Introduction and Dr. Andersonu2019s Background

This is Doctor Talks, real talk from real doctors on the issues that matter to you most. Hello everyone. Welcome again to the Prostate Cancer Summit where we have another amazing episode with our special guest.

Dr. Paul Anderson. Dr. Paul Anderson is a naturopathic oncologist renowned in the space of naturopathic oncology. You've been in it for a while, right, Paul?

You've been in it for… Are we senior people in our profession? What's considered a senior member of naturopathic medicine? Do you know? I think now we are, yeah.

Wait, you're saying we. Why are you including me? Why are you including me in this scenario? What's the number before you become a… I don't, I don't know the number, but what, what I look at is who, who is left, who is, you know, been around longer, which there's some, but it's getting to be a smaller number all the time.

So, uh, by default you become that. Okay. Okay. If it's 20 years, then that I'm in that category. Cause I think oh three. So we're, yeah. 21 years in.

So see. And, and if also, you know, we have a small profession, but it's so much larger now. compared to 20 years ago, and certainly compared to 30 or more years ago, that just by a numeric default, you're in the one, three standard deviations away from the median.

Right, exactly. You're rare, regardless of what. Well, I'm fine. I remember we're looking up to Dr. Sensenig, right? He was like, this is a new member of our profession.

And like, I look at Jeff Bland, I'm like, you know, Pizorno, I see him all the time. I was like, man, these guys are like legends. Like, They don't consider themselves that they just doing what they do.

I'm like, you don't understand who you are. I just amazing that you're still here. And I want to take photos and selfies with these people. You know, it's like, man, I, you know, you guys were in the battlefields back early, early in the days.

Speaking of battlefields, it's amazing what you do. You deal primarily with advanced cancers, all cancers, and certainly prostate cancer that's advanced.

Most people deal with low risk, prostate cancer, low Gleason scores, perhaps intermediate risk. Even advanced cases are not that advanced all the time.

So if somebody has an advanced case, let's say Gleason nine or, or something that's not that advanced. I'm talking about metastasis metastasis, you know, B to the bone and beyond the bone to lungs and brain and things like that.

So you deal, you deal with those. So let's start here, Paul, why you do what you do. I mean, like, what got you to say, you know what? I want to be challenged.

I want not only cancer cases, I want advanced cancer cases. Why? So at least consciously, it was not a conscious decision to say, oh, this is what I want, at least long ago.

In those days, like three decades ago, there were so few of us And the normal referral was somebody would go there on colleges. They would say, we've done all we can for you.

Go make yourself comfortable. If you want to seek alternative care, now's the time to do it, right? So the only

people we saw were dying next to death, et cetera, which is not a great sample size, but it really makes you learn quickly where the guardrails are and all that.

And so literally my early introduction to clinical medicine in the oncology space was that. And it was not like, oh, here's some prevention you can do and all that.

It was like, what can we do to help you be more present and have good quality of life? So it kind of started that way. And then we sort of went in reverse where people now start to seek out people, you know, earlier diagnosis and prevention, all that.

Well, I think just it's one of those things just to, you know, luck of the drawer timing, because that was the primary group of people I saw were very advanced cancers.

Then you sort of reach, well, I'm half or one generation, you know, older than the bulk. then it's like, well, okay, we'll take care of these and we'll send these other ones over to people like Paul.

And there's a group of us that are, you know, kind of there. And I think that's kind of how it did, how it happened.

Why Advanced Prostate Cancer Cases Come to Him

And then what really cemented it was, and I always get the years wrong because it was kind of a blur of work, but when I was, I was full-time at Bastyr University for five years and we had a collaboration with the Seattle Cancer Care Alliance, which is UW, Brett Hutchinson, Seattle Children's, et cetera.

Big, big stuff. And we had NIH funding. And the collaboration was our center was going to work with people who wanted integrative care. And then all those other places did standard of care.

And it wasn't that we excluded. It was, do they want to add on integrative care? And our only outcome was, do they live longer with XYZ cancer? But then within that, that was five years NIH funded, and we had so much as many things.

This ended in probably 2015, 16, something like that. We have so much data that still has never really been published. They came out of it, but I've tried to teach doctors what we found out.

But anyway. Why is that data not published? Well, what happens for those who've never been in a research sort of bubble. So I was not a PI. I was in charge of a section, but the PIs control everything.

So we had a- PIs, principal investigators. From the CL Cancer Care side and from the Bastyr side, we had co-PIs. And what happens is they're churning and doing all this stuff during, while they've got funding, And then there's publications that come out that it's like, what can we get out the quickest?

And then if you're in that world, you're on to the next thing when this ends. And so what happened was, which they didn't really put in the calculus, which was good for us as far as investigating things with humans, was I had the interventional whole part, which included IV therapy and all this stuff.

And the IRB, Institutional Review Board, which allows you to do human research and what to do, was essentially unrestricted in that sense, because they didn't realize what we could do.

They'll never make that mistake again. So we did a lot of things that drug companies now have, not because we gave it to them, but because they worked.

and drug companies saw our data and took them. So what really happens is we were doing whole practice. So there was acupuncture, nutrition, mind, body, every other thing you can think of.

And then there was the interventional stuff with IVs of mostly natural substances. So what happens is it's easier to

publish basic survival data and these other things.

So that's what comes out. But then NIH money ends and your PIs have gone on to the next thing. unless someone just takes their own time and, you know, and publishes, which I've tried to do.

And, you know, I've written books and put it in there and stuff and talk a lot. You just don't see the rest of it come out because it's, it's all still there.

So, but what I got there though, was because they said, well, your interventions like intravenous therapy is different from, primarily different from nutrition.

and acupuncture and herbal medicine and mind, body, and all of the other parts we had. And I said, well, what does that mean? And they said, well, you're only going to get stage four cancer patients, right?

And I said, why? And they said, well, because it's harder to prove an effect in somebody with lower stage grade cancer, which is true. But that was my whole career up to that point.

So that didn't bother me. It's just that really cemented sort of that reputation as, well, this is where those people go. Right. And, and we had, you know, collaboration with, with people who were involved with prostate cancer.

And it was the same thing. You know, if you're, if you're at active surveillance and you're, you know, all of that. you're going to stay in this area.

You don't need to see Paul. If you get metastasis, high-stage grade, we're kind of beyond the surveillance thing. Let's see if Paul can help you. And so that really was sort of a turning point.

And for better or worse, having NIH funding to do it and all of that, not in the eyes of a lot of oncologists, we give you a little bit of credit to do those things.

And the thing about it was there was nothing terribly remarkable that I learned that I didn't already know, but research forces you to be critical and to keep track of your data and do all of this stuff.

And that's where I learned a lot of lessons that I've tried to bring into practice now. So I think that's how I probably wound up getting those tougher cases.

Lovely, and it's such a pleasure to call you a colleague and a friend because your information is just top quality. I've been at your conferences as a speaker and also as an audience member, and it's just really top notch in terms of the scientific rigor, clinical outcomes, and all the things that we're all looking for from a natural or integrative perspective.

So I always thank you so much for doing what you're doing. We were talking before we started recording, hey, how's your health? No, I'm saying it for selfish reasons.

How's your health? I need you to be around for a long time because my health is my health is better than it's been a long time. So, yeah, that's right.

My goals are all about staying here for a while. Yep. Yep. Yep. Good. Good. You do it. You do it for selfish reasons. And I'll ask for selfish reasons, too, because we need you.

We need you and your quality of work for as long as possible. So a guy goes to you with stage four prostate cancer and stage four actually advanced prostate cancer has different definitions actually.

So even somebody with, for example, a Gleason 9 that has, let's say, you know, invasion in the seminal vesicles, that's advanced, you know, if it leaves the prostate, it's advanced prostate cancer.

If it's even Gleason 9 encapsulated, it's not stage four, but it's like T3B. It's like right there. Recurrences, obviously once it leaves, you know, even if it's in a lymph node, which if it's in a lymph node, it's not such a big deal as long as you catch it early with imaging and so forth.

But then it gets to the bone and then beyond the bone, it becomes a bigger issue. You know, soft tissue, it could metastasize to the lungs and brain and so forth.

What do you, what's the process with that type of patient? What do you do and how do you, do you work in an integrative fashion where they do whatever they do conventionally, hormone therapy or chemotherapy, or do you just take them along and I say, okay, you do only natural methods.

What's the approach? Right. So generally speaking with somebody who's the, the cancer has left the area. It is now, you know, around the body in various places.

The, each you know and we talked about this offline you get six prostate cancer patients you have six different prostate cancers yes you know there's never one yeah and and when you get over to the world of advanced prostate cancer i always tell people it's actually a different It's prostate cancer that's not outside the capsule is one prostate cancer.

Prostate cancer becomes aggressive, which is the only things I get referred. We should call it something else. I would even break it down like this, Paul.

Prostate cancer that's encapsulated, that's one cancer. Prostate cancer that metastasizes not yet to the bone, seminal vesicle lymph node, that's a cancer.

bone that's another type of cancer outside of the bone that's then that's something even more so it's like four different types of advanced prostate cancer yeah yeah and and i would say the only people i get are are three and a half and four in that group grouping right exactly yeah exactly okay so and i think this is a good because this exact discussion i would have with the patient is look you know, and this is not uncommon.

Integrative Care for Advanced Disease

X number of years ago, when you were in active surveillance, you know, maybe you changed your diet, you did these nutrients, you do this other stuff, you did whatever your urologist was doing, and you were good to go, right?

Things were cool. And then all of a sudden, boom, you know, it's like this new thing happens, it's spreading, the regular stuff is not controlling it.

We need, we need to sort of match the aggressiveness with what we do for interventions. So the first thing is when it comes to you know, do you mix and match with the standard oncology approaches, etc.

The answer is usually yes. I mean, it depends what it is. And I would say one really, you know, not universally, but a good thing I've seen change over the last three decades is oncologists are getting more realistic with their patients.

And so there comes a point where, okay, now we don't even have statistics for how our standard therapies are going to work here, because your aggressiveness is at this level.

So we could do these things. They might help, they might not, et cetera. And if we do, here's the good and the bad of it. And not always, but I've had a lot of oncologists now tell patients, look, up to this point, I would do everything from the book.

At this point, you have some decisions to make because you're balancing, I know I can give you a lot of side effects of this treatment. I don't know if I can help with your cancer at this point.

And sometimes there's palliative things that have to be done such as focal radiation or other stuff. That's a whole other ball of wax. So each person's calculus, as far as are we including the more advanced chemos and biologics, all that, sure if they have a good chance of working because here's the thing what you and I do can not only make those things work better but can protect the normal tissues that don't have cancer so the person's quality of life doesn't just completely go you know down the tubes while they're doing more aggressive, you know, traditional oncology therapy.

So that's really a very individual discussion and I'm not for or against anything. I'm for what's best for you right now. So essentially what we're helping, I think we're doing two things.

I think we're helping the good self stay healthy, which is very important. Paul, I do think that we're trying to, at this point, a lot of prostate cancer patients I see nationally, globally, and they go back to their doctors, how do you treat prostate cancer with these natural methods?

My God, they're doing so well. The quality of life is better. I can honestly say, because I have no evidence, that I'm treating prostate cancer. I don't know what's happening there.

I really don't know. What I think is happening is that we're treating the healthy cells But we're also trying to create a microenvironment that's hostile to these cells.

Very much. So you have to, for cancer cells to spread and move, they need a favorable environment. Well, we're trying to make it unfavorable so they don't attach to things and move around.

And I think that's one of the elements that we help. Maybe the radiation that kills the cancer cell. I don't know that I kill cancer cells. I don't know.

I have no evidence for that. Microenvironment and keeping healthy cells healthy is what we do, I think. Yeah. Yeah. That's a real critical thing that, you know, from a patient perspective, I mean, cancer is very confusing, you know, if you're the patient and also you don't want that diagnosis, so it's overwhelming.

What you just were talking about, about the microenvironment is that is literally the battleground, even if you have wide metastases where you win or lose or where you gain quality of life and length of life.

That's, those are the two things that we know. can be affected. The micro environment, and now it's in the tumor biology literature much more than it used to be.

So one of the things that we know, and this is not, you know, this is not a slam on standard therapies, but it's very well published, is if I give you radiation therapy or chemotherapy of a traditional type, I will engender stronger cancer stem cells.

I will weaken your regular cancer cells, but the stem cells get stronger. And that's been in the literature all along and it just gets stronger. And Dr.

Stengler and I wrote Outside the Box Cancer Therapies. We were the first book I know of to actually take that research and summarize it in a textbook.

And the reason that I wanted to make sure that got in there was not to be a bummer to everybody, but like to underscore, it's great if we knock down the major tumor cells, but this battleground of the cancer stem cells and the microenvironment That's where long-term you win or lose.

And what you and I do affects that in a way that standard therapies can't do. There is not a biologic drug or anything that's going to undo what traditional chemo radiation does.

So it's like everything can be good, but why not support your micro environment and keep you as healthy as possible. I always tell people you got way more normal cells than cancer cells, or you wouldn't be here.

We're mostly interested in the normal ones staying really healthy and not being recruited in the tumor micro environment over to the bad side, which can happen.

So, so that is a big target. And I think, you know, where, where you're saying, well, you know, we can't prove that we actually reverse say a tumor process or something like that generally, but Integrative therapies like we do definitely affect those things.

Keep the cancer stem cells very quiet, not wanting to do anything. Keep the microenvironment against recruitment, against pro-cancer. you may still have wildly aggressive cancer, but it may slow it down enough and it may open up your normal cells to work better.

So your quality of life is better and usually your length of life is better too. So that's from the tumor biology perspective, that's why what we do works.

It's just what you might do with an active surveillance or earlier stage person, we kind of have to kick up the intensity quite a bit when it gets outside in the bones and beyond, right?

And like I said, that's where my experience is. So what I noticed there though is to kind of dial back a little bit, you might say then, okay, what is it about these more aggressive cases that may take the practitioner has to step back and say, there's tumor biology that we understand reasonably well, But what else is pushing on that?

Like once it's gone into the bones and beyond, what things can push on tumor biology to literally kind of pour gas on a fire, right? That's when a literal You could call it holistic or whole person or whatever term you like to use.

That's where that comes in. And here's the thing that even, you know, when I'm working with doctors who do this, et cetera, practitioners, they'll often miss because often they see, you know, the, the more surveillance oriented ones in the literature.

There are, there are pockets of areas that have. seemingly nothing to do with cancer that are tied to aggressive prostate cancer, for example. So just one area, and I'll elaborate on the areas I like to look at.

One area is infections, but what's interesting is there's well over, I'm going to pick a low number just so I can be conservative, well over 30 peer review publications and it's probably 100 but let's say 30 that talk about aggressive prostate cancer and it's not and here's the thing and this is what researchers do because I understand it you're looking for the holy grail you know it's like everyone's you know knight templar or something looking for this holy grail and you want to find the one organism that causes prostate cancer but you're doing it all around the world so if you look at all that read all that research which I've done it's not one everything they look for that is a bad chronic infectious agent has a relationship to aggressive prostate cancer and it's not from just bacteria there's viruses there's parasites there's fungus you know anything bad they look for they find okay Is it something very similar, like say human papilloma virus and ovarian cancer and things like that?

Is it something similar to that? I think two things got them looking, and then it led to this sort of, as you know, subspecialty research areas, you'll find the same authors involved in half the papers, right?

So I think what started was really two things. One was we know in other cancers, there's viral triggers, et cetera, you know, or H. pylori and, you know, GI stuff.

Hep V and liver cancer. Yeah, Hep V and liver cancer, et cetera. So we know the concept. So the first thing was, does that exist with prostate cancer?

So they just start hunting. And the viruses, I think, were one of the first places they looked. But then they also, this is my assumption based on the way they language things, they're looking at, well, what are other chronic things that prostate has problems with chronic prostatitis, et cetera?

What do we find there? Well, we find all sorts of weird organisms in the seminal vesicles and stuff. And do they

have any relationship then to advanced prostate cancer?

And so they start looking at that. And it just mushrooms out from there. What I would tell patients is, OK, so the researchers didn't find the holy grail.

There's not one bug we can kill. But there are chronic infectious things that we all carry around.

Microenvironment, Cancer Stem Cells, and Treatment Effects

But once our immune system gets beat down because of treatments or when you have advanced cancer, it's not working the right way, et cetera, those infectious agents just are unchecked.

But what they do is not necessarily cause cancer. but they mess up your immune system in a way that is, again, makes it easier to have more cancer. It makes the tumor microenvironment more pro-cancer.

So infections are a big area, but what I'll always tell patients is let's look at the more common things, but let's also look and just see, do you have this super high chronic inflammatory marker rate?

There's probably brewing infections. And it's not that maybe they didn't cause the cancer, but they're permissive. And killing them is not going to make your cancer probably go away, but it's going to take away another guy pouring gas on the fire, right?

And it's like 20 years ago or more. that was considered like lunacy and heresy and all this stuff and I didn't care we still did it. Now we have all these papers and it's like no one reads them except the guys who write them I swear.

But that's true yeah we have all this research and I'm sure those researchers are probably like hey guys you should really listen to this you know. What are your thoughts on, and this is like fungal infections as well.

Is that part of the potential issues? There's definitely like every category of infectious agent that they test, there's relationships. Yeah. And so, and this is another thing that it's something that I definitely do nowadays with advanced cancers of any kind, especially prostate.

This is an intersection, I think a good place to bring it up. A lot of, not all, but a lot of the repurposed oncology drugs or off-label oncology drugs that are real hot now, and because the internet people read about them, a lot of them are repurposed anti-infectious agents.

A lot of them are antiparasitic. But here's the thing that, so I always tell people I'm a recovering pharmacology professor and biochemistry professor, so that's near to my heart, pharmacology, and it's almost all out of me, but I still think that way.

What people miss, and especially now with the internet, it's like you can say whatever you want and people believe it. But what they miss is, if you look at the mechanism of most of the drugs that are anti-parasitic or even the antifungals or that stuff, yeah, they kill things.

Great. But they're also immunomodulatory substances. There's almost no useful repurposed cancer drug that's not immunomodulatory. So it might be doing two good things at once or multiple.

One is maybe killing some bugs that are there. But the other is making your immune system has to ebb and flow. When you have cancer, it sort of ebbs and stops flowing.

And it's like high here and low here and it's stuck. So immunomodulatory substance is trying to get you back there. If you take the bugs away, it's easier to get back there.

But also, a lot of these agents, whether it's the benzimidazole category, or the Avormectins or the whoever. Most kill things, but they also are immunomodulatory.

So that's another, it's another avenue. And again, what I tell patients is like, there's a lot of repurposed cancer drugs. our goal with you is if we can layer, we know you've got these bugs.

How do we know we have these bugs? Well, largely from, largely from testing, which is, is limited as I'll also tell patients for every one bug I can find, there's 30 hiding next to it.

We don't even know how to tell exactly. So would that change treatment? Wouldn't you do still anti-infectious agents? Even if nothing, if you, if you're one of the people who get referred to someone like me, at this point, I would probably just empirically do it anyway.

The research is big enough now to say, you've got something. But why don't we choose things that we know also have an anti-cancer immunologic effect and we'll kill some bugs at the same time?

And usually we do that in a particular way and all that. So that's a big area like immunomodulation. And you can imagine if you have chronic infectious things, they're going to not let you immunomodulate because your immune system is twisted towards infections.

And then you got cancer and it's twisted over into cancer. So infections are a thing. But the treatments are more than killing bugs. The treatments are also helping your immune system.

And to your point earlier about the microenvironment, That's one of the things that keeps it anti-cancer, is getting the immune system back to being flowing and not going too far up and too far down.

So that's one big area. And I was thinking earlier today, because I knew we were talking. And I meant to ask you off camera, so we'll see if we have the same experience.

Another area with my more advanced prostate cancer patients is not all. But most, if you look hard enough, you'll find a either occupational or in other environmental exposure, especially to solvents and other chemicals in the more aggressive cancers.

And it was, it was always more obvious if they were, you know, painters and contractors and people that worked in, you know, oil fields or whatever. But also this, cause I'm in the Northwest, we have a lot of aerospace folks.

Little aerospace engineers who you think while they're working on CAD designing and stuff, but the facilities they work in are full of aerospace chemistry and a lot of like, I can't remember the last advanced, so truly advanced prostate cancer person I met who didn't, once we dug deep enough, didn't have occupational exposures to these things that people say, well, a lot of people do and they don't get prostate cancer.

Well, sure. People are exposed to all sorts of stuff. A lot of people have infections and they only get cancer, right? A lot of people smoke and they don't get lung cancer.

Did you stack up all the wrong things in the wrong places? And then it's like, okay, we've got enough pressure here. your prostate is going to be where we express cancer because we screwed up the genome, et cetera.

So toxins are a thing. Now here's, and again, as opposed to 10, 20, 30 years ago, you can test more for toxic things now that we used to be able to. And also that leads to, we now have research to show these things definitely don't help many cancers, especially prostate.

But at that point, it's like the infection discussion where, OK, who knows if it caused? It was not helpful to have these chemistry around. Why don't we do things at the very least that just keep the door open so your body gets rid of these things at a faster rate?

Maybe you've had 20, 30, 40 years in a profession where you've marinated in chemicals. You're not going to get those out of a person in their lifetime, probably, but not quickly.

But why don't we make it so that that is less of an issue in your body. Okay. And kind of like with the, the infection discussion. A lot of the things that we might do to help your body get rid of, or just keep up with the chemistry it's got are also you know, potentially anti-cancer are helpful with cancer, but it's because they're doing all these other things, you know.

So on the infectious side, you've got the repurposed oncology drugs which are anti-infectious and immunomodulatory. In the world of the toxicity type things, you'll often get people that will come in and they'll say, hey, you know, I've been, you know, not great with my prostate, but it's been stable for years, right?

Now it's not.

Infections, Toxins, and Immune Disruption

And they don't know what to do. And they, you know, they say it's, it's moving. They will come in and say, I want, I want high dose vitamin C therapy, or I want, you know, some other injection type therapy or something.

Well, another thing that a lot of those therapies, especially vitamin C do is they really support your body eliminating a lot of junk. Like there's the, there's the known kind of name brand reasons to use the kind of vitamin C, which might be to create, you know, peroxide surge and, you know, assault the cancer cells.

And it turns out that the same vitamin C is helpful to normal cells. Great treatment. But it also does a lot to help your body get rid of junk. It makes it harder for the bugs to live there.

You know, it covers a lot of bases. So So I think that like, and there's other areas too, but if, if I just look at every prostate cancer patient, you know, every guy that came in that it was like, and usually it was stable, stable, stable, and then, you know, it blows up.

Toxicity was almost universal, infectious things and immunologic damage is almost universal, or you can't have that sort of cancer. And so why not do things that help your body with that fight, right?

Take as much away as possible. So, you know, there's other things that we see with folks who have had that, but if I had to pick the top two, like comorbid things that, you know, that keep the fire going, I think by the time you get to advanced prostate cancer, those are the two big ones.

So we're talking anti-infectious agents and we can get deeper there in a second and IV vitamin C, not just oral. Right. So there's nothing wrong with oral vitamin C, but to get to these biologic effects that, that would create an oxidative, you know, space.

And what happens is, and this is why I say it's sort of a nice therapy with cancer. If I give you a traditional cell-killing cytotoxic chemotherapy like Doxorubicin or anything, it goes to your body.

It will kill all the cells, whether they have cancer or not it encounters, right? So it's good, but it's also not good for the normal me, right? Vitamin C at high dose, within some parameters, will create this peroxide surge.

And with a lot of cancers, they don't have the enzymes to take the peroxide away, whereas my healthy cells do, right? So all my healthy cells get is some vitamin C and some antioxidant support.

My liver gets some detox, boom. The cancer cells, on the other hand, become weakened in a way because of the peroxide, because they can't deal with it.

But this is something that We, we now know, cause we watched enough people over time that we, it's not a caution. It's more of a informed consent thing.

If, if you were to, for example, come in and you had surveillance level, you know, low stage grade prostate cancer, I would have you focus on all sorts of things.

And you don't really need these sort of high level interventions. Normally you have high grade prostate cancer. It's great to do these things, but high dose vitamin C has this way of normally causing what you and I know as pseudo progression, which is the lab start to look worse in the beginning, right?

And it's because suddenly there's something going in there and there's an immune war now going on. So we have the cancer cells are weakened. The immune system says, oh, I should maybe look at these guys and beat them up.

the cancer can actually swell and the PSA can spike and go up a little bit for a while with high dose vitamin C. It's not because it's making the cancer worse.

It's actually, it's reacquainting the immune system with the fight it should have had 10 years ago. And so we always tell people, look, a lot of times though, you know, PSAs follow like they should, but in a lot of people, if you have a lot of cancer burden or your immune system's really been kind of sleep at the wheel, The vitamin C is going to reacquaint your immune system with this.

And even to the degree, you know, with modern scans, now we see a lot of stuff we didn't used to, but we'll have people have local nodes light up on a PET scan that weren't lighting up before, you know, and they get really worried, of course.

And a lot of times it's just, Oh, there was metastatic disease there. The vitamin C has injured the cell enough that the immune system's doing this beat up job.

And this happens in the prostate and all, wherever you got it. And it will actually look like a bigger tumor for a bit. Now, again, this is something that I learned 25 years ago from pioneers in this world who are all dead and gone now.

It was really a fringy thing like radiologists knew about pseudo progression and in quiet rooms oncologists will talk about. In that situation, everybody's freaking out, including the oncologists, when they see these things lighting up.

So I don't think either they know about it or they want to know about it, because they're going even stronger. And if they're saying, well, this happened from some vitamin C, who prescribed that?

Oh, this guy, Dr. Paul Anna. It's like, how far does this go in the wrong direction, honestly? I guess learning the hard way, always the best, right? These are now conversations that we have on the front end with people and we explain all of this.

But the only thing in our favor really is about somewhere between seven and 10 years ago, a particular category of biologic cancer drug was developed and it causes pseudo progression.

And so suddenly oncologists had to be taught about pseudo progression so they didn't freak out when they gave the biologic drug. And when I teach this to, and I wind up nowadays, you know, that some of the barriers are broke down.

I teach to medical doctors and in naturopathy doctors, but all kinds of practitioners, right? I use pseudo progression slides from the company that made those biologic drugs because they're the most beautiful things you've ever seen.

And they show it's like, yes, the tumor got bigger, but it's mostly immune inflammatory response against the tumor. And they have these different color things.

And I give them credit, of course. But it's like, now it's not a fringy thing. It's like, oh, that's pseudo progression. Now at least we can say, okay, dear patient, this may happen here.

This is known in the world of targeted therapies with certain drugs that happen also, but we've known about with

vitamin C forever. So if this does happen, we need to use specific terminology.

It's called pseudo progression. And people will say, well, how do you know if it's pseudo progression or real progression, which is a legit question. And the answer is, and this is another thing, like, I mean, I have to give them credit in order to keep selling those drugs.

They had to educate everybody about this. So they came up with these little charts and it's like, and it's sort of basic medicine 101, but okay. I, my imaging looks worse and maybe my PSA looks worse.

but are all the rest of the physical and lab characteristics of the patient improving or not? Are they getting cachexic? Are they having negative things?

It's probably a real profession. are they just having this imaging and PSA anomaly, but everything else is getting better? That's kind of pure pseudo progression.

It's still a fight though, because like you said earlier, and believe me, I've heard exactly what you've said. It doesn't matter that now we know that a category of drugs do this.

They will still look and say, well, the vitamin C is not that biologic class, right? So the vitamin C must be making prostate cancer worse. So you have to do this ahead of time.

You have to talk them through it. And the other thing is the more toxins you have sequestered and the more infectious agents that you don't know you have, the more the inflammatory response is.

And if you think about it, and this is all cancers, but breast and prostate are really good examples. In some cases now, especially especially prostate we have infectious data but glandular tissue loves loves chemicals chemicals love them and they just stay there you know and they'll marinate and so imagine the poor prostate cells trying to do the right thing and they're you know they've got all these solvents and things hanging out well now i'm giving you something that helps your body you know to recognize and deal with these problems of course you're going to dump more psa you're going to you know things are going to swell up etc so So it's a conversation you have to have ahead of time, because as we all know, if you tell a patient before something happens that, hey, this thing that looks scary might happen, it's less of a problem.

If you don't tell them, they're not going to believe you if you come back and say, oh, that happens all the time. The other thing is that they cannot work with medical doctors in that situation because they're not going to play along.

So it gets tricky for the patient. They have to choose their doctor. Are you either going to go with Dr. Anderson or Dr. Espinosa or the oncologist? Yeah, it becomes, and I mean, you and I both know there are instances of colleagues we have in the medical oncology world that have developed trust and might go with it.

But by and large, yeah, if you have just a patient with the rest of the 98% of medical oncology, they're just going to freak out and say whatever. And so the discussion I usually have is, OK, how far along the trail are we, considering my patients start at a pretty far end of the trail?

If you're in a place where all they might have are experimental treatments and other stuff like that, There's going to be a little more hands off on the medical oncology side.

If you're still under active, say traditional chemo or some therapeutic radiation or whatever, it's going to be a different conversation. And the way I deal with it after all these years is look, it's still your body.

I'm going to explain to you why these things might happen. You got to decide whether you want to do this or not, because it might happen. But if it comes down to it and your oncologist says, well, this is why you shouldn't do all these things.

That's, that's not that specific of advice. And it's your body, you get to decide how you want to move forward. A

portion of our patients are, the oncologists aren't doing a ton.

You know, they're doing androgen deprivation, maybe. they're doing you know a couple things and they're watching they think you know they're getting at least you know their imaging done and then there's people at all other places so yeah it's that is a and I guess I for you know I just don't think about it that much because that's been my only reality is advanced cancer pretty much that's part of dealing with it is the fact that you know we're kind of beyond the window of what traditional oncology can do at this point or if they are doing something, you really want us doing our thing to protect the rest of you from it.

But yeah, those sort of discussions, I just make sure the patient knows, I tell them exactly what the oncologist is going to tell them. And you know, the logic that will be used or not used.

And then we just, you know, move on. And this happened in the research thing, because we were partnered, I had way more traditional oncology people working, I was working with than folks like us.

And there were only two categories. One were people I could share data with and they would say, and this is like the chief of oncology somewhere. And they're like, I didn't even know that data existed.

Okay, go ahead. You know, it seems, seems like, you know, what you're doing. And the others were just sort of morally, literally, I had one person say they were morally opposed to what I did.

And it was like, well, you know, And we got in this kerfuffle one time. And I was like, well, wait a minute. How much data do you have for this fifth line treatment that you're recommending?

100%. Yeah, exactly. And I was like, well, so we're on the same footing. Let's at least be honest about it. Yeah, exactly.

Repurposed Drugs and Natural Anti-Infective Options

They came up with some other reason they didn't like me. But they called me privately, literally, on my cell phone. This is off the books. We have the big fights on the books.

And they were like, all right. I still don't agree with what you do, but I will tell you the patients I share with you are much healthier than all the other ones.

And I'm intellectually curious, but then they retired two years later. So they, they got to retire with their look, I think as a generational element, I am cautiously optimistic now urologists.

They are my friends, these people, we ride and die. They love what I do, they send them to me, they do well, no problems with you all. Oncologists, that's a tough nut to crack.

Now, there's a newer generation that I'm thinking that they just think differently. And a lot of the younger people just are more holistic, just from whatever, from their life, from reading, from the internet, from whatever.

So I'm cautiously optimistic that there's going to be a lot more of integrative oncologists, even if they don't call themselves that. So we can at least have better conversations about And be real with each other.

Like, Hey, yeah, we're all trying here. And this is a tough thing to, to, to, to, you know, to treat. So let's just figure out how to work together. Well, what are, and we'll end here.

Cause man, we can talk, we can talk for a while. What are some of those anti-infectious agents, anti-parasitics, um, both natural and, and pharmaceutical that you'd use?

Yeah. So there are. There are so many categories now. So there are the. the ones that have the most press in the standard oncology world started out more insulin manipulating, you know, like metformin, et cetera.

And then we, you know, we might see someone using berberine or dihydro berberine, the active form for a similar reason. And those are not, they're immunologically modulating through the insulin channels, et cetera, but they're not as much an anti-infectious agent.

But then you look at like, and then on the other end, you've got autonomic drugs that we might use for blood pressure or neurological things, and they don't have a ton of, you know, like anti-infectious effect.

Everything in the middle are repurposed some kind of anti-infective drug. So most people at this point have heard doxycycline and common antibiotic family from the tetracycline family.

It turns out it also does some manipulation with the way that we metabolize in our cells. And it turns out that that could be used to, to aggravate cancer cells in some cases.

So then that's was before it was thought of as primarily anti-infective. And then I think largely from urology and dermatology, we knew it was also an inflammatory, but it's an immunomodulator in addition to killing bugs.

So, but it's also, it's a metabolism manipulator. Okay. So that's an example from the antibiotic world, but then you get to. the anti-parasitics, which are a big category.

And in the US, the benzimidazoles, which includes mebendazole and albendazole. And then in Europe, phenbendazole. But in the US, that's an animal-only drug.

But really, they're very similar. They're just made in different generations. Yes, they kill parasites and a few other types of organisms. but they also are really immunomodulatory.

Then there's a category, and it's always interesting. Like if this was pre-COVID, I could say this category, no one would have ever heard of it. COVID has caused everybody to hear about it with really weird connotations.

But the category is called the AVER, Avermectin family. And it includes ivermectin. Okay. But other things, there is a cousin of ivermectin that is not used in the U S but is used in many other countries specifically for cancer.

It was developed as a anti-parasitic drug because it was supposed to be like the, the better ivermectin. And I know, you know, now like you, you know, now we talk to people all over the world.

People are using this drug and it was primarily like it You know, it was like, well, how many parasitic infections are we going to have? But we tried on cancer.

Well, it really worked. Well, that category, and there's other relatives there. that category, yes, kills some bugs, but I truly think it's the immunomodulatory effect of it.

So this sort of next generation better, you know, hypermectin mostly is used for cancer. And it's because again, it brings immunomodulation in. And then you get- What's the name of that drug?

It's called, and it's real similar name to another cancer drug that is not the same at all. So it's selenomycin, which sounds a lot like about three other drugs, but S-A-L-I-N-O-M-Y-C-I-N, I believe.

And it's actually structurally related. It's an aviromectin. And no selenium in it? The name would imply that, no. No, it's just the way, it's the biochemistry of the way it looks.

Okay. And again, it was made to kill bugs, right? And then they thought, well, this is a real big immunomodule, let's put it in. And then you have some antifungals in the triazole class that work in there.

And again, they, so these trials, most people have heard of, oh, you know, like keto. Keto, keto, keto, right. Which is, which is used in prostate cancer.

Yeah, actually more as a anti androgen. Yeah. It's so you look at that whole triazole family like keto and intraconazole and you know, although it's got even stronger cousins, they initially, and this is, this is like, so yeah, they kill fungus, but they also do this androgen blocking thing that we sort of discovered after we learned they killed, you know, fungus, but also it turns out that they do, they do some beyond their hormonal manipulation, which is stronger than most people believe.

they do some immunomodulatory action as well. And so again, like in your world, they might use it, you know, in the prostate cancer setting and more on, you know, looking at the androgen manipulation, but they're probably getting immunomodulation as well there.

And another that's not, it's definitely an off label sort of thing, but it's very common now in the world, but it's not anti-infective. is using instead of high dose naltrexone like he is for addiction and stuff using low dose naltrexone and that is now we know a lot more about it at low dose it actually goes in so at high dose it just suppresses opiate receptors and and it has a really heavy hand which is not what you want with cancer at low dose it actually goes in and goes to the T cells, the cell mediated system, and there's all these families that are supposed to bring this orchestration of immune response.

In cancer, the T cells sort of shift over one direction. Well, naltrexone at low dose can go in and just sort of push everybody back into where, you know, so they're all working like they're supposed to.

And there's actually not as much in this country, but in Europe, there are hardcore medical oncology researchers that are using low dose naltrexone in research quite a bit.

And my experience with it is it's like the other things. It's good to bring in to help out. It's not going to pull all the weight on its own. Nothing is.

But it's like the repurposed drug world is only going to get bigger The idea is a lot of these things are off pat and they're fairly cheap. We can, you know, mix and match and we can do layers of them, but all of them have usually an immunomodulatory effect.

Some have hormone effects, like you mentioned. and then some have, you know, like nervous system effects, which actually affect cancer as well. So these drugs, do the natural and the botanical world, if somebody wants to go completely natural, can they compete?

So warm wood, oregano oil, oregano capsules, berberine, any of those things, can they compete? You know, the short answer is yes. There's a little bit of emerging data, like people actually trying to use them maybe head to head or looking at that sort of thing.

I would say definitely if you go to the sort of OG repurposed drug metformin, which is the only one you see in research a lot of times, you get berberine or dihydro berberine.

It can be just as effective. It's sort of an equal transfer. You get to antifungals. So, you know, oregano and thyme and all the other sort of aromatic herbs.

They also, like we think of them as antifungal agents, they kill other infectious agents too, and they actually have some immunomodulatory effect. I'm always cautious with that because they don't, it's often not a one-to-one transfer.

It's like the two, the drug and the herb might both kill the same bug. but their immunomodulation may be different. So you, but again, it's, it's always in, in my experience with advanced cancer, it's about sort of layering them so that they have synergy and you can do that with botanicals and you can do that with drugs and you can mix and match.

And it's never about like one or just these three are always going to work for you. That's not how it works. You know, the, One of the most hilarious things that I've had in my career was reading a fairly big textbook about repurposed drugs.

And in the introduction to chapters, I was reading and I thought, this looks really familiar. And they had reprinted, they gave me credit, but they reprinted something I'd published somewhere about treating cancer from a metabolic point of view.

And I didn't even know I was in the book. And the author put it in there and it was like, they had all of these sort of things that had been published, written about, et cetera.

And the whole lead-in was, you have to do these other things to get the metabolism to be body-friendly, cancer-averse. You have to do these things to maybe beat up the cancer.

And then all of this repurposed drug business makes more sense. And you mentioned Wormwood. So one of the things that we got to do was there are constituents of Wyrmwood, like Artemis and Artestinate, etc.

And those can be used parentally, intravenously. We had some really amazing results with advanced stage four breast cancer and combining that and then high dose vitamin C with just survival, which to an advanced breast cancer patient, that's what they're after.

Like they want to feel good and they want to live as long as they can. And similar with prostate, but because of the pseudo progression thing, like when you add artemis and artesanate, you get a much harder punch, you know, because artesanate is used for malaria, but it kills a bunch of other stuff.

Well, it's what people miss is it's famous for killing bugs. It has more research in rheumatology as an immune modulator. So what I'll tell people is yes, the first 30 minutes in your body, it's going to kill whatever's there, and it's going to create redox surges.

But the next day it's in your body, it's going to work more like curcumin, where it's leveling out your immunome.

Final Advice and Where to Find Dr. Anderson

And now we think maybe the reason we kept those patients alive longer was the bony and brain metastases, et cetera. What makes them grow faster is an out of balance inflamed immune system.

Well, it turns out that like the vitamin C, yes, but also the artesanate, was having this one or two day long immunomodulatory kind of haze afterwards.

So it's never one thing. It's obviously I've been doing this thinking about for most of my life. And so it seems real obvious to me, but when you're trying to talk to patients and trying to say, this is why we're doing these things, yes, your oncologist is probably not gonna buy into it.

They're not gonna understand why we're doing it. But here's my goal. is to make all your healthy cells so healthy and make the tumor microenvironment so chill that it doesn't want to do any more cancer business.

That will make you feel better. It'll make you probably live longer. And when you have advanced cancer, that is, those are the two goals most people have, right?

Right. You know, and I mean, we do 80% more stuff now and we know 80% more than we did 15 years ago. And thank God, we're learning. Yeah, it's an endless process, endless process.

Paul, another masterclass by you and you have so much more to offer. Parting thoughts and how can people find you or your work? So I think because I'm certain a portion of the people watching this are loved ones or people with advanced prostate cancer, you know, it's tough.

There's no cancer that's not tough, but it's tough. And when it gets to the point where, you know, it seems like it just is a whole different animal, it is.

And it's these other things that if you can work with somebody to, you know, work on these underlying things that are, as we talked about, pouring gas on the fire, throwing your immune system off.

And sometimes that takes maybe a couple or two or three practitioners, because everyone does things differently. But if you can bring that into your team, from my own experience with my own eyes and watching people, the more you can do their length and quality of life are all of our goals.

But once we have cancer, they become very, very acute goals that we want to look at. And I've really never seen anybody, even if the cancer kind of kept pushing, where improving quality of life didn't lead to length of life and better quality and all that.

So the more of these things you can look at, the more people you can work with. It's not that the standard system of medical oncology, radiation, they're great.

They have their place. All of these things have their place. And if you're dealing with it, your loved one is, and you're willing to kind of step into this world, it can add a lot of depth to that.

So I think that would be my parting final thought is You want to do everything you can to make yourself as small a target for the cancer as possible. Once you have advanced cancer, it's not going to go away barring a miracle, but you can make yourself so you're less of a good host.

That's right. And where can you be found or your work or? Yeah. So I had help with my online personality. I have a hub website. So if you do a lot of YouTube and podcasts and writing and stuff, just go to dranow.com.

and there's links to pretty much anything I do there. So that's easy. Dranow.com. I love it. Paul, thanks so much for being on and for really educating us in such a high level that I'm always appreciative to listen to you.

So thank you so much. Thank you for having me. It was fun. It's always fun talking to you. Absolutely. All right, everyone. Thank you so much for listening to this.

Another just amazing episode of the prostate cancer summit with our guest, Dr. Paul Anderson. Stay tuned for more. We have more coming. I'll see you next time at the next prostate cancer episode, prostate cancer summit episode.

So long. Thank you for tuning in to Doctor Talks. We hope today's episode has enlightened and inspired you on your path to optimal health. Each day is a new opportunity to make choices that empower your well-being.

For more insights and strategies, subscribe to our podcast and visit our website, www.doctortalks.com. Stay connected, stay healthy, and join us next time on Doctor Talks, real talks from real doctors on the issues that matter to you most.