Grasp Non-toxic Treatments: Personalized Chemosensitivity & Low-dose Chemo Transcript

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Introduction and Clinic Background

Well, Dr. Henning Saupe I'm so excited to have you on this section of a Cancer Breakthroughs Summit. So thank you so much for joining me today. Thank you, Dr. Michael Karlfeldt It's a pleasure and honor to meet you again on your summit.

And I'm excited to contribute to your program and let's have a let's have a talk about how we can improve treatment results in oncology. I love it. I love.

And you've you've written one of my favorite books here, A Ballistic Cancer Medicine that it's a fantastic book. I recommend everyone to to get that. That's the interest.

Again and holistic therapies. You're born Dr. Henning Saupe you're born and in Germany and you have your license and said in 1992 see you've been around you've been doing this for a long time.

Yeah. For 31 years to be accurate. Yeah. 31 years ago I got my medical license and cancer became my number one topic of interest. So I've been around cancer treatments for more than 30 years.

And currently you have a your clinic, it's in Bad Amstel, Germany and you actually have rooms so people can be inpatients there. Exactly. We have 11 guestrooms for 11 patients and their families if they want to bring a family member to to our place.

And it's located right in the middle of Germany between the cities of Hanover and Frankfurt in a beautiful remote area with woods and meadows around. It's a purity of village, but in Germany means baths, so it's not bad style.

It's bathroom style if you pronounce it the English way. So it's a it's a natural hot spring here in the vicinity of our clinic. And Rain Meadows and a park.

So the ideal place to recharge your batteries when you need time for recovery. Well, I'm almost. Yeah, I just want to come. Even though I don't have cancer, just to hang out and recharge.

Well, be my guests and come to buy them. Sell and let's enjoy a few days. I love it. And and you have quite a team there. I mean, you have three medical doctors there on staff.

25 employees. Yeah. That's that's quite a quite a group. It's quite a group. Yeah. Yeah. So massage therapists, nurses, physiotherapists, mental training coaches, Chinese medicine experts.

And as you mentioned, we are three doctors and all together it's 25 people who work at our cardiac clinic in Germany.

Critique of Standard Oncology

So so tell me a little bit about, you know, chemo when when you talk about cancer, you think, well, chemotherapy, radiation, surgery, you know, and now immunotherapy and hormone deprivation therapy.

I mean, those those are some of the main kind of therapies. In your mind, is that paradigm working that we're we're functioning from right now? Do you feel.

While it functions sometimes and sometimes? Not at all in a in a in a way that is satisfactory. And if that would not

be the case, we would not be doing what we do here from morning to evening.

And my journey with cancer started some 30 years ago when my mother fell ill with breast cancer. I was still at medical school and I had to witness how she, at the age of 52, went from breast cancer to metastasized breast cancer and died far too early at the age of 40.

54. Sorry. And she was treated by my professor at the med school of the University of Rome, where I studied. So I had to learn and to acknowledge at a very early time in my life.

I was 27 at that time what medicine can do and what it can't do. It couldn't save my mother's life. So that changed my my view on on academic oncology and made me questioning the, the standard approach that is from a certain point of the career of the patient, from the point on where the patient is in a metastasized stage, in my opinion, too toxic, too harsh, and follows the reductionistic paradigm that looks only at the cancer cell and not at the empire organism or the individual around the cancerous tumor.

So that is that is what what I describe is the holistic approach of cancer. You should not only look at the cancer, but at the entire organism around it.

And that you and I and our colleagues in holistic medicine, we know that we should not only look at the cancer, but at the metabolic terrain and the biological terrain and also the psychological aspects of health and and life around the phenomenon of cancer.

So we we all who work in measure pass a complementary oncology. We care for a healthy train that elevates healing, that empowers the immune system, that balances the various biochemical reactions that support lives, vitality and longevity.

And of course, in oncology, we have a very, very specific problem that is this lump of cells that grow out of control that we need to stop from growing in a way.

And our our traditional approach in Western world medicine uses toxic drugs called chemotherapy or blockers, hormone deprivation therapy or the surgical knife or radiation.

And that was your question. Yes, sometimes it seems to work, but too often it does not work. And the numbers, the survival rates of metastasized cancer patients suffering from metastasized cancer and how long they can expect to live with stage three or stage four cancer has not changed.

So much in the last 20 years, despite all the billions that have been invested in drugs. There are some exceptions in some corners. Some of the drugs are very, very powerful and very good at doing what they're supposed to do, like in leukemia.

But in the in the majority of cancers, diseases that represent the majority of the problems in ecology, like prostate cancer, lung cancer, breast cancer, colon cancer, we we have not changed the prognosis so much in Western world medicine.

And still plus mine is a few months as it has been 20 years ago. And this is my point. How can we improve the success rate of therapies when we need to block growing tumor and that is the headline of my my little contribution to your summit today.

How can we make the therapy more effective and less harmful? And I have a few ideas to share with you and our audience today that we use here at our cardiac clinic.

And let me mention the headlines, and then we can go into details. Number one, we look forward, indeed, the advice treatment. We do not treat our patients following a guideline, but we make an individual assessment using special laboratory tests.

And number two, we use less toxic drugs, nontoxic or less toxic drugs than the standard drugs in mainstream oncology. And we amplify their efficacy with a few tricks, with a few biological and physical tricks that make these drugs much more effective and more powerful.

Although we use a lower dosage compared to the standard approach and these metabolic tools or tricks, as I call them, are hypothermia. We warm up the region where the tumor grows and we change the metabolic biochemical terrain around the tumor by lowering blood sugar with insulin.

And that allows the tumor to absorb many times more of the drug that is around compared to normal blood sugar conditions. And that principle is called insulin potency, Asian chemotherapy with low dose chemotherapy.

Insulin Potentiation and Low-Dose Chemotherapy

And I think it's you made some amazing points. I mean, one one of the thing is that that I really want to point out is that cancer you can't just isolate cancer and just think of it as an entity that that operates in isolation.

You know, it functions within an environment. And so you have to take an account of that environment. And all the factors that exist within that environment is going to then determine the behavior of the cancer.

So you can't just ignore that environment because that's where all the drivers are. And then another point that that is really important is that, you know, it's not an either or.

You know, it's not that we just do natural things or we do, you know, the traditional lung ecology it is to marry the two and to find the best tools and how to maximize the effect of all of it in the the healthiest and nontoxic and most effective way.

I mean, that to me, that sounds like what you're doing exactly. You nailed it. And that is exactly what it is all about. And that's why I would not say that what we do here is pure naturopathic.

We add strategies from all kinds of modern science and marry them, as you said, with traditional naturopathic medicine or traditional Chinese or Indian medicine or preventive medicine to get the best treatment result for our patients.

And only if we do that, we have a chance to turn around to stage three or stage four cancer, which is otherwise looked at being a incurable disease. So we have all the reasons to use tools from various schools and philosophies and bring them together.

There is no conflict at all in using a modern drug in a lower dose dosage, amplify by blood sugar, change with insulin, and combine it with a traditional herbal drug to help deliver to detoxify more powerfully.

So we have all the reasons to bring the world together and that is what we do. And so one of the things that I see frequently with with oncologists is that they try to push the limits, you know, with the chemo drug to the point, you know, just kind of seeing how far can I push this individual, how much can this this body handle, you know, before it literally just kind of croaks it just from the toxicity of the chemo.

So you have that kind of maximum tolerated dose paradigm, you know, so what what is how does that work? I mean, do we need to change that? Do you feel I mean, it sounds like you're going in a different direction and using it in a different way to maximize the effect, but at a lower dose.

Exactly. Yes. We definitely need to change the paradigm of maximum tolerated dosage. For me, there is only one corner left in oncology where this paradigm is successful and that is the treatment of acute leukemia, a disease that we hardly treated our clinic because that's what university clinics are specialized in doing with bone marrow transplant and and the high dosage of sophisticated poly chemotherapy.

But that's a relatively rare disease. The common diseases of our day, of our time is breast cancer, colon, lung and

prostate cancer. And for these more common types of cancer, the maximum tolerated dosage is totally wrong as a principle because there is no cure of these diseases with even with high dosages of chemotherapy.

We know that we have been doing it now for 70 years. Chemotherapy for these common types of cancer cancers were developed in the fifties and sixties. So we can look back at a history of 70 years of treating these common types of cancer with toxic chemotherapy, and the results have never been very good.

It's a way to suppress tumor growth, but only to a certain amount, to a certain limit. And if you give more toxic chemotherapy, you weaken the organism and the immune system more than what you give the patient as a benefit.

And from a certain point on, in the course of treatment or disease, the the drawbacks outnumber the benefits by far. And you can literally kill the patient with standard of care, high dosage chemotherapy.

So we need to change the paradigm. It's not like acute leukemia where the cells are very sensitive to chemotherapy. Prostate cancer and lung cancer is the opposite of acute leukemia.

The cells are not very sensitive to chemotherapy. That means you need dosages to have some effect that are so harmful to the rest of the organism that the difference between harm to the bad cells and harm to the good cells is almost zero.

And that's why we definitely need to change the paradigm. And that is also the point. With insulin potency aided low dose chemotherapy, we need to find ways to make cancer cells more sensitive for the attack with the drugs that we use and to protect all the other cells that we don't want to kill.

Yeah, if we have a tumor of two or three centimeters inside our lungs, we need to protect the human body around this to a more. And we cannot kill the entire organism for the sake of tumor reduction.

That's that's the dilemma. So insulin modernization therapy seems to be a very good way to get more benefits and less side effects. Already in the sixties and seventies, there were scientific studies done with insulin, pot and station therapy that showed that the uptake of chemotherapy, for instance, in breast cancer cells, in petri dishes in the laboratory can be up to 10,000 times more under insulin changed blood sugar levels compared to normal blood sugar 10,000 times.

There was a laboratory in vitro test and that shows the power of insulin condensation therapy. If we lowered blood sugar to about 50% of what is a normal blood sugar level on an empty stomach, we make cancer cells so much more sensitive to chemotherapy, we caused them to open their gates for both sugar and drugs.

We we expose them to we give the drugs when blood sugar is low and we give a little shot of glucose to close the gaps. Again, too close to the channels for glucose and and drugs in the cancer cells.

And that gives a selective toxic reaction in cancer cells and the tolerable for all the healthy cells is is many times better. So insulin prioritization therapy should be done everywhere.

If you ask me, I'm a member of the International Academy of Insulin Participation Therapy Doctors, and it's it's a pity that it has not been recognized by the large universities around us and that it lives its life in clinics like yours and mine and other so-called alternative clinics.

It should be mainstream and not alternative. The science behind it is rock solid. So how how does that therapy work based upon I mean, because we know that that cancer cells are very sugar hungry and they have a very kind of faulty metabolic process.

They're not very efficient in how they produce energy. So does does insulin potentiation therapy work based upon those principles that, you know, more and more sugar is driven down towards the cancer cell and the using then insulin to kind of drive drive the chemo more efficiently into the cancer cells or or tell me how how does it work?

It works in the same way as a PET scan works in the radiology department. If a patient wants to have a a thorough analysis of all the metabolically active cancer spots inside his or her body, the PET scan is the best way to find out whether there is cancer in it.

In a human body. So how does PET scan work? Well, the doctor injects a radioactive form of sugar and uses a device that is sensitive to the tiny little bit of radioactivity that that is radiated from these sugar molecules and track the way the sugar takes.

Personalized Chemo Sensitivity Testing

And that is into cancer cells, because cancer cells absorb sugar 10 to 15 times faster and more compared to healthy tissues. So a pet scan is the proof for the sugar dependency of of of tumors areas or cancer cells in a human body.

And we use the same principle for therapy. Cancer cells are sugar dependent. Cancer cells have 10 to 15 times more insulin receptors and glucose channels.

Sugar channels. And if we lower blood sugar, we make cancer cells very, very hungry. That means they open their their their channels for for food. They're hungry and they want to absorb whatever is around them glucose to not die from energy deprivation.

So it's a little mean to the cancer cells, but sorry, that's what we need to do. We need to open their mouth by lowering the blood sugar. And then we feed them with poison sugar.

We feed them drugs that kill cancer cells. And we can do that with natural drugs like high dosages of vitamin C or our testimony, which is Chinese wormwood or turmeric, extract curcumin from turmeric or sugar, oil from ginger or lectins from mistletoe, or we can use at that.

The dosage is lower dosages of synthetic chemotherapy, and that's the doctor's work to find out which kind of combination with which constellation is the best.

And that's where the chemo sensitivity test comes in. And I will speak about it in a few seconds. So my insulin modification of the blood sugar we open to the cancer cells channels and then we administer the infusion with the anti-cancer drug.

And at the end of the procedure, we inject a little bit of sugar to close the sugar channels again. So we we we open the door, we deliver the drug, we shut the door, and we have a ten fold higher efficacy of the drugs compared to normal blood sugar conditions.

And that's really worthwhile doing on one side. Higher, higher die off rate in cancer cells on the other side, almost no side effects. So is there a certain percentage then of the chemo drug that seems that seems to be enough?

I mean, as as like, I know in the past, I mean, 10% has been kind of the the common standard amount. Have you seen that that is enough or do you feel that you you need to use more?

And what sometimes we or relatively often we need to use more ten times would be the drug that we are, the dosage that we use in secondary prevention.

Let's say the patient has undergone successful surgery. There is a certain risk for a reoccurrence of the disease. Maybe there was a lymph node metastasis around and colleges recommends an adjuvant chemotherapy.

In this case, when there cancer burden is low or we sometimes choose 10%, but we rather go to 15. And in cases of metastases, cancer, we found out that dosages of around 20% of the recommended dosage that is mentioned in the guidelines is necessary to get a good result.

And some times in late stages with multiple metastases. And to a patient that has been treated, treated, treated intensively with all kinds of chemotherapy and there is already some chemotherapy therapy resistance, we go up to 25 and in rare cases up to 30%, but 30% is still so much lower than the standard dosage that my fellow them colleges would give at the hospital, that it is still much less harmful, much less side effects compared to full dose.

If you compare it with a with an alcoholic drink, if you drink one bottle of beer, all three makes quite a difference. Or if you go down to the 20% dosage, if you drink one glass of wine or five rule, that's a big difference in toxicity. So you can compare the dosages.

30 is the highest we've ever given. 20 is for metastasized cancer and 10 to 15 would be preventative or secondary prevention or primary prevention. But secondary prevention, that means after successful surgery, to prevent a reoccurrence.

And the key is not always the candidate immediate, you know, the first battle success where you see the tumor shrinking, but it's the longevity of life, quality of life, you know.

So, yes, if you just blast the body with a huge amount of chemo, you're probably going to see tumor shrinkage. But like you mentioned earlier, what is going to look like after what's going to now you have less resources and the reoccurrence and, you know, skyrockets tremendously so.

So you have to look at, you know, for the long game, not just that that immediate success. Exactly. And that's what I tell my patients many times, because patients need to learn how the the dynamic is of a cancer is disease.

There is a temptation to only look at the falling numbers of a tumor marker or that to want to see a shrinkage in the next CT scan as if that was the main goal.

That's not the main goal. The main goal is to live a long life with a good quality of life, and that is not defined short term by a falling tumor marker number or a short lived shrinkage of the tumor.

So it's better to keep in many situations, it's better to keep the disease stable, but for ten years, compared to a fast shrinkage that gives the patient a good feeling after three months.

But then as a consequence of the harsh therapy, the body is so weak, the immune system is so much weakened from therapy that the next recurrence comes already after six months.

And then the cells are more aggressive than ever before. So I try to to teach my patients to have patience and to live with the cancerous condition in a metastasized form and go for a good long term stability.

And I have a growing number of patients that are in their fifth in their rates in their 10th year living with cancer and a good quality of life. And these patients have understood that it is very dangerous to treat harshly, aggressively for the sake of a short lived reduction, with a high risk of a reoccurrence that comes very fast thereafter.

And usually with the different cancers, let's say colon cancer, then they have a different kind of the FOLFOX combination or, you know, bringing in another drug now to try to make it even, even stronger.

So they have kind of a formula with each type of cancer, if you have triple negative, then they go with, you know, x, x type of chemotherapies. Are there better ways of of doing this?

I mean, is there a way to really then cannot check and see, is this chemo drug actually the most effective in regard to this this this type of cancer?

Yeah. Thank you for bringing up that question that leads us to the topic of chemo sensitivity testing so that we do the experiment with the patient's cancer cells at the laboratory instead of doing the experiment inside the patient's body.

So for the last ten, 15 years, more and more laboratories have developed techniques to do something called chemo sensitivity test. And that can be done with two types of of samples.

Number one, it can be done with cells that we find inside the bloodstream of our patient, that these cells are called circulating tumor cells with the abbreviation CTC.

So every patient who has a metastasized form of cancer has ten thousands, hundreds or thousands of circulating tumor cells, and a modern laboratory can detect and filter these cells out and use them for experiments where the cells are exposed to the drugs that could be used.

And to find out which one of the 20 drugs that we theoretically could use are the best in this particular situation, because in former times we believe there is a good combination of drugs for breast cancer and that is another good combination of drugs for colon cancer.

But today we know that the difference is between two two patients suffering from the same type of cancer, breast cancer can be huge. We know that the diversity of cancer is almost as big as the diversity of humans.

So I spoke to a laboratory expert in tumor genetics and he said literally, we know today that everybody has its own type of cancer. So it's Peter's cancer and it's Susan's cancer.

And it's John's cancer. And today it is of secondary interest, whether it's from the colon or from the prostate or the lungs. We need to understand the particular individual role, tumor type and the genes that are out of order in in in this individual case.

Clinical Results and Closing Remarks

Otherwise, it's like guessing is like I go to a to a shop for men's clothes and without showing the shop attendant my size, I say, Oh, I need a shirt, give me an average short shirt for a guy.

Well, I can be lucky and find the right one, but I can be unlucky and find a shirt that doesn't fit me at all. And that is like a one size fits all chemotherapy for all patients with colon cancer as if they were the same.

They're not the same. So an individualized testing is the modern approach that avoids tragic old mistakes and critical forms of wrong treatment. See how you can follow the guideline, but the guideline therapy can be totally wrong for this individual because she or he has a very special pattern of genetic impairments in their cancer cells that might be totally out of the range of an average person.

So that's why we need individualized approaches. So I told you already there is this one approach or the organs that we can use a blood sample and filter out the circulating tumor cells and do a laboratory based chemo sensitivity analysis and the second approach would be with a with a solid biopsy, with a with a needle biopsy where the laboratory that we collaborate with, it's a laboratory in the city of Philadelphia, in Germany, where the laboratory can do a complete gene analysis.

And this is pretty new and pretty awesome that it is possible at all. This laboratory can measure 20,000 tumor genes from a tissue sample, and based on this tumor or gene analysis, tell us what drugs are likely to work and what drugs are unlikely to work.

And it's an enormous value to have such a laboratory report at hands to make the decision for an individual patient which combination of drugs is the best.

So I really believe that this is this is tomorrow's oncology that we can provide for our patients already today. Why do I say tomorrow's oncology? Well, because it will probably take at least another five, maybe another ten years to get these techniques into the guidelines.

That is how long it takes for a new tool to make it through all the steps of clinical approval to finally be mentioned in

a guideline. So and our patients don't have ten years to wait, so we need to use these tools already today.

I couldn't agree more. I mean, and that's the thing is that when you're dealing with cancer, you know, you just want to bring in the most effective tools that's that exist at that time, whether it's gone through the whole process to them become standard of care or not.

Yeah, it doesn't really matter. We just need to use the most cutting edge technology that's available. Do you feel that oncologists are open to these type of ways of testing or what?

What are you seeing in the community as a whole? And I'm sure it's different in Germany versus here in the U. S.. Well, the situation in Germany is that we medical doctors are allowed to use these techniques as long as we communicate them honestly with our patients.

And I have to say, while this test is based on tons of science on published data, but sorry, it's not approved in form of large randomized clinical trials, those trials cost hundreds of millions of dollars and take forever to get them done.

Forever might be ten years or more or more so as long as I communicate it openly and honestly and say This is what it is, but sorry, we don't have the approval for large clinical studies.

We can do it in Germany. And that's one of the big advantages we have in Germany as medical doctors. We we're allowed to step outside the box and use tools that are not mentioned in the guidelines.

And that is not the case in many of our neighboring countries. A doctor in France, in the United Kingdom, in Scandinavia would not be allowed to do what I'm allowed to do as a medical doctor in Germany.

So we have a group I'm a part of a group of German complementary doctors and oncologists that use these tools. And I would say we are maybe a group of 50 in Germany, 50 that I'm in contact with.

And we all together, we work in private clinics like I do in my clinic. And none none of the doctors in this group is a clinical oncologist as at a large hospital.

So if I would ask my my respected honorable colleague at the regular hospital who is an oncologist, he would tell us, sorry, I can't use this test yet because it's not approved by the board of oncologists and it has not gone through all the clinical stages of clinical evaluation.

That's the truth. It would probably say. It's very interesting. Yeah, I believe there is a lot of bearing in this approach, but sorry, I'm not allowed to use it.

So that's the discrepancy between large hospitals and private clinics. Yeah. Yeah. And and that's the thing is that when you have a smaller clinic, you can pivot faster and you don't have to deal with all the bureaucracy that exists obviously within a larger organism that the hospital.

And that's also the insurances that urge the hospital doctors to follow the guidelines because a national insurance would not pay for something that is outside the guideline and to make it up into the guideline, that's what I just said.

Costs hundreds of millions. And pharmaceutical companies invest nowadays between $4 and $5 billion to bring a new drug to the market. So that's an enormous amount of money.

Yeah. So when people ask, you know, well, have this gone through the research, the studies, you know, has it been approved then just kind of recognizing that the dollar value is so high that it is impossible, you know, when when there's something where you don't have a rate of return. Yeah, yeah.

Like Artemisia or curcumin, you know. No one them and see that, you know. Yeah. That's, that's one of the issues that we have to deal with. It's a political issue and you and I cannot solve it.

And I have to be grateful that my country allows me to step outside the box. And as I said, as long as I communicate honestly and openly with my patients, my patients and me are are open to do whatever we want to do, as long as it helps the patients.

And as long as I don't cause any obvious harm to the patient. And I mean, what could the harm be if you take cancer cells from the patient and check what they're sensitive to in a laboratory and then use what the laboratory, tells you the risk that you do something wrong with this approach is very, very little.

And what are some of the results that you've seen? I mean, so so people can get a feeling of, you know, these type of therapies. How has that changed the outcome of patients?

Well, I just prepare a lecture that I will give at the doctors conference in Munich on Saturday. Now, in three days where I present five best cases that I'd freed following approach with chemo sensitivity testing and insulin loop low dose chemotherapy insulin potentially aided low dose chemotherapy.

And I picked five cases where the prognosis was very poor in the beginning of our contact with the patient, they're all in stage four have all been pretreated intensively with chemotherapy to the point where chemotherapy failed and the disease progressed.

And there's this group of patients that there's one with gallbladder cancer, one with uterus cancer, endometrial carcinoma, two with breast cancer and one with ovarian cancer.

They are in stability with this excellent quality of life. Two and three years after their first contact with our clinic, the prognosis was in the few months when they came to our clinic, and they have survived now 2 to 3 years in average with an excellent quality of life.

The end is not visible, they are not cured, but their disease is stable and their quality of life is excellent. And I'm very proud to share these results at the conference on Saturday.

Well, Dr. Saupe, it'sbeen such a pleasure. It's always a pleasure to hang out with you, chat with you. And I look forward to many, many more encounters in the future.

Likewise. Michael was a pleasure talking to you and all the best for your work and your cancer summit. Thank you.