

Detoxification of Patients in the Dedifferentiation Phase

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Toxins and cancer are closely related. A number of environmental toxins contribute to the development of cancer and may do so even in minute doses through the process of hormesis.¹ Toxins may affect the DNA itself and act as genotoxins, or they may function as adjuvants to the development of certain cancers in genetically susceptible individuals.^{2,3}

Cancer therapies themselves are toxic and harmful to healthy cells as well as diseased cells. Antineoplastic agents are useful in treating tumors but have several side effects and may accumulate in the tissues, increasing the toxic burden. There is also clear evidence that some antineoplastic drugs are themselves carcinogenic.⁴

Special precautions in cancer patients

As a general rule, patients undergoing active chemotherapy should be put on only the advanced organ support phase of detoxification, not on the drainage part with Lymphomyosot, because the concentration of chemotherapy drugs needs to be maintained for as long as possible for full effectiveness (see protocol in Table 1).

Unless they are in true long-term remission, patients with soft tumors such as lymphoma and leukemia should not undergo drainage with Lymphomyosot and Galium-Heel at

all. Increased lymph drainage may spread the tumor.

Severely debilitated patients or patients who are in remission or post chemo but still weakened should not undergo aggressive detoxification and drainage.

Special care is also needed in patients with hormone-dependent cancers such as breast or prostate cancer, which may respond to endocrine-disrupting toxins (e.g., organochlorines) released from the matrix. Detoxification and especially drainage should be extremely gradual in these patients. They often benefit from a longer period of advanced organ support (12 weeks) and from administering the components of the Detox-Kit in succession rather than simultaneously: Nux vomica-Homaccord first, followed by Berberis-Homaccord and finally Lymphomyosot. (For the general protocol and rationale for advanced organ support vs. basic detoxification, see BT Spring 2007.)

With these considerations in mind, we can separate patients into groups with different detoxification needs:

1. Healthy patients at high risk for cancer

In such cases, treatment is prophylactic and can often be quite aggressive. However, for patients in one of the high-risk groups (including obese patients or those with known high toxin exposure) advanced organ support must be administered first, as described in Table 1.

Detoxification and drainage should be performed at least twice a year for three years, especially if the patient is non-reactive. (Non-reactive patients are often not susceptible to acute feverish illnesses but are susceptible to deep viral recurrences, such as Epstein-Barr and zoster. This is a sign of Th2 rigidity and is therefore indicative of a low cellular immunity, which is a risk factor in cancer.) Extended drainage with Lymphomyosot (at least 12 weeks after the basic detoxification and drainage with the Detox-Kit is completed) is advised. These patients may experience an episode of acute feverish illness, which is a good sign.

2. Patients in remission who need to detoxify aggressively

This group consists of patients who have completed cancer therapy and are officially in remission after subsequent check-ups. Their detoxifica-

tion needs are similar to those of group 1, but detoxification should be more gradual, especially as these patients may have residual kidney and liver damage from aggressive chemotherapy. For them, the detoxification and drainage process begins with an advanced organ support phase, followed by the basic detoxification and drainage phase. Again, drainage alone is continued for several weeks after the basic treatment.

3. Able-bodied patients with seemingly incurable cancers

Here, the aim is to prolong high quality of life. Antihomotoxic medicine is very well suited to these patients, and they often enjoy a heightened sense of well-being after a course of treatment. In general, the

drainage phase is not implemented in these patients unless they are well and the tumor is progressing slowly. Support for cellular respiration is very important in these cases, as is advanced organ support, which allows the body to detoxify at its own pace (for general protocols, see BT Winter 2007). The organism needs extra energy to detoxify properly, so it must be sufficiently vigorous before detoxification and drainage are initiated. Since the object is to preserve quality of life, aggressive detoxification and drainage should not be implemented.

4. Cancer patients who have received chemotherapy

As mentioned earlier, at least six weeks should elapse between com-

pleting chemotherapy and beginning tissue drainage. See the protocol in Table 1 for treatment during chemo and support afterwards.

References:

1. Calabrese EJ, Baldwin LA. Hormesis: U-shaped dose responses and their centrality in toxicology. *Trends Pharmacol Sci* 2001;22(6): 285-291.
2. Armstrong B, Hutchinson E, Unwin J, Fletcher T. Lung cancer risk after exposure to polycyclic aromatic hydrocarbons: A review and meta-analysis. *Environ Health Perspect* 2004; 112(9):970-978.
3. Brody JG, Rudel RA. Environmental pollutants and breast cancer. *Environ Health Perspect* 2003;111(8):1007-1019.
4. Hausmann W. Carcinogenicity of cytostatic agents – Secondary malignancy after chemotherapy. In: Rütger U, Nunnensiek C, Schmoll H-J, eds. *Secondary Neoplasias Following Chemotherapy, Radiotherapy, and Immunosuppression*. Contrib Oncol. Vol 55. Basel: Karger; 2000:36-61.

Disease-specific treatment 1. Select organ system where cancer is present
2. Add Ginseng compositum

Advanced organ support (may be started during chemo)

| | Liver | Urinary tract/ Kidney | Lymph | Gut | Connective tissue |
|--|--|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| Advanced organ support | Hepar comp. | Solidago comp. | Tonsilla comp. | Mucosa comp. | Thyreoidea comp. |
| Alternative products (if above not available) | Hepeel | Reneel | | Nux vomica-Homaccord | Pulsatilla comp. |
| For cellular detoxification, add | Coenzyme comp./ Ubichinon comp. | Coenzyme comp./ Ubichinon comp. | Coenzyme comp./ Ubichinon comp. | Coenzyme comp./ Ubichinon comp. | Coenzyme comp./ Ubichinon comp. |
| Note | The organotropic compositum medications support the organs of detoxification but do not stimulate active drainage. If patients are very ill, do not start them immediately on Ubichinon comp. Tonsilla comp. must be given by mouth. Cutis compositum (supportive in alopecia) can be added when chemotherapy affects the skin and hair. | | | | |
| Dosage | Ampoules: In general, 3-1 times weekly 1 ampoule i.m., s.c., i.d. Drops: In general, 10 drops 3 times daily | | | | |

Begin six weeks after chemotherapy or as a follow-up to advanced support:

Disease-specific treatment 1. Medication specific to the type of cancer
2. Ginseng compositum

| | Liver | Urinary tract/ Kidney | Lymph | Gut | Connective tissue |
|--|--|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| Basic detoxification and drainage | Detox-Kit | Detox-Kit | Detox-Kit | Detox-Kit | Detox-Kit |
| For cellular detoxification, add | Coenzyme comp./ Ubichinon comp. | Coenzyme comp./ Ubichinon comp. | Coenzyme comp./ Ubichinon comp. | Coenzyme comp./ Ubichinon comp. | Coenzyme comp./ Ubichinon comp. |
| Note | If patients develop expectoration from the lungs, Bronchalis-Heel can be added. Use with caution in patients with bronchial carcinoma as Bronchalis-Heel will promote expectoration, and thus mucous flow. | | | | |
| Dosage | Ampoules: In general, 3-1 times weekly 1 ampoule i.m., s.c., i.d. Drops: In general, 10 drops 3 times daily | | | | |

Table 1: Protocol for cancer patients after chemotherapy