Documented cases of successful cancer therapy and recent discoveries in cancer therapy

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INTRODUCTION

Ladies and gentlemen,

First I should like to present some success stories in cancer therapy from my practice.

CASE HISTORIES

Case 1: H.L., male, aged 69
Colectomy 3/96 due to carcinoma of the colon

10/2000 CEA raised at 6.7

EAV ***diagnosis:*** Ascaris lumbricoides, Fasciolopsis bush rediae in large intestine, Clostridium perfringens, Candida albicans and glabrata, Aspergillus fumigatus and ochraceus, Nocardia, Penicillinum frequentans, Mucor mucedo, Helminthosporum hel.)

- Ortho-phospho-tyrosine
- Trichomonads on liver and gallbladder meridian
- Leptospirosis icterohaemorraghia
- Tumour supporting ampoules

4/2001: liver segment resection with infiltration of a partially highly differentiated carcinoma with intestinal differentiation

8/2001 ultrasound normal, tumour supporting ampoules no longer tested

12/2001 laboratory values and tumour marker normal

8/2002 tumour marker NAD, lung involvement NAD

- Very mild preneoplasia no longer tested

3/2003 ortho-phospho-tyrosine locally with *Kurzbak* (Ref. 2) at 0.15, fungi following provocation at lung meridian at 0.2, Ascaris larvae at 0.05

Case 2: E.N., female, aged 62

Case history at start *of* ***treatment:*** cytological results from gynaecologist on 7/02 showed PAP III-IV (suspected even positive: possible hysterectomy planned due to pathological cells and degenerative changes).

Own results on 9/2002:

- Renal and intestinal detoxication not guaranteed
- Parasitic infestation with Ascaris larvae and Ascaris lumbricoides, Fasciolopsis buski, Trichomonads
- Ortho-phospho-tyrosine
- Tumour supporting ampoules, program 51
- Geopathic stress
- Radioactivity
- Mycotic infestation (Candida glabrata and krusei, Aspergillus niger, Nocardia asteroides)
- Bacterial infestation (Clostridium septicum and cadaveris)
- Insecticide (PCP) and heavy metal stress (Mercurius solubilis, bijodatus, Aurum, Plumbum, Palladium)

Cytological results at end *of 10/2002:* PAP I-II (normal cytogram with inflammatory changes of varying intensity).

Cytological results in March 2003: PAP I, normal cytogram.

Case 3: E.R., male, aged 77, treatment begun 7/01

Case history: medullary thyroid carcinoma, s/p complete removal of thyroid 4/2001, sip prostate cancer 1996

- Geopathic stress
- Fasciolopsis bush cercariae, Ascaris larvae and eggs, Ascaris lumbricoides, Trichomonads

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[6] Candida glabrata, stelladoidea, Fusarium solare, moniliforme, Nocardia asteroides, Cryptococcus neoformans
- Ortho-phospho-tyrosine
- ❍ Mercurius solubilis and corrosivus, Aurum
- Clostridium septicum and acetobotulinum

8/2001 tumour marker increased, patient felt well subjectively, calcitonin level above 400 (norm at 35, above norm suspected medullary thyroid carcinoma, values above 300 pg,/m1 provide practical evidence).

9/2001 calcitonin dropped to 370

- Ascaris lumbricoides at 1.3

10/2001 calcitonin dropped to 270

- Ascaris lumbricoides on triple warmer no longer tested, search not continued as connections not known
- Geopathy no longer tested

1/2002 calcitonin at 278

2/2002 calcitonin at 319

3/2002 calcitonin increased to 408, nuclear magnetic resonance normal, patient good overall state of health as before, Ascaris tested again both with Kurzbak at thyroid and as general infestation
- Ascaris lumbricoides at 1.45, Trichomonads at 56
- Fungi at metabolic meridian (OD — organ degeneration) at 1.5
- ❍ Clostridia no longer tested
- Ortho-phospho-tyrosine at 1.95

4/2002 calcitonin dropped to 341

5/2002 calcitonin dropped to 242

- Ascaris lumbricoides at 0.1

8/2002 calcitonin at 140

- Ascaris lumbricoides at 0.65

10/2002 calcitonin at 240

- Ascaris lumbricoides with *Kurzbak* at 0.15
- Fungi at 0.9

11/2002 Ascaris lumbricoides no longer tested

- Fungi at 0.05 following provocation

1/2003 calcitonin 196

- Ortho-phospho-tyrosine no longer tested
- Fungi no longer tested after provocation
- Trichomonads no longer tested
- Ascaris eggs and larvae no longer tested

Case 4: E.W., female, aged 58, Norway

Case history: 1988 breast cancer, two lymph nodes removed which were not contributory. January 2000 changes in breasts and metastases in the lungs detected, 5 small nodes in the breast removed. Two chemotherapy and 25 radiation sessions between January and March 2000, which did not reduce metastases yet did stop growth. (Husband contracted cancer in 1995 and died 1999.)

Start of treatment: May 2001 (so far 20 therapy sessions until now, approx. once a month). Continued chemotherapy until September 2001.
- Geopathy and radioactivity
- Spinal block 915, 581
- Fasciolopsis buski miracidien, Trichomonads, Ascaris larvae and Ascaris (on circulatory and lung meridian)
- Ortho-phospho-tyrosine
- Clostridium perfringens and tetani
- Aspergillus fumigatus together with Ascaris, Tuberculinum klebs, Nocardia asteroides, Fusarium pulm
- Tumour supporting ampoules
- Mercurius solubilis

11/2001
- tumour neither grown nor reduced in size
- Ascaris gone at circulatory meridian, lung meridian at 1.7

1/2002 Ascaris at 0.85 at lung meridian

4/2002 Ascaris at 34 at lung meridian

5/2002 CT of thorax, 2 metastases, the larger measuring 2 cm in diameter, no new metastases, no regional recurrence, patient in excellent general state of health

10/2002 metastases 2 mm smaller

1/2003 CT thorax: slightly reduced lung metastases, no new metastases suspected since July 2001, lymph nodes craniocaudal and near Aorta pulmonalis slightly thickened

3/2003
- nodes again slightly reduced
- Ascaris larvae at 0.5 locally with *Kurzbak* at sternum
- Ortho-phospho-tyrosine at sternum 0.3
- Clostridia at sternum 0.9
- Tumour supporting ampoules in D15, program 56 no longer tested

- Nocardia 0.65 at nervous system
- Trichomonads at sternum 0.9

Case 5: K.T., male, aged 70

s/p 5 operations on papillocarcinoma with severe cytological atypia 1998, diabetes. Recurrence at least in form of adenoma suspected since October 2000. Not possible to operate due to occluded by-pass (hepatic artery).

5/2001 s/p endoscopic partial removal of a papilloadenoma with partially severe cytological atypia, no invasive growth of the tumour yet required urgent monitoring.

History in August 2001:

- Elimination of scar interference, intestinal and liver detoxication
- Parasitic infestation
  - Eurytrema pancreaticum
  - Fasciolopsis buski
  - Fasciolopsis buski cercarie
  - Ascaris larvae at gallbladder meridian

Ascaris larvae

- October 2001: gallbladder meridian 1.4
- January 2002: gallbladder meridian 1.2
- June 2002: no longer detectable

Ortho-phospho-tyrosine

- No longer detectable in November 01

Tumour ampoules R1 A3 and A4, A7

- No longer detectable in March 2002

Mycosis

- Candida parapsilosis, robusta, albicans, lcrusei
- Nocardia asteroides
- Aspergillus fumigatus and versicolor
- Fusarium solare

Fungi no longer detectable in June 2002

- Mercurius solubilis
- Clostridium tetani
- Coxsackie **B1 and B5,** A4

Results March 2002, Nuremberg Hospital: All in all we are pleased to confirm that, at the present time, there is no indication of resumed growth of the tumour. We recommend the next check-up in one year's time.

It is with some pride that I can say to you today that, since the remarks in my last paper on cancer therapy at the international colloquium in Fulda in 2001, we have come a step closer to ensuring success.

Today I should like to present to you the latest discoveries leading to this success. I should add straight away that these should be regarded as an expansion on the remarks I made in my 2001 lecture (Ref. 1).

I would therefore ask you to read that information once again if you are interested in the whole concept.

RECENT DISCOVERIES

The first of these, for me, fundamental discoveries arose from a case at my practice.

A patient with suspected malignant thyroid nodule had high levels of calcitonin (an important factor in this clinical picture). After we had cleansed all the parasitic infestations, Clostridia and environmental toxins in the traditional manner and carried out supporting ampoules for cancer therapy, most of his stresses had disappeared and his calcitonin levels had fallen to such an extent that the patient and his doctor were very satisfied.

Some months later however, it emerged during the course of a routine check-up that these levels had risen again very rapidly.

Consequently I tested the patient thoroughly and compared my results with the earlier testing protocol when his calcitonin levels were lower. I noticed that, at that time, Ascarides and infestation with Ascaris larvae had disappeared and yet had now reappeared.

Ascaris and tumour markers

As I result, I considered whether these parasites could be connected in some way with the tumour marker. We then worked very quickly and intensively with this patient who cooperated willingly as he had already experienced one positive result. This means he carried out one Papain treatment after another, which I prescribe against Ascariasis in such cases, and took high doses of L-Cysteine capsules, which I use against larvae.

We treated him intensively with bioresonance and the frequency generator. Treatments were continued until I could hardly detect any Ascarides or Ascaris larvae in the patient. I should say at this point that it is essential to check with the *Kurzbak*

(Ref. 2), for only this device can reliably indicate local infestation of the tumour or nodule by Ascarides.

We were extremely pleased when the patient had another blood count and his calcitonin levels had dropped again considerably. I then conducted this, for me highly significant, experiment on a whole series of patients who I was treating at the time and who were known to have high levels of various tumour markers.

We concentrated on Ascarides infestation and always used the *Kurzbak* to check. In addition we prescribed Papain treatment to be carried out roughly every 8 days. We already knew, as you will recall from the last lecture, that Ascarides infestation is inevitably present with all cancers. I can now at this point announce something quite sensational.

We were able to prove in virtually every case that, provided the patient still had the strength to undergo this treatment, tumour markers could be reduced by these measures.

This even applied, for example, to a patient with extremely advanced cancer who came to me from Sweden and whose hospital had already given up on her. Her condition had relapsed and metastases had spread all over her body (her primary cancer was in the breast) and cachexia was so far advanced that chemotherapy was not really feasible.

Nevertheless, we were able to reduce this patient's tumour marker (CEA) from 9000 (yes, you read it correctly!) to 7000. At her next examination at the hospital they wondered why this tumour marker had fallen to 7000. Naturally this patient unfortunately died shortly after.

It seems that, at least in most cases, the activity of the tumour can be equated with the presence of Ascarides activity.

Attention: The tumour marker's fall obviously does not mean, dear colleagues, that this tumour has disappeared or got smaller but just that its activity has largely declined, which can still be considered a positive result. How we now get the body to absorb the tumour is the next step.

As this problem with the Ascarides became evident in an extremely dramatic manner, I worked desperately to acquire a grasp of it more quickly and developed a so-called mega Papain treatment for severe cases. It is often important for the patient to produce at least a partially successful result before the next hospital examination to makeit easier to decide whether or not to then begin or continue chemotherapy or radiation.

In the same way that when a patient, who has not yet been examined at hospital, comes to me and whose cancer is already very advanced, then the activity must be reduced as quickly as possible. This mega Papain treatment proceeds as follows:

Patient has no food for two hours, then:

- Every hour: 1000 mg Papain
  500 mg L-Cysteine
  300 mg wormwood (1 capsule)
  for 6 hours
- He is then allowed to eat again, low protein food if possible
- Treatment period 6 days

Provocation

The next, no less astonishing development was that, for Ascarides, which were no longer found with the *Kurzbak*, I have developed two methods for provoking the tumour so that, after this provocation, Ascaris and Ascaris larvae could be tested again!

The procedure is as follows:

- First carry on treating and conducting mega Papain treatment until no Ascarides can be tested at the next session.
- Then, before the next test session, get the patient to carry out a so-called turmeric (Curcuma) treatment for between two and four days.

Turmeric is a well-known vegetable chemotherapeutic agent for cancer.

The administration pattern for turmeric is the same as with Papain treatment.

Patient has no food for two hours, then:

- Every hour: 2 capsules Curcuma
  for 6 hours
- He is then allowed to eat again, low protein food if possible
- Treatment period 4 days

At the end of these four days the patient comes back for testing and what do we find: by provoking the tumour with the turmeric substances it may well be that Ascaris larvae can be tested again, at which point you must continue to treat them.

The second method, which is quicker, is to provoke the tumour by applying zapper current or frequency generator current for about 1 minute up to a maximum of 1 min 30 sec. You must ensure that the electrodes are placed so that the tumour is provoked, in other words that the current flows right over the appropriate area.

Then, through the phenomenon of electrophoresis and thus through the opening of the cells which this current causes, totally different stresses than previously can be tested. And it is often the case that Ascaris larvae can be tested again.

Attention, be careful at this point: If you apply the current for much longer than 1 min 30 sec, then the patient cannot be tested for another 20 to 40 mins. A fact which very few therapists realise and which often leads to misinterpretations if it is not taken into consideration.

Trichomonal infestation

The second major discovery which we made at this time with cancer therapy arose after I came by chance upon Mrs Lebedeva's book. This book is entitled "Krebserreger entdeckt" [Carcinogens revealed]. In this book Mrs Lebedeva, a Russian chemist, claims to have discovered the true cause of cancer, namely the monocellular Trichomonads!

A claim which I could not initially really take seriously for she claims not only that Trichomonads cause this cancer but that cancer cells are really Trichomonad cells which assume different forms, e. g. cystoid or encapsulated forms.

A closer look at her research work shows, however, that she really should be taken seriously as a scientist and her claim examined.

As a result, I began testing cancer patients with Trichomonad ampoules. Two initial forms are available: Trichomonas vaginalis and Trichomonas muris.

I was totally amazed that Trichomonads actually tested positive in over 90 % of cases of cancer. This made me sit up and take notice, so I studied the literature more carefully.

Mrs Lebedeva claims there are three different Trichomonads: vaginal Trichomonads, oral Trichomonads, which are less well known, and intestinal Trichomonads. By checking up in parasitology, it is possible to see that a whole series of different Trichomonads exist.

She also claims that these Trichomonads exist in three forms: the flagellar stage, the amoeboid stage and the cystic stage. These different formsand types of Trichomonad give rise to the variety of different tumour tissues.

As this claim went a bit too far for me, I kept this knowledge to myself for a while and simply integrated Trichomonad treatment in my patients' cancer therapy.

As a result, I wanted to have this fact confirmed for myself in the laboratory. So I endeavoured to obtain tumour tissue, put it in a Trichomonad bouillon and finally send it to the lab to obtain confirmation of this daring claim. It was virtually impossible to obtain human tumour tissue in Germany.

Consequently, a vet at one of my parasite seminars suggested investigating with animal tumour tissue.

The following thought raced through my mind:

"If this claim is justified for human tumour tissue, then it should also be correct, at least to a certain extent, for animals." We then obtained various types of tumour tissue from several vets. A special thank you now to all those vets who provided us with material.

I divided up the tumour tissue, prepared it and, in each case, we sent one piece to the lab and looked at the other piece ourselves in the surgery.

I can report to you here that we were occasionally, but not always, able to observe isolated Trichomonad cells developing. Yet in the three cultures, which we had sent to the lab, we obtained no positive confirmation. Further research therefore had to be carried out. I was able to observe, however, that the cancer patients, in whom Trichomonads were tested and integrated in the therapy, improved quicker overall.

My position today is: on no account can I confirm whether tumour cells really are Trichomonads. However, on the basis of tests and the occasional development of Trichomonads in animal tissue, I can claim at this point that they play a part in the development of cancer and they must be taken into consideration. I have tested out many substances to find appropriate agents which are effective against Trichomonads. The following emerged from this:

- fish oil
- cranberries
- garlic
- propolis

These are used alternately in the treatment of my cancer patients.

Spin tester

The third fundamental point is the integration of findings about the spin tester in tumour therapy, which I have illustrated in my lecture about the spin tester.

This is an extremely interesting fact for us. We assert namely, as you know, that geopathic stress, whether old or current, is present in 98 % of all cancer cases.

This geopathic stress causes an overwhelming proportion of the blood to be left-spin. Through my cancer patients I came upon the idea of including the spin tester, which has become somewhat forgotten, in therapy. After I had observed that this geopathic stress persists for a relatively long time in most cancer patients — even after changing the place where they sleep.

I went one step further. We prepared a blood ampoule routinely for each cancer patient. The left-spin content of this ampoule is checked at the traditional points for geopathy, namely triple warmer, nervous system, spleen and at the meridian on which the tumour is located, i. e. we check all frequencies thoroughly with an A program (e. g. program 990) and all amplifications as well, to see whether the right-spin setting on the spin tester is needed.

To interpret this: we test whether we have to reinforce the right-spin part of the patient's blood or not.

Autologous
blood ampoule 9 Spin tester on "R-Drehend" [right-spin]

Test Bi Com **program 990 through all amplifications**

You obtain a positive testing here in all cases without exception. I then go through these amplifications, beginning mostly with 1 or 2, e. g. program 990 is suitable. You go through each amplification and oscillate this, and this is the great thing about it, on the chip! I take my time here and when I have gone through all the therapy, I go through all amplifications once more on the circulatory meridian. As I said, everything is charged to the chip as I do this.

After treatment, this chip is then stuck on the patient right over the site of the tumour so that he constantly receives right-spin information.

So I was very surprised when, after careful therapy such as this, the patient came back for testing and all his meridians no longer needed this right-spin information, I nevertheless determined with the *Kurzbak* that the tumour tissue itself was still overwhelmingly left-spin and still needed its right-spin content reinforcing.

For me this was sensational as it really showed that this spiral development of left-spin pathological information in the blood and tissue changes something to such an extent that a tumour tissue develops which clings persistently to its left-spin right up to the end.

In this case you simply carry on with therapy. The right-spin content is reinforced, charged to the chip and placed on the tumour area. The obvious question which arose from this was: "What causes such a strong left-spin; could it be that the parasites previously tested contain this left-spin information?"

This was not the case with Fasciolopsis buski and Ascarides did not make an impression in testing either. What are actually completely left-spin in their pathological state, however, and improve the value of a right-spin are (wait for it):

1. the Trichomonads. And, as I explain in my lecture on the spin tester, also
2. bacteria, that means also Clostridia which are inevitably present with tumour tissue and obviously environmental toxins,
3. the polycyclic aromatic hydrocarbons, which here have no right-spin content at all and so are pure left-spin unnatural substances.

The outcome for therapy was that we treat Trichomonads with an inverse oscillation and also reinforce right-spin with the spin tester. This information is also added to the chip which is stuck over the site of this tumour tissue.

Treating Trichomonads simultaneously with right-spin and inverse information over a prolonged period going through all the stages and amplifications caused one patient in my practice to vomit spontaneously and another to have an immediate attack of diarrhoea which she had to attend to in the surgery!

So this demonstrates what a violent effect this therapy has.

Obviously we also use the frequency generator and the latest-generation zapper equipped with a chargeable chip which patients can use to treat themselves each day. All patients need this. The programmable zapper and which regulatory blocks

can completely prevent bioresonance therapy and how these can be broken down, is the topic of my new book ("Sanftes Heilen durch Frequenzen" [Gentle healing with frequencies], see Suppliers and information).

Polycyclic aromatic hydrocarbons, which I have just mentioned and which are always present, test in the form of toluene, xylene, benzanthracene, DDT, lindane etc. and should always be taken into consideration.

Further information is contained in my 2001 lecture (Ref. 1).

Samento — Cat's Claw

The final essential point which I have integrated into cancer therapy was the discovery of an extremely strong immunomodulator in the form of a plant called Cat's Claw which is already well-known in the literature. It is an old remedy originating from the Peruvian rainforest and used by the Ashaninka Indians. Around 10 years ago when it came into fashion, it naturally did not entirely live up to its promise as a rheumatic agent.

I noticed that this was due to the method of harvesting and manufacturing the remedy and that a company had taken it upon itself to adopt the production methods of the Indians. As a result, certain alkaloids, namely TOAs, which destroy the effect of Cat's Claw, are not present in the preparation known by the name Samento and so the preparation actually keeps its promise. Unlike traditional Cat's Claw products, Samento does not contain tetracyclic oxindole alkaloids (TOAs) which act on the nervous system and limit the therapeutic effect. Instead Samento contains exclusively pentacyclic oxindole alkaloids (P0As), which influence the cellular immune system, strengthening it considerably. According to studies in Austria, traditional Cat's Claw products contain around 80 % TOAs. Samento is a guaranteed TOA-free Cat's Claw product.

As, however, even 1 % TOA can, by its effect of blocking the immune system, cancel out up to 30 % of the immune-promoting effect of POAs, it is clear why in the past the remedy had to be taken in extremely high doses of up to 20,000 mg per day to produce the desired effect on the immune system. And only one in ten experienced a definite improvement in their condition.

I was extremely surprised to notice with a test ampoule that Samento not only actually tested strongly as an antidote to all intracellular micro-organisms, i. e. mainly Borrelia, Chlamydia, Rickettsia and also viral stresses such as hepatitis and Epstein-Barr, but also indicated as necessary as immune support with all cancer patients in testing and consequently positive results could be expected from its use. Incidentally, there are studies on the effect of Samento on Borrelia and viral stresses, even a double blind trial which was published recently. I would ask you to request the literature (see Suppliers and information).

Summary

Dear colleagues, these are essentially the latest results in cancer therapy.

Summary:

- treat Ascaris and Ascaris larvae carefully and comprehensively
- look out for Trichomonad infestation
- reinforce the autologous blood's right-spin information
- prescribe Samento as immune support

CONCLUDING REMARKS

I hope you find that these measures work well against this dreadful disease as its incidence rate is increasing literally each year in Germany and throughout the whole world, to the extent that it now lies in second place in the mortality stakes after cardiovascular disease but will probably overtake it in the foreseeable future.

Thank you for your attention!

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