

Lung cancer: New prospects for treatment

Dr. Sinan Akkurt, Doctor, Izmir, Turkey

My dear colleagues and bioresonance friends;

We are together in the 54th international Bicom bioresonance congress. I especially thank Mr and Ms Brugemann for giving me a chance to speak. Besides, I thank Sissi Karz for her great efforts in the cancer treatment protocol and Dr Zeynep Karabey for her support and informing us about all developments and innovations of bioresonance.

This year I would like to talk about primary and metastatic lung cancer and its treatment through Bicom bioresonance. As you know, during my speech in the previous years, I mentioned the Bicom bioresonance treatment of my mother who had peritoneum cancer, and my sister who experienced inflammatory type breast cancer when she was pregnant for 32 weeks. I have been receiving e-mails concerning this matter so I would like to state that my mother and sister are in the 5th year and at full remission. Even, my sister has given birth to her second baby. Before sharing my study with you let's remember lung cancer briefly:

The lungs

The lungs are 2 sponge-like organs found in the chest. The right lung has 3 sections, called lobes. The left lung has 2 lobes. The left lung is smaller because the heart takes up more room on that side of the body.

Cancer cells

When you breathe in, air enters through your mouth and nose and goes into your lungs through the windpipe (trachea). The

trachea divides into tubes called the *bronchi*, which enter the lungs and divide into smaller branches called the *bronchioles*. At the end of the bronchioles are tiny air sacs known as alveoli.

Many tiny blood vessels run through the alveoli. They absorb oxygen from the air you breathe in and pass carbon dioxide from the body into the alveoli to be breathed out when you exhale. Taking in oxygen and getting rid of carbon dioxide are your lungs' main functions.

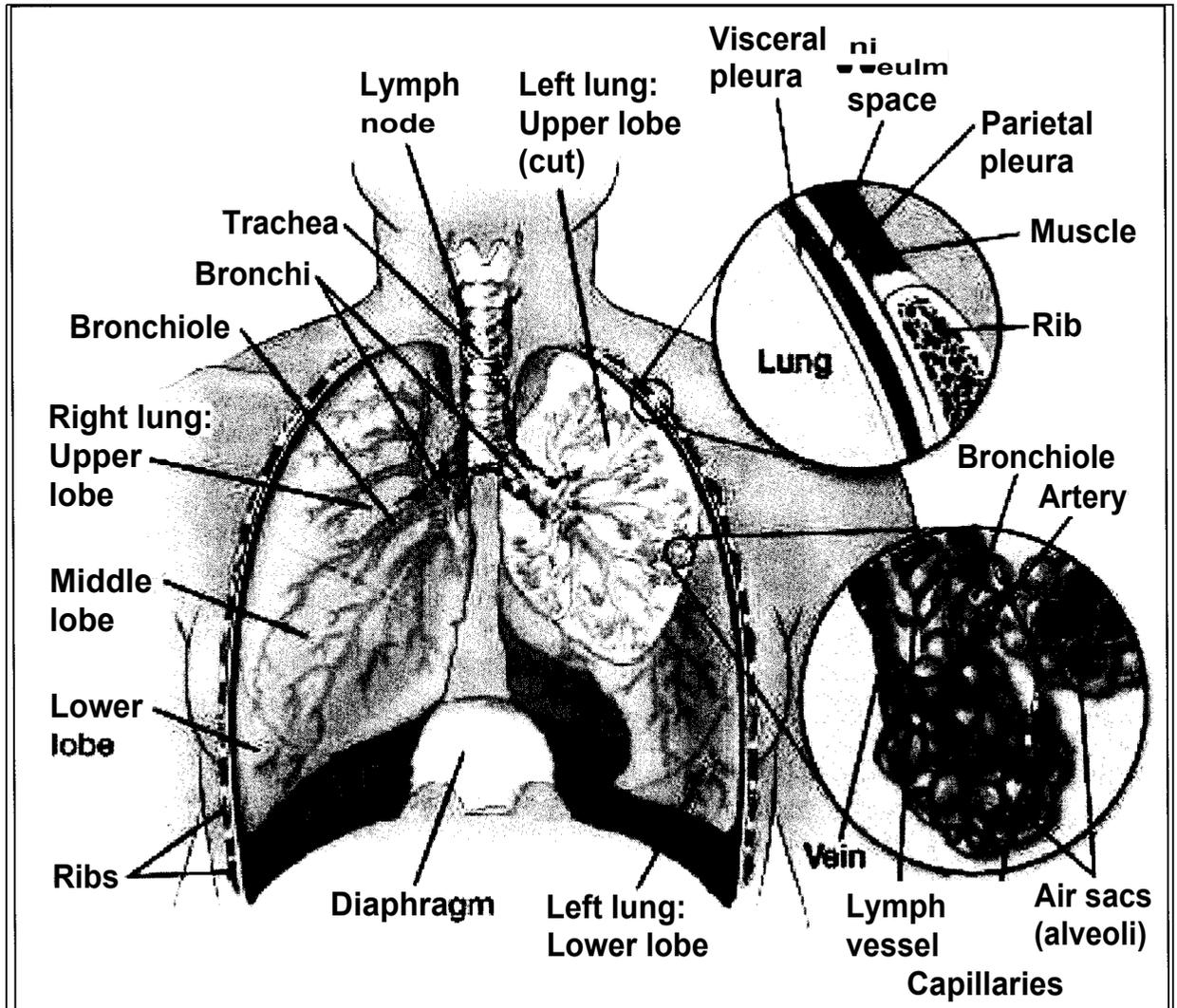
The thin lining around the lungs, called the *pleura*, helps to protect the lungs and allows them to move during breathing. Below the lungs, a thin muscle called the *diaphragm* separates the chest from the belly (abdomen). When you breathe, the diaphragm moves up and down, forcing air in and out of the lungs.

Cancer begins in **cells**, the building blocks that make up all tissues and organs of the body, including the lungs.

Normal cells in the lungs and other parts of the body grow and divide to form new cells as they are needed. When normal cells grow old or get damaged, they die, and new cells take their place.

Sometimes, this process goes wrong. New cells form when the body doesn't need them, and old or damaged cells don't die as they should. The buildup of extra cells often forms a mass of tissue called a growth or **tumor**.

Tumors in the lung can be **benign** (not cancer) or **malignant** (cancer).



Benign tumors:

- Are rarely a threat to life
- Don't invade the tissues around them
- Don't spread to other parts of the body
- Usually don't need to be removed

Malignant tumors (lung cancer):

- May be a threat to life
- Can invade nearby organs and tissues
- Can spread to other parts of the body
- Often can be removed but may grow back

Lung cancer is a disease characterized by uncontrolled cell growth in tissues of the lung. Its early detection is of paramount importance for diagnosis, classification, treatment, and improvement of

survivorship. If left untreated, this growth can spread beyond the lung in a process called metastases into nearby tissue or other parts of the body.

Lung cancer is the leading cause of cancer death worldwide. The incidence of lung cancer is strongly correlated with cigarette smoking, with about 90% of lung cancers arising as a result of tobacco use. While the risk of lung cancer is increased with even a 10-pack-year smoking history, those with 30-pack-year histories or more are considered to have the greatest risk for the development of lung cancer. Among those who smoke two or more packs of cigarettes per day, one in seven will die of lung cancer.

Passive smoking or the inhalation of tobacco smoke by nonsmokers who share living or working quarters with smokers, also is an established risk factor for the development of lung cancer. Research has shown that nonsmokers who reside with a smoker have a 24% increase in risk for developing lung cancer when compared with nonsmokers who do not reside with a smoker.

Some other things increase lung cancer risk, but they increase the risk far less than smoking. They are: exposure to radon gas, exposure to certain chemicals, air pollution, previous lung disease, a family history of lung cancer, past cancer treatment, previous smoking related cancers, lowered immunity.

There are two major types of lung cancer, **non-small cell lung cancer (NSCLC)** and **small cell lung cancer (SCLC)**.

Small cell lung cancer is called this because under the microscope the cancer cells look small and are mostly filled with the nucleus (the control centre of cells). It is also called oat cell cancer. Small cell lung cancer results from smoking even more so than non-small cell lung cancer, and grows more rapidly and spreads to other parts of the body earlier than non-small cell lung cancer. It is also more responsive to chemotherapy.

There are three common types of non small cell lung cancer. These are grouped together because they behave in a similar way and respond to treatment in a different way to small cell lung cancer. The three types are squamous cell carcinoma, adenocarcinoma, and large cell carcinoma. Occasionally it is not possible to work out which type of non small cell lung cancer you have. It may not be possible to tell if only a few cells are taken during a biopsy. It can also be difficult if the cells are very undeveloped. Undeveloped cancer cells are known as undifferentiated cells. Different types of treatment are available for patients with non-small cell lung cancer. Some treatments are standard (the currently used treatment), and some are being tested in clinical trials.

Other types of lung cancer

Along with the 2 main types of lung cancer, other tumors can occur in the lungs.

Lung carcinoid tumors: Carcinoid tumors of the lung account for fewer than 5% of lung tumors. Most are slow-growing tumors that are called typical carcinoid *tumors*. They are generally cured by surgery. Some typical carcinoid tumors can spread, but they usually have a better prognosis than small cell or non-small cell lung cancer. Less common are atypical carcinoid *tumors*. The outlook for these tumors is somewhere in between typical carcinoids and small cell lung cancer. For more information about typical and atypical carcinoid tumors, see the separate document, *Lung Carcinoid Tumor*.

Other lung tumors: Other types of lung tumors such as adenoid cystic carcinomas, hamartomas, lymphomas, and sarcomas, are rare and are treated differently from the more common lung cancers. They are not discussed in this document.

Cancers that spread to the lungs:

Cancers that start in other organs (such as the breast, pancreas, kidney, or skin) can sometimes spread (metastasize) to the lungs, but these are not lung cancers. For example, cancer that starts in the breast and spreads to the lungs is still breast cancer, not lung cancer. Treatment for metastatic cancer to the lungs is based on where it started (the primary cancer site). For information on these primary cancers, see our separate documents on each.

Risk factors for developing lung cancer

Lung cancer develops when the cells that line the lungs sustain genetic damage. Scientists have identified several different chemicals and environmental factors that are capable of causing the kind of genetic damage that can lead to lung cancer. Substances capable of producing cancerous changes in cells are called carcinogens.

The majority of lung cancers occur in people who are either current or former smokers.

While the relationship between smoking and lung cancer is well-established, other factors also come into play. We know this because only about one out of every ten smokers develops lung cancer. Further, approximately one out of every six people who develops lung cancer never smoked. These statistics tell us that lung cancer development is a multi-factorial process, meaning many different factors contribute to developing the disease. Known lung cancer risk factors are reviewed briefly in this section.

Smoking

More than 85% of all lung cancer cases occur among people who are either current or former tobacco smokers.' The relationship between smoking and lung cancer is caused by the carcinogens present in

tobacco smoke. The risk of developing lung cancer from smoking is influenced by many factors including the age at which a person began smoking. The younger a person was at the time he or she started smoking, the greater the risk of lung cancer. The effects of carcinogens accumulate over time. Therefore, a person's total lifetime exposure to cigarette smoke is considered when trying to determine his or her risk of lung cancer. Total lifetime exposure is usually expressed in pack-years. See Figure 1 for how pack-years are calculated. Recent studies suggest that women are more susceptible to the carcinogenic effects of tobacco smoke than men are.⁹ This means that if a man and a woman have the same pack-year history of smoking, the woman is at greater risk for lung cancer than the man is.

<u>Packs per day smoked</u>	x	<u>Years of smoking</u>	=	<u>Pack-years</u>
2 packs/day	x	10 years	=	20 pack-years
1 pack/day	x	20 years	=	20 pack-years
1/2 pack/day	x	40 years	=	20 pack-years

Figure 1: Calculating Pack-Year Exposure to Tobacco Smoke

Tobacco smoke is not the only type of smoke that contains carcinogens. Scientists have shown that the smoke from marijuana and crack-cocaine contain numerous carcinogens. Therefore, smoking marijuana and crack-cocaine increase a person's risk of lung cancer.

The good news is that a smoker's risk of developing lung cancer can be greatly reduced by quitting. Lung cancer risk does not immediately drop after smoking cessation because most lung cancers are present for several years before they become symptomatic. However, ten years after quitting, lung cancer risk drops to a level that is only 20-50% of the risk experienced by those who continue to smoke. Lung cancer risk continues to decline gradually

over time. Nonetheless, a former smoker's risk of lung cancer never drops to the same level as someone who has never smoked. A former smoker's risk always remains higher than that of a never-smoker.

Smoking is not simply a bad habit. Smoking is a physical and psychological addiction to the nicotine in tobacco. Nicotine meets all the criteria of an addictive drug.

Second-hand smoke

The health risks of tobacco smoke are not limited to smokers. The lungs of anyone who breathes in air that contains tobacco smoke are exposed to its carcinogens. Therefore, exposure to smoky air in the home, workplace, or in public can increase a person's risk of lung cancer. Children are

particularly vulnerable to the health risks associated with second-hand smoke.

Environmental carcinogens

Environmental carcinogens are substances in the environment capable of producing genetic damage that could contribute to the development of cancer. Following is a brief review of some of the most common, known lung carcinogens.

- Asbestos
- Radon
- Arsenic
- Chromium
- Nickel
- Polycyclic Aromatic Hydrocarbons (PAHs)

Other environmental lung carcinogens

Known lung carcinogens not already mentioned include bis(chloromethyl)ether, chloromethyl methyl ether, ionizing radiation (X-rays), gamma radiation, mustard gas, soots, tars, mineral oils, and vinyl chloride. Suspected lung carcinogens include acrylonitrile, cadmium, beryllium, lead, and ferric oxide dust. Many other known, suspected, and potential carcinogens could contribute to the development of lung cancer.

Genetic factors

The transformation of normal cells into cancer cells is a complex, multi-step process. Everyone is exposed to lung carcinogens. While we know that the total amount of exposure is one factor that governs whether someone develops lung cancer, we also know it is not the only factor. Most lifelong smokers never develop lung cancer, and a significant number of people with no known personal or environmental risk factors develop lung cancer. These facts make it obvious that it is not only what we are exposed to, but also how our bodies handle the exposures that determine whether lung cancer develops.

Genes control how a person's body handles carcinogens, how susceptible it is to genetic

damage, and how capable it is of repairing damage that occurs. Genes also control how well the immune system detects and destroys cancer cells. Therefore, an individual's unique genetic make-up contributes to his or her susceptibility or resistance to lung carcinogens. One of the most striking features of lung cancer cells is the large number of genetic changes present in them. Often 10-20 genetic mutations are found, indicating a genetic instability in lung cancer cells.

Age

Age itself may contribute to a person's risk of lung cancer. Genetic damage tends to accumulate over time. Scientists currently believe that cells accumulate multiple genetic defects before becoming cancerous. Therefore, as we age, the probability of accumulating enough genetic damage to lead to cancer increases. In addition, the immune system works less effectively as we age. This increases the likelihood that cancer cells will slip through our natural cancer surveillance system.

Lung cancer is rare among people less than 40 years of age. The vast majority of lung cancers are diagnosed in people over the age of 50. The average age of newly diagnosed lung cancer patients is around 60 years of age.

Common signs and symptoms of lung cancer

Most lung cancers do not cause any symptoms until they have spread too far to be cured, but symptoms do occur in some people with early lung cancer. If you go to your doctor when you first notice symptoms, your cancer might be diagnosed at an earlier stage, when treatment is more likely to be effective. The most common symptoms of lung cancer are:

- A cough that does not go away or gets worse
- Chest pain that is often worse with deep breathing, coughing, or laughing
- Hoarseness

- Weight loss and loss of appetite
- Coughing up blood or rust-colored sputum (spit or phlegm)
- Shortness of breath
- Feeling tired or weak
- Infections such as bronchitis and pneumonia that don't go away or keep coming back
- New onset of wheezing

When lung cancer spreads to distant organs, it may cause:

- Bone pain (like pain in the back or hips)
- Neurologic changes (such as headache, weakness or numbness of an arm or leg, dizziness, balance problems, or seizures)
- Jaundice (yellowing of the skin and eyes)
- Lumps near the surface of the body, due to cancer spreading to the skin or to lymph nodes (collections of immune system cells) in the neck or above the collarbone

Most of the symptoms listed above are more likely to be caused by conditions other than lung cancer. Still, if you have any of these problems, it's important to see your doctor right away so the cause can be found and treated, if needed. Some lung cancers can cause a group of very specific symptoms. These are often described as *syndromes*.

Homer syndrome

Cancers of the top part of the lungs (sometimes called Pancoast *tumors*) may damage a nerve that passes from the upper chest into your neck. This can cause severe shoulder pain. Sometimes these tumors also cause a group of symptoms called *Horner syndrome*:

- Drooping or weakness of one eyelid
- Having a smaller pupil (dark part in the center of the eye) in the same eye
- Reduced or absent sweating on the same side of the face

Conditions other than lung cancer can also cause Horner syndrome.

Superior vena cava syndrome

The superior vena cava (SVC) is a large vein that carries blood from the head and arms back to the heart. It passes next to the upper part of the right lung and the lymph nodes inside the chest. Tumors in this area may push on the SVC, which can cause the blood to back up in the veins. This can cause swelling in the face, neck, arms, and upper chest (sometimes with a bluish-red skin color). It can also cause headaches, dizziness, and a change in consciousness if it affects the brain. While SVC syndrome can develop gradually over time, in some cases it can become life-threatening, and needs to be treated right away.

Paraneoplastic syndromes

Some lung cancers can make hormone-like substances that enter the bloodstream and cause problems with distant tissues and organs, even though the cancer has not spread to those tissues or organs. These problems are called paraneoplastic *syndromes*. Sometimes these syndromes may be the first symptoms of lung cancer. Because the symptoms affect other organs, patients and their doctors may suspect at first that a disease other than lung cancer is causing them.

Some of the more common paraneoplastic syndromes that can be caused by non-small cell lung cancer include:

- High blood calcium levels (hypercalcemia), which can cause frequent urination, thirst, constipation, nausea, vomiting, belly pain, weakness, fatigue, dizziness, confusion, and other nervous system problems
- Excess growth of certain bones, especially those in the finger tips, which is often painful
- Blood clots
- Excess breast growth in men (gynecomastia)

Again, many of the symptoms listed above are more likely to be caused by conditions other than lung cancer.

The TNM staging system

The system used to describe the growth and spread of NSCLC is the American Joint Committee on Cancer (AJCC) **TNM** staging system. The TNM system is based on 3 key pieces of information:

- T** indicates the size of the main (primary) **tumor** and whether it has grown into nearby areas.
- N** describes the spread of cancer to nearby (regional) lymph **nodes**. Lymph nodes are small bean-shaped collections of immune system cells to which cancers often spread before going to other parts of the body.
- M** indicates whether the cancer has spread (**metastasized**) to other organs of the body. (The most common sites are the brain, bones, adrenal glands, liver, kidneys, and the other lung.)

Numbers or letters appear after T, N, and M to provide more details about each of these factors. The numbers 0 through 4 indicate increasing severity.

The TNM staging system is complex and can be hard for patients (and even some doctors) to understand. If you have any questions about the stage of your cancer, ask your doctor to explain it to you.

T categories for lung cancer

TX: The main (primary) tumor can't be assessed, or cancer cells were seen on sputum cytology or bronchial washing but no tumor can be found.

TO: There is no evidence of a primary tumor.

Tis: The cancer is found only in the top layers of cells lining the air passages. It has not invaded into deeper lung tissues. This is also known as carcinoma *in situ*.

Ti: The tumor is no larger than 3 centimeters — slightly less than 1 $\frac{1}{4}$ inches — has not reached the membranes that surround the lungs (visceral pleura), and does not affect the main branches of the bronchi.

If the tumor is 2 cm (about $\frac{4}{5}$ of an inch) or less across, it is called **T1 a**. If the tumor

is larger than 2 cm but not larger than 3 cm across, it is called **T1 b**.

T2: The tumor has 1 or more of the following features:

It is larger than 3 cm across but not larger than 7 cm.

It involves a main bronchus, but is not closer than 2 cm (about $\frac{3}{4}$ inch) to the carina (the point where the windpipe splits into the left and right main bronchi).

It has grown into the membranes that surround the lungs (visceral pleura).

The tumor partially clogs the airways, but this has not caused the entire lung to collapse or develop pneumonia.

If the tumor is 5 cm or less across, it is called **T2a**. If the tumor is larger than 5 cm across (but not larger than 7 cm), it is called **T2b**.

T3: The tumor has 1 or more of the following features:

It is larger than 7 cm across.

It has grown into the chest wall, the breathing muscle that separates the chest from the abdomen (diaphragm), the membranes surrounding the space between the two lungs (mediastinal pleura), or membranes of the sac surrounding the heart (parietal pericardium).

It invades a main bronchus and is closer than 2 cm (about $\frac{3}{4}$ inch) to the carina, but it does not involve the carina itself.

It has grown into the airways enough to cause an entire lung to collapse or to cause pneumonia in the entire lung.

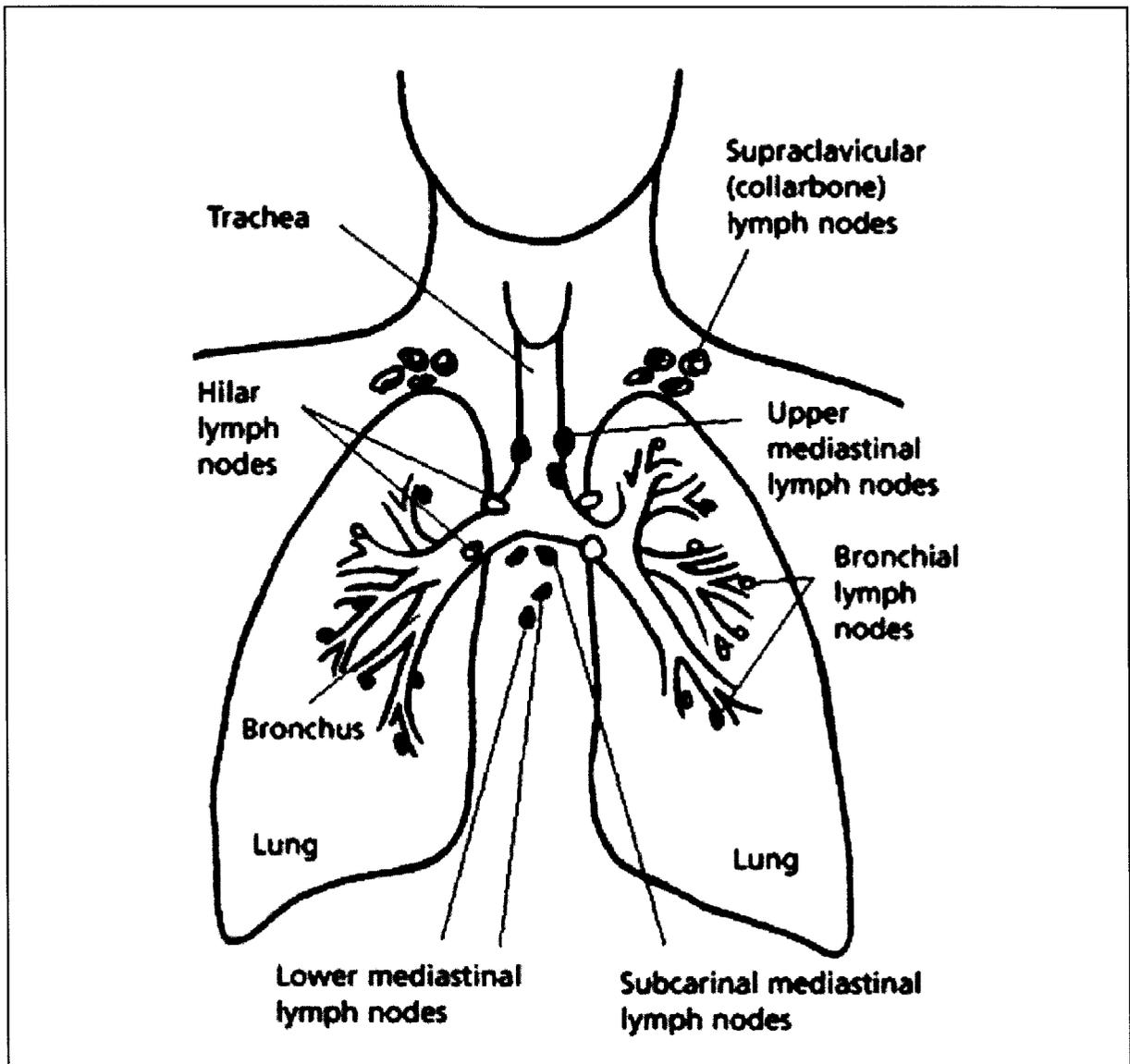
Two or more separate tumor nodules are present in the same lobe of a lung.

T4: The cancer has 1 or more of the following features:

A tumor of any size has grown into the space between the lungs (mediastinum), the heart, the large blood vessels near the heart (such as the aorta), the windpipe (trachea), the tube connecting the throat to the stomach (esophagus), the backbone, or the carina.

Two or more separate tumor nodules are present in different lobes of the same lung.

N categories for lung cancer



N categories for lung cancer

NX: Nearby lymph nodes cannot be assessed.

NO: There is no spread to nearby lymph nodes.

N1: The cancer has spread to lymph nodes within the lung and/or around the area where the bronchus enters the lung (hilar lymph nodes). Affected lymph nodes are on the same side as the primary tumor.

N2: The cancer has spread to lymph nodes around the carina (the point where the windpipe splits into the left and right

bronchi) or in the space between the lungs (mediastinum). Affected lymph nodes are on the same side as the primary tumor.

N3: The cancer has spread to lymph nodes near the collarbone on either side, and/or spread to hilar or mediastinal lymph nodes on the side opposite the primary tumor.

M categories for lung cancer

MO: No spread to distant organs or areas. This includes the other lung, lymph nodes further away than those mentioned in the N stages above, and other organs or tissues such as the liver, bones, or brain.

M1 a: Any of the following:

- The cancer has spread to the other lung.
- Cancer cells are found in the fluid around the lung (called a *malignant pleural effusion*).
- Cancer cells are found in the fluid around the heart (called a *malignant pericardia effusion*).

M1 b: The cancer has spread to distant lymph nodes or to other organs such as the liver, bones, or brain.

Diagnostic tests

The final stage of the cancer can only be decided after surgery, when the tumor and lymph glands have been removed. However, the following tests help predict the stage and guide treatment recommendations:

CT scan: The CT scan is a simple and effective test that provides information about the size of the tumor, and can suggest whether the tumor has spread to nearby lymph glands or organs. Findings on a CT scan, however, must be interpreted with caution. For example, enlarged lymph nodes seen on a CT scan do not always imply spread of the cancer. They may be enlarged for other reasons, such as infection.

PET scan: A relatively new technique, the PET scan is also used to help determine the stage of lung cancer. Unlike a CT scan, the PET scan can image the entire body at one time, and can indicate whether the cancer has spread to distant organs such as the bone or liver.

Mediastinoscopy: Surgical procedure performed under general anesthesia is one of the most important and accurate tools used to determine the stage of lung cancer. During the operation, a small incision is made above the breastbone. A telescope is then inserted, and samples are taken from the lymph glands within the chest. A pathologist will then determine whether the cancer has spread to these lymph glands. Mediastinoscopy is a simple procedure that usually requires less than one hour. Mediastinoscopy may be performed as an

outpatient procedure, or before a larger operation to remove the lung tumor.

Needle biopsy: A needle biopsy is a procedure in which a piece of the tumor is removed using a small needle. The tumor is then examined under the microscope to determine if it is malignant. This test is often used to determine whether a "spot" seen on a CT scan or chest X-ray represents cancer.

Occult stage lung tumor

Tumor cells are found in sputum, but CT scans and other imaging tests don't show a lung tumor.

Stage 0 lung tumor

Abnormal cells are found only in the innermost lining of the lung. The tumor has not grown through this lining. A Stage 0 tumor is also called carcinoma in situ. It is not an invasive cancer.

Stage I lung cancer

The lung tumor is an invasive cancer. It has grown through the innermost lining of the lung into deeper lung tissue. The tumor is surrounded by normal tissue, and it doesn't invade nearby tissues, such as the chest wall.

The tumor is no more than 5 centimeters (about 2 inches) across. Cancer cells are not found in nearby lymph nodes.



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A tumor that is 5 centimeters across is about the size of a lime.

Stage II lung cancer

The lung tumor is smaller than 7 centimeters across, and cancer cells are found in nearby lymph nodes.

Or, cancer cells are not found in nearby lymph nodes. The lung tumor is more than 5 centimeters across, or it invades nearby tissues, such as the chest wall, **diaphragm**, pleura, main bronchus, or tissue that surrounds the heart. More than one malignant tumor may be found within the same lobe of the lung.

Stage III lung cancer

The tumor may be any size. More than one malignant tumor may be found within the lung.

Cancer cells may be found in lymph nodes on either side of the chest or the neck. The tumor may have invaded nearby organs, such as the heart, **esophagus**, or trachea.

Stage IV lung cancer

Malignant tumors are found in both lungs. Or, the lung cancer has spread to other parts of the body, such as the brain, bones, liver, or adrenal glands. Or, cancer cells are found in fluid between the two layers of pleura.

After reviewing lung cancer briefly, we can pass on to our study.

Our study included 42 patients with primary or metastatic lung cancer whom we treated between 2009 and 2014. Patient approvals were also taken.

The average age of our patients is 63.21. 29.3% of these patients are women and 70.7% of them are men. These findings are also supporting the studies. There is no exact data about the incidence rates in our

country, however, according to the results from the cases reported to the Ministry of Health in 2013, the incidence of lung cancer increases as the age increases. As a result of the study, the average age for diagnosis is found to be about 60. And, lung cancers are observed in 30% of males 5% of females. In other words, the disease seen in male is more often. According to the 2012 report of American Cancer Society, 21% of male cancers and 5% of female cancers in the European Union countries are lung cancers.

Of the patients whom we treated, 25 have primary lung cancer and 17 have lung metastasis. Metastasis to lung is mostly from lymph nodes in males and from breasts in females. Of the patients with primer lung diagnosis, 64% have brain and 19% have bone metastasis.

24.3% of our patients have been treated through chemotherapy and bioresonance treatment, 4.8% of them by radiotherapy and bioresonance treatment, 58.5% of them by chemotherapy, radiotherapy and bioresonance treatment, and 12.1% of them through only bioresonance treatment.

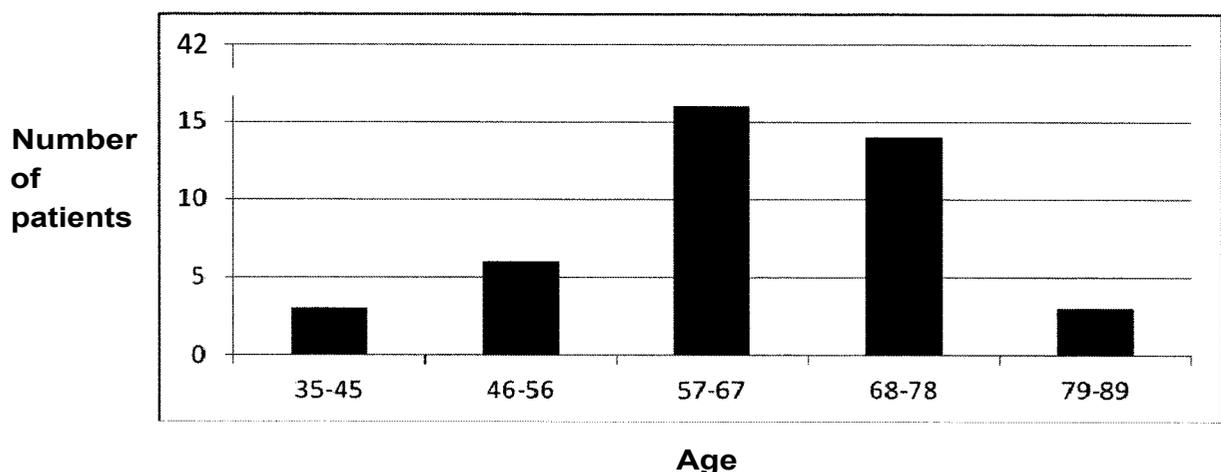


Figure 2: Lung cancer incidence according to the age groups

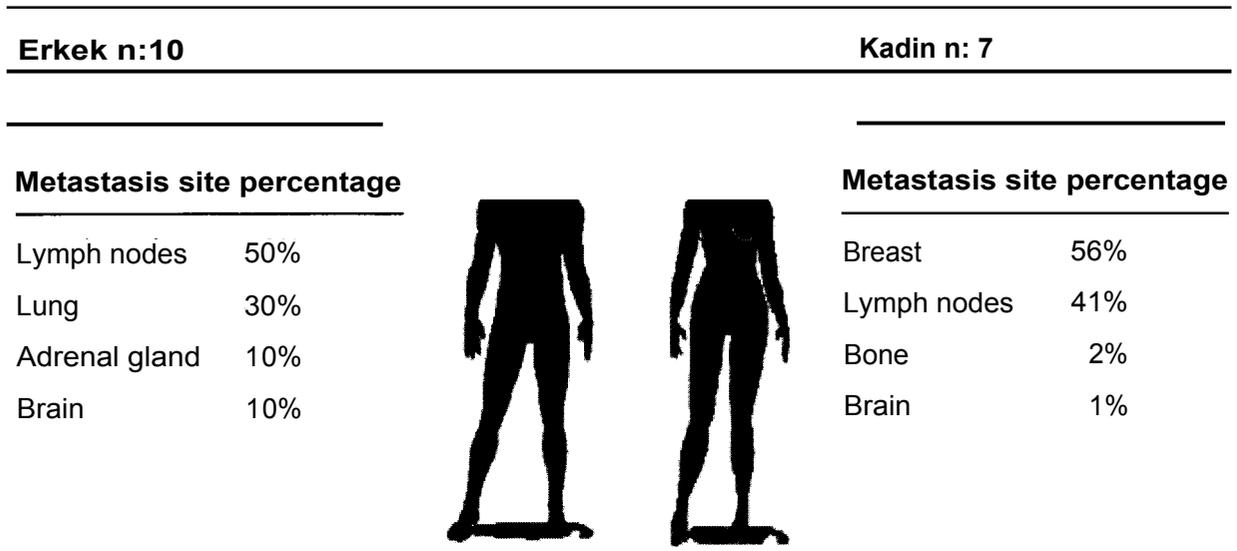


Figure 3: Lung cancer metastasis sites according to gender

In the results of our blood tests, the most remarkable findings in our patients are as follows: 31.7% Gamma Herpes (Epstein-Barr-V.) (VF 011) in virus group, 90.2% Candida Mix (VF 035) in fungus group, 56% Parasite 5 (Lungs) (ELP 013) in parasitic group, 41.4% Formaldehyde (ELP 040) and 51.2% X-Rays (ELP 053) in the chemical substances and radioactivity group, 58.5% Milk (AS 037) in allergy group, 51.2% mercury (VM 045) in heavy metal group.

As a result of our DC panel scanning, DC 001 was defined in 21 of our patients and DC 003 was defined in 28 of patients. In other words, most of the patients consulting our clinic are at the advanced stage.

Our treatments are composed of 2 sessions and our average session number is 40.9. Fatigue of our patients decreases in the 3rd-4th sessions. Zeroizing (sifirlama) of degenerative cells has taken 6 months averagely. DCs of 21 patients have been zeroized, then it has been observed that there was a recession in 11 patients, 7 of our patients passed away and 3 of our patients could not be reached. All of our patients who passed away applied our clinic at the terminal

period. As a result of radiology, in 65% of the patients whose DCs were zeroized, tumor disappeared.

We have stated that smoking is the prominent factor responsible in lung cancer etiology. About 90% of the lung cancer patients are smokers. Studies have shown that the lung cancer incidence is 24-36 times more in smokers. Therefore, we make our patients stop smoking who are ready to do it through Bicom bioresonance therapy of quitting smoking. Even though smoking is not the primary cause of lung cancer, it increases the risk (see Table on top of next page, top left column).

Patients generally apply our clinic for the purpose of treatment or supporting the treatment they are having with their reports prepared by another physician or hospital. After a detailed anamnesis is taken and the patient is examined, we take blood from the patients and scan their CTT panels. Our and our patients' greatest advantage is that we can define the organs where the tumor is located by defining the vibration code at an early stage, in other words by determining the vibration code as a cancerous cell, in these biophysical testing methods that we apply. CU oncology method gives information about which

Relative risk		
Stop-smoking period	Male	Female
2-9 years	0.66	0.41
10-19 years	0.27	0.19
20-29 years	0.17	0.08
30 + years	0.08	0.13
Never smoked	0.04	0.11
Still smoking	1.00	1.00

Table 1: Lung cancer risk eliminated after stopping smoking
 (Simonato L, Agudo A, Ahrens W, et al. Lung cancer and cigarette smoking in Europe: an update of risk estimates and an assessment of inter-country heterogeneity. Int J Cancer 2011; 91:876-87)

tissue is exposed to change, the expansion and level of cancer. The ampler anti virus defined is given to the patient through the number 192 program or BICOM optima second channel along with bacteria and parasite bulbs. Our aim of giving anti ampoules (ampuller) provides also the treatment of mycobacterium, Epstein-Barr-V. and Parasites 5 (Lungs) which we have

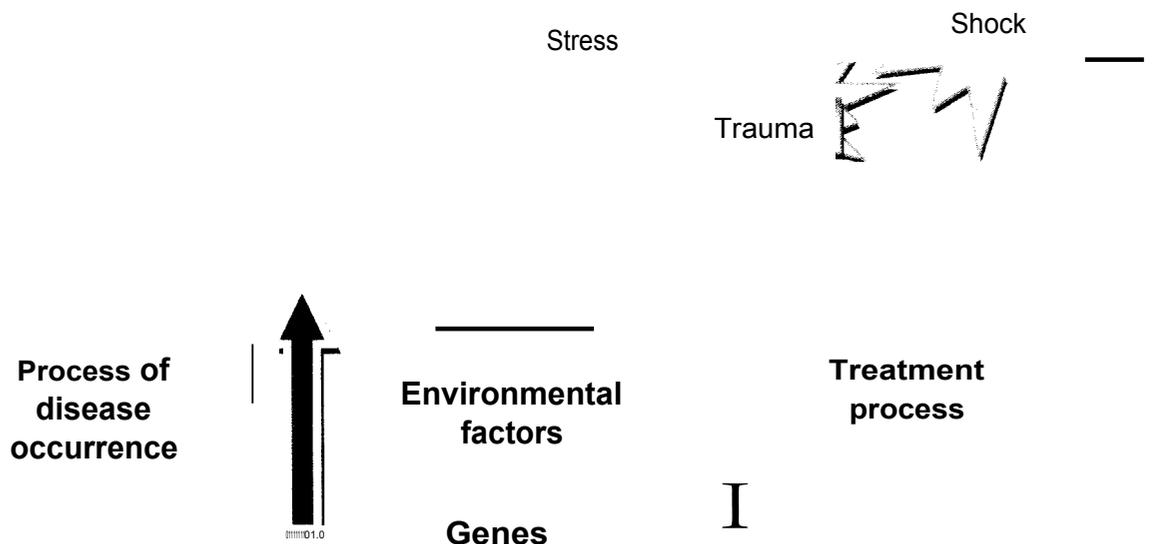
mentioned and which are effective on the formation of cancer. DC (Degenerated Cells) of our patients are controlled once in a week. Thus, if there is a new formation, we can realize it. We are taking our patients under treatment with intervals of 3 days. However, when DC ampoules are zeroized, this period decreases to 1 week and according to the patient's immune system, the intervals of sessions expand as once a month, one in 3 months, once in 6 months. Even if our patients are under full remission, their oncology panels are scanned once in 3 months. Besides, we asked our patients for the preparation of the cancerous tissue, if possible, and we apply the program of number 998.

Input Electrode:

Output Electrode: — On the cancerous region

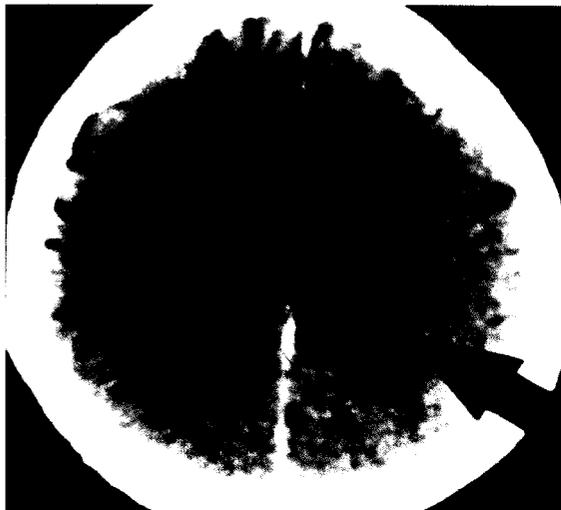
Input cup: — preparation

When approaching to the cancerous patients, we use the cup method. According to this method, there are genetic factors at the basis of cancer as well as the environmental effects (bacteria, allergy, toxin, etc). And, the top layer is composed of unsolved inner conflicts.(UIC) If the person is exposed to a long time stressor or



experiences a sudden loss or shock, the limit is exceeded and cancer occurs. This case is 100% true in all cancer patients. We start to treat our patients from the opposite direction of the cup.

In the treatment of cancer, as I mentioned, the testing of CTT panels, geopathic factors, electromagnetic exposure should take place at the first stage. In the first session of the patients, the treatments of geopathy, blockage, Hamer focus, and shock therapy are applied. Hamer focus and shock therapy composes the subconscious part exceeding the limits and causing cancer. I said that we treat the cup from the opposite direction, which means that we clean the subconscious of the patient, primarily. In order to achieve this, I also apply the psychological kinesiology which is a supplementary technique.



Ring-shaped Hamer focus
at begin of the healing phase

Hamer focus is a blockage and it must be treated, certainly. Cancer and chronic illnesses occur after the sudden shocks experienced simultaneously at psychological, mental and organ levels.

During the development of Hamer focus, there occurs a focus in the brain due to the shock and seen in CTs. Every psychological shock causes inner conflict. If the person solves this inner conflict, s/he gets over the shock and the focus disappears; if it is not solved, there occurs cancer at the related organ. Thanks to this treatment, the relation between that focus and tumor is disconnected.

Input Electrode: On the tumor
Output Electrode: applied on the focus
Magnetic matt: on the back

After the program has ended, treatment is repeated by switching the places of the electrodes.

By testing the treatment numbers 923, 998 and 999, proper care is taken accordingly.

The logic of shock treatment is the same as well, meridian psychological is located from the center line of the head to the cervical 1.

Input Electrode: long flexible electrode along the meridian
Output Electrode:
Magnetic matt on the back/front

The program number at BICOM optima is 10147; at BICOM 2000 they are 1050, 1051, 1052 and 432.

Other programs that we used during the treatment are as follows:

For the patients not operated

BICOM 2000	BICOM optima
830 Lymph activation	3040 Tissue regeneration
951 Immune system support	3032 Blood circulation disorders
802 Improve oxygen absorption	3125 Cell regeneration, chronic
911 Phantom pain	3066 Lymph activation, low frequency
940 Supporting central nervous system	3084 General regulation
926 Tumour shrinking program	

For post-operation

999 Mucous membrane detox
905 Dissolving of drug blockages
927 Wound healing

For the programs below

Input Electrode: hands and feet

Output Electrode: spike electrode or knob electrode on top of the place of operation

BICOM 2000	BICOM optima
915 Blockage program	3036 Detox regulation
844 Regulation of adrenaline secretion	3021 Improving blood values
630 Injury, pain	10026 block in tissue
340 Treatment of Connective tissue	3124 Cell regeneration, acute
402 Cell stimulation	10187 Post-operational wound healing
931 Wound healing anregen	10192 Cell regeneration nach OP
951 Cell regeneration, infection resistance	10122 Postoperative treatment
920 Postoperative treatment	3066 Lymph activation
930 Lymph activation	10097 Lymph activation

After radiotherapy

Input Electrode: spike electrode or knob electrode on the diseased region

Magnetic matt: crosswise on the kidneys

BICOM 2000	BICOM optima
925 Tissue regeneration	10058
951 Cell regeneration, infection resistance	10026
927 Wound healing	10175

Patients undergoing chemotherapy

BICOM 2000	BICOM optima
999 Mucous membrane detox	
960 Vegetative Control disorder	10170 Vegetative Control disorder

1 -2 days before Chemotherapy

BICOM 2000	BICOM optima
241	3021+3053

For all Patients

BICOM 2000		BICOM optima	
828	Bismuth point	10089	Consecutive Treatment in Cancer
915	Blockage program	10178	Healing of Vital Capacity
431	Healing of Vital Capacity		
926	Consecutive Treatment in Cancer		
980+981	1st Stage:	Input Electrode:	left heel
		Output Electrode:	2 hand plates
	2nd Stage:	Input Electrode:	7th vertebra, knob
		Output Electrode:	left heel
900	1st Stage:	Input Electrode:	1) forehead + flexible electrode 2) solarplexus
		Output Electrode:	both toes
	2nd Stage:	Input Electrode:	on both metatarsal bones of the feet
		Output Electrode:	on the forehead + flexible electrode

Supporting this treatment protocol which we apply, according to Sissy Karz, we test the vitamin and mineral points of our patients and stimulate these points while providing oral vitamin supplements, especially 16 mg of vitamin C daily for the adults (see, doctor Hulda Clark). Besides, when we first meet our patients, we tell them to cut off meat and sugar. Our aim is, on the other hand, to make the cancerous cells starve and to prevent metastasis. The study carried out by Johns Hopkins hospital also supports our aim. According to the study, sugar is a cancer feeder. By cutting off sugar, a significant food for cancer cells is also cut off. Cancer cells thrive in an acid environment. A meat-based diet is acidic and it is best to eat fish, and a little chicken instead of beef or pork. Meat also contains livestock antibiotics, growth hormones and parasites, which are all harmful, especially for the people with cancer. Thus, these people with cancer should not eat meat and sugar.

In addition to these programs, we have made EAP measures on the patients with cancer:

1. Measuring Hypothalamus, quadrant values of the 40 terminal points
2. Determining pathological values (Which organ or organ systems are under stress and what kind of energy lack exists?)
3. Reactive Measuring on the pathological points which have high energy levels

(We are making a test with 991 program. We put blood, saliva, oncology panel and the preparation, if there is one, into input cup (girl§ kupasi). If the pathological values of the patients become normal, we can say that the chance of healing is high for that patient.)

If the pathological values of the patients become normal, we can say that the chance of healing is high for that patient.)

My advice to the patient on general therapy

1. Basic therapy should be carried out according to quadrant values
2. Blockage treatment should be carried out first in order to assure energy distribution (including Hamer focus and shock)

3. Testing and treatment of vitamin and mineral points should be carried out
4. The patient should receive treatment with oncology panel in every session
5. Preparation treatment should be carried out with program 998 if possible
6. Immune system should be supported continuously (428, 950, 951, 570/1005)
7. Wash out and detox programs should be carried out in every session
8. The diet of the patient should be regulated (meat and sugar restricted, vitamin C plenty)
9. Psychological kinesiology can be preferred if needed.

SAMPLE CASE

O.D., 40 years old, male patient, he was diagnosed with lung cancer in 2011.

He is at stage 4, no metastasis. He was having his 4th cure of chemotherapy when he applied to our clinic. He took radiotherapy for 30 days. His degenerative cells were positive and 16 minutes and the preparation was 13 minutes. He was having the effects of the chemotherapy heavily, he had lost 12 kilos (app. 26 pounds) and

had extreme fatigue. In a month or two after he started taking the treatment, he had less fatigue, he did not feel the effects of the chemotherapy as usual, and he had good appetite and gained kilos/pounds. The DC ampoules and preparations, and his chemotherapy was zeroized when the radiological findings showed that he was in full remission, but we continued with our supporting treatments. We followed up the patient for 6 months with sessions twice a week. Then we extended the sessions and our patient has been in full remission for 2 years.

During the cancer treatments we have been carrying out for about 6 years, as a Professional, I have observed that we can help our patients at every stage of cancer disease with Bicom bioresonance therapy. We can treat our patients with bioresonance therapy alone whether the patient asks for conventional therapy or rejects classical medicine. I am telling this honestly to my colleagues as someone (as a Doctor) who treated his mother and sister with Bicom bioresonance method: My dear colleagues, you can treat cancer with Bicom bioresonance method!

Thank you for listening

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