Letter 49 July / August 2006

Tig, 56-year-old male, had colon cancer that had spread to the liver. He underwent an operation in Jakarta to remove the growth in his sigmoid colon. He then came to Penang to seek a second medical opinion about his liver metastasis. In Jakarta he was told that there was only one lesion in his liver. At the hospital in Penang he did a CT scan and blood test. According to the radiologist’s report dated 30 June 2006, there are 4 hypodense lesions in the liver. No pseudocapsule is seen and the lesions have poorly defined margins. The two largest lesions are in segments 5 & 6, measuring 3 cm each. A lesion 2.5 cm is present in segment 2, with the fourth lesion in segment 8 measuring 1 cm.

Blood test results are as follows:

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Value</th>
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<tbody>
<tr>
<td>White cell count</td>
<td>11.5  High</td>
</tr>
<tr>
<td>Red cell count</td>
<td>4.69</td>
</tr>
<tr>
<td>Haemoglobin</td>
<td>11.5 Low</td>
</tr>
<tr>
<td>Platelet</td>
<td>319</td>
</tr>
</tbody>
</table>
Alkaline phosphatase
84

ALT
31

AST
24

GGT
101 High

Alpha-fetoprotein
4.7

CEA
16.1 High
The doctor suggested three options:
a) Go for surgery to remove the four tumours in his liver plus chemotherapy. This modality would give him a 50% chance of success and he can expect to live for 20 years more. (Note: if this is true, Tig who is currently 56 years old can hope to live up to a ripe old age of 76! An attractive and tempting proposition indeed)
b) Go for chemotherapy, with no surgery. This will give him a 50% chance of living for 3 years and a 20% chance of living for 5 years.
c) Do nothing and he can expect to die within a year.

Tig (with his wife Debbie and son) came to seek our advice and explore the option of taking herbs. Tig wanted to know if we have a better alternative for him. I am saddened by this for I fully understand that Tig and his family flew all the way to Penang in search of a magic bullet. Perhaps, he and his family are hoping to hear that I have a magic potion to offer. It would indeed be irresponsible for me to say that I can cure cancer or promise him a cure. I could see the disappointment is his face (also the faces of his wife and son). At times like this, I am in a dilemma. To tell the truth really hurts, but not to tell the whole truth is to cheat and mislead. So, in my effort to tell them the truth, I also stress that the situation is not as hopeless as they may might think. If he is prepared to take care and change his diet and lifestyle, he is not at the end of the road yet. So, let us try. Perhaps the situation can turn out to be better than medical options.

I told him the story of Suria (not real name), a 38-year-old man, who was also from Bogor, Indonesia. The doctor told him that if he resected his liver he would have a chance to live 10 years longer. The surgeon who resected his liver jamin (guarantee) that it was going to be a 98% success. Three months after the surgery, Suria suffered a recurrence in the liver, with metastases to the lung. Gone were the prospects of living 10 years longer or the guarantee of a 98% success.

This story about Suria is not the only sad story. I have many of such stories. When patients go to see their doctors they hear the good side of medicine but when come they come to see us they present the bad side. That is understandable, because only failures come to us for help. While doctors give out optimistic options, we encounter the pessimistic outcomes. However, I made it clear to those who come &ndash; that at the end of the day, the patients (and their family members) themselves must make their own decision. I can only offer my views based on my experiences over the years. So, I spent time explaining how Tig can take care of himself and learn how to live with his cancer.

When I came home, I felt agitated. I wanted to know more and find what the truth is. I spent hours surfing the net for more reports on metastatic colorectal cancer. You can do the same. Go to http://scholar.google.com/ and search for: metastatic hepatic cancer, metastatic colorectal cancer, etc. I ended up with more than 40 peer-reviewed articles on the subject. Evaluate what these medical authors said against what the doctor told Tig. Then draw your own conclusions.

Review of Medical Literature
Surgery versus Doing Nothing

Of the many hundreds of medical research papers I have read, I must say that this one by James Wagner et al. of Mayo Clinic is most exceptional. The natural history of hepatic metastases from colorectal cancer: A comparison with resective treatment. Ann. Surg. 1984. 199:502-507. They wrote:

As physicians and surgeons, we have many obligations to the patients &hellip; but two are most important. Our first duty is to try and relieve suffering or extend comfortable life as best we can. (Very well said indeed. That is what we at
CA Care is hoping to do all the time).

But then we are bound to justify our efforts. Most of us are good at trying hard but we have not found good ways to evaluate what we have done. (Indeed, some or many have gone to the extreme trying to justify their efforts &ndash; to the extent of refusing to see no evil, hear no evil or know no evil).

To try to show what might be good or bad to do is not easy because our view of cancer is so clouded. (Indeed, clouded by our personal experiences, prejudices or professional bias?)

Fulfillment of our obligations is precluded by &hellip; aspects of our ignorance. (It takes men of great conscience to dare admit their ignorance and mistakes).

It is clear from looking at the survival of patients &hellip; that many patients died early and were not helped at all &hellip; we have no good way to know whether their longevity should be attributed to removal of their hepatic lesions or to the natural history of their disease (that is to say, they live because of the treatment or because Nature heals! Left alone the body will heal itself?).

The natural history of untreated cancer is the standard against which the effectiveness of any treatment should be measured but seldom is. (Exactly, all kinds of treatments are offered, but are these better than doing nothing? Such a question is almost always never asked).

The decision of whether or not to resect hepatic metastases remains a guessing game &ndash; and will remain that way until techniques for accurate staging have been found.

The authors studied the records of 252 patients with unresected liver metastases and found out that:

a) 39 patients had solitary tumour.
b) 31 patients had multiple tumours. These were confined and were deemed resectable.
c) 182 patients had widespread metastases which were deemed unresectable.

Take note that not all liver metastases are operable. From the above, only 28% of patients presented with resectable metastases. Patients with widespread liver metastases would not benefit from resective treatment.

Analysis of survival rates showed that patients who have hepatic metastases left in to grow live longer than we have been led to think they did.

Median survival for unresected solitary tumour was 21 months, multiple tumours confined to one lobe was 15 months.

More than 20% of patients who had solitary liver lesions left behind lived 3 years or more.

The authors reminded readers to compare our therapeutic efforts critically with what nature can do alone. We should then evaluate our treatments objectively and not take credit for what might have happened anyway. This is indeed a very good and pertinent point &ndash; for example, if by doing nothing patients can live for 3 years or more, what then is the benefit of chemotherapy if it can &ldquo;extend&rdquo; life for 3 years? Think hard and long. Is it the treatment or Nature that is keeping the patient alive!

The authors concluded that if one-fourth of these patients (28% of them) were truly helped by surgery, it means that only about 7% of patients who have liver metastases are indeed helped by surgery.

G. H. Gallantyne & J. Quin (Surgical treatment of liver metastases in patients with colorectal cancer. Cancer. 1993. 71(12 Suppl.): 4252-4266) wrote:

The median survival of patients with unresected hepatic metastases is approximately 10.6 months.

Patients with solitary lesions or small tumour burdens may attain a median survival of 16 to 20 months, but 5-year survivors are extremely rare.
Not All Patients are Candidates for Liver Surgery


Approximately 10 to 20% of patients with liver metastases are candidates for hepatic resection.

The factors that limit surgery are: there must be no evidence of metastatic cancer outside the liver, no evidence of advanced disease, i.e. ascites, jaundice, liver enlargement.

Martin Adson (Resection of liver metastases – when is it worthwhile? World J of Surgery. 1987. 11:511-520) wrote:

One-fourth or more of patients who have liver metastases have hepatic tumours that can be removed, but only about 25% of these patients will live five years or more after the surgery.

R. Adam et al. (Five-year survival following hepatic resection after neoadjuvant therapy for nonresectable colorectal (liver) metastases. Ann. Surg. 2001. 8:347-353) wrote:

Surgical resection is the most effective treatment for colorectal liver metastases but only a minority of patients are candidates for a potentially curative resection.

G. H. Gallantyne & J. Quin (Surgical treatment of liver metastases in patients with colorectal cancer. Cancer. 1993. 71(12 Suppl.): 4252-4266) wrote:

When feasible, patients with metastatic colorectal cancer limited to one lobe of the liver should undergo hepatic resection. Unfortunately, only approximately 5% of patients with colorectal cancer fall into this category.

So resection of hepatic metastases can improve overall survival of patients with colorectal cancer by only 1 to 2%.

Survival Rates and Treatment Failures


Survival rates of patients who had undergone hepatic resection are as follows:

<table>
<thead>
<tr>
<th>Cancer stage</th>
<th>No. of patients</th>
<th>1 year survival</th>
<th>2 year survival</th>
<th>3 year survival</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
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Survival Rates and Treatment Failures
Of the 37 patients in Stage 1, 18 patients or 49% had relapses (9 with intra-abdominal recurrences, 5 patients with within liver substance, 2 locally in colorectum, 2 generalised). In addition, 6 patients had lung metastasis and 3 patients had bone metastasis.

94% of the recurrences were evident within 2 years of the hepatic resection.

Take note: the percentage of one-year survival was an impressive 93%, but almost half of them had relapsed. What good is that? The percentage survival does not tell much in term of quality of life or recurrences. What good is survival if patient spend time going in and out of the hospital? This not only extended suffering but also drained off the family's financial resources?


No patient who had resection of multiple metastases lived for five years.

However, 42% of patients with solitary lesions lived for five years or more after removal of a metastatic lesion, ten-year survival was 28%.
The authors reported the results involving 34 patients who underwent a major liver operation. Eleven patients had multiple lesions while 23 patients had lesions varying from 7 to 17 cm (average size of 10 cm). The results were:

- Two of the 34 patients (6%) died during hospital convalescence.
- 82% lived for one year or more.
- 77% lived for 1.5 years or more.
- 58% lived for 2 years or more.
- 41% lived for 3 years or more.

R. L. Jamison et al. (Hepatic resection for metastatic colorectal cancer results in cure for some patients. Archives of Surgery. Vol.132 (5) May 1997) reported the results of 280 patients who had undergone hepatic resection at Mayo Clinic from 1960 to 1987:
- Overall 5-year survival was 27%.
- 28 patients were alive at 10 years from the time of hepatic resection.

In spite of the above encouraging numbers, the authors wrote:

- Nearly 20% must be considered as obvious therapeutic failures.
- Only 24% are considered to have benefited from resection of their hepatic lesions.
- It is tempting to include and conclude that there is success but take note that some patients who lived long also suffered long.


<table>
<thead>
<tr>
<th>Survival Period</th>
<th>Survival Rate</th>
</tr>
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<tbody>
<tr>
<td>3-year survival</td>
<td>51%</td>
</tr>
<tr>
<td>5-year survival</td>
<td>38%</td>
</tr>
<tr>
<td>10-year survival</td>
<td>26%</td>
</tr>
<tr>
<td>15-year survival</td>
<td>24%</td>
</tr>
</tbody>
</table>


B. Nordlinger et al. (Surgical resection of colorectal metastases to the liver. A prognostic scoring system to improve case selection, based on 1568 patients. Cancer. 1996. 77:1254-1262) reported the performance of French patients as below:
2-year survival

5-year survival

64%

28%

R. Doci et al. (One hundred patients with hepatic metastases from colorectal cancer treated with resection: analysis of prognostic determinants. Br. J. Surg. 1991. 78:797-801) reported the outcome with 100 patients in Italy as below:

Stage

5-year survival

1

42%

2

34%

3

15%

The crude 5-year survival of 187 patients was 24.7%.
Disease-free survival was 18.8%.

A. Efthimios et al (Determinants of survival following hepatic resection for metastatic colorectal cancer. World J. of Surgery. 1998. 22:399-504) reported the outcome of 245 patients in Ohio, USA, who underwent hepatic resection.

The 5-year survival rate was 29%.
The median survival time was 35 months.
8 patients survived more than 7 years.

Jeng Yi Wang et al. (Resection of liver metastases from colorectal cancer: are there any truly significant clinical prognosticators? Disease of the Colon & Rectum. 1996. 39:847-851) reported their results with 54 patients who underwent hepatic resection as follows:

Average survival time from date of hepatic resection was 26 months.
Estimated five-year survival rate was 25.5%.

J. Scheele, R. Stangl & A. Altendorf-Hofmann (Hepatic metastases from colorectal carcinoma: impact of surgical resection on the natural history. Br. J. Surg. 1990. 77: 1241-1246) studied the performance of 1209 patients with colorectal liver metastasis in Germany. Patients were divided into three groups.

Group 1 consisted of 921 patients of whom 902 were deemed to be nonresectable. In this group, only 21 patients lived longer than 3 years, 7 patients lived for 4 years and no one made it to 5 years. The median survival time was 6.9 months.
Group 2 consisted of 62 patients whose metastatic spread was confined to the liver. The median survival time was 14.2 months and no one lived to 5 years.
Group 3 consisted of 226 patients who underwent hepatic resection with intent to cure. The tumours from 43 patients could not be removed completely, 10 patients died after surgery, 25 patients survived 5 years and 7 patients survived 10 years.

J. Yamamoto, et al. (Factors influencing survival of patients undergoing hepatetotomy for colorectal metastases. Br. J. Surg. 1999. 86:332-337), studied 96 patients who underwent hepatic resection and pointed out that:

the factors associated with poor prognosis were tumour-related such as: number of tumours (four or more), presence of portal vein invasion, hepatic vein invasion and absence of fibrous pseudocapsule.

T. J. Gayowski et al. (Experience in hepatic resection for metastatic colorectal cancer: analysis of clinical and pathologic risk factors. Surgery. 1994. 116:703-710) studied 204 patients who underwent hepatic resection for metastatic colorectal cancer. The results are as follows:

Severity of disease

1-year survival

3-year survival

5-year survival

Patients without nodal disease or direct invasion, unilobar solitary tumour of any size, or unilobar multiple tumours of 2 cm or smaller.
Patients with bilobar single large tumour or multiple tumours of any size.

88%

28%

20%

Patients with nodal involvement or extrahepatic disease.

80%

12%

0%

Morbidity, Mortality and Recurrence


Operative mortality rate was 7%, prior to 1975, 30-day operative mortality rate was 17%

L. T. Jenkins et al. (Hepatic resection for metastatic colorectal cancer. Am. Surg. 1997. 63:605-610) studied the performance of 131 patients at Rush-Presbyterian-St. Luke’s Medical Centre, Chicago and reported:

3.8% of patients died after the surgery.
18% suffered minor morbidities.

G. H. Gallantyne & J. Quin (Surgical treatment of liver metastases in patients with colorectal cancer. Cancer. 1993. 71(12 Suppl.): 4252-4266) wrote:

Operative mortality for liver resections should remain approximately 4% and major morbidity should be in the range of 20 to 30%.

Henry Bismuth et al. (Resection of nonresectable liver metastases from colorectal cancer after neoadjuvant chemotherapy. Ann. Surg. 1996. 224:509-522) reported the outcome of 53 patients who underwent hepatic surgery:
64% of patients suffered hepatic recurrence but more than half of them were amenable to repeat surgery.

Martin Adson, & Jonathan van Heerden of Mayo Clinic (Major hepatic resections for metastatic colorectal cancer. Ann. Surg. 191:576-580) wrote:

The postoperative mortality was 4% and 20% of surviving patients lived five years or more.

R. Doci et al. (One hundred patients with hepatic metastases from colorectal cancer treated with resection: analysis of prognostic determinants. Br. J. Surg. 1991. 78:797-801) reported the outcome with 100 patients in Italy as below:

Postoperative mortality rate was 5%.
Major morbidity rate was 11%.


Postoperative mortality rate after liver resection for 108 patients was 6.5%.
The most important prognostic factor influencing survival was the presence or absence of extrahepatic metastases.
The best results were seen in patients who had resection of a solitary lesion.


Recurrences were observed in 51 patients (of the 80 liver resections).
Two thirds of the recurrences occurred during the first year after liver surgery.


For patients with hepatic metastases of colorectal cancer, liver resection is the only potentially curative therapy.
However, 38% to 53% of patients develop extrahepatic tumour recurrence.


Recurrent disease was evident after hepatic resection, most commonly in the lungs, liver and locally, in that order.

Henrik Petrowsky et al. (Second liver resection is safe and effective treatment for recurrent hepatic metastases from colorectal cancer: a bi-institutional analysis. Ann. Surg. 2002. 235:863-871) wrote:

After resection, most patients develop recurrent disease, often isolated to the liver.
Repeat liver resection for colorectal liver metastases is safe.

Comments: I hope the quotations from medical literature are sufficient to provide you with some idea of what is involved in hepatic or liver surgery. It is not as simple as you do surgery you get 20 years more life or you do chemotherapy you get 5 years, etc. etc. There are many factors that need to be considered and many more factors influence outcome. Take note that the best result obtained from surgical resection is a solitary tumour which is in only one lobe. If there are multiple tumours or both the two lobes are involved, then the chances are slimmer. The risks of surgery are: death after surgery, morbidity or complications after surgery, poor quality of life besides high rates of recurrences. These are issues that were never taken into account when discussing 1-, 2-, or 5-year survival.

There is one important thing we need to note here. Tig is down with colon cancer. This itself, is a big problem. To find a cure for it, is already difficult. In addition, he has metastatic liver cancer. In a situation like this, we tend to pay more attention to the more serious problem – that is, to focus on the liver, which may require a major surgery. But, this surgery is not going to make the colon cancer go away. There is a possibility of his colon cancer recurring (in addition to liver recurrence after resection.).
We are not against surgery but we also wish to caution patients about the optimism regarding surgery. Dr. Robert Mendelsohn (in Confession of a medical heretic, pg. 19) wrote: Doctors in general should be treated with about the same degree of trust as used car salesman. Whatever your doctor says or recommends, you have to first consider how it will benefit him. By this quotation I am not insinuating that doctors are dishonest or cannot be trusted. Dr. Mendelsohn is not just any doctor. He is the director of Chicago’s Michael Reese Hospital, chairman of the Medical Licensure Committee for the state of Illinois and an associate professor at the University of Illinois Medical School. Perhaps this learned man wants you to think really, really hard before you place your life in the hands of others. For me, I see it not directing at the medical doctors alone. His line is equally applicable to practitioners of alternative/complementary medicine. It is equally applicable to CA Care!

On page 12 of his book, Dr. Mendelsohn wrote: Doctors almost always get more reward and recognition for intervening than for not intervening. Indeed, most people appreciate heroic acts; we must be seen to do something. Unfortunately, sometimes, doing more, may cause more harm than good.

There is another good advice from Dr. Medelsohn (page 16): Your first defense is to become more informed about your problem than the doctor. You’ve got to learn about your disease, and that’s not very hard... You can find books written for laymen on just about every disease you’re likely to have. The idea is to find out as much about it as possible so that you can discuss your problem on an equal; or better; informational footing with the doctor.

Those who are to embark on resecting their liver tumours may wish to read once again what James Wagner et al. of Mayo Clinic said about doing nothing (see the first paragraph of the literature review). Let me repeat what the authors said: the decision of whether or not to resect hepatic metastases remains a guessing game.

Doctors versus Patients Perception
In the last letter (Letter 48), we related the story of Johnny (colon cancer patient) and his encounter with an oncologist. It has been six months after Johnny had his surgery and three months after he started taking our herbs. It was time for Johnny to have a routine follow up. He went to see an oncologist from another hospital. A blood test, scanning and X-ray were done and this cost him RM 684. After that Johnny came to see us with his blood test results which are as follows:

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
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<tbody>
<tr>
<td>White blood count</td>
<td>5.56</td>
</tr>
<tr>
<td>Red cell count</td>
<td>4.97</td>
</tr>
<tr>
<td>Haemoglobin</td>
<td>11.3</td>
</tr>
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</table>
The oncologist was surprised that the results turned out to be so good. He wanted to know if Johnny was taking any herbs. Johnny said he did not — denying the fact that he was and is taking our herbs since the past three months.

The oncologist recommended that Johnny undergo chemotherapy. This would cost him about RM 40,000 for the entire course. Johnny can also opt for a cheaper treatment by taking oral chemo-drug (UFT? Xeloda?) and this would cost
around RM 15,000.

Johnny enquired the purpose of him undergoing chemotherapy since his blood work was so good. The oncologist replied: Surgery would help you 60%. You can add 10% more by taking the chemo. Johnny asked: By increasing my chance by 10%, how many years will this treatment extend my life? The oncologist replied: 3 to 4 years.

Johnny declined chemotherapy. He told us: What is the use of me spending RM 40,000 to bet on a 10% chance of living for an additional 3 to 4 years. I don’t have that kind of money to spend anyway.

Comment: Doctors and patients differ in their perceptions of managing cancer. Medical protocol requires that patients undergo chemotherapy after surgery. The benefit to be expected is an extension of life by a few years. But patients want permanent CURE, not just life extension.

Some doctors would say that chemotherapy promotes quality of life. Well, not all patients would buy this. And for some patients, chemotherapy need not automatically extend time. On the contrary, some apparently “healthy” patients died while on chemotherapy. Another picture often painted is: If you don’t go for chemotherapy, you will die or you would not last long. The cancer will spread fast and you will die suffering. Is this perception based on scientific facts or is it a scare tactic? Let me present you the results of medical research about this.

Wolmark, N. et al. Postoperative adjuvant chemotherapy or BCG for colon cancer: results from NSABP protocol C-01. J. National Cancer Inst. 1988. Vol: 80:30-36. A total of 1,166 patients who had undergone surgery for Duke’s B and C colon cancer were divided into 3 groups and given the specified treatments. The results of the study were as follows:

<table>
<thead>
<tr>
<th>Treatment</th>
<th>5-year disease-free survival</th>
<th>5-year survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery only (control)</td>
<td>51</td>
<td>59</td>
</tr>
<tr>
<td>Surgery + 5-FU + semustine + vincristine</td>
<td>58</td>
<td>67</td>
</tr>
<tr>
<td>Surgery + BCG</td>
<td>56</td>
<td></td>
</tr>
</tbody>
</table>
The results demonstrate that the use of 5-FU + semustine + vincristine after surgery for Duke’s B and C colon cancer provides higher rates of disease free survival and 5-year survival. Leukemia has been observed in 3 of 479 patients who had received semustine. The above research is one of two studies that formed the basis or gold standard of today’s practice – treat colon cancer patients with 5-FU + leucovorin. Preach that gospel. Cultivate and propagate the perception that this is what cancer patients need to save them.

Look at the results again. Did colon cancer patients die if they do not undergo chemotherapy? The answer is: NO. 59% of patients who had surgery alone were still alive after five years as opposed to 67% in patients who had undergone both surgery and chemotherapy. What is the difference between the numbers of those who did not undergo chemotherapy and those who underwent chemotherapy? Only a mere 8%! From the patients’ viewpoint, is 8% advantage justification enough for doing chemotherapy?

The truth is: One does not die if one does not undergo chemotherapy. This is a shocking revelation for me. The perception I had was without chemotherapy, colon cancer patients would die; if not all of them, at least a great majority of them. But the data does not support that perception. After 5 years, 59% of patients were still alive even without chemotherapy.

And what if they had undergone chemotherapy? I expected almost all or a great majority of them to be alive at the end of five years. No, the data showed only 67% of them survived. This is another shocking truth; even if one were to undergo chemotherapy, research showed that 33% of patients or one-third of the total number of patients still die from colon cancer. One doctor told his patient that taking herbs and getting well is a matter of luck. Now, what about chemotherapy? Chemo-patients probably need just as much luck?

The difference in the 5-year survival between chemotherapy and no chemotherapy group is only 8%. Chemotherapy is proven to be beneficial by only a very slim margin. Indeed, from the academic point of view, the result is statistically significant. This would please the statisticians and the scientists, but I am not sure if it pleases cancer patients at all. I believe this is not what patients are looking for. They are seeking for a real cure. If this is not possible, at least they expect a much greater chance of achieving it. I wonder if 8% is good enough?

One question comes to mind: Can this slim margin of 8% not be achieved by some other non-invasive ways? For example, a change of diet or taking herbs. Perhaps we can also increase our chances of healing colorectal cancer and the result could be better than chemotherapy.

In the case of Johnny he took herbs and changed his diet and lifestyle. Of course, it is too soon to predict the eventual long-term outcome of his case. But for now, there is reason to be optimistic.

Hunting for the Elusive Medical Cure for Colorectal Cancer

As I was putting a finishing touch to this letter, an e-mail and fax came in from Indonesia. This is the story.

Sam (not real name), 48-year-old male, was diagnosed with a moderately differentiated adenocarcinoma of the transverse colon in 2005. He went to the United States for consultation and underwent an operation of his colon. On his return to Indonesia, he came to see us seeking for herbal option. Unfortunately he declined our therapy - the herbs, change of diet and lifestyle; was not convincing enough. Sam went to China on 25 November 2005 and underwent a variety of medical treatments; including chemotherapy and cryoablation of his liver metastases. After months of treatment in China he came home to Indonesia and found himself lying in the bed of one hospital in Jakarta. Sam’s wife called June (our colon-liver cancer patient in Jakarta; Episode 4 &ndash; Letter 48) for help. He was surprised to see that June who also had colon-liver cancer was doing so well. Now, Sam too wanted to take our herbs and wanted to know how to eat and live right. (Latest update: he decided not to take the herbs yet. He wanted to eat many things; first and after a month would consider following our advice!).

You might want to ask how Sam and his family know June. They had met before and they knew about CA Care before.

June came to us and is on the herbs religiously; Sam opted out.
Today, the fate of these two persons differs. June is well — living a normal life. You don’t see or think that she is ill at all. On the other hand, Sam is in the hospital bed undergoing more chemotherapy. (Note: when would such toxic treatment ever going to end?). According to the medical report, Sam suffered metastases to his liver, lungs, pancreas and left adrenal gland. These are not all. There are also multiple metastases to the lymph nodes in the left neck and both collarbone. In addition, the cancer has spread to his bone. It is hard to believe that with the so-called best of medical treatments, within such a short period of time (from September to July 2006) the cancer has invaded so many parts of his body. A lot of money has been spent. No doubt, the treatment resulted in much suffering and anxiety not only to the patient but also his whole family.