Jane McLellandu2019s Cancer Journey

Well, this is an absolute pleasure. I have Jane McLelland with me. She is the author of How to Starve Cancer. Jane, thank you so much for being with me here today.

Always a pleasure to be with you. Michael. Well, you are your you're a warrior. You you. Yes you are. You survived a very serious type of cancer. And then you altered how to start cancer.

Going through your journey, can you tell me a little bit what happened in your own cancer journey that made you so determined to help other patients understand their office? Yes.

And I think from a patient's perspective, you know, when we're looking at because my my big thing is I've become like the founder of the repurposing drugs movement for cancer.

And my journey really was a ten year journey from 1994 to 2004. And I had cancer recur several times. Initially it was in my cervix. It was aggressive.

It was already in quite a lot of my lymph nodes. They took out loads, right? I didn't know that metformin at that time was useful for I've just read about that literally in the past few days.

Metformin may stop lymphedema. It remains a big problem in my life, but much less. And then I it then spread to my lungs in 1999. Meantime, I lost my mother to breast cancer.

Cancer has been a big feature of my life, right? And then when I thought I was kind of controlling it, I was doing a lot of integrative things, intravenous vitamin C supplements, and I thought that was controlling it, but it wasn't.

And then I ended up having another occurrence, and this time it came back as Milo dysplasia, which was mutating to acute myeloid leukemia, which is a rapid progression to the ground.

If you know what I mean, into the. So it was an urgent situation that demanded a complete rethink. So what I've been doing, I realized, probably wasn't enough.

I'm not one to sort of turn my back on traditional standard medicines, and I wouldn't have done it. I thought there was something they could have added that would have helped.

But the problem was that chemo and radiotherapy, which I'd had prior, had actually caused the problem. So I didn't want any more of that. But I put together a cocktail that involved various repurposed strokes.

So I added one called die, which I think is vastly underused by many integrative doctors. And this works on it's normally used as an antiplatelet drug, but it works on a cholesterol pathway.

It also stops a cancer pulling in and reusing nucleosides to build new DNA. Then I added I added a stat in, so I added lover Satin, which was very common back then.

Had anybody gets hold of that these days. And then I added a toddler, which is an arthritis strike. It's more of a non-steroidal. So I did that in. Then as I progressed I sort of I'd already added berberine, which is kind of like a natural form of metformin.

But later on I added the metformin in about 2007. So like moving down the line. But in 2003, this is when I got this

myeloid dysplasia happening. I added this in thinking, well I might buy myself some more time.

I really didn't think I had long, nobody thought I had any time and it completely disappeared within seven months. My markers were almost normal. They didn't quite get back to normal.

I had a marker done called PKM two, which kind of detects glycolysis. Didn't quite get into normal range, but I thought I'd done enough. And I see this a lot.

I see patients coming off their repurposed cocktail too early. Well, I did because I didn't know anybody done it. I was kind of like my own guinea pig here.

I'd gone to different doctors to pieces together because nobody said he'd go, Jane, here's a cocktail. Try this. I was breaking new territory here, and I didn't know how long to be on them.

How much? How what? There were so many questions, and I. I was unsure, so I came off them. My cancer came roaring back the next year. Fortunately, it was a big enough cocktail to suppress the cancer.

And I've been, you know, it's gone. I haven't had any cancer since 2004 touching wood. But yeah, so I've been I've been healthy and this whole thing was so traumatic, I can't tell you terrifying at, you know, at such a young age, because I was only 30 when I was first diagnosed and then 35 when it spread to my lungs.

Messed up my whole life for a long time. It took me a while to get my whole life back on track. I knew I could, you know, I'd had a stroke to me. I couldn't have kids.

I thought my partner at the time was going to leave me. All of these things were so it was hugely traumatic emotionally, very straining with my mum dying as well.

So I, I have empathy with, with cancer patients out there. So let's do this. Let's, let's get you better. Let's not make you suffer in the same way that I, I really suffered, you know, and I want to make sure that we actually smooth the path a little bit easier for patients who follow on behind.

So that's part of my plan going forward, is to create more evidence for patients to look at these cocktails of drugs and personalize what works best for different patients.

Because out there on the internet, I see a lot of noise about people promoting particular things, and they just focus on a few little things and they say that's going to be right for everyone.

Of course, it's not going to be right. You know, the Kito diet doesn't work for everyone either. Make tin doesn't work for everyone.

Repurposed Drugs and the Metro Map

And yet we have all of this going on in the background out there on the web, you know, and people are confused. They don't know what to do. And when you've got sage for cancer, your ground for anything.

You know, if somebody says the keto diets are going to be the answer, they'll do it. But I've, you know, I'm I'm writing a lot more on I've got a Substack and I write a lot more about things.

And I wrote one recently about how some cancers actually use ketones. So pancreatic cancer and acute myeloid leukemia, for example, actually use ketones.

And you are much more likely to become sick. So there are these nuances to every different type of cancer. And my mission, if you like, now, is to save as many lives as possible, making it as easy for patients to be given the right cocktails, which is not the biggest cocktail.

What I want to find to cocktails that are the most effective, most evidence supported for them personally. Right. So it's not the ketones going to work for everyone that doesn't work.

Or, you know, there are doctors out there just prescribing very high doses of ivermectin and fan design and pretty much nothing else. And, you know, it's ignoring the science that's out there already.

So yeah, it's a mission I feel yeah, I feel like it's gone off track. Right. I felt I felt the repurposed movement was doing fine and now it's just wash.

It's gone off. It's headed off into a different direction. I don't know whether you found that it. I see that it becomes so hyper focus on the IRA mechanism is all that they all the other tools just kind of seem to fall into the background.

And they, you know, that conversation is so strong on the internet. So it's hard for patients that are newly diagnosed to not listen to that conversation because it's so prevalent.

So you, you wrote, I mean, in your book, How to Start Cancer. I mean, you created this Metro map. Yeah. Right. Right here. Yes. That's what I'm most known for, which is that and it was a simplistic view of the different fuels that you get.

You got your carb protein and fat, right. And fat tends to be ignored by some people as well. But there are fat pathways that are, you know, all cancers will use not I mean, they will use glucose, they will use glutamine, which is an amino acid.

But the fat aspect is another area which I feel is totally underutilized because it's not just that the cancer is taking. In fact it does. It has fat transporters. It has. So the LDL and the CD 36, these are transporters that will actually bring fat in to the cell.

But the cell itself is making fatty acids to create new building blocks for its daughter cells. So there are lots of different pathways that the cancer is using differently to the healthy cells.

We're trying to look at the differences between what a healthy cell is doing and what a cancer cell is doing, so that we can target specifically, we're not trying to damage the healthy cells, we're just trying to target the cancer cells.

And we can be quite specific about that with the metabolism, because most of your healthy cells, the hardly any I think really that you psychosis all the time but that that is specific to cancer.

So by attacking that by actually trying to reduce the glycolysis or this aerobic glycolysis that happens in the cancer cell, we can be quite specific about trying to kill the cancer cell and trying to keep the healthy cell healthy.

Yeah. And so the challenge that I see frequently is that people then get wrapped up into saying, well, I gotta stay away eating glutamine. I get to stay away eating serine Metheny.

I mean, all these different amino acids. And then here they go. And obviously our healthy cells are not getting nutrition and they getting weak, feeble while they're trying to starve their cancer and they're starving themselves.

So how how do you how do you deal with that. Well, that is an issue. And I think again, that's a lot of noise out there. And for me, I did a low GI paleo type of diet.

It wasn't a real keto diet that could be seen as sort of 70 or read an 80% fat. Mine was very much a sort of a well-balanced paleo diet, but it was low GI.

So I had things like I actually had black rice, red rice, and mixing with quinoa, and I had porridge for breakfast. I had sweet potatoes. I didn't have huge quantities of them.

I kept the volume low and I'd always mix them in with, you know, there weren't carbs on their own. I'd always make

sure that I had. They followed something else.

So you actually had fat and, well, lots of vegetables first. But the kind of fat was olive oil. I take a lot of fish. I still do take a lot of fish oils every day. So.

So it's a matter of getting the balance right. And I think today most diets are completely out of sync with what would be deemed healthy in the past. So do you feel that?

I mean, obviously low glycemic. Yeah, that seems to be a good standard. So it is standard, I would say for anybody who's actually going through cancer, that is the number one thing you should do.

But Laird, on top of that you can do a bit of intermittent fasting. You can even do two days of, you know, not the same day necessarily, but two days of fasting during the week.

They've looked at some cancers that respond well to that. But things like breast cancer, they're now running a trial, doing a 168 and layering metformin into that.

So that's that's a trial that's ongoing at the moment. They did the Mar 32 trial which was looking at metformin and breast cancer. And it was like, oh, it failed.

But actually they didn't look at it in the right synergistic way. Right. So they knew that metformin is great for diabetics. And they could see the results when you add met warm into a diabetic person and they have cancer, you can see they lost.

You know, they survive in fact longer than than people who haven't got diabetes. So there was that very strong signal. So they thought they would have a look at breast cancer patients who were non-diabetic and have a look at whether there was that signal with the metformin, but it didn't really show up.

And that's a problem with when you look at just individual drugs or just combining things, but they're not quite looking at the right synergy.

Diet, Fasting, and Metabolic Phenotypes

So the thing that triggers and this is research that's been done by Ricardo Cabot Soley and his partners. But they had a look at metformin combined with fasting.

And it's when you do the two together boom. That's when you get really good effects with metformin. So they're looking at metformin with the 168 daily intermittent fasting.

So that's ongoing at the moment. So we'll wait and see what the results are of that. But certainly the signal seems to be very positive on that. And how do you and I want to get back to diet a little bit.

But I want to kind of follow a how do you navigate the, you know, synergistic effect. Because, I mean, it seems to me that a lot of people, they, you know, they get a little familiarized with repurposed drugs and they just kind of stack things on top of each other.

And, and it just becomes more and more and more versus just really being kind of keeping us as tight and effective as possible. Yeah. And that is the issue is so look at what are the main drivers.

What is the key metabolic phenotype of your cancer. But not only that, you also have to look at what drug that patient has been given if they're on oxygen or if they're on full strength.

The actual cocktail will differ entirely. So in fact, with Sylvestre, you might need to be on more of a keto diet. I don't like Kito generally for breast cancer patients, but if you're on any of the other drugs, tamoxifen powder, all of the other ones that are there for for breast cancer, then you're looking at more of an intermittent fasting and you are

looking at a completely different cocktail of drugs, because the result that the escape routes of cancer can be different.

And I think this is an important point that people need to understand. It's all about the escape groups that cancer can use to get around all of these drugs, the standard of care drugs, because they all have resistance mechanisms.

And I like to teach people that cancer is a bit like a seasoned criminal. Right. So at stage 1 or 2, they're like a petty thief and they can do a bit of shoplifting.

You put them in detention, give them a bit of chemo, and they might learn to live with society. But then when they get to say, 3 or 4, they've learned the escape routes.

So if you've got chemo coming in the front door, they go, well, I've got the back door, I've got the tunnel under the wall, I've got the escape hatch out the roof, I've got that side window.

Then you've got the escape routes of the escape routes. Right. And so it's it is this a process? And you know that the point being that we need to understand not just the metabolic phenotype, but we also need to understand the escape routes of the drugs, you know, and actually work out how best to keep that patient doing really well, not necessarily take them off the sound of care, but even with chemo, you can make chemotherapy work much better if you understand what those escape routes are.

Now, I don't particularly like to high doses of chemo when you get to stage four because you're just killing off your immune system, there are there's I think a lot more people are starting to use lower dose.

Chemo doesn't have to be totally low dose. I mean, a lot of doctors are actually using 10% in a metronomic way, and that seems to work quite well for colorectal cancer.

But, you know, I do worry that there is this overload of chemo with stage four cancer patients and that kind of ruins their chance to get their natural killer cells working to get the T cells into the tumor.

And the other thing we've got to look about, actually, is the physical nature of the tumor as well. So some tumors have got really thick stroma. So how do you reach that stroma.

So pancreatic cancer for example who's got this really thick stroma. So you can't get the drug. So you can't get the supplements in. It doesn't matter whether it's standard of care, whether it's intravenous vitamin C, whatever it is, you actually need to breach the stroma.

Although actually interference vitamin C has been shown to be particularly useful with pancreatic cancer. But the point being that you need to breach that stroma in order to make things work better, you've got to breach that stroma.

And there are there's kind of like little cocktail, which I think is really good to try and breach that stroma. One of them is para calcium, which, it helps to just break down the it's like a vitamin D analog, but it just helps to break down some of that fibrous network and then dissolve because it breaks down the tubulin and it just makes it easier to get in.

And then what was the other one blows out. And so that's a blood pressure medication. And that trio really helps really well to help the drugs get into a pancreatic tumor for example.

And they're doing research on that combination at Fox Chase I think. So that's that's all useful information. And Doctor Steve Biggleswade, who is a long term survivor of pancreatic cancer breaching the stromal, was kind of like the number one thing he had to do.

And I think that's important. We need to look at the physical nature of, you know, there are so many different

aspects to it and it is complex. So yeah. What do you focus on first?

And I think it varies depending on the type. The nature of the cancer is to wait where your focus is, and that's where something like you, you've got experience working with cancer for many, many years.

I know a lot of people have come in recently, some doctors, and they don't have the knowledge base of understanding the nature of cancer. And you can't you can't replicate that kind of knowledge.

You've you've acquired it over many, many years. Right. So I'm hoping that we will eventually get much more collaboration between oncologists and integrative oncologists.

But right now, I feel like there's too much noise going on about the ivermectin and the keto, and it's just creating a clash between both sides. And we should be working together.

And I felt like we were doing well with the revolution. And I feel like it's kind of been dismantled. But it's made certainly made doctors more aware of repurposing since Covid.

But I do feel there's this sort of kickback where doctors were really punished for prescribing either. And there's a bit of a I told you so going on with doctors trying to vindicate themselves from saying, I got all these results for, for cancer and you should not have stopped, as you know, I mean, I, I just feel we need proper collaboration going forward.

The cancer patient is not interested in politics and why you should be pushing. You know, the push for either marketing has got to noisy way too noisy.

I don't know whether you feel that, but you know, some I do, and I think the issue is that we I think as a society we moved towards kind of like a TikTok society where we can only handle some bites and then that becomes our whole world.

And so we, we are not willing to take the time of the energy to go dig deeper. And so we listen then to simplistic messaging. Yeah. And that is what we follow.

And that can be then idles ivermectin and been dissolved. It can be ketogenic diet. It can be let's stay away from all amino acids because they all feed cancers.

And I'm going to be for it. I mean so it's all these different things. And so I'm going to start my cancer and I'm just going to be, you know, fasting all the time.

And so it's all these kind of simplistic pathways that people then follow because they hear that, that messaging so strongly and or whether it's, you know, chlorine dioxide and this is the only, only solution or, you know, it's that kind of thing, you know, and not recognizing, like you're saying, cancers complex, cancer is evolving, a cancer is shifting cancers.

I mean, it's a highly intelligent tissue that is continually finding ways to figure out how to how to survive. Exactly. So shapeshifter and that's what patients really need to understand.

So I've met and van benzyl will be blocking quite a few. I mean they both blocked quite a few pathways. But if you look at my metro map, there's a huge number of things that they're not blocking.

And of course, there's you know, a lot of the noise is about I had a patient who had prostate cancer seven months later, their prey, there are no evidence of disease, but how long are they no evidence of disease for.

And you and I could talk about that every day about patients that we see that go into no evidence of disease. We don't go on to social media shouting about it all the time.

But we see it so often, like every day. But it's using a bigger, carefully curated cocktail. But we know it's going to be safe for the patient. Very worried about the safety of patients taking very high doses of either Magdalen.

And they're basing these. I mean, we're now looking at one milligram per kilo of body weight is now being recommended by one particular doctor. Well, actually goes up to 2.5mg/kg sometimes. So.

Oh my god. So no where is the evidence. And they're basing this on in vitro tests. And we know that that doesn't correlate to results in the person.

Escape Routes, Stroma, and Personalized Cocktails

And they looked at this with ivermectin and Bal which is an immune a therapy drug. Then they thought that it would have great effects. But in fact out of eight patients, I think one didn't get into remission but had stability and six of them progressed, you know.

So actually you've got to look again at the bigger cocktail, what's actually happening in the patient. You can't see the escape routes just by looking in a petri dish.

Right. And not really. You've got to see how the patient responds. And it's short sighted in my view. There are better cocktails out there. And I might and does do a lot of things, but it overlaps with a lot of other things that are in my metro map.

So do you need it? Where is the distinct functional reason for having so much either met and when there are safer drugs that you could actually load in that would do a better job in a bigger cocktail.

So actually, as long as there's synergy, you can get a bigger cocktail, much lower doses of everything. And I know that most doctors in my network kind of prescribed by Vermette, and some of them are doing it more regularly, but twice a week, maybe three times a week at much lower doses.

That's program to be safer. The liver toxicity also comes from the basil at very high doses, so that should be pulsed as well. It's tricky to get it all right.

You know you have to be a magician. But this is where I'm trying to create this AI tool, created this framework. So and I know that you're doing some stuff as well, but this is all to create for my network of doctors if they want to.

And it's a clinician facing tool to be able to look at all the different aspects of the cancer and from from the physical nature of the cancer right through to the metabolic phenotype.

Synthetic lethality is everything to try and look at different ways we can get better cocktails together. It's not necessarily the biggest or the highest dose.

It's the smallest, best supported combination, that we can create that addresses all of those important escape routes. So that's that's what I want to do. And I'm building this register.

I'm going to have a registry. It'll be on a website called G or dog that's global integrative oncology registry like dial. And then that'll be where patients can go and log their details so they can put in for free.

They can just add all their details in there. We need that information. We need to collect the data. We can look at all of this high dose ivermectin stuff.

Let's see how long these patients actually survive where I want it to be treatment agnostic. So whoever it doesn't matter which protocol you're doing, I just want to see you know, what the results are.

How long they last are maybe entirely wrong about high dose ivermectin, but right now I'm. I'm concerned. That's all I'll say is I'm very concerned about it.

And so what are you when you say kind of a what type of dosage do you feel okay with just so people can hear that, you know, because they hear, you know, 1mg/kg.

And like I mentioned, sometimes, you know, some more aggressive than two and a half. So what dosage do you tend to feel. Okay. But. Well, you know, I'm not a doctor, so I can't say.

But the doctors who I work with tend to prescribe 24, 36mg twice a week, and that's that's, that tends to be around that kind of dosage. Not higher than 36th January.

Yeah. Yeah. And so you're talking about phenotype. And obviously you have genetic mutations. You have the type of cancer the physical structure of the cancer.

How does a patient figure out what kind of phenotype they have. This is the wonder of a I Michael. So it's so easy right. So I would try and do this by hand if you like, in the old days before I and I'd be on PubMed search and searching.

I have built up files of things about the metabolic phenotype. But there are this is something that is being explored by cancer researchers. They are building up documents that sort of provide you information on what kind of behavior that cancer cell is going to demonstrate, and it's kind of like a, a fingerprint.

And each different kind of cancer has a specific fingerprint. So it's easy for easy these days. I mean, I'm so jealous, really. I mean, I think how hard it was for me, right?

And, you know, I've been pouring through so much research every day, and I still do it, but, you know, and it's important to keep on top of the research.

But now you can just type in what's my metabolic. So that's the first thing you should do is what is the metabolic phenotype of my cancer. In fact that may not be the first thing you should do.

You should probably write in a different thing first, which is does my cancer? Is my cancer driven more by glycolysis or ox Foss? That will give you a big clue if it says Ox Foss.

Ketogenic diet is a no no. So that's a big, big point for people to know. So if they type in Oxford versus glycolysis, if it's like this. Well, there's there's good reasons for doing it, you know.

But the low GI diet will help both. That's not to say don't do a low GI diet, but the ox foss means you need things to block that pathway. This is something that Tom Seefried is not particularly happy about.

But blocking Oxford is really important. And breast cancer patients, if you look up the metabolic phenotype of estrogen positive breast cancer, which is like the majority of patients that we see, their phenotype is that it will be driven by Ox Foss above glycolysis.

Right. And the metabolic phenotype means that they shouldn't be doing a ketogenic diet. And this has caused a bit of eruption. I did some articles on Substack about it.

I've got a bit of kickback on it. That's fine, but we all need to be discussing it, right and raise these points. We shouldn't just be sitting there feeling happy that, oh, the ketosis, what I've been told.

So no, I want patients to do their own research and to be independent thinkers. And that's what I like. I love it and patients questioned me. They say, well, what about this?

It means they're thinking about it. They're not just being passive patients. They're being proactive and they're helping themselves. And I love that. And so and that's a challenge as we're talking about.

It's that some doctors yeah some some voices out there are very evangelistic you know and it's like becomes a

faith. And they have to defend their faith, you know, because they've spent so much energy and time into it.

And so then and when they feel the back is against the wall, then they push harder, you know. So I think that is a big challenge. And what I love is to always be okay with being wrong.

Yeah. Not not not only to. Yeah, yeah. Not to be. I want to be proven wrong. It doesn't mean that I'm always wrong, but I if there are better ways I want to do better ways.

Yeah. And I wrote a an apology. Kind of like an apology a few days ago on subsect because I had been concerned because asparagine, which is amino acid, can actually drive metastases.

It drives the EMT the to transition. So and I mentioned it in my first book in 2018. And this is the time when the whole asparagine kind of problem with breast cancer was being exposed.

And they all the journalists were talking about to stay off asparagus. So I was a bit concerned about it. So I didn't know the amino acid content of prosperous.

So I said self asparagus. And I realized that she is actually very low, just historical. It's just a historical incident that it just happened that when they were testing asparagus juice, that they noticed this amino acid.

So the amino acid got named after asparagus, but it's not very high in. And asparagus has got a lot of benefits. I kind of said, look guys, I was wrong.

And I'm, you know, and I'm happy to admit when I'm wrong. And it means patients are eating healthier. Great. You know, but I think there is a lot of food anxiety out there.

But this is where, you know, and particularly with looking at lowering some of these amino acids. But this is where the repurposed drugs come in. So disulfiram circling, they can be great at lowering the lowering serine which can drive colorectal cancer.

Disulfiram seems to be particularly good for colorectal cancer. And it works a bit. It has synthetically fallacy with an APC deficient cancer, and about 60% of colorectal cancers have got an a PC deficiency.

So that's a massive synergistic cocktail that could be added. And I don't know very many colorectal cancer patients who are actually using disulfiram. But that's like a big thing.

And I wrote another Substack is kind of like my new thing. I have so many articles bursting from me. Right. And I've been thinking about this for years.

I've got to tell people about, oh, and then just running out of time. But actually doing a subset makes me publish something every week. And it's good discipline for me, and I think people are enjoying it.

So I'm enjoying it. Yeah. I'm. Yeah. Oh, you're on this. Okay, great. Okay, good. I love what you do. So. Yeah. Yeah. So, you know, and I, I think it's important and that the science is moving so fast in this area.

That thing about metformin, the lymphedema, it's like, oh, God. You know, only I'd know if only they were prescribing that when, you know, when I had the risk of the lymphedema.

Nobody ever told me that I ended up with both legs, but mostly in my right leg, and traveling on a plane disaster. And they didn't give me any support stockings for years.

Nothing. They gave me no information, nothing at all. And I was wearing Ted stockings because it couldn't get hold of anything else, you know, all full, awful hopeless.

Really? Yeah, yeah. Madison and I see this in the integrative space. I see medicine evolving. But, you know,

integrative space, you know, we're evolving so much or we're dealing with two decades ago and what the tools we have now, I mean, it's night and day and and it's really cool to see.

Yeah. It's really it is.

AI, Registry Data, and Patient Guidance

So I want to can I go back a little bit, you know, because I, you know we talked about ketogenic diet, but I don't want to kind of make that one point where you're saying that some cancers actually produce ketones.

So yes, means that they are actually benefiting from ketones and it is part of their survival mechanism. Exactly right. That's exactly right. And pancreatic cancer and acute myeloid say again acute myeloid leukemia are two cancers that do that.

So you cannot be using, you know, and the toad that there is some evidence, short term evidence looking at the keto diet with pancreatic cancer. But really it is to me the it's not looking at the big picture, very short sighted is what kills a lot of pancreatic cancer patients.

The Kito diet will just promote Axia not safe in my view. That is not something that anybody with pancreatic cancer should be looking at. Not unless they're doing some other stuff, which again, is dodgy looking at dexamethasone, looking at.

So there, you know, there are ways to try and block that. But there is safer, easier ways to do it. You know what I mean. It's looking at the best cocktail for that person, for that patient sitting in front of you.

And I know a lot of doctors kind of prescribe the same cocktail of medicines, thinking, well, it worked for this patient with that cancer. So therefore it might work with this patient with cancer.

But each cancer is specific and it has to be personalized. You have to look into all the nitty gritty details. And that was part of my metro map, was to say, you've got to check this out.

Which of those pathways on that map are going to be best for you? So I have an online course where I teach people about them, and then they go away and research them.

People do like that as well. So it's been it's been a journey. I've gone from the book, which I didn't really want to write, but I did it. And then I didn't want to create the online course, but people saying, I don't get it.

So then I had to create the online course, and now I think we've got AI. Let's make use of that. Right. So I've got this framework, and I'd love you to think about trying it out and be a better user for it and give me some feedback on it.

And yeah, just just see if that helps you or not. It's it's meant to help the clinician and in fact other health. I'll be also creating some more lifestyle and supplement information to back up what the doctor's stirring.

So it should be a deepening of the effect. So it's all about not contraindicated. So they work together right. So you can have a nutritionist. They might undo what you're trying to do in the clinic would be disaster.

So it's meant to be so that we get this overall effect and a collaboration between people. And I want with the evidence going back into the registry as well, so that when we see doctors doing particular cocktails that are similar, they can collaborate, write a case, write their own case reports, write a paper on it, and then we can hopefully move the needle.

Right. And so I, you know, that's that's a plan that is the big the big pan the master plan. Of course at the end of the day, like you're saying, it's not how things are behaving on a, on a PT dish.

Yeah, it's not about that. It's what actually happens in individuals that are doing these things. And that's the beauty. Now with AI, if you can feed this information, it has this tremendous capability to analyze a large quantity of data.

And but it's just that we need the data there. So if people are then willing to kind of bring in and kind of report exactly what they're doing, and then the impact of what they're doing, now, we can analyze that and we can make sense of that.

And that is what's phenomenal to be able to to have registry. And so I everyone out there, you should take advantage of it because I feel that this is going to help us move the needle and understand and prove what is right, what is wrong, and how to do it best, you know.

So I applaud your at for ten doing this because I know that it's not easy. You know these things and it's linked up to data behind. So it'll be able to work out the kind of pathways that have been blocked and maybe what the gaps were.

It's all about not just why it failed as well as why it worked. So that's that's all part of it. Yeah, it's a big project. And yes, it's getting there.

It's getting there. And one of the comments you made is that you got off your cocktail too early, you know. So a lot of people there in the mindset. Well Foreman it does this that on my body.

You know I started does this and I want to kind of get off this I'm no evidence of disease. Now what kind of time frame should people have in their mind in regards to the cocktails?

Oh, I still take a cocktail every night and every morning I take my metformin. And I also have cystic fibrosis, which I didn't know when I was diagnosed.

And this has become another. This wife had so many chest infections and things going forward and in the past, and I could never understand it. But yeah, I still take that cocktail and it was a lesson to me.

And I see the patients who do the best are the ones that stick to it, and it's not a big effort to just carry on taking them at forming in the satin, and I take them all every night as well I have because I've also, you see, I'm a real genetic mess.

I have to that I'm homozygous for ApoE4 as well. So I know that the lipid side can be a potential problem. But as long as these things are low toxicity and they're not interfering with other drugs that you may need to be on.

Terrific. I mean, there's now research coming on, coming out on PCs, canine inhibitors, which show they help immunotherapies work better. This is all emerging information.

So this is called statins by themselves don't work very well. But actually link in the PCs canine or die. And you create a circuit that means it works better.

But this is you know I think it's a big learning curve. It's a big learning curve. But patients are the ones that want to know it. Unfortunately, oncologists don't want to know it because they feel overloaded.

It's overwhelming. There is so much information out there. How did they find you know, and they hear about ivermectin. They hear about from vendors. They hear about mob and us all.

And they look it up and they go, well, that's just overdosed and doesn't sound safe, but it puts a bad name on the whole of the integrative, side, which is a problem.

You know, I want collaboration between each side. Not a war. And, you know. Exactly, exactly. That's a whole that's a whole idea, you know, is that we it's not going to benefit the patient, is it?

Yeah. So no. Exactly. Yeah. Me defending my position is not helping the patient. We want to make sure whatever is needed is is where we need to go. Yeah.

And that's exactly that's really going. Yeah. So for someone that is an overwhelmed. Yeah. Kind of to finalize it. Someone that's overwhelmed by cancer diagnosis.

What in your mind are the three most useful questions they can take to their care team. And what are the three most important things to do? I think number one is educate yourself.

I think that's really key. Unless you have you know, that's that's really important to educate yourself, get yourself a good mindset. Now a lot of people get that mindset from finding survival stories.

Now you might just come across all the testimonials on the high dose either. But you need to move beyond that. Right? So so number one is sort of fine.

Fine. Educate yourself and survivors, and then find themselves find a good doctor like you. Right. This is so important. You cannot put these cocktails together on your own.

You just can't do it. And you need a good doctor. And, you know, first thing, it's like, off you go. And obviously a good mindset. So the mindset comes from all these survival stories and that's what you need to do.

So really education mindset doctor that I would say would be my three top recommendations. Yeah yeah I love that. And I think just kind of reiterate to people understand cancer can manufacture, they can recycle, they can obtain nutrients that we try to remove in our diet.

So these metabolic treatment must account for these escape routes. You know, that you're talking about while preserving your energy, the patient strength, your energy.

So because because kept sexy is a big deal. And so we need to kind of look at the whole picture rather than just having simplistic approaches. Totally agree.

And it is complex and there are so many factors to come into it. The algorithm in my AI has about seven steps that it goes through, looking at from the fuel sources through to the the overall coverage of what it's doing.

And each step. It goes through a whole world of trying to look at everything, and then it tries to eventually piece it all together into this cocktail.

But it's hugely complex. I could never do that. Now. I defer to AI all the time now cause it's so good. I created this framework, which is great, and it's I've loaded it with the certain number of, you know, accessible, easy, repurposed drugs.

And I've loaded it with supplements with the most benefit and pre-clinical research behind. And yeah, it's terrific I, I'm thrilled with it. Yeah I mean it's a game changer in so many ways.

So yeah. Yeah. And I just hope that oncologists actually start to use it a little bit more. I mean, they're a bit wary of it quite rightly. And it does tell you what you want to hear.

Right. It is a suit say yeah. Yes. And you need to say be honest and find the contrary evidence and you know, and actually make it look in all the right places and then come up with an answer.

Right. But it does tend to focus sometimes on tiny contrary evidence when there's a ton of positive evidence. And but, you know, that's all that's all part of the big picture.

And just understanding all of that and weighing out the benefits and the negatives. And I think the cancer patients, if you're stage four, and this is where the danger is that you're much more willing to take a risk.

For me, I took that risk because what was the alternative? I was going to die. So I took that risk, and I went running out to find different doctors to prescribe me things.

And people are getting these high doses of drugs because they're accessible and they're cheap relative to going to a doctor and getting a much better curated, more intelligently stacked, list of drugs to put on there, you know, put into their protocol.

It's the way it is. Unfortunately, and some patients will do well. But, you know, let's look at safety first. I would say I agree, I agree. Well, Jane, thank you so much for what you're doing for your I was I was going to use the word untiring but I know it's not untiring.

So it's exhausting. So I appreciate what you do and what you're bringing. I mean that's such an important conversation. And you're really. Yeah. With the amount of resources that one young lady can have to be able to move the needle to such an extent.

You're doing a phenomenal job. Thank you. Thank you. Michael. Thank you so much for having me on. Thank you.