Teoria Trofoblástica do Câncer de John Beard - 1902

John Beard's Trophoblast Cell Theory

(and a mention of its modern equivalent)

Dr John Beard of Scotland described a plausible fundamental model for all cancers and published a paper on in 1902. He stated, and later showed clinically, that cancer was likely the result of failure of the pancreas to produce proper amounts of pancreatic enzymes. He stated that cells left over from embryonic development of the fetus (trophoblast cells) are scattered throughout our bodies and later in life are occasionally stimulated (by toxins or wear-and-tear, etc.) to begin replicating themselves. It is the job of pancreatic enzymes to digest these cells the moment they begin to multiply. What makes this theory compelling is that cancer cells are **very like** young undifferentiated trophoblast cells, in appearance and behaviour. Beard called his theory The Unitarian Trophoblastic Theory of Cancer. It deserves a great deal of respect because:

a. it fits the facts
b. predicts which cures will help.

If, for any reason, the pancreas failed to release enough of the pancreatic enzymes which digest protein, these primitive cells begin to multiply and the result is cancer, the rapid, uncontrolled growth of undifferentiated (trophoblast-like) cells. If it's true, the treatment is obvious! Give pancreatic enzymes. The whole theory was soon rubbished by the medical establishment but as a result of Beard's announcement, clinic began springing up all over (there were 40 in London), offering a cure for cancer using crude pancreatic enzymes. However not long afterwards Madam Curie came along and convinced people that X-ray was the way to go because it was so "safe" and "effective" and the pancreatic cancer cure was quickly abandoned. Marie Curie became famous and John Beard was promptly forgotten (that's called "scientific progress"!).

The trophoblast cells of pregnancy are typical cancer cells that eat into the uterine lining to prepare the nest. These cells are eventually turned off when the fetal pancreas turns on, otherwise the deadly cancer of pregnancy - **chorion-carcinoma** - ensues and kills the mother and baby very quickly (today there is an excellent cure rate for chorion-carcinoma). This was the key to Beard's discovery of the link between cancer and pancreatic insufficiency - the fact that in every specie he investigated, it was the turn on of the foetal pancreas function that coincided with the end of growth of the trophoblast cells of pregnancy. Trophoblast cells of pregnancy are exactly like cancer cells. Based upon his theory an early cure of a sarcoma was effected by one of his MD friends who injected the pancreatic enzymes - they believed at the time that the enzymes needed to be injected because digestion would inactivate them. Fortunately, pancreatic enzymes survive stomach digestion and so can be taken orally.

William Donald Kelley, a dentist from Grapevine, Texas, cured himself of pancreatic cancer in the sixties, largely using Beard's theories, and went on to develop a nutritionally-based, do-it-yourself home cure for cancer which is probably over ninety per cent effective in patients who have not been overly destroyed by chemotherapy and orthodox treatments.

No-one need die of cancer. However, it is a full time job to cure yourself of cancer. The cause and cure are known and at hand. See the Kelley programme in full.

HERE'S SOME BEARD STUFF I PLAIN STOLE FROM DR NICHOLAS J. GONZALEZ (with lots of links back to his site, so I guess he won't mind!):

Enzyme Therapy and Cancer
By Nicholas Gonzalez, M.D.
The Scottish embryologist, Dr. John Beard, proposed in 1906 that the pancreatic proteolytic enzymes represent the body's main defense against cancer, and would be useful as a treatment for all types of cancer.1 Particularly during the first two decades of twentieth century, Dr. Beard's thesis attracted some attention in academic circles, and several case reports in the medical literature documented tumor regression and even remission in terminal cancer patients treated with pancreatic enzymes.2,3,4,5,6 In 1911, Dr. Beard published a monograph entitled The Enzyme Therapy of Cancer, which summarized his therapy and the supporting evidence.7

After Dr. Beard's death in 1923, the enzyme therapy was largely forgotten. Periodically, alternative therapists have rediscovered Dr. Beard's work, and used pancreatic proteolytic enzymes as a treatment for cancer.8

Dr. Beard believed the enzymes had to be injected, to prevent destruction by hydrochloric acid in the stomach. However, recent evidence demonstrates that orally ingested pancreatic proteolytic enzymes are acid stable,9 pass intact into the small intestine, and are absorbed through the intestinal mucosa into the blood stream as part of an enteropancreatic recycling process.10,11

I began researching the use of oral pancreatic proteolytic enzyme therapy as a treatment for cancer after completion of my second year at Cornell University Medical College in 1981. At that time, I had the opportunity to meet Dr. William Donald Kelley, the Texas dentist who for twenty years had been treating cancer patients with a complicated nutritional therapy based on Beard’s enzyme treatment. Although Kelley had been attacked in the press because of the unorthodox nature of his work, the Dr. Kelley I met was an unassuming man whose primary wish was to have his controversial work fairly evaluated by the academic medical world. I thought his request reasonable.

My research advisor at Cornell, Dr. Robert A. Good, at the time President of Sloan-Kettering, agreed to support a case review of Kelley's patients, which I continued despite the rigors of third year medical school. During my fourth year at Cornell, I was given a considerable block of time under Dr. Good's direction to investigate Kelley's work and

results in a more structured manner. Eventually, what began as a student project developed into a two-year formal research effort which I pursued during my formal immunology training.

During my study, I reviewed nearly 10,000 of Dr. Kelley's patient records. I interviewed and evaluated intensively over 500 patients with appropriately diagnosed advanced cancer, and summarized my findings in an extended monograph completed in 1986 as partial fulfillment for my fellowship training.

The written report consisted of several sections. In addition to outlining Kelley's theoretical approach, I discussed at length 50 of his patients initially diagnosed with a variety of poor prognosis cancer, all of whom had enjoyed long term survival and/or apparent regression of disease while following their nutritional regimen. As a separate chapter, I also evaluated all cases of unresectable pancreatic cancer, both compliant and non-compliant, who had come to see Kelley between 1974 and 1982. I eventually identified 22 patients in this group. For all of these patients, I obtained complete medical records, including death certificates for those who were deceased. I interviewed all surviving patients repeatedly and at length, and in the case of those who had died, I interviewed family members as well as the original attending physicians.

Ten of these patients had visited Kelley only once and had never followed the protocol: these individuals had been discouraged from proceeding largely because of the negative influence of family and physicians who thought Kelley to be an outright fraud. This population, with a median survival of only 60 days, served as a convenient control. Among the remaining 12 patients, I found a number who had survived far beyond what would be expected for the disease, including one patient with pancreatic cancer to the liver who had, when last contacted, been alive over ten years from her original diagnosis. (Discoveries in Medicine review)

Despite the careful documentation and the five-year investment of time, no one in academic medicine could, at the time, accept that a nutritional therapy might produce positive results with advanced cancer patients.

In 1986, probably as a result of endless pressures, Dr. Kelley gave up research and patient care, and I myself have not spoken to him or any of his associates since 1987. He passed away in January 2005. (Obituary of Dr. Kelley) In 1987, I decided to move to New York to try and salvage the enzyme approach, and observe for myself the results with poor prognosis cancer patients. My goal throughout has been to generate research support, so that this method, if it indeed proved to have value, could be integrated into general medical treatment.

In July of 1993, the then Associate Director for the Cancer Therapy Evaluation Program at the National Cancer Institute invited me to present selected cases from my own practice as part of an NCI effort to evaluate non-traditional cancer therapies. Dr. Isaacs and I prepared for presentation 25 cases representing a variety of poor prognosis or terminal malignancies who had either enjoyed long term survival or tumor regression while following my program. (NIH newsletter description) Included in my presentation were patients diagnosed

with advanced breast, lung, prostate and other cancers. Most of these patients are still alive, now more than ten years since that presentation.

After the session, the Associate Director suggested we pursue a pilot study of our methods in ten patients suffering inoperable adenocarcinoma of the pancreas, with survival as the endpoint. He suggested pancreatic cancer because the standard survival for the disease is so poor, and an effect could be seen in a small number of patients in a short period of time. In fact, I was told that if three of ten patients lived a year, that would be considered a positive result. Nestec (the Nestle Corporation) agreed to fund the trial, which began in January 1994. The study has been completed and was published in the June 1999 issue (Volume 33, Number 2) of Nutrition and Cancer. Of 11 patients followed in the trial, 8 of 11 suffered stage IV disease. Nine of 11 (81%) lived one year, 5 of 11 lived two years (45%), 4 of 11 lived three years (36%) and two have lived longer than four years. In comparison, in a recent trial of the newly approved drug gemcitabine, of 126 patients with pancreatic cancer not a single patient lived longer than 19 months. (Abstract of article) Subsequently, the National Cancer Institute, in conjunction with the National Center for Complementary and Alternative Medicine, approved funding for a large-scale controlled trial evaluating our approach against chemotherapy, again in patients diagnosed with pancreatic cancer. For those interested in the clinical trial, we have been asked to refer patients to government websites such as the PDQ site at the NCI.

In addition to these clinical trials, we have also been working collaboratively with basic science researchers to test our enzyme approach in animal models of pancreatic cancer. In May, 2004, the results of these studies were published in the peer-reviewed journal Pancreas. In these experiments, a very aggressive form of pancreatic cancer was induced in mice, then half the animals were given our enzymes, half were given no therapy. Those treated with the enzymes showed a significant improvement in survival and behavior compared to animals not receiving the enzymes. In a second experiment, tumor growth was substantially reduced, and survival prolonged again, in animals receiving the enzymes. (Abstract of article) We want to emphasize that the results were particularly significant for a first attempt, since the investigators were using only the enzyme part of our program, and did not use a variety of doses to determine the most optimal for a mouse. As the principal investigator of the study wrote in the conclusion of the article: "In summary, PPE (porcine pancreatic enzyme) is the first experimentally and clinically proven agent for the effective treatment of PC (pancreatic cancer). The significant advantages of PPE over any other currently available therapeutic modalities include its effects on physical condition, nutrition and lack of toxicity."

We also want to emphasize that in our practice we prescribe, and in the pilot study and in the animal experiments we used a formulation of pancreatic enzymes made to our strict specifications. These enzymes are available only to our patients, and are not available over the Internet or in health food stores. In our experience, quality, manufacturing methods, and composition vary widely among commercially available preparations of pancreatic enzymes. The results of our studies cannot be used as validation for any other product, whether obtained from a health food store, a pharmacy or an Internet source.

Although our published research deals with pancreatic cancer, in our office we treat

patients with all types of cancers. We also treat patients with a variety of other problems, ranging from chronic fatigue syndrome to multiple sclerosis. Each treatment protocol is individualized for each patient, regardless of the underlying problem.

The therapy itself is quite complex, but basically involves three components: diet, aggressive supplementation with nutrients and enzymes, and detoxification. The protocols are individualized and each patient receives a diet designed for his or her specific needs. The diets are quite variable, ranging from a pure vegetarian program to a diet requiring fatty red meat 2-3 times a day.

The supplement regimens are also individualized, and intense: each cancer patient consumes between 130 and 175 capsules daily. Non-cancer patients will require considerably fewer supplements per day. The supplement regimens include a range of vitamins, minerals, trace elements, anti-oxidants and animal glandular products, prescribed according to the particular patient's needs and cancer type. These nutrients do not, we believe, have a direct anti-cancer effect, but instead serve to improve overall metabolic function. In addition to these supplements, every cancer patient takes large quantities of freeze dried porcine pancreatic enzymes in capsule form, which we believe provide the main anti-cancer action.

The animal glandular products and pancreatic enzymes that we use are derived from animals raised in Australia and New Zealand, where there has been no history of BSE (mad cow disease) or other prion diseases such as scrapie. The animal husbandry regulations in Australia and New Zealand are the strictest in the world, and prohibit the feeding practices that have caused problems in other countries.

The third component of the protocol involves what we call "detoxification" routines. On this therapy, we find that as patients repair and rebuild, large amounts of metabolic wastes and stored toxins are released. As a result, patients routinely develop a variety of symptoms, most commonly described as "flu-like," such as low grade fevers, muscle aches and pains, even rashes that we hypothesize result from low grade tumor lysis. "Detoxification" refers to procedures such as the coffee enema, which are believed by alternative practitioners to enhance liver function and in turn, the processing and excretion of metabolic wastes. The coffee enemas are done twice daily, and patients most commonly report symptomatic relief.

Coffee enemas have been discussed in the orthodox medical literature for the better part of this century. Many nursing texts routinely recommended coffee enemas, and the Merck Manual advocated coffee enemas as a stimulant in all editions from the first in 1898 through 1977.12 During the 1920's and 30's, coffee enemas were prescribed for a variety of conditions.13,14,15,16,17 In terms of their physiological effect, studies have shown that the rectal instillation of fluids will stimulate gallbladder contraction and emptying.18

Of the hundreds of Kelley patients I interviewed during my research study, virtually every one reported significant symptomatic relief from the enemas. In my own practice patients repeatedly report the same improved well-being and relief of symptoms after a coffee enema. The enemas, in my experience, appear to be safe: I have yet to document a single

serious side effect either in the thousands of Kelley patients I evaluated, or in my own practice. However, I do not encourage anyone to attempt coffee enemas except under the care of a knowledgeable physician.

Our goal remains to have our approach properly tested in an academic environment, and should the results continue to prove positive, to have our work mainstreamed into the orthodox medical world.

(For further information, you may wish to order a lecture tape. Tapes of lectures given by Dr. Gonzalez over the years to both lay and professional groups are available. These tapes provide more intensive explanations of the program. A recording of Dr. Gonzalez on The Deborah Ray Show is available here)

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