to support research into the disease. More recently, he founded Fastercures, a Washington-based action-tank that attempts to accelerate the translation of basic scientific discoveries into medical treatments."

If one were to read between the lines, be it cancer, or stem-cells, the continuing emphasis on million/billions of dollars smacks of "an individual style attack" on cancer, reminiscent of such attacks by the USA on Vietnam or Iraq. The gullible public and the press are made to feel that all that is lacking is just enough dollars and enough push.

Robert Ardrey, an eminent thinker/writer/anthropologist left behind a good truth in 4 words: *Apples still fall down.* All our knowledge on gravitation, from the time Newton gave the concept, has not helped us alter gravitation; nor make the apples fall up. The moral of the story is that an oceanic mass of information on a cancer or a cancer cell may still be obstinately accompanied by your total inability to dictate a single cell. This is the essence of the new science of *epistemology* or *gnosology* (from *Skt. Gnan* = knowledge). Epistemology evaluates a knowledge-scene and tells you what you can do, and what you just can not. From Sushruta and Charaka, to today – 2500 years – mankind has striven to challenge the naturalness of cancer, with results that are both disturbing and destroying. The saving grace is that the less you do against cancer, the more it obliges you to live longer and better with it. Cancer is kind. The kindness begs for recognition.

It will be clear to the readers of this book and the new update that the authors have striven to adopt the PRIDE approach as proposed by them at the Leadership Conference on Best Practice, Health Care in India, held at New Delhi on November 19-20, 2005. PRIDE as an acronym connotes – Public/Patient Rationally Informed, Donors Enlightened. Public/patients should not over-expect. Doctor/donors need not over-promise, nor over-perform. PRIDE thus becomes a symphony of shared knowledge and ignorance. Bill Gates and the like may be told that cancer research is a bottomless pit, a black-hole that sucks everything and gives back nothing. Clyde Dawe of National Cancer Institute, USA generalized that trillions of animals sacrificed on the altar of cancer research have not provided any clue that science did not already had had before the experiments began. If this means the cancer institutes and laboratories could better close down,

so be it. The SPCA will be happy. And so would be Albert Schweitzer and his motto *Reverentio Vitae*, or Reverence for life.

As this text goes to the press, a flyer has arrived from a prestigious new cancer hospital. It has the typical overpromisism and razzmatazz of modern medicine - rich in intellectual appeal, but thoroughly impotent in reality. It is a classical universal ploy of keeping the flame of a defunct science alive. There is a research 5-star research establishment – in physics, genetics medicine – that must periodically produce "results" to satisfy the public and the funding agencies. They get satisfied, and the cycle of survival continues. The only casualties are truth and candor. But then that is pure science and who worries about that facet of *Goddess Sarswati?*

Our attempt is not to find who is at fault, or what is wrong but to stress what is self-evidently right. Cancer is easy to understand. The simple truth that binds a cancer patient with his/her doctor is that the latter is endowed with the ability to ease, if and when there is dis-ease. Cancer yes, but no dis-ease, then let cancer be. If dis-ease, seek ease, dis-ease-far and no further. Cancer by itself can NEVER be treated. What doctors treat is not cancer, but a symptom or sign. But that also is a great blessing from a noble profession.

The foregoing citations are a few drops from oceanic oncology that expands every minute. It is a game of scientific research, one-upmanship, bio-industry-promotion, and of course, Nobelitis: "To a great many people, medically trained scientists as well as layman, the pot of gold at the end of the rainbow of medical research is the discovery of the cause and cure of cancer." We first published *Myths and Realities* of the *Cause and Cure* of *Cancer* in 1979; the text is unaltered even by a punctuation mark as of today. How come the oncologic juggernaut continues to run amuck!

Does it come out of a current world-view that nothing is unsolvable by science if there are enough money, machines and men? Scientists have chosen to connive at the fact that, *science* as a word is from *scientia*, i.e. to know, having no relationship with doing, which is *technique* from Skt. *takshta* meaning skill. That is why when we say God is omniscient, we imply the Lord's all knowingness, and omnipotent connoting all-doingness. The moot question is: Is there *any* science of cancer? Bier's lofty, 60 years old, generalization that "All we know about cancer can be written on the back of a calling (visiting) card," the text being WE KNOW NOTHING is robustly viable today. And if that is so, let it be noted as of 2008, that all cancerlolgy is all technique *sans* any science. Burnet, the hard-hitting Nobelist has summed up succinctly:

It is a current article of faith that if America can put a man on the Moon, America can discover the cause of cancer. In Arizona there is, we are told, a cemetery where people who have died of cancer are preserved by being frozen in liquid nitrogen 'in the sure and certain hope' of revival and cure by the medical scientists of the twenty-first or twenty-second century. I have been and remain a sceptic and was castigated in public by a local president of the British Medical Association for saying about ten years ago that I could see no hope for any revolutionary improvement in the cure of cancer. It is still an unpopular attitude. As long as money for research must be sought from men without sophisticated understanding of biology we can be certain that every geneticist and molecular biologist will be careful to add to his exposition of what he is doing, the safely irrefutable statement that it may well have importance for the understanding of cancer!

Sir Macfarlane Burnet
Genes, Dreams and Realities

But, the current craze of nano-/pico-/femto technology has promised breakthroughs in all medical fields through the miracles of molecular biology. Some have gone a step further to hold discussions on *Submolecular Biology of Cancer.* Be as it may, Burnet needs to be read in 2008 for the candour he exhibited in 1971.

I have more than once expressed the opinion that so far there has been no human benefit whatever from all that has been learnt of molecular biology. I doubt if any other biological scientist has been quite so blunt in public but a few eminent biochemists have agreed with me in private.

Any of the other aspects of cancer research that I have mentioned could provide opportunities for expansion and interpretation but I think it would fit best with the general approach of this book to look rather critically at that perennially repeated justification for work in molecular biology – that all competently done research in fundamental aspects of biology will help toward discovering the cause and cure of cancer. I believe that most scienctists who make this claim, usually to justify public support for

> *their own work, feel that they are virtually compelled by social forces to tell this white lie with as much apparent conviction as they can muster. They know that their own work is rated as good by their peers, who are concerned not at all with its bearing on cancer but deeply with its originality, its integrity of approach and interpretation, the elegance of the methods used, and the implications it will have for the interpretation of other biological phenomena. They are rightly proud of their achievement and equally rightly feel that they have won the right to go on with their researches. But their money comes from politicians, bankers, foundations who are not capable of recognizing the nature of the scientist's attitude to science and who still feel, as I felt myself thirty years ago, that medical research is concerned only in preventing or curing human disease. So our scientists say what is expected of them, their grants are renewed and both sides are uneasily aware that it has all been basically dishonest piece of play-acting – but then most public functions are.*
>
> ***Sir Macfarlane Burnet***
> ***Genes, Dreams and Realities***

The last line in the above portrays a global situation that is MAD – **Mutually Assured Delusion**, the rulers, senators, legislators, politicians, and the big-purses ready to dole out yet more funds without understanding the trans-science nature of issues involved. The researchers on the other hand survive, *nay* thrive, by asking more and more funds without wanting to own up and explain the limitations of the science they are ostensibly pursuing. Funds flow in to fuel research that must be published to justify yet more funds.

A heady mix of medicalese, politicalese and journalese is exemplified by a recent cover story in *Time* (Oct 15, 2007). A pretty woman adorns the entire title page, with much of the world map painted on the front of her torso, her right hand cupping the left breast, the title being *Why Breast Cancer Is Spreading Around The World.* From the editorial through the whole story, aggressive, accusative generalizations veer the reader into championing "the US-based Susan G. Komen for the Cure, an advocacy group with 125 affiliates around the world." While the story bemoans the poverty of the Third World as one major handicap against tackling breast cancer, it shamelessly promotes population explosion, and yet more poverty, by generalizing: "Research shows that women who give birth to

fewer than two children have a high risk of developing breast cancer than woman who have larger broods. Part of the reason is probably that pregnancy and nursing provide the body with a sort of estrogen holiday, as the menstrual cycle is shut down for at least nine months and often a lot longer." Moral is, Stay Perpetually Pregnant to keep breast cancer at bay.

At the end of the whole story, you get reminded of Sir Hadley Atkin's brilliant despair that the science of breast cancer is now so advanced that no one knows how to prevent it, or, treat it. And what is true of breast cancer is true of cancers at all other sites. This cultivated global democracy of ignorance allows anybody and everybody to prevent/investigate/treat the way it pleases a fancy, even if, in the bargain the patient gets destroyed. It is Albert Camus' axiom: Nobody in the world of oncology is wrong because nobody is right.

The utter phoneyness of modern oncology as also the TRUTH about cancer between the lines, is revealed by fresh-from-the-frying pan *Current Medical Diagnosis and Treatment* 2008, a medical bible read and respected by medical world over for the past 47 years.

> The single most important risk factor for developing cancer is age. About 76% of cancers are diagnosed in persons aged 75 years or older.
>
> An additional cause of cancer is chemotherapy or radiation therapy for prior malignancy. More aggressive chemotherapy and radiation regimes – and especially those combining two treatment modalities – have been associated with increased rates of both secondary leukemias and solid tumours. The latency period may be short (2-5 years for leukaemia) or very long (10 – 20 years for solid tumours), but the prognosis is uniformly poor.
>
> ***Hope Rugo***
> ***Current Medical Diagnosis and Treatment 2008***

The above tells the layest of lay that cancer is a part of aging, a part of one's *course*, not in need of a *cause* that never existed. The other glaring revelation of the above is that all chemotherapy is basically cancerogenic, or more truly, an ager that accelerates all modes of aging, including cancer. Sadly but significantly, the truths gleaned in 2008 will not alter by 3008, for cancer is a biological issue, well beyond the nose of medical men, who are supremely placed to ease, whatever, wherever the dis-ease thereof. What is cancer, we cannot treat. Whatever we treat is not cancer.

We are, in the concluding part of this neomillennial update, tempted to introduce a new science called CommonSensology, a mosaic of basic understanding available to any lay or learned and guiding in what to expect, and what not to, for all times to come. The sole principle of commonsensology is to realize, and declare, the Himalayan limitations of the might of modernest medicine, may be in the richest country, with latest gadgetry, and all superqualified medicos.

I met a traveller from an antique land
Who said: "Two vast and trunkless legs of stone
Stand in the desert. Near them, on the sand,
Half sunk, a shattered visage lies, whose frown,
And wrinkled lip and sneer of cold command,
Tell that its sculptor well those passions read,
Which yet survive, stamp on these lifeless things,
The hand that mockt them and the heart that fed:
And on the pedestal these words appear:
'My name is Ozymandias, king of kings:
Look on my works, ye Mighty, and despair!'
Nothing beside remains. Round the decay
Of that colossal wreck, boundless and bare
The lone and level sands stretch far away.

Ozymandias
Percy Bysshe Shelley (1817)

Shelley's poetic summing up of the fate of mighty kings makes you recall a small event that came to pass on the seashore at, Southampton, England, a little over 1000 years ago. King Canute (Cnut) ordered the oceanic wave not to advance towards him. Yet, "When it advanced and wetted him, he said to his courtiers that they called him king, but that he could not stay by his commandment so much as this small portion of water." Time and tide wait for no man nor monarch, be it the time without, or more so, within.

Taking a leadline from Shelley, we can travel inwards into a universe called the human body. Let our journey be summed up in a few banal words:

I met a saint from every land
Met prince, rich and pauper
And one and all did acclaim
We control all, but never ourselves.
Our sneeze, snore, yawn, burp,
Vomit, Pee, Shit and Fart
Are kingdoms we never reign

And there lies the moral dart.
We inspire to expire
And cease to expire
Once we cease to inspire
Death's end to dying.

We need to appreciate that a single human body is a cytodemocracy of astronomical numbers, 100 trillion human cells covered by 1000 trillion microbial cells, all living in peace and harmony, from womb to tomb, often over a hundred years without ever needing a medico around. It may surprise us that, after nearly 2 centuries of research on the *healing of a wound* – ranging from a shaving-scratch to multisystem trauma following a car crash – modern medicine has understood next to nothing of this highly computerized orchestration of cells, fibres, and blood vessels. At the *Lister Symposium on Wound Healing, circa* 1970, at Glasgow, chairman Bullough summarized the whole meet on 4 counts: (1) Nature attained its zenith of perfection in wound-healing long ago. (2) We know nothing about it. (3) We can do nothing to accelerate it. (4) Much of what we do, decelerates it. If Wound-Healing has been our Waterloo of medical insights, what to talk of the more complex issue of canceration!

A "normal" cell in your body, before it shifts to the pre-programmed cancerhood, converses with all cancers of the total human past, present, and future to see to it that it spawns a unique cancer, which talks to your own herd to decide at which age to occur, how fast to grow, whether to trouble you at all through life, when exactly to cause trouble, and so on. Your cancer cells enjoy the same genotype as all other cells, multiply never faster than your gut/bone marrow/hair follicle cells, and refuse to be classified as abnormal even after a battery of 400 comparative tests. Your cancer is a cosmic event, fashioned by forces beyond the constraints of space-time, and has antecedence over all your so-called normal cells. As a cosmic event, it is beyond any cause. If it is to occur, it will. If not, nothing can cause it. Your clinician, no matter how well-trained and well-armed has a reach that is too local to affect the cancer's course. The fault is not of the clinician's incompetence. It is rooted in all his limitations.

The above, ordinary and understandable but undeniable facts explain why a very tiny drop of oceanic water, forming your normal or cancer cell, is unable to obey the clinician's demands much as the seawater at Southampton could not care for the order issued by King Canute. Your cancer cell, like any of your 100 trillion cells, is, like God, too subtle to be subservient to you or your science. Einstein loftily synthesized Nature's brighter as well as the inevitable darker side by perceiving it as a game. So he assured us: "Subtle is the Lord, but malicious He is not." We can use the same words for an amazing, interesting, universal, impartial, precise, perplexing cytologic phenomenon called CANCER.

The ceaseless search of all sciences is a sense of certainty, a sense of precision, and direction. Given the vast array of tests and techniques, that keep on increasing their numbers and sophistication every other day, a cancerologist and his patient are justified in expecting a predictable outcome from this interaction. This has failed to happen so far. In cardiology or cancerology, every individual doctor-patient-interaction is blighted by uncertainty. So the doctor resorts to what is called Controlled Trial, wherein he treats a bulk of patients to arrive at some certainty, but, at a group level. Encouraged by this, he then foists the procedure/-treatment on an individual patient, as blighted by uncertainty as before. The doctors, conferences, journals and media brag about the certainty they arrived at the group level. The misery of an individual patient gets drowned in this din and noise.

Why such a mess after thousands upon thousands of scientifically impeccable trials? The explanation is simple, provided we replace our unending hubris by humility. Take the simple exercise of *Squaring a Circle*, that is, "To attempt an impossibility". Why can't our great 3rd millennial science square a circle? "The allusion is to the impossibility of exactly determining the precise ratio, pie (∏) between the diameter and the circumference of a circle, and thus (the impossibility) of constructing a circle of the same area as a given square. Approximately, pie (∏) is 3.142857142857142857……." *ad infinitum et nauseaum.* If you the *Homo modernus et scienticus* is forced to be only approximate in the ordinary exercise of squaring a circle, why don't you admit that uncertainty must rule over every moment? Oncologists and allied clinicians may argue that while treating a patient, they do not have to bother about squaring a circle. Fair enough. But they cannot connive at the unrecognized hollowness of much of their science and the phoneyness of much of their technique.

From a global survey of treated *versus* untreated cancers at various sites, Hardin Jones, of the National Cancer Institute, USA, arrived at a sober conclusion way back in 1956, but valid to the dot in 2008: "It is most likely that in terms of life-expectancy, the chance of survival is no better with than without treatment, and there is the possibility that treatment makes the survival of cancer cases less." Jones stands validated – and will be so for ever – if we juxtapose the *uncertainty* of the harm that a cancer would do to its bearer and the *certainty* of the harm that every therapy would inflict on the patient. It is an intellectual exercise through which even the blind can see clearly.

Firstly, the discreet silence, the innate wisdom of a tumour is now scientifically, cytokinetically recognized. A tumour takes a decade or two even after its start, before it dis-eases the bearer. So its track record is undeniably good. Having dis-eased, there is no certainty that it will be

responsible for death. Now let this be "attacked" by what have you, and you *certainly* unleash spread of the tumour by the swipe of your knife, you kill for sure a million normal cells before you may kill a cancer cell, that the hormones you give may assuage the tumour, but kill the person by accelerated aging and cardiovascular disease. The above juxtapositioning allows you to arrive at a generalization Powers did in 1972 that, *the deterioration of the body from disease, especially cancer, proceeds further than it would without medical interference.*

The above can be summed up in the telling words of Dr. Arthur Bloomfield, who enunciated them after an iatrogenic (doctor-made) tragedy *circa* 1930 - 36:

> Every hospital should have a plaque in the physicians' and students' entrances**: There are some patients whom we cannot help: there are none whom we cannot harm.**

Bloomfield's rueful red light is both benevolent and bothersome, for the physician as also the patient. It poses forever a Hamletian dilemma – to be, or not to be, treated, or be or not to be a treater. Such an irritating intellectual crisis can be resolved by analysing, and then synthesizing, some real-life situations.

> *Ubi desinit philosohus,*
> *Ibi incipit medicus.*
> Where the philosopher stops,
> There the physician begins.
>
> ***Aristotle***
> ***Quoted by Marlowe in Dr. Faustus***

The oncologist on the one hand, and a cancer-patient on the other have to steer their course through a maze of do's and don'ts, not knowing which way to go, and which way to be damned. An oncologist is "tumour-oriented", seeing/attending the tumour, as something apart from its owner, a game in which the owner willy-nilly participates. Both claim that, philosophy apart, *something must be done.* In a monetaristic/gadgetic/technocratic world, the temptation always is – *Costlier the better,* forgetting that costlier may be ghastlier. A fairly clear way is available, however.

We reproduce below, verbatim, a cautionary box that has adorned numerous editions of the *Oxford Handbook of Clinical Medicine*. What follows is from the latest, 7th edition of 2007.

Advice to asymptomatic men asking for a PSA test

The prostate lies below the bladder, and surrounds the tube taking urine out. Prostate cancer is common in older men. Many men over 50 to whom this advice applies) consider a PSA blood test to detect prostatic cancer. Is this wise?

- The test is not very accurate, and we cannot say that those having the test will live longer – even if they do turn out to have prostate cancer. That is because the cancer is often very lazy , so that in most men with prostate cancer, death is from unrelated cause.

- The test itself has no side-effects, provided you don't mind giving blood and time. But if the test is falsely positive, you may needlessly have more tests, such as sampling the prostate by the back passage (which may cause bleeding and infection in 1-5% of men).

- Only one in three of those with a high PSA will have a cancer.

- You also may be worried needlessly if later tests put you in clear.

- Even if a cancer is found, there is no way to tell for sure if it will impinge on your health. Treatment may be recommended – and then you might end up having a bad effect from treatment which was not even needed.

- There is much uncertainty on treating those who do turn out to have prostate cancer: options are radical surgery to remove the prostate (this treatment may be fatal in 0.2-o.5% of patients), radiotherapy, or hormones.

- There is indirect evidence of benefit of screening from the USA where fewer radical prostatectomies reveal cancer-affected lymph nodes than those done before widespread PSA-based screening. Intensive screening and treatment for prostate cancer does not, however, appear to be associated with lower prostate-specific mortality in retrospective studies.

- Ultimately, you must decide for yourself what you want.

The utter compactness of the box-text finds a welcome expansion in *Oxford Handbook of General Practice*. What follows is verbatim account on the same issue culled from the 1st (2002), and the latest, 2nd edition (2005).

Screening in the future

Prostate cancer

The most common cause of death from cancer in UK men. Prevalence is rising. Problems with screening: Incidental post-mortem evidence of prostate cancer is high (=80% men >75y.), very few become clinically evident → many more men would be found by screening with prostate cancer than would die or have symptoms from it; natural history of prostate cancer is not understood – there is no means to detect which 'early' cancers become more widespread; inadequate screening tests (see below); it is not clear if early treatment enhances life expectancy; and, peak incidence of morbidity and mortality is in old age (75-79y.) so potential years of life saved by screening are small.

Screening tests

PSA is routinely measured in men with urological symptoms .Abnormal PSA is one of the most common reasons for referral to a urologist. Its sensitivity and specificity are poor. Other reasons for ↑ PSA: acute and chronic prostatitis, BHP (Benign Hypertrophy of Prostate), physical exercise, instrumentation or ductual obstruction. PSA may be normal when early prostate cancer is present. GPs are often asked to perform PSA testing by patients – explain its llimitations before performing the test.

DRE (Digital Rectal Examination) is operator-dependent, fails to detect early prostate cancers and lacks specificity. Annual screening in the USA and Germany has not ↓mortality.

Transrectal ultrasound (TRUS) – too expensive for widespread use.

Ovarian cancer

4th most common cause of cancer death in women. Confined to 1 ovary = 90% 5y. survival but 80% are picked up at later stages when 5y. survival is = 10%. No reliable screening test. Options are USS (UltraSound Scan), measurement of CA125 and genetic screening. USS and CA125 both have low sensitivity/specificity. Genetic screening can only detect a few familial cancer. If an abnormality found on screening, laparotomy is required to exclude cancer which is unethical if specificity is not high. There is no evidence anyway that treatment at an early stage ↓ mortality. Further information will be available when a large-scale study, just begun in UK, reports in 2010.

Large bowel cancer

Common cause of death with a well-defined premalignant phase(adenomatous polyp). Prognosis depends on stage at diagnosis. Patients with strong FH (Family History) of large bowel cancer, or ulcerative colitis are screened already with colonoscopy with proven benefit, but colonoscopy is too

expensive for use in a universal screening programme. Possible alternative:

Faecal occult bloods (FOBs): +ve in 56-78% patients with asymptomatic colorectal cancer. Malignancies detected are less advanced but uptake is disappointing. Problems: 40% are missed and high false +ves – but does ↓ mortality. Very short lead time, so frequent screening is needed. Pilot is under way.

DRE < 40% within reach.

Sigmoidoscopy: Could detect 60% cancers. May be protective for up to 10y.

Problems – overtreatment(some polyps may never become malignant), acceptability of test, cannot detect proximal tumours.

From screening, the learned text deliberates on the pros and cons of treatment, in persons without symptoms or with.

Prostate cancer

Symptomless local disease

Controversial. 2 arguments:

(a) As nothing proved beneficial, benefits of treatment are outweighed by risks *or*
(b) Aggressive treatment before spread is the only way to ensure cure.

The picture is further complicated as 30% men > 50y. of age dying from other causes are found post mortem to have prostate cancer – prostate cancer kills only a small minority of men who have it. The personal and economic cost of treating men whose cancer would never have caused them any problems must be considered. *Options*:

1. *Watchful waiting* – Monitor with PSA/DRE. ↑ in PSA or size of nodule triggers active treatment. At 10y. follow up < 10% will have died from prostate cancer.

2. *Radical prostatectomy* – Has potential for cure but in the age group most affected by prostate cancer mortality is 1.4%. Other common complications: impotence (50%), incontinence (25%).

3. *Radiotherapy* – May not be effective – persistent cancer is found in 30% on biopsy.

4. *Hormone treatment* – No convincing evidence gives survival benefit in early disease.

Symptomatic disease

30% 5y. survival. Hormone manipulation is the mainstay of treatment and gives 80% ↓ in bone pain, PSA or both and a lower incidence of serious complications (e.g. spinal cord compression) if treatment starts at time of diagnosis. *Options*:

1. *Luteinising hormone releasing hormone (LHRH) analogues* (e.g. goserlin) – sc injection every 4-12 wk. Testosterone levels fall to levels of castrated men in < 2mo. *Side effects:* Impotence, hot flushes, gynaecomastia, local bruising and infection around injection site. When starting LHRH analogues, LH level initially ↑ which can cause increased tumour activity or 'flare'. Counterqcted by prescription of anti-androgens (e.g. flutamide) for a few days before administration of the first dose of LHRH and concurrently for 3wk.

2 *Anti-androgens* - e.g. cyproterone actetate, flutamide, biclutamide. Anti-androgens do not suppress androgen production completely. Used to prevent side effects due to testosterone flare during initiation of LHRH analogues, as monotherapy in those who find LHRH analogues unsuitable (flutamide 250mg tds – monitor liver function if used long term)and in combination with LHRH analogues to produce maximum androgen blockade.

3. S*urgical castration* - ↓ testosterone secretion permanently without the need for medication. Cheaper and fewer side effects than other options.

We urge the readers to go through the above, all over again and again, to allow the message to sink, namely that, two learned works from the House of Oxford, over 500 years old, have held nothing back in admiring the some scope and many limitations of modern cancerology. In place of prostate/ovary/bowel cancer, you could put pancreas/testis/brain cancer, and every line will be found equally applicable with as much ease. The whole cited text is a validation of the entire *Other Face of Cancer*, and allows you to generalize simple Commonsensology of Cancer, useful for the lay and the learned, patient and the physician, researcher and the resource-bodies, like the government, philanthropists, and fund providers.

The following Decalogue (10 points) present the gist of Commonsensology of Cancer.

1. The most important rule is the Hippocratic axiom – *Primum, non nocere,* meaning, firstly do no harm. Laurence and co-authors in their *Clinical Pharmacology,* give a terse advice: When in doubt DON'T – diagnose/investigate/treat/prognose. The errors of omission are preferable to those of commission.

Pay heed to Bertrand Russell: “The trouble with the world is that the stupid are cocksure and the intelligent full of doubt.” Learn to doubt, and thus suitably deny whatsoever modern medicine offers as beneficial to you.

2. We now offer a Commonsensocratic axiom – *Secundum, quieta non movere* – Don’t trifle with a tumour/tumours at peace with the owner.

Since life evolved from cancerous *prelife*, cancer or tumour is much older than mankind. Cancer or tumour is life’s innate wisdom and merits respects from modern cancerology, which is no science but only technology.

3. *Advaitism*, monism, plain-oneness or selfsameness prevails between a cancer and its carrier – the so-called patient. The physician telling a patient YOUR CANCER must understand and convey YOU R CANCER, and *vice versa*. Any “attack” on cancer is an equal attack on the patient’s body, psyche and soul, with “side effects” writ large in the above Oxford accounts.

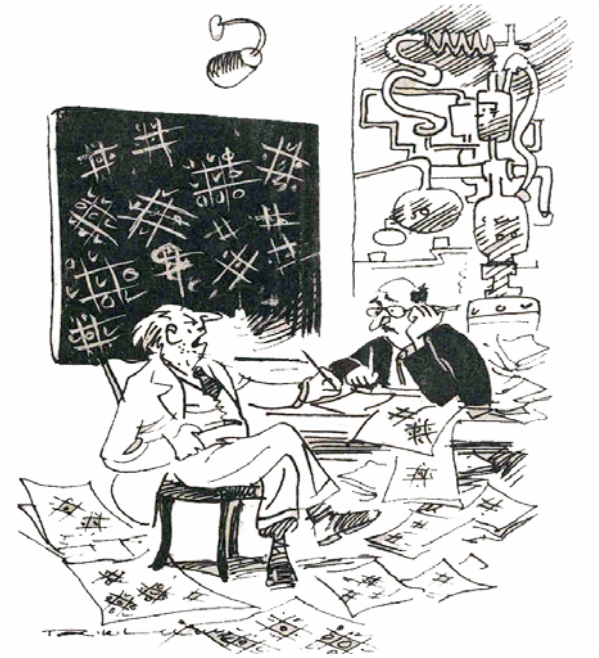
4. We draw the reader’s attention to the learned confession from Oxford, viz., “natural history of prostate cancer (or any other cancer) is not understood.” Now compare this with the following cardiological candor on coronary artery disease.

> *The natural history of this disease remains unpredictable in individual patients. Surprises are in store for any physician who takes care of a number of patients with this malady. Witness the surprise that is expressed, even by physicians, when someone in the neighbourhood dies suddenly and unexpectaedly because he or she had no former symptoms and had been “checked” recently by a doctor. Also, note the surprise, even among physicians, that accompanies the survival of a patient with inoperable three-vessel atherosclerotic coronary heart disease who has lived 10 years beyond the time he or she should have died (according to statistical data). (Parenthesis as per the original text).*
>
> ***The Natural History of Atherosclerotic Coronary Artery Disease: A Historical Perspective in, Hurst’s The Heart. 10th edition, 2007.***

None of the fancy tests like genetic print-out, tumour markers, CEA, or PSA are anywhere near reliable in guiding treatment or prognosis. Take all of them as variants of what is essentially a normal event for the body. Let not your investigations be treated, nor used to scare your wits out.

4. Read PSA as Prostate Specific Anxiety. If you can be PSA+ve but cancer-negative and *vice versa*, it makes little sense to rely on this test. Much less does it pay to resort to hormones/castration just to bring the

"PSA down", and then nurse "impotence, hot flushes, gynecomastia," and so on. Likewise, (see above on sigmoidoscopy), the cancerologists tend to err on overdiagnosis, overtreatment, and overdamage, all because she/he is keen on scoping you to diagnose. Cancer diagnosis is not a compulsory exercise, in anyone at peace. You can genealize that there is "No reliable screening test" (see above on Ovarian cancer) either for diagnosis, or for prognosis. Most tests are *Much Ado About Nothing*.



After spending so much on lab and research we just can't tell the board we couldn't find a cure for common cold. We must carry on with what we are doing.

Courtesy *RK Laxman*
Passing Thought (The Times of India, May 6, 2001)

5. Like common cold, coronary artery disease, carotid artery disease, cancer has never been, nor will ever be beneficently researchable, statistiable, or scientiable. All that modern cancerology can offer, and will continue to offer, is newer and newer, costlier and costlier methods of easing whatever your dis-ease. All cancer treatments are iatrogenic, i.e., they themselves produce a wide array of dis-easing. So, when at peace, or in doubt, just do not submit to the therapeutic promise.

6. Cancer is NOT an arena for any expert, whatsoever. A cancer specialist is one who THINKS that he is a cancer-specialist. All that is achieved is debulking the lump in more than one way and then wait for its reappearance. So even when you are subjected to an attack on the lump, go dis-ease far and no further. Remember YOU R CANCER, and CANCER IS BUT YOU.

7. (See Box) “There is much uncertainty on treating those who turn out to have prostate cancer.” The uncertainty is no less if it is any other cancer, save the fact that if there is dis-ease, the same can be mitigated, at a price.

So from the time of Sushruta and Charaka until 2008, no cancerologist worth his name knows what to do. And the reason is simple. Cancerologic techniques are so advanced, technicalized, and complicated, that no one really knows what to do, and hence everyone gets away with whatever he does – of course, to the patient.

8. In “Symptomless local disease”, so the text above asserts, “As nothing proved beneficial, benefits of treatment are outweighed by risks!” This certainly is a most damning statement on the treatment of cancer prostate or any other cancer. *The Times of India* (March 26, 2008) headline – “US doc performs unbelievable surgery”, is a triumph of surgical technique, but no triumph whatsoever against the biology of cancer. The foregoing is discernible from the actual report below.

> *To get to the tumour, which was buried deep in Brooke Zepp’s abdomen and threatened to kill her within months, the organ transplant specialist said he first had to remove her stomach, pancreas, spleen, liver and small and large intestines.*
>
> *The organs were chilled and preserved outside Zepp’s body during a painstaking 15-hour operation at the University of Miami/Jackson Memorial Medical centre. They were re-implanted in their normal position after the tumour – which was about two inches in diameter and wrapped around Zepp’s aorta and the base of two other arteries – was removed. (Truly, digging a whole mountain to retrieve a mouse!)*
>
> *Kato said that never before have six organs been removed from a patient’s abdomen to allow doctors to go after a malignant growth previously considered inoperable because of its location. “There is nothing really simple here,” Kato, who trained as a surgeon at Osaka University in Japan, said on Monday,”I don’t want to say acrobatic but it’s a kind of, in a way. It’s very tricky operation.*

It is now a trite fact in cancer surgery that extensive, glorified, glamorized surgery is not translatable into any victory against cancer. You remove atheroma from the coronary or carotid, and remove a carcinoma from the prostate or pancreas, the atheroma/carcinoma get removed, but bits of the same and the body’s capacity to form a quick atheroma (atherability) or a carcinoma (cancerability) remains. In fact, this is an ordinary biological truth that continues to defy all advances in all modes of therapy of cancer or coronary/carotid artery disease.

9. (See Box, Last line). **"Ultimately, you must decide for yourself what you want."**

The above generous offer by modern medicine to a hassled, harried, confused patient and the kith and kin smacks of cancerolgy being a cafeteria where the learned doctor presents a menu card of treatments, each full of ifs and buts, from which the patient has to choose, and having chosen, give to the doctor "informed consent" in writing, to allow the therapy to be inflicted. If the doctor made the above offer out of utter desperation, how on earth is the patient to make a choice as to what to choose and why? It must be admitted that in this *laissez-faire* world-view on cancer therapy, the medical establishment continues to betray the admittedly-ignorant lay person called a patient. It is high time texts such as from Oxford learn to call a spade a spade and condemn clearly much of condemnable cures which are so often glorified, costly palliations.

Brian Inglis (*The Diseases of Civilization*, Granada, 1981) referred to a situation that prevailed in UK in the 50's to 80's, when a case declared inoperable by all standards, would however be assaulted by the wild knife of a "tinpot surgeon" who invented such atrocities as forequarter/hindquarter amputation, and hemicorporectomy, chopping the patient's body below the umbilicus, not excluding the two lower limbs. Thank God, the beknighted surgeon is dead and the surgeries are defunct.

We draw the attention of the reader to the story of Moris Abram's leukaemia, narrated earlier. Abran's famed therapist Holland "attacked my illness as if it were a personal enemy, as if the mere existence of leukaemia were an affront to his power."

Take most areas of modern medicine – infections, cardiovascular disease, cancer HIV-AIDS – the doctors and the establishment pose as fighting a pitched battle against the enemy disease, with the patient's body as the battlefield. It is like a losing gambler playing at heightened stakes – the only snag is that the loser is neither the establishment nor the doctor but the patient. As one of our students, a practicing ICCU-specialist put it, "the patient often dies and the family's finances have to be buried." No wonder in the meticulously insuranced America, the 5th largest cause of personal bankruptcy is medical bills. India has 3-upped USA. Next to dowry as the first cause, medical expenses are the 2nd largest reason for individual bankruptcy.

10. Ivan Illich, introduced *The Other Face of Cancer* to the world, as the first book that helps a layperson *use* expert advice rather than *be used* by the expert. After a sojourn of over 30 years during which our book has not only survived, but thrived, we can dare say that our book makes every

person an expert on cancer, for the simple reason that genuinely there has been NO expert worth his name on cancer. If you want the most reliable guide on your tumour/cancer/dis-ease, look into the mirror, and you will find one who is quite trustable.

Point 10 is, all things considered, the most practicable Commonsensology of Cancer.

The readers may justifiably feel let down that Illich, and we, are throwing down the burden of crucial decisions on the patient. The reasons for this major shift are easy to comprehend. This is the ICE – Information Communication Entertainment – Age. A little fondling of the mouse of your laptop googles you into knowing all that is known about your assumed or actual illness. So you can't deny that YOU ARE/CAN BE WELL INFORMED (to the point of developing Nettochondria – illness arising from scanning the Net). Now, with all your Net and *Reader's Digest/TV chat shows/Newspapers/Magazines* stuffing your head with all details, if you don't take the course of your problem in your hands, you are burdened with conflicts.

So we urge that you learn to read your own reports, and the media reports, intelligently. Intelligence, as a word is derived from *intel* = *inter* + *legere* meaning to read between the lines. The authors have seen a number of "cardiac" patients walking into our room with a huge file and the advice that a bypass/angioplasty is a must. When we just read out the 2-D echo to the "patient", there emerges positive data that the heart is good, and the advice for intervention has no investigational basis at all. You must not forget that your fears and the funded-fullness of medical practice tend to go together.

We cannot resist offering for your perusal the latest of the global double-speak from the research establishment. *The Times of India*, on the basis of *JAMA* of 2008, has headline: "Discovering hope from tiny strands of DNA – Since'05, 100 DNA Variables Have Been Linked to 40 Common Diseases." Modern medicine, never had it so good.

> *Scientists are scanning human DNA with precision and scope once unthinkable and rapidly finding genes linked to cancer, arthritis, diabetes and other diseases.*
>
> *Since 2005, studies with the gene-scanning technique have linked nearly 100 DNA variants in as many as 40 common diseases and traits, scientists noted this month in the Journal of American Medical Association.*
>
> *"There have been few, if any, similar bursts of discovery in the history of medical research," two Harvard researchers declared last summer in the New England Journal of Medicine.*

> *What does all this excitement mean for ordinary people? Not so much just yet. Simply finding the genes that can raise the risk of an illness doesn't mean you can prevent the disease. And developing a treatment for it can take years.*

The last Para in the above is a classical escape-clause every such breakthrough is usually pregnant with. The news-leak, tells the fund-giver to provide funds without being allowed to be at all certain about the outcome. The whole genetic bluff, however, gets called off by a report from USA (*The Times of India,* March 30), declaring an "an Indian-American red-flags gene cure."

> ***New York:*** *A research team led by an Indian-American scientist has challenged the validity of a prototype gene treatment based on Nobel prize winning work that has attracted billions of dollars in investment for developing cures for cancer, diabetes and other diseases.*
>
> *The team, led by Jayakrishna Ambati, made the surprising discovery that the gene silencing method, rooted in a 1998 breakthrough that earned the Nobel prize for medicine in 2006, works not by targeting the specific culprit gene, but by having a generalized effect of blocking blood-vessel growth that could harm a wide range of tissues.*

This teeter-totter game goes on and on – the public expectant all the time, kept pregnant with expectations all the time, and then the delivery-date never given.

The whole purpose of our briefing the so-called lay reader on a wide range of issues is to convey that the medicos, researchers, and media have proved to be Don Quixotes tilting at the windmills to cure mankind of illnesses that never existed in the first place. All age-related issues – Cancer, Coronary, Carotid (Stroke), Diabetes, Arthritis, and what have you – are all Age Governed Evolution, inherent to an animal body. If you are at peace with the wildest assortment of demonstrable pathologies, you are NOT diseased, hence no patient, hence not in need of any investigation/diagnosis/treatment. Set below are a few tips useful to you, and your near ones, so very often.

1. If you can peacefully and comfortably walk into a clinic for advice, you are NOT a patient.

2. If your 3 basic flows of air, water, and food are unflawed, life will go on merrily despite your scan showing a tumour here, a block (in the coronary) there.

3. With all reports normal, be ready to die with the very next breath.

4. With all your reports abnormal, be ready for your doctor to die. Did not Marcus Aurelius, the philosopher-emperor, whose glimpse you have had in the *Gladiator* movie, declare: “Many a physician forecasting doom for his own patient has had his funeral attended by the same patient.”

5. Remember what a Harvard dean told the newly-admitted medical students, in his inaugural address, way back in 1958, but worth its weight in gold as of 2008.

> *“Gentlemen, I urge you to engrave this on the template of your memories: there are thousands of diseases in this world, but Medical Science only has an empirical cure for twenty-six of them. The rest is … guesswork.”*
>
> ***Erich Segal***
> ***Doctors***

Whatsoever cure (=care) that Medical Science offers is *empirical,* synonymous in the lexicons, with guesswork, quackery, arbitrariness, and tyranny. Much of the modern management of cancer/coronary/carotid falls in the category of arbitrariness, often bordering on tyranny.

Another dean, USA, generalized: It’s generally known that 50% of what we teach in modern medicine is right. The trouble is no one knows for sure which 50%.”

6. A natural question would be – how come the so hotly pursued, funded, gadgetized, laboratorized, published, conferred, advertised Medical Science is so empirical, and so uncertain of itself. The answer is simple: Medical Science is *claiming* to research the unresearchable in terms of altering the course and providing a cure. These processes are part of biological programs which are governed by biological laws which are as unalterable as physical laws – apples cannot fall up.

You may just review Laxman’s incisive cartoon. More than 200 rhino (common cold) viruses have been isolated, but no one knows if they are mere passengers or drivers. And as of today after 50 years of research and a few billion dollars down the laboratory drain, no one knows what is common cold, why is common cold, and what to do about it.

> What I like about WHO
> (WHO = World Health Organization)
> Is, no one knows what they do.
> We still wait to be told
> The cure for common cold.

7. All that all –pathies do for all age-related issues is to provide *palliation*, a term derived from *pall* = the cover over a coffin (hence pall-bearers, in funeral procession).

Palliation is acceptance by its provider that "we have put the understanding of the main disease in a coffin. All that we offer is to ease your whatever the dis-ease."

8. Since the HEALTHY do NOT always SURVIVE, and, the DISEASED do NOT always DIE, learn to live, King size or Queen size, in presence of an age-old friend called disease. You may remember the assurance that Meyer Perlstein has left as a legacy: "If your time hasn't come, not even a doctor can kill you."

9. About many proscriptions ("Don't do this, don't do that") perpetually coming out of the increasingly moralistic medical establishment, have the resilience of a common man/woman to have the daring to eat the forbidden fruit. When it comes to say, drinking, remember what an old Arab tells to a young man while offering him a drink, in Paulo Coelho's *The Alchemist*: "Son, it is not important what goes into your mouth, but what comes out of it."

To that end, peruse the following warning that Henry Louis Mencken, a pioneer US journalist and mentor to Joseph Pulitzer (of the Pulitzer-prize fame) and acknowledged satirist on "the cruder manifestations of American Civilization" gave way back in 1923 and pertinent till this day for it forms the launching epigraphic statement of the celebrated *Oxford Textbook of Medicine*, 2000.

> *Hygiene is the corruption of medicine by morality. It is impossible to find a hygienist who does not debase his theory of the healthful with a theory of the virtuous. The whole hygiene art, indeed resolves itself into an ethical, exhortation, (and in the department of sex, into a puerile) and belated advocacy of asceticism. This brings it, at the end, into diametrical conflict with medicine proper. The aim of medicine is surely not to make men virtuous; it is to safeguard and rescue them from the consequences of their vices. The true physician does not preach repentance; he offers absolution.*

10. Emboldened by the liberating spirit of Mencken, we can do no better than to relish a poem by the British poet-laureate, W.H. Auden, himself the

son of a General Practitioner, in whose eyes, an *Ideal Doctor* be as follows:

Give Me a Doctor

Give me a doctor, partridge-plump,
Short in the leg and broad in the rump,
An endomorph with gentle hands,
Who'll never make absurd demands
That I abandon all my vices,
Nor pull a long face in a crisis,
But with a twinkle in his eye
Will tell me that I have to die.

Mencken and Auden may seem out of sync with the current global craze of "Healthy Life style" bordering on puritanism. Rene Dubos, founder microbiologist at the Rockefeller Institute, thinker, author of such classics as *So Human An Animal, Choices That Made Us Human, Man Adapting,* and *The God Within* wrote a brilliant critique of the medical scene in 1959, significantly titled *Mirage of Health – Utopia, Progress, and Biological Change*. Like Burnet, he candidly stated that the *Health Utopia* envisaged by Modern Medicine and backed by such bodies as WHO, just DOES NOT exist, nor is feasible no matter what. Modern Medicine's bankrupting business was perceived by him long ago.

> *A special report to the President also revealed that in 1952 a million American families had spent 50 per cent of their total familial income on medical care, and 8 million were in debt on that account. These enormous figures are alarming not so much by reason of their size but because they represent a trend (now gripping the whole world). As is well known, the very advances in medical science are constantly increasing the cost of medical care, a consequence of greater availability of various therapeutic procedures.*

Medical Image, April 2008, as the *Monthly Bulletin* of the *Indian medical Association,* Mumbai (West), more than justifies the tragedy stated by Dubos. A psychiatrist urges that all cancer patients, also consult psycho-oncologist, for "Diagnosis of cancer evokes a far greater emotional reaction than the diagnosis of any other disease." (Then why not avoid the diagnosis that is, clearly, avoidable, so often). Doctors know how to invent new specialities. The *Bulletin* announces "Anti Ageing Medicine Comes to

India," promises conferences, and ends on a brazenly lucrative note: "Join the Multi-Billion dollar Anti-ageing Medicine Market." The ad echoes Marlowe's lament in *Dr. Faustus:*

> *Be a physician, Faustus, heap up gold,*
> *And be eternized for some wondrous cure.*

Having so rubbished (the then) modern medicine, Dubos, in the style of Mencken, Auden and Morris, goes on to liberate the harried human mind.

> In the words of a wise physician, it is part of doctor's function to make it possible for his patients to go on doing the pleasant things of life – smoking too much, eating too much, drinking too much – without killing themselves any sooner than is necessary.

Desmond Morris is the greatest watcher/observer of *So Human an Animal.* His *People Watching* (Vintage, 2007) has a colourful picture of a lady celebrating her 121st birthday. The legend to the picture is a story by itself.

> *Ageing: The oldest person who has ever lived – Madame Jeanne Calment (of France) celebrating her 121st birthday. She died at the age of 122 without ever having experienced a single day's ill-health after a lifetime of enjoying rich food, alcohol, and cigarettes*.

Modern medicine has been almost ferociously championing *preventionism* – the art of telling the common person that "it's all your fault that you get cancer/coronary/carotid/HBP, and so on." It must be appreciated that the current prevention-crusade is the last resort of a discipline that is intellectually bankrupt, therapeutically impotent, intrusively arrogant, calculatively killjoy, and scientifically rudderless. Fuller Torrey, an eminent American psychiatrist has some penetrating thoughts on the prevention game.

> The most sacred shrine of the medical model is the temple of prevention. It is the sanctum sanctorum accorded homage equal to that given to cleanliness and godliness. The curing of a disease is good, nut the prevention of a disease is always better - sixteen times better, in fact, since "an ounce of prevention is worth a pound of cure." Prevention is powerful efficient, and American.
>
> ***E Fuller Torrey***
> ***The Death of Psychiatry***

Winston Churchill turned 80 and a pressman clicked him and said: "I hope to photograph you, Sir, next year also." And the great man who smoked

like a chimney and drank like a fish just quipped: “Why not, young man!! I see nothing with you.” Mark Twain the irrepressible American wit while being feted on his 70th birthday, was asked the secret of his health, happiness, and vigor. And he was brief:

> I have made two simple rules in life: I never smoke when I am asleep. And at a time, I never smoke more than one cigarette.

So, relax, enjoy life, enjoy even your illness. Dubos asserts that health-n-disease, like Yin-Yang must ride together. Do not opt for Health Utopia. Live life to its fullest.

Cancer as a biological phenomenon is not bereft of life’s inherent compassion, kindness and wisdom. These are the qualities that comprise *The Other Face of Cancer.* All age-related phenomena start with your first breath and live with you simply, peacefully, may be unto your grave. Pickering, world authority on *High Blood Pressure*, and Regius Professor of Medicine at Oxford University, summarizes the decency of all your diseasing in a convincing manner.

> *Thus, the myocardial infarction, the cerebral infarction, or gangrene of leg which terminates a patient’s life may be seen as the final episode of a series which remain silent over a long period of the patient’s life before they obtrude into his experience and finally terminate it.*

And what terminates you is not the disease, but your next breath which failed to turn up, for reasons well beyond you, us, and modern medicine.

As a climax to the laicization of cancer in particular and science in general we present two poems in light verse. Einstein urged that complex issues be so presented that “even a child can understand.” We hope you do.

The Soul of Your Sickness
-cancer, as an example

By the time your
Cancer gets detected
It has been with you
For a decade or two.

So if you lived with it
Without knowing about it
You can as well
Live with it for long.

What is cancer

Cannot be treated
What we treat
Is not cancer.

Do not trouble trouble
Unless trouble trouble you
And trouble your trouble
Trouble-far, no further.

It is really dis-ease
That warrants treatment
Hence seek treatment
Dis-ease-far, no further.

Cancer that dis-eases not
Merits neither diagnosis
Nor any treatment
Like grey hair, wrinkled skin.

In place of cancer, you can safely put coronary artery disease, carotid artery disease, HBP, diabetes or atrhitis, and you won't be much in the wrong.

The following lines have been inspired by Adi Shankaracharya's 10th century generalization that "if *gnan* (knowledge) can be infinite, so can be agnan (ignorance)', as also Pascal's 17th century metaphor that 'knowledge is the inner surface of a sphere whose outer surface is painted with ignorance. The reader is already acquainted with Thomas-n-Watson's 20th century generalization on the profundity of science's ignorance.

We know not
that
We know not

We seem to know.
We claim to know.
We pretend to know.
We do not know.

We do not know
That we know not.
We do not know
That we cannot know.

We refuse to know
What we should know,
And can easily know
If humility we know.

Apple hit Newton's pate

Gravitation was born.
We know all of it
But apple up won't fall.

Cell, cancer, coronary
Medicine knows them all.
Despite money, machines
They do what they want.

Human, humus, humility
Threads of single rope.
It's time *Homo sapiens*
Fullfills Linnean hope.

Mumbai,
April 7, 2008.

Manu Kothari
Lopa Mehta