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Case examples from the gonzalez protocol for treatment of cancer

Abstract

The Gonzalez Protocol for the treatment of cancer involves four components: pancreatic enzymes; specific diets; supplements; and detoxification. The effectiveness of the Protocol is evidence-based at Level II because it is supported by cohort studies involving over 160 patients with a variety of MRI and biopsy-confirmed cancers, many of them in advanced stages with poor prognoses. In this report, a series of representative cases is described in order to communicate the remarkable outcomes achieved with this treatment approach. The Gonzalez Protocol should be the subject of serious research and study within mainstream medicine and physiology.

Keywords: cancer treatment, the trophoblast model of cancer, pancreatic enzymes

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Introduction

The Gonzalez Protocol for the treatment of cancer and its historical origins are described in a series of books and papers.[1–12] The Protocol has four main components: pancreatic enzymes; nutritional support; supplements; and detoxification with coffee enemas. The pancreatic enzymes are thought to be the active anti-cancer component, while the diets and supplements are for support of the person, and the coffee enemas are intended to stimulate more efficient excretion of the breakdown products of tumor cell lysis, thereby reducing nausea, fatigue and other common side effects of cancer treatment. The present paper will discuss only the pancreatic enzyme component of the Protocol.

The trophoblast model of cancer, which is the foundation for the use of pancreatic enzymes in cancer treatment, was originally developed by the Scottish embryologist, John Beard, at the end of the nineteenth century.[1–3,11,12] Beard, who was nominated for a Nobel Prize, studied thousands of slides of embryos throughout fetal development in many different species. He observed that about 15% of trophoblast cells split off from the trophoblast and are seeded in tissues throughout the body; he called these cells "wayward trophoblasts," but today they are called adult stem cells. The wayward trophoblasts normally remain in a dormant state in adult tissues.

Beard next observed that the trophoblast converts to the stable placenta at the same time that the fetal pancreas begins to secrete enzymes. He hypothesized that trypsin is the biological signal that triggers the conversion of the trophoblast to the placenta. Beard also understood the properties of normal trophoblast cells, which are required for them to implant in the uterine wall: they are migratory; undifferentiated; invasive; angiogenic; lack normal cell adherence; and resist immune surveillance. These are also the properties of cancer cells. Beard also knew that when the trophoblast does not convert to the stable placenta, a choriocarcinoma develops, invades the mother, and kills her.

The next step in Beard's thinking was his hypothesis that cancer arises from wayward trophoblasts that have escaped from normal regulatory control, and start behaving like normal trophoblasts do: they differentiate in the direction of the local tissue due to local signaling in that tissue, and take on the appearance of being de-differentiated normal cells from that tissue. Rather than arising from normal cells that de-differentiate backwards, he thought, cancer arises from normal trophoblasts. It followed, then, that pancreatic enzymes, principally trypsin, could be used to convert cancer cells back into a stable state, just as they convert the trophoblast into the stable placenta.

Beard had considerable success treating cancer with pancreatic enzymes early in the twentieth century, but his work was forgotten until it was revived by Dr. Donald Kelley in the 1970's and 1980's.[4] Dr. Nicholas Gonzalez studied Kelley's cases for a period of years and then refined Kelley's approach in his own private practice. The trophoblast model of cancer has been formulated in considerable detail as a scientifically testable set of hypotheses.[11] It provides the foundation of The Gonzalez Protocol.

The purpose of the present paper is to briefly explain the core ideas underlying the treatment of cancer with pancreatic enzymes, and then to provide brief summaries of a series of representative cases from Dr. Gonzalez's practice.[8,9] The outcomes of these cases are so remarkable that the trophoblast model of cancer should be studied seriously through in vitro research, animal studies, and eventually human trials.

Sample cases treated with the gonzalez protocol

Survival times in the following cases are up until the last contact with Dr. Gonzalez, or confirmation of their survival by other means.

Case 1

A 70-year old male in good health was observed to have a small right lung nodule on chest X-ray in July, 1991. A CT scan of the chest revealed a 6 mm nodule in the lateral aspect of the right lung, thought to be consistent with bronchogenic carcinoma, a metastatic lesion or a granuloma. A CT scan of the abdomen showed a 4.5 cm mass in the head of the pancreas and enlargement of the left adrenal gland, and a bone scan showed abnormal uptake in the right hip and shoulder. In September, 1991 a biopsy showed adenocarcinoma of the pancreas metastatic to the right lung, and with a liver metastasis 3.4-4 cm in diameter.

The patient first saw Dr. Gonzalez in December, 1991, having received no treatment for his metastatic pancreatic cancer. He began

The Gonzalez Protocol and by 1998 there were no masses in his abdomen on CT scan. He was alive and well 15 years later.

Case 2

In March, 1993 a 65-year old woman in good health experienced blood in her urine. Cystoscopy revealed a 1.2 x 0.8 cm papillary transitional cell carcinoma of the bladder, grade II/IV. In September, 1993 and January, 1994 she had additional bladder tumors excised. Then in April, 1994 A CT scan of her abdomen showed a 2.5 x 3.5 cm mass in the head of the pancreas, diagnosed as pancreatic cancer. In August, 1994 she had extensive tumors in her bladder on cystoscopy which improved in response to a BCG vaccine infusion of her bladder. She first saw Dr. Gonzalez in November, 1994. Her bladder and pancreatic cancers were both in remission 17 years later with her sole treatment being The Gonzalez Protocol, and she was well and active.

Case 3

In 1992, this patient experienced heartburn, weight loss, diarrhea, weakness and shortness of breath. Blood tests revealed anemia and an elevated gastrin level. In October, 1994 a CT scan revealed a 6-7 cm retroperitoneal mass. On laparotomy, tumor was seen to be infiltrated throughout the pancreas, was deemed inoperable, and proved to be a metastatic carcinoid islet-cell pancreatic cancer on biopsy. In March, 1996 the patient began The Gonzalez Protocol and in September, 2002 a CT scan of the abdomen revealed no masses. The patient was alive and well 10.5 years after first seeing Dr. Gonzalez.

Case 4

This patient first experienced abdominal pain in 1980. In 1982, the pain became excruciating and she underwent a laparotomy. The surgeon observed an inoperable pancreatic cancer invading the surrounding tissue, with a 1 cm liver metastasis. The prognosis was thought to be a survival of 9-15 months. The patient then had a consult at the Mayo Clinic, where she was advised not to have any treatment, since none would be helpful. She first saw Dr. Kelley in 1982 and began treatment with pancreatic enzymes. Subsequently she was followed by Dr. Gonzalez and was alive and well 24 years later.

Case 5

This patient first observed two small masses in her left breast on self-exam in 1972. In 1986, the masses seemed to begin growing but a mammogram was inconclusive. A mammogram in 1987 revealed a probable malignancy in her left breast. In 1998, her CEA was 8.8 (normal < 2.5) and in 1992 she underwent a left modified radical mastectomy for removal of a 2.2 x 1.8 cm invasive ductal cell carcinoma: 5 out of 17 left axillary nodes were positive. She began treatment with The Gonzalez Protocol, and was alive and well 21 years later, at age 64.

Case 6

In October, 1991 this patient was observed to have a suspicious breast mass on mammogram. A lumpectomy revealed a 2.1 cm infiltrating ductal carcinoma. A bone scan in December, 1991 revealed abnormal uptake in the right proximal femur and an MRI in 1992 revealed a lesion in the right trochanter. She first saw Dr. Gonzalez in early 1992, at which time she was experiencing severe fatigue, and chronic right hip pain that was so severe she had to quit working and go on disability. She began her sole treatment with The Gonzalez Protocol; a bone scan in May, 1992 revealed no evidence of metastases. She was alive, well and disease-free 15 years later.

Case 7

In May, 1987 this patient observed a small mass on his posterior neck. An excision biopsy by a dermatologist revealed malignant melanoma extending beyond the margins of the sample. A second resection was done, at which time no positive lymph nodes were observed. In March, 1989, the patient observed an enlarged right supraclavicular node which on biopsy was positive for malignant melanoma, as was a right axillary node. The patient was enrolled in a NIH trial of an experimental vaccine for melanoma, which proved to be ineffective: out of 60 patients in the trial, there were only 2 long-term survivors, both of whom were treated by Dr. Gonzalez. This patient began The Gonzalez Protocol in June, 1990. CT scans of the head, chest, abdomen and pelvis in 1991 and 2010 showed no evidence of disease and he was alive and well at age 77 in 2015, 26 years after being diagnosed with recurrent metastatic malignant melanoma.

Case 8

In 1992, this patient noticed a mass in her left abdominal wall, which was thought to be a lipoma. When it was excised in 1994, it proved to be a lymphocytic lymphoma. CT scans in 1995 and 1996 showed metastases to the liver and lower pelvis. She began The Gonzalez Protocol in April, 1996, and with no other treatment was alive and well 18.9 years later at age 71.

Case 9

This patient was found to have a 7 x 8 cm mass posterior to her bladder on ultrasound in 1989. A laparotomy in November, 1989 revealed extensive ovarian cancer with 21 out of 21 sampled lymph nodes being positive. With no treatment other than The Gonzalez Protocol, she was well until she died of pneumonia at age 87 in 2007, after a 17-year survival with metastatic ovarian cancer.

Case 10

In October, 1990, this patient's family physician noticed an abdominal mass during his annual physical examination. A CT scan revealed a 14 cm kidney tumor which proved to be a renal cell carcinoma on nephrectomy, with a positive regional lymph node. In November, 1991 he developed a lytic skull lesion and a small nodule was observed in his lung on CT scan. He began The Gonzalez Protocol in January, 1992 and after three months the skull lesion had completely resolved. In June, 1993 a bone scan was clear. The patient was alive and well at age 82 after 15.6 years on the Gonzalez Protocol.

Conclusion

Although The Gonzalez Protocol has not been validated by randomized, controlled trials, the cases presented in two books.[8,9] and a paper,[6] totaling over 160 patients, provide compelling evidence of its effectiveness in advanced, lethal cancers. Such cohort studies are classified as Level II evidence by the US Public Health Service.[13] Level I evidence consists of randomized controlled trials, and Level III evidence consists of expert opinons, case reports, and professional guidelines. The treatment outcomes described in the case series cannot be accounted for by selection bias, misdiagnosis, spontaneous remission or any other explanation other than a treatment effect. The assumption of the trophoblast model of cancer is that the pancreatic enzymes are the active anti-cancer component of the protocol; therefore they should be the focus of future in vitro and animal studies. Two animal studies reported in the same paper demonstrated prolonged survival in mice treated with pancreatic enzymes compared

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to controls in an animal cancer model,[14] but additional studies are required. The Gonzalez Protocol is not "alternative" medicine; it is evidence-based in terms of its clinical effectiveness, is supported by two animal studies, and is formulated as a scientifically testable model. The treatment of cancer with pancreatic enzymes should be studied within mainstream medicine and physiology.

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Conflicts of interest

None.

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