Introduction and Summit Context

Well, my dear friend, Dr. Nasha Winters. I mean, here we we've, I mean, you're educating the world in regards to, you know, how to kind of create this, this, this terrain and what areas to focus on and, where we need to go in order to be able to address cancer, because cancer is so complex, and we need to distill it in kind of the main, most important buckets. So.

So I'm so excited about this conversation. Well thank you. This has been an absolute joy to be on this journey with you and pulling this summit together.

We were just saying before the recording how what an honor it's been to interview some of the most brilliant minds and tender hearts in the industry, and I'm so proud of what has come together.

of the people that you've gotten to interview directly and I've gotten to interview directly. I can't wait to share this with the world. So now it's our turn.

Thanks for, interviewing me and talking to me about the way I view cancer and the way I approach cancer. And and a little bit, I get to turn the tables and do the same with you. So thanks, Michael. I'm looking forward to it.

Yeah. It's so exciting. And I, I agree with you. I mean, this has been so amazing, this, this, this Summit, you know, going through and getting to to pick people's brains and see where they're at and, and seeing the excitement in the integrative space of what is evolving and how we are getting better at addressing cancer and understanding it and and being more effective, you know, so this, this is really been an amazing journey.

So good, so good. Yay. Let's do. This. Yes, yes. So so you created you wrote a book. Yeah. Metabolic approach to cancer. And in that book you you've highlighted ten very specific topics.

You know, ten areas that that each individual should really focus on and understand. And by addressing these, you're then much better able to, to support the body to battle cancer. So.

So tell me a little bit about, you know, how does this come about? I mean, because you there's so many direction and individual could go. But you went there. Yeah. Why.

Yeah. So well first of all, I mean, just to start, you know, my own journey, I am now, gosh, 32.5 years into a terminal cancer diagnosis, which still just first of all, I'm not that old in my own mind.

That's one thing. but second of all, it just blows my mind because I shouldn't be standing here having these conversations with you. there were no ways, so I had to figure out the way and create the path for myself.

And you and I and many others like us, have created the path for ourselves and those that we serve all along the way. And in doing so, I learned a few things about my own process, like why would a 19 year old have stage four in stage ovarian cancer?

Like why no one was asking that at the time and I was too second, too far gone for them to even offer standard of care. So they sort of sent me out to pasture.

And so I was left to my own devices to kind of figure this out on my own.

Why the Metabolic Approach Was Created

And fast forward these three plus decades later, I learned a few things along the way that I applied to myself first

and then had the, opportunity to apply it to thousands, if not tens of thousands of patients directly over, you know, the decades.

So that being said, fast forward. There was a time in 2009, my husband, Steve Ottersberg, and I started to facilitate women in cancer retreats, and then they later became people with cancer retreats and caregivers and people at cancer retreats.

And it just, you know, doctors and, you know, like, it just became this whole thing. What was happening, though, is we would basically inundate people over a Friday afternoon to a Monday morning.

And everyone said, Nasha It's like drinking water out of a fire hydrant. You're teaching us so much here. You really need to put this into a book. So I'd had enough content to write six books.

As our publishing company at Chelsea and Green Publishing said, so we distilled it down to The Metabolic Approach to Cancer. Book that was, came to publication in May of 20, 2017.

Blows my mind. In fact, it still hits in the top ten bestsellers of books on oncology. Every time I do a summit or a podcast, it pops to the top to number one.

it just came out in Chinese. It's now in, I think, 8 or 9 languages with more on the way. It just kind of blows my mind because I kind of wrote this book just for my mom to read and a few patients.

And so now it's well over 100,000 copies sold in multiple languages on audible, etc.. And to your point, it's still, even though it came out, you know, in 2017, it's still highly relevant today.

Not much has changed. If anything, it's just added to, the information not taken away from it, which I'm very proud of that. So to that effect, what I have come across in my three plus decades of doing this for myself and many others, were ten major drops in the bucket, if you will.

You alluded to that. And so I think of the bucket as our mitochondria or mitochondria, these signaling agents that take in information translated and then send messages back out into the body, and they're entirely dependent on the information that we feed them.

And that could be from food, water, light, sound, emotion, toxins, pharmaceuticals, you name it. It's affecting us and it's affecting that bucket. And so the train ten was born.

And so I'll briefly race through what these terrain ten drops in the bucket are. So number one is our blueprint known as our epigenetics. Above. The gene you might be have have been someone who's tested your single nucleotide polymorphisms, which are kind of little hiccups in your genetic code that's not set in stone.

And that is highly determined by your dietary and your lifestyle choices. But you are still born with this blueprint. But you can certainly rearrange the furniture in that blueprint at any given time based on your dietary and lifestyle choices.

So there's number one drop in the bucket. So maybe you have a long family history of certain propensities or vulnerabilities or even strengths within your genetic code that make you more vulnerable to or resistant to certain disease processes.

So we like to look at that, to evaluate and strengthen your your, your areas of weakness and really harness the power of where you where you really shine.

Number two, our metabolic health. So now that we have less than, 6.8% of Americans are considered metabolically healthy, you bet your bottom dollar this is an important drop in the bucket.

And so with that, that's basically what is the fuel you are feeding your cells, specifically your mitochondria. Is it you

know, what's your ratio of fats to carbohydrates to proteins.

And and what is the quality of those fats carbohydrates and proteins. And what is the timing of those fats and carbohydrates and proteins. And it really takes in your diet, your nutrition in a very specific way.

Number three, your exposure to toxins. both Dr. Michael and I have a, a dear colleague who's since passed, Dr. Walter Crinnion, who was considered kind of the father of modern day, environmental medicine.

He used to say to us, it's no longer a matter of if you have toxicity, it's how bad is it and how does it interface with your blueprint? Because, for instance, my husband could walk down the aisle at Home Depot and not even notice all the smells, right?

He actually loves the smell of diesel, but I walk down it and I get a massive headache, I get nauseous, I'm doubled over in pain. If I get behind a vehicle that's got really bad exhaust or diesel.

We have different genes that make us process those chemicals in a different way. So our toxicity is massive. Today. We live on basically, unfortunately, a giant Superfund site known as Planet Earth.

And we have to become more aware of those toxins, which I'll be talking about in one of my little mini sessions. And I know we have a lot of other people touching on a lot of these topics throughout the summit.

Number four is all about our microbiome. Michael, do you remember just a short few years ago, everyone Pooh poohed us about the idea that microbiome had anything to do with our health and well-being, right?

Yeah. Yeah, it's it's like this is now that we can monetize it with pharmaceuticals to target the microbiome or certain nutraceuticals to target the microbiome, or even things like fecal transplants to enhance the microbiome.

Now that we can actually monetize it and have meaningful paid for grants and research around it. Now we kind of bless it that it's real. And yet, even Hippocrates said, all disease begins and ends in the gut.

And so we as naturopaths is aggravated practitioners of Chinese medicine practitioners by the mystic, practitioners have known that the gut was integral to our immune system.

We have known this for decades, that over 80% of our immune system comes from out of our gut, but also over 80% of our neurotransmitters come out of our gut.

So our gut and microbiome health is another big drop in the bucket that needs to be evaluated. That leads us into the immune system. So if you don't have a working microbiome, you also don't have a working immune system.

And we've all come out of this crazy, you know, few years of an experiment on our immune systems, showing us exactly who's was working well and who's wasn't and who's was altered.

And who's wasn't. And so that's a really critical one, because even the best clinical researchers today in conventional oncology will tell you that the immune system is at the helm of both prevention and treatment of cancer.

The Terrain Ten Framework

And yet again, for decades, the conventional medical establishment made fun of people like doctor Allison, who was the one who found the PD1, Pd-l1, receptor in which we now have pharmaceuticals to target, that he was a disgrace to his medical community, shunned for decades, and then finally can exactly remember which year 2017, 2019, won a Nobel Prize for this work.

And now, today, immune therapies are the hot topic of cancer therapy. So I'm trying to also illustrate to the listeners that places where we were made fun of, like therapeutic ketosis and fasting.

We have Nobel Prizes in autophagy on this places where we made fun of the microbiome. We have, you know, Pd-l1. we also have even shown that Pd-l1 inhibitors depend on good microbiome, to actually work.

We have the immune system now, we won, you know, Nobel Prizes to this. So hopefully you're sure to catch that. Even though I might be a crazy nature path, these drops in the bucket matter and then the final last ones should be pretty obvious to you.

Inflammation. If you don't believe inflammation is a problem here, you know this is a this is a big, big, big one because that is the driver of cancer cell proliferation and metastasis.

And then the other one is, your oxygenation and perfusion. So this whole place of how, how, hypoxic are you. So how low is your oxygen levels, which that's what cancer thrives in.

And so addressing that hormone balance again in the swimming pool of the hormonal endocrine disruptors that we live on on planet Earth today, most of us are dealing with an excess, hormonal imbalance.

And then the way our bodies metabolize endogenous and exogenous hormones play a role. And we can test and find out exactly how that's playing out with our patients and adjusted accordingly.

And then the last two biggies that no one ever wants to talk about is stress and the circadian rhythm being one. Again, circadian rhythm biology is also one Nobel Prizes and mental emotional, which even though it's sort of the 10th drop in the bucket, I'm here to tell you, I know Michael's had this experience, and many of the beautiful people that will be presenting on this summit will tell you it is very difficult to bring someone back into balance and back into harmony.

If that mental, emotional peace is not tackled head on. So those ten drops in the bucket are what I evaluate for each of my patients. And we go through a process of tests, assess, address, don't guests.

We now train clinicians and patient advocates, which are allied health professionals all over the globe, and we follow this methodology to really understand the why of every patient's cancer journey, to understand where they are in that moment, to understand the proper tools to bring on in that moment to change their outcomes.

So I'll take a breath, and see how we're doing here. But that's the terrain. Ten I love it, I love it so. Addressing these. So when you have patients coming to you and, how what what is it used to look like?

I mean, where are the areas that really kind of tend to stick out and where you have to lean and the most for individuals? That's a great question. And so what we have found in the bench side research is anywhere depending on the research you read, 70 to 90% of all cancer types are glycolytic in nature, meaning sugar hogs in nature.

So one of the simplest, easiest, lowest hanging fruit is to really carbohydrate restrict our patients. That's a really important one to say, okay, we're going to hit target potentially 90% or better of all people dealing with cancer.

That's a really good starting point, right. The next anywhere from 10 to 20% have, a driver of glutamine being an issue, which might suggest that these patients should not over, ingest protein, for instance, should maybe be mindful about, certain nutrients like whey protein or different supplements like glutamine that they may have been taking historically in the integrative oncology space, but they may need to reconsider.

So that's one place that we look at that metabolic drop pretty closely because it's so prevalent, I would say out of the terrain, ten drops in the bucket.

The second most prevalent is going to be in the mental emotional. And I think that people like Doctor Lawrence Leshan in his book cancer as a Turning Point, did a really beautiful job illustrating the fact that when you really sit down with patients and you say, tell me what was going on in your life, six months to two years prior to this diagnosis?

More often than not, there was some big pressure, emotional pressure to the system, be it a very high stress job environment, loss of a of a loved one, a major injury or accident or illness, something that change like shook their world up like a snow globe, you know, something fierce that really left a ripple.

And you're going to hear from a lot of people who are far more expert in this than I. But what we found is if we don't clear those patterns, the body is unable.

The vagal nerve and the immune system and the neurotransmitter system are stuck in a place of fight or flight, which makes it any therapy we want to apply, whether it is the best that standard of care has to offer from, say, a really well appointed immune therapy to say the best that integrative or alternative medicine has to offer, such as high dose IV, vitamin C or hyperbaric oxygen or intramural mistletoe therapies, any of those if the body is in a state of fight or flight, if it's still in that trauma zone, it can't receive, and it can't apply that wisdom to those cells to turn off their growth factors, to turn off their signaling molecules.

So those are the two biggest that we probably see again and again and again. And then the theme varies widely. So you mentioned this. It's like let's say we take ten of your patients Michael.

Let's say they're all triple negative breast cancer. And let's say they're all around the age of 30 to 35. So they're all premenopausal and they've all had the same diagnosis.

Perhaps they're all stage two, let's just say so. Maybe there's a little bit of microscopic lymphatic or, not lymph node involvement. Right. But otherwise it's not left.

It's not moved out of the building and around the building. Okay. You would think, because this is how standard of care will treat all ten of these women, they will be given the exact same menu, the exact same treatment.

Some of those, maybe two of that ten will have an amazing response never to see cancer again, right? They'll go on living long lives. Just follow the rules of standard of care and they're good to go.

There is a wide swath of those women that will have a recurrence within a few years, if that. That is probably let's say six of those women will come back to us.

Stage four. That leaves people like just wondering, because they're getting the same treatment as those other two, that had a great outcome, and then those other two that are the other outlier.

These are people that may go ten, 15, 20 years and suddenly come back with a brand new cancer type. And yet we treated them all the exact same, and their outcomes were completely different over time.

What people like Michael and I are able to do is to assess who those ten women are in front of us, to understand the why of their diagnosis, and to understand the better way to approach it.

So, for example, if they have a low proliferation score, a Chi 67 score, which is routine on your pathology biopsy, if that score is low, more aggressive treatment is not warranted and can make things worse.

That's one example. Number two, did they have full workup ahead of time to see if this was truly contained? So oftentimes Michael and I have to go digging to see if anybody even had a baseline tumor marker before undergoing surgery, chemotherapy, radiation targeted therapies, endocrine disrupting endocrine therapies, whatever.

Right. So you and I had to, like, go and hunt that information down. And oftentimes it's not performed, nor has there been a good set of imaging done to see if it has, in fact, stayed intact or if it has in fact left the building.

We have the ability today to test things like circulating tumor cells. We have the ability to see if this has even got a different personality in circulation, as it does at the tumor site, and to treat it accordingly.

We also know that for things like triple negative, they often use radiation therapy. And what patients are taught is if

their glucose or insulin levels are elevated at the time they use radiation, their cancer cells are desensitized to the radiation, which leads to more aggressive mutations.

So what people like you and I get to do is, frankly, we get to make Western medicine work better. We get to do the the detective work ahead of time to help people understand exactly why they arrived at this moment, and to prepare their bodies.

So if their insulin is high and radiation is indicated because they have a high K 67 score, well, let's get you let's get you metabolically flexible in preparation for that therapy.

Or if you aren't sure if this has left the building, let's do deeper dive in. Tumor assays in liquid biopsy is encircling tumor cells and better imaging and some baseline foundational testing.

And then let's make sure for those who do make it through the process that you don't just ignore them. We got to look at survivorship so that we don't have them coming back 1015 years from now.

Stage four this is where you and I get to help them clean up their terrain. We get to evaluate those ten drops in the bucket. And we get to help them say, actually you had chronically low vitamin D levels all of your life and hypothyroidism.

Let's deal with those because both of those are risk factors for you having a recurrence or a progression of cancer. So this is how we apply the methodology through test to actually do meaningful metrics through a drive through assess, which is looking at pattern.

So whether there were like even the side of the breast makes a difference, like left sided breast cancers may show us that there were issues with child or a mother or their own feminine self, where right sided can often be related to the partner, the husband, the the father.

Right. those are things that we want to also make sure that those are being addressed in real time. And so that's what you and I get to do. It is such a joy. There is never a dull moment.

We learn every single patient teaches us, and every single patient is entirely unique and therefore requires a very unique approach. I love how you brought in the, because because people always think of you have the traditional oncology, and then you have kind of the natural therapies and you always separate the two.

And, and now we we stepped into the world where, you know, the the marriage of the two is becoming so powerful. And so, so the question is always, you know, how do I how do I communicate this to my ecologist?

How do I combine this with the type of care that I'm using and how what kind of a decision tree should I, should I have, you know, because the oncologist is always going to just say that this is what we have to offer, and they are limited to their tools.

And and sometimes they bring in tools that are and they just do it because that's all they got. You know, they don't realize all the other possibilities.

So, how how should a person kind of go through, kind of think through that process in regards to, with their interaction with the oncologist and how to kind of bring in some of these therapies?

I love that question. And one thing we can add into the the, interview notes here is we have on the doctor nasha.

How Cancer Patients Are Assessed and Treated

com site and the MTI forg site, a five steps if you're diagnosed with cancer, which starts to give you a little bit of that information to run to before you get stuck in the assembly line of standard of care.

And so one of the first things is stop and breathe. You know, I was just interviewed recently on a podcast that you're actually going to be on soon about my experience that I think when I was diagnosed in 1991, I was lucky because if I was diagnosed today with that diagnosis of end stage, stage four ovarian cancer, I probably die just from paralysis by analysis.

Okay. The overwhelming, well-meaning advice of so many from family, loved ones, church members, influencers, you know, this doctor, that doctor, this healer, that healer.

In 1991, there was nothing like this. I was left to my own devices. So as such, I had to get very quiet and still, and I had to start to understand and ask myself those questions that I now ask other people.

Why do you think this showed up? Right? I wanted to understand that and then luckily stumbled. It was like every time I asked the question an answer, we kind of pop up, right?

So that's number one. Number two, you need to vet your medical team very well. Do not settle on one opinion or even two. If you need to get a third and fourth opinion, do it.

The diagnosis of cancer is is is invariably the emergency, whereas the reality is that it's very rare that there's actually an emergency, that you have to rush into anything.

Okay. Unless there's like valuable real estate being taken up, this is not a need for you to do something. You did not go to bed one night and wake up with cancer, right?

This has taken anywhere from 7 to 10 years to really fully express, to be big enough and loud enough to capture your attention. And it's those six months to 24 months prior to that diagnosis that was like the final straw on the camel's back.

And so that's where you need to go and look at that and go, okay, what might some of the triggers have been over these last ten years? Evaluate for that and then construct your team.

So your team is not just your standard of care and collagist your team is also your integrative oncologist. It's also your nutritionist. It's also your therapist or your mind body support.

It's also your, physical therapist or your, you know, fitness coach. It's a confidant, you know, a confidant of someone that you feel like you can share what's going on with you.

It's a it's a bringing together your board of advisors. But you are the CEO. You are the chair of that board. And at the end of the day, it lands on you.

And so you have to make educated decisions based on a lot of information coming at you. And the number the next big one is you need to interview your oncologist to know they don't have to be experts in integrative oncology, because none of them are right.

It's really rare. They're like a zebra when you find a true standard of care. And trained oncologist who's also really gifted in integrative oncology, they're out there. But there's zebras.

So you need to ask them, Will you work with my integrative team? They don't have to understand it. They have to be willing to trust your desire to bring your board together.

And then questions that you will ask in my book also, I can't remember. It's early on in the book, there's like ten major questions to ask your oncologist.

And some of those questions are like, how are you supporting my cancer stem cells during this process? They can't answer that, right? So that's where those questions are going to help them understand why you're bringing experts in.

There are experts in your tumor. People like Michael and I are experts in your terrain. And that's what you need. You need to have a terrain expert on board just as much as the tumor expert.

And those two need to be able to communicate with each other, even if one doesn't agree, you are still the CEO of that process. So knowing that and then knowing that you are likely going to have to go out a standard of care to get good care, right, you will likely not be able to get all the labs you need to run to actually make a good clinical choice for yourself to get to have informed consent, informed information, to know what to do next.

So be prepared to ask for help. People do GoFundMe. These people reverse mortgage their homes. People, reverse their life insurance policies. There's lots of grants and opportunities today.

There's a lot of help for this and my community. I know Michael's, we are working hard to build more access to this type of care. It should not just be for those with means.

So my my passion and purpose is to change that. And you'll hear more about that in my little mini course I'll be doing here in a moment. But this is where it's important, is know that you're going to have to leave the system to, as my patients say, save your ass, university.

You'll get your degree and save your ass university. And so it's going to require you getting out of the box. And that's where people like Doctor Polly Anderson's book, Outside the Box, cancer treatments and Michael's book and mine and many others out there start to speak to you about other options and opportunities.

They are so vast, they are so vast, and they're going to be dependent on what your body needs at this time. And talk to me a little bit about the fear that a lot of people have, you know, to.

Yeah, when when they interact with their oncologist there, there's so much fear to not do what they're saying and being afraid that, well, if I don't agree with this, then they may dump me and not want to treat me and and then nobody's going to treat me.

I mean, because these these are big fears that I see in patients. You're so right. And, I mean, first of all, I think it's very important for people to understand the power of fear over completely dismantling your immune system and disempowering you in this process.

So I need you to fight back that fear. I need you to dive, to lean into that fear. I need you to address that fear head on. Like that's going to be a big one.

So if you do not feel like you have someone who's on your team that is going to support your decisions, you really have to look for another team member.

In some situations, people are in small towns or areas where they can't. They don't have that luxury. Perhaps they can't travel abroad. So this is where you need to come through and say, I want to be a good patient, but I have to be good to myself first.

As such, I'm going to need a lot more information before I choose whatever steps I'm going to choose. As such, I'm going to need you to honor my choice so that I'm not saying no to standard of care.

But I want more information. Before we dive in, I would like you to help me order a tissue biopsy or a blood biopsy so I can know what my targets are.

I'd like to understand my coach genomics, so I can understand my risk factors to toxicity and be able to ward that off. Had that off at the pass, I'd like to be able to use less of the of the pro drugs and use things like intermittent fasting so that I don't continue to spike my blood sugar and diminish my immune system all through chemo.

I'd like to be able to use imaging that doesn't involve, smashing, radiating, or, contrast dye to my system, where we now have access to a lot of these really innovative tools.

This is the patient advocating for themselves. And I promise you, when you do that, you first of all, dismantle the fear immediately. And you also show, frankly, the doctor that you know as much, if not a lot more than they do.

So they will respond in one of two ways. They will either respect you and jump on board, or they will completely try to shut you down and belittle you.

You never want to be in the field with people who do not believe that you can be anything but a statistic because their field, their beliefs, their thoughts impact your outcomes.

So you need to be with someone, even if they don't understand it and maybe don't wholeheartedly embrace it. They need to at least be willing to hold space for you.

So I know that's a concern and a threat. But our community, Michaels community, we have so many resources now. We have so many advocates and clinicians all over the globe that can help you advocate for yourself and find and manage, pull together the right team for yourself.

And you mentioned something, this one, like with chemo, they it's always comes with steroids now. And, and you were talking about intermittent fasting or, you know, fasting, mimicking diet.

Working With Oncologists and Advocating for Care

So how can and steroid we know has such a negative impact on, on cancers. So obviously as you're fighting cancer you don't want to feed it at the same time.

So talk told me a bit about that. The safety of, you know, how to go about maybe asking for not using the steroids. and still having a good outcome and not being afraid again.

So good. Well, first of all, especially if you're someone who has elevated insulin, insulin growth factor, elevated glucose levels, like elevated, C peptide, elevated hemoglobin A1.

See, if you have any of those markers of, you know, metabolic dysfunction alive and well. You really need to avoid the steroids. So let me just let people know, first of all, these steroids are given as a severe okay, steroids, Benadryl or an antihistamine and an anti-nausea medication are considered pro drugs or excuse me, pre drugs.

Preload drugs that they give in effort to thwart side effects of the chemotherapy. But here's what's interesting. The majority of patients that will have an adverse event with their chemotherapy already have those drugs on board.

So what I'm trying to tell you is that's going to happen no matter what your being given these drugs in the safety of a clinical environment with multiple staff around you, if you start to have a reaction of any kind, the first thing they're going to do is give you roids. It's in an IV.

So of course you're not going to deny it if you have an emergency. But prophylactic treatment is bullshit. I'm just going to be really blunt, okay? Because of all the things you could go through so much.

This is absolutely negligence in my opinion, and I will get people hating me on this. I don't care, because in my practice, I never needed these drugs.

We were able to create relationships with oncologists to avoid these drugs. We never had a problem ever with a patient having any issues. The only patients I've ever had issues were the ones who preemptively took those drugs and then had to go through a desensitization with Taxol or carboplatin later.

It was never because they skipped on the steroid right. And so the worst part is patients will tell you they feel great the first two days after chemo, and then they crash hard and they feel awful.

That, my friends, is a direct reaction to steroid withdrawal. So to understand, if you come in fasted, you don't need

the steroid. If you come in fasted, you don't fall two days later and go into a spin.

You stay pretty consistent all the way through. My patients who've gone it with steroids and gone it without, will tell you again and again night and day difference of the experience.

If someone's afraid and their doctors are afraid, I have no problem. If you kicking up the antihistamines and the anti-nausea meds preemptively, if that's going to be your crutch to get you through that.

And again, if you have any issues, you're there in a chair with a million people around you that will start an IV drip immediately with immediate results to start with steroids.

So this is something that is not necessary. It's a CYA. There's also tons of patients out there who end up with steroid psychoses, who end up with horrible sleep patterns, unbelievable blood sugar issues, unbelievable.

eye changes, unbelievable bone health changes. All because of the preload steroid drugs. Right. And we can watch their labs change throughout the course of this.

So wherever I'm able to prevent patients from using steroids, I have the better outcomes with those patients. Just plain and simple. So yeah. Yeah. Well, well thank you.

Because that's such an important topic. It's such a huge topic. kind of to finalize. I would love to for you to just say, kind of give a picture of what is possible for people when they go through this process, you know, where they, you know, do the ten steps along side with potentially, you know, traditional oncology or sometimes maybe traditional oncology is not needed, you know, so what what does that look like.

And and what are some of the results that, that you've seen. Well let's talk about kind of the worst case scenario where it would have been nice had we been the first, you know, line of action versus the last resort.

Because still to this day, unfortunately, the vast majority of patients that come to somebody like Doctor Michael and myself are coming to us as a last, like a Hail Mary.

Okay. At this point, their bodies have been through multiple lines of treatment that has failed them, not the other way around. The language, standard of care says of the patient failed the treatment.

That is absolutely not the case. The treatment failed. The patient. So when that happens, we get patients in stage very bulky tumor processes. Their their their labs look horrific.

They feel horrific. They are now basically sent home to hospice or they're being told, now we're just going to throw palliative treatments at you. And it's a, you know, it's kind of a blindfolded pin the tail on the donkey process at this point.

That's when somebody like me says, we're going to pause. We're going to wait a good ten days to two weeks of you taking anything. So we get kind of a washout.

We're going to do a fresh blood or tissue biopsy, depending on how accessible fresh tissue is. If people have the resources, I like to do both to get more information, we're going to do a deep dive evaluation of their labs to understand exactly what's off and what needs support.

Fasting, Steroids, and Chemo Support

We're going to understand what that patient is overly oxidized, which the vast majority of treatments, both in alternative and in standard of care, are over oxidizing.

We're going to understand if they're in a place where they can handle a bigger push of oxidative therapies, we'll know that from their labs. That information, it'll take us about two weeks to get their results back from the blood or

tissue biopsy.

And at that time, we have new actionable targets that might be from standard of care, that might be from off label drugs, that might be from nutraceuticals, herbs, other like dietary interventions, other immune therapy interventions.

But now we have a fresh start, and we're basing it on the patient of exactly where they are in that moment. That's a really powerful place where we've had so many patients that we have were sent home to die.

This is how we this is the type of patient that I get to have beautiful testimony eel's all over our website about these are the patients who everyone gave up on them but themselves, and these are the patients who are now years out with either a manageable, stable disease process or years out with no evidence of disease.

And either way, a good quality of life. And they're living and thriving. That's like the worst. And there's also times where unfortunate Dr. Michael and I get people that are so far gone that sometimes the only thing we can offer is just supportive end of life care.

And I can't even tell you what an honor that is of how many families have come forward after. My husband will tell you to me those are the hardest ones.

When the families come to us after and say, thank you for giving my loved one a few extra days or a few moments of quality of life, or took care of their pain as they passed, help them really face their mortality with such elegance and grace.

Those are the ones that really get me, because I always feel like had I gotten them a month, three months, six months before, maybe those weren't the conversations we needed to have, but they happen, right?

If I'm lucky enough to get someone like just the last week, someone came to me saying I was just diagnosed, got a biopsy back, triple negative breast cancer in my left breast.

when she did, she'd already listened to me on several podcasts, so she'd already run a bunch of labs and knew that her insulin was high, her A1 c was high.

She's heard me say that triple negative breast cancer is diabetes of the boobs. She put herself on a ketogenic diet. though she realized she needed some extra support.

And so by the time she came to me, her numbers were already improving. The breast mass was already getting smaller. While she was waiting to prepare for her, lumpectomy.

So that was really cool. We got to spend the ten days getting her body ready for the lumpectomy, and she actually had time to do her research, and she was to go and have a cryo ablation instead of just cutting it out.

So she went and had a therapy that not only freeze dried that tumor, but also created an AB scalpel immune response. So already she's harnessing the power of her immune system versus stressing it or suppressing it.

Outcomes, Recovery, and Prevention

She's already lowered one of the drivers of this process, and she also recognized right away that this left breast issue was lifelong issues with her mother and her mother died ten years before from colorectal cancer, and her mother, despite her bringing all like this, this person bringing her mother to me saw all the opportunities and her mother chose none of them.

So she understood. And she told me way back ten years before that, she knew that maybe her mom wasn't ready to adopt this approach, but she knew if she ever faced it in the future, she would.

And she'd had a hell of a couple of years. And so she knew the why she landed in this predicament, and she

started making changes in her career and her schedule and her stress management and her diet and her lifestyle.

So by the time we actually looked at her labs and got some good imaging and got her in with a truly integrated standard of care trained oncologist, she's already way ahead of the curve.

And so next week she has her ablation and now she gets to go into terrain cleanup. Like that is like my dream patient right there. I wish all of them walked through the door that way.

So I just kind of showed you both ends of the spectrum. And then the biggest end of the spectrum is had she listen ten years prior, perhaps applying these things to herself might not have ever had to have this conversation with me.

So prevention is truly the only cure. Yeah. And that is so important. You don't have to have cancer to go through the Terrain 10. Correct. And address that. Yeah.

It is something that each one of us need to do at this moment and clean that up, because the best cancer is the one that you never had. Exactly. You nailed it, my friend. Perfect.

Well, Nasha. You are awesome. And what you're doing well, what you're bringing to the world is incredible. And you are. You're truly a light in this space.

And, And it's such an honor to get to have you as a co-host for this Summit that it's it's such an honor. So thank you. Thanks, love. So, so grateful as well.