Introduction to Dr. Paul Anderson

Well, Dr. Paul Anderson, I'm so excitedto have you on this segment of Breakthroughs Cancer or Cancer Breakthroughs. And you are someone that I so deeply respect.

And you are a leader in this field. So I don't feel like discussing this subject without your input would have really made the summit just as. Just to give the audience a little bit of a of a feeling of who you are.

Dr. Anderson is a recognized educator and clinician and integrative and naturopathic medicine with a focus on complex, infectious, chronic and oncologic illness in addition to three decades clinical experience.

He also was head of the interventional interventional arm of a US NIH funded human research trial using I. V. and integrative therapies and cancer patients.

Former positions include multiple medical school posts, professor of pharmacologyand clinical medicine at Bastyr University and chief of Ivy Services for Bastyr Oncology Research Center.

He is the coauthor of the Hay House book and I own both of these books and I tell my patients to get them and they are amazing and should be a resource for every one of you out there.

One is “Outside the Box Cancer Therapies” with Dr. Mark Stengler, as well as a coauthor with Jack Canfield in the anthology “Success Breakthroughs” and the long press publishing book Cancer The Journey from Diagnosis to Empowerment.

He's also coauthor with Dr. Dr.’s Osborne and Carter of the IV textbook “A Scientific Reference for Intravenous Nutrient Therapy”. And I have that book as well. So.

Well, Dr. Anderson, thank you so much for being here and for taking this time. I really appreciate that. Thank you very much for having me. So as a leader in this field, I really want to take this advantage.

You know, what are what are some of the what are you seeing? We're moving forward and integrative oncology. What what are some of the breakthroughs that you're seeing that you're working on and trying to understand more at this time?

Yeah, I think that's a really wonderful direction to go because honestly, after doing this is as long as I have and now with really working with a lot of other clinicians and you know, what they're doing with people who have cancer.

Therapeutic Synergy in Integrative Oncology

What I, what I've seen for a long time and kind of what I had a feeling of, but it's been more evidence when we were collecting data and doing trials, things like that is the direction I think that the integrative oncology world is in and is moving more into is therapeutic synergy.

And so, you know, if you go back 25 or more years ago when there really weren't very many people doing any integrative type oncology. There were some, but not very many.

There were a few things, you know, that we all did. We did the best we could to help people with side effects of chemotherapy and radiation, help them recover from surgery.

Many people were doing, like me, high dose vitamin C and other I. V. therapies. And then there were a lot of other, you know, botanical medicine, etc..

And I think that, you know, if we go back to 25 plus years ago, our thought was if we just could find that one thing, you know, that would push cancer into a corner or that one thing that would maybe minimize the cancer activity and maximize the immune system activity of the patient.

We might have sort of a universal treatment. And while there are certain treatments that are very universal in in the nature of many people have benefits such as high dose vitamin C and other treatments.

What we found over time and what we kind of crystallized when we were doing that trial with cancer patients in a very integrative fashion was there's not a clear cause and effect between this therapy is always good for this type of cancer.

And I always had this feeling because that was what we saw clinically. But a single therapy has to work within the patient. And one of the things I'll tell patients is, for the most part, when we do integrative therapies with you, it's different from, say, chemotherapy, where chemotherapy, if I put it into 100 people, it's going to have a kind of a predictable effect in the body because it's not working.

Generally speaking, some of the new ones, maybe. Yes, but the traditional chemotherapy doesn't work with your body or your immune system. It kills what it kills.

It harms the bad cells and the good cells the way we know. And so that's more of sort of a universal type treatment. If I give you a natural immunotherapy or a oxidative therapy or an antioxidant, a day of therapy, it completely depends on what your body's immune system is doing and what its status is.

Do you have any immune system left, etc.? So you could have ten people with colon cancer and may have ten different reactions to the same sort of a treatment plan.

So I think that what that led to then if you, you know, we go back about ten years was to really sort of the the I guess the advance statement of truly integrating therapies so that you get synergy.

And what I see is the way we're going and hopefully the direction we go in the future is the more synergy we can bring to the patient and the more we have a respect for meeting them where their body is.

We're meeting them where their immune system is, etc. Then we can layer the synergy of the treatments in in a very holistic manner. And I think what I see personally in what I see in speaking to other clinicians is that's where we get better and better responses with people with cancer.

And so I really think that's the, you know, as a big picture, that's the direction that we've been going and that's getting even more. I think a deeper understanding of that is synergy and synergistic therapies, again, keeping their own patient's body and you know where it is in mind.

Yeah. Because in pharmaceutical medicine, I mean, we know with drugs, I mean, they are there to override natural processes in the body. So they, they do what they do and don't care really about what's going on with the body.

And, you know, like you mentioned, chemotherapy is very much like that. So how how would an individual then when you say that, you know, you have ten different patients, colon cancer, and it's interesting.

I'm just seeing more and more colon cancer for whatever reason. How do you determine which one needs what? I mean? Because obviously, as a patient, you know, I have colon cancer.

I go to an integrated practitioner, you ask them, you know, well, these type of therapies, you know, I see the studies. They're good for colon cancer.

You know, I want to be on ivermectin. I want to be on IV, you know, Tagamet, I want to be on these repurposed drugs and these IVs. And so how does a clinician then look at the individual and the uniqueness to determine what direction to go?

Yeah, I think I think that's really the core question and you know, really it's back to more of the art of practicing medicine in in regard to being able to assess each individual patient and say, well, we have you know, we have this patient here who's had very few other therapies.

Their immune system is very robust. Everything's going well. Their vitality is very well. Well, they probably have a number of things that they're going to respond to that are going to be, you know, very, very well received by the body.

Now, you might still have to go through a few iterations of treatment plans and things, but generally speaking, that person with a stronger vitality and less damaged immune system is going to do better with more things.

If, on the other hand, the patients had a surgery and maybe some local radiation therapy and then some chemotherapy, their immune system was a totally different immune system than the other patient I described, and they may actually need more treatment on the front end to bring their immune system back into actually working and into play so that then these other therapies can work.

So a lot of it is, like you say, that that art of medical assessment and it can go back to, you know, you mentioned, say for, for example, repurposed drugs, they can be kind of good across the board for many people because of the way that they work.

But they still are going to go further or, you know, less far based on what kind of because they're mostly manipulating the person's immune system. If my immune system can't operate or, as you know, been beat up real bad by the disease or by the therapies, immune focused therapies, which most integrative therapies are going to have a harder time kind of reaching in and doing anything.

Personalizing Treatment by Vitality and Immune Status

And although I would say this is not a big at least not what I've heard anyway, in the more standard world of oncology, there are people of published, very well respected people in the standard oncology world in regard to immunotherapies and saying, you know, we've kind of been doing immunotherapy backwards with our cancer patients in saying, well, this is the third or fourth or fifth line treatment, so we're going to do the immune damaging therapies like chemo and radiation first.

And they they will come with these conclusions saying, you know, if we're going to give a therapy that works with the immune system, maybe we should give it before we ruin the immune system.

They've actually published this and, you know, said this to their colleagues. So I think in our case, it's kind of that same calculus is we we've all seen this where we get somebody maybe whose body is a little less touched by the system.

And they you know, we, for example, have a lot of examples of more elderly patients where the oncologists say, we're not going to give you any therapy because it's you're you're too old for it and it would hurt you.

And they have sort of a blank slate with the immune system in a lot of our therapies. Work faster in those folks. You get somebody who's had surgery, radiation, chemo or some combination of those, and we may have to work for a month just to get them sort of repaired and, you know, back on line before we can start doing all this.

So I really think a lot of it is about finding out what the patient's been through, assessing their immune function and their vitality to the degree that you can, and then sometimes almost rehabilitating them before you put them into, you know, more of the advanced therapies that we're going to talk about.

But I really think that's the clinical like that's the crux of the clinical decision making that is very much more of the medical art really than science, although it's involved with both.

Is is that sort of discernment with the patient? And what can you say to that people that, you know, let's say they

are beat up, cancer is advancing and there is that really strong sense of urgency to to turn things around.

But they don't have a lot of vitality, a lot of an immune system. So then to go into the more gentle, preparing, restorative, what have you seen or what have you heard with the practitioners that you interact with that outcome to be more gentle than in the beginning, even though it is that sense of urgency versus then going full bore with heavy duty, powerful, even integrative, you know, heroic type of therapies.

Yeah. And you know, there are times where you have maybe a very rapidly progressing cancer, one of the ones that's poorly survivable, such as a high stage, high grade pancreatic cancer or something, where you you kind of have to meet with the patient and say, look, we have maybe one chance to intervene here.

You've had a lot of treatment. You've had chemo, your systems beat down. So we're going to have to do a lot of things kind of at the same time. So in in a case like that, that's the other part of the calculation is how much time do I really have?

How much, you know, runway or lead time do I have with this particular cancer or so with the patient in mind? You also want to be considering, you know, kind of these two, you know, almost like the the angel and the devil on the shoulders of we have to make you strong enough for the therapies.

But on the other hand, we have to be aggressive enough to meet your disease where it is. So in some of those cases, what I have found is, especially if the patient will engage in dietary changes or maybe, you know, a little more aggressive than they were thinking of, whether it's getting them, you know, into a full ketogenic diet plan or something similar and maybe what we would do would be alternate treatment.

So they might come, you know, on Monday or Tuesday and get a very, you know, I would call it like a happy therapeutic combination. So we do nutrients to help rebuild the body and hyperbaric oxygen and maybe some photodynamic therapy.

And then they might come back on Thursday or Friday when they're they're doing all this stuff at home, of course, with diet and supplements, etc.. And then on the end of the week, we might do more of an oxidative type treatment because we got a little bit of a boost.

So it's not like you always have to wait, you know, four, six, eight weeks for them to build up. Sometimes you can do a push pull where the beginning of the week we strengthen you and then we do, you know, really maybe more aggressive, immune stimulating treatment.

And and then, you know, I always just tell patients, well, how how do we do that? How close together, how much we do of that your body will tell us your body's the only thing that knows how this is going to be received.

But even in very frail people, I've had them where maybe they had a, you know, cancer. It's nothing slowing it down. You know, you don't have a whole lot of time in that case.

I'll usually do that where the same week we're building up and then also, you know, hitting the system pretty hard in somebody with maybe a slower growing or more, you know, more factors to consider, like a lot of, you know, advanced prostate cancer, where there's many other places you need to treat the patient, but they're probably the you know, they're not in as dire straits as somebody with advanced pancreatic cancer.

We might set something up or we're doing a lot of things to build them up and then treat the other areas. And then we work into the cancer therapy over time.

So so that's another factor. How much time do you think you have and all of it? I think as long as the patient knows that all of it actually is going to be quite aggressive can compared to not doing anything.

So they're going to really feel like they're getting a lot of things done anyway. And how do you feel and I thought is really interesting point that you made in regards to the immunotherapy.

You know, that obviously the person needs an immune system in order to be able to respond to immunotherapy.

Balancing Urgency with Supportive Care

And if you destroy it and, you know, you have nothing to respond with, how do you feel kind of the the integrative or the I say the the more naturalistic type of treatment, nutritional based treatments, how they interact with with traditional medicine and when should traditional medicine be heavily looked at and and what areas may not be, as you know, have a strong of a role?

Yeah, I think that that's another piece hopefully early on in the communication with the patient, the way I try to break that down so that the patient gets the picture is there are some standard of care oncology treatments that have over 90% nearing 100% success rates.

And so if I had a cancer that had that sort of success rate with a standard treatment, I would do the standard treatment and I would do everything I know of in in our world to support it and support me and heal from it because it's it's never it's never only two choices.

There's, you know, what you're doing and maybe with standard of care treatments, but then there's all the things you need to do to heal from those standard of care treatments and keep your things like cancer, stem cells, com, etc.

for survivability. So I will contrast that with patients. I said so on one end you've got that where we've got a real high cure rate. That still means that what we do in the integrative world can make that even better.

And your bodies survive it better and heal better afterwards. On the other end of the spectrum, you have a standard of care treatments where I've heard a lot of oncologists tell patients, Look, if I had your cancer at this stage you have, I would not do the standard of care oncology treatment because it's got less than 5% chance of doing anything and it's got about 100% chance of side effects.

Now, there's every shade of gray in between. There. But certainly if you on one or the other end of the spectrum, it's kind of easy to make the calculation of, gee, I got a 90 plus percent chance here with standard of care, and that I can do integrative care, you know, to do better on the back end and heal up.

Great. Over here, I've got less than 10% chance of a positive outcome, less than 5%. But I've got, you know, a 90% chance of very bad side effects. That's a maybe a pretty easy calculation to make on that side.

It's when you get into the middle where these things can get a little bit muddy and you really and that's one of the problems is, you know, sometimes people will write a paper or, you know, about the efficacy of chemotherapy, etc., and you really can't do that because the efficacy of chemotherapy is based on the the tumor type and how advanced the tumor is.

And to some degree, other factors like gender and, you know, age and things like that. So I think that's the first question that has to be answered. You certainly you know, wouldn't want somebody with, say, you know, testicular cancer, close to 100% cure rate.

And there's so many things we can do to get them through on the other side. You wouldn't want a person with that kind of a cure rate to to not do that treatment because the cancer will progress.

On the other hand, you know, advanced pancreatic cancer, usually your success rates are under 10%, usually under 5% and 90% likelihood of side effects.

That's a little easier calculation to make. Those are ones where I often hear the oncologists say, you know, if it was me, I wouldn't I would not do the standard treatment because it's just too low yield.

So I really think that's another thing on the front end. You know, you've got this big piece of assessing where the

vitality and, you know, the person is, but also you've got what are my chances with standard treatments?

And just because I do a standard treatment or I don't do it doesn't mean that there's not all these other things we can do to support that. Those discussions are easier if the person's already failed standard treatment.

You know, we get a lot of those patients where, you know, they tried and and the cancer is progressing anyway. So that's you know, that's sort of a third category.

And one of the issues is, you know, kind of like the studies with, you know, let's say Tamoxifen, for instance, that it it helps in certain areas and it has been studied then to lower the risk of the specific cancer that it's addressing.

But then at the tail and it increases the likelihood of other types of cancer. So so that is when it becomes really important then to make sure that you use, you know, some nutritional support and integrative therapies in order to be able to balance that out.

So you get the best of both worlds. Yeah. Yeah. I think that's another, you know, and we one of the books you mentioned, the outside the box cancer therapies, there have been a number of publications in the oncology world about standard of care, chemotherapy and radiation being very good on the front end, but then setting your body up to have a recurrence later.

And that's really very wasn't borne out in the in the data. And I think we were the first book to ever summarize that data and actually put that in that, you know, yes, there are some benefits on the front of the standard of care.

But if we don't do anything with your body and your immune system to keep the cancer stem cells calm and quiet, long term, we might be buying more problems.

So like I said, it's never either or. It's what do we do to take the best of something and make it optimal over time? And what are some of the therapies that you've seen?

We talked about when it hit the body harder? You know, I hit it with what are some of the heroic therapies that you're seeing, really making it, making a difference and people that are needing to turn things around.

I mean, obviously, you talked about how we need to meet the person where they're at and not just kind of impose the treatment on them, but then to work with with the body and and so forth.

When to Use Standard Oncology Treatments

So but what are some of the kind of newer that's out there that you're really seeing, you know, making a difference? Yeah, I think when it comes to therapies, another thing that I kind of realized, I kind of knew it, you know, but sometimes you look back over a number of years and you really see the you see patterns emerge.

So all of the therapies, the more interventional things work better when a person's taking care of a person and their providers are taking care of three kind of foundational parts of their body.

The first one is around their diet, and I think we've all seen that where the more, the more focused the diet changes are, the more focused the diet is on immune function and surviving cancer, the better.

The other is the physical body. You know, what are we doing to keep the physical body, you know, moving and metabolizing appropriately, etc.? And then the third kind of foundational pillar is, is the brain and the mind body connection, but also what are we letting come into our mind?

You know, from the outside there's a lot of negative things that can change your mind, body function and immunity. So those are always a base. And if we get those, then all of the other things become much more, I think, impactful long term.

So the areas where I see really, you know, none of the things I'm going to talk about here are really technically new, but I think they're newer in the way that we think about putting them together with respect to helping a cancer patient and helping to see some change.

So you have what I would call global therapies in the body, such as hyperthermia, heat therapies very commonly used in Europe and Asia. Less commonly here, a little bit in North America.

There's studies going on currently in North America, thankfully. But a lot of the people that that I trained with and I work with in regard to hyperthermia were, you know, standard say radiation oncologist from Europe.

And it's just part of what they do in radiation or medical oncology to do hypothermia. So hypothermia is something I think that's so very potent and helpful.

Another one that I consider kind of a body wide treatment is hyperbaric oxygen therapy. And up until 2012, it was kind of believed that maybe hyperbaric might make cancer worse.

And then in 2012 and 2016, there were two very pivotal papers published showing that that actually is not the case. And it's a real deep well to go into why in the tumor biology of hyperbaric oxygen but again not not as something you know, where you would only do one treatment but as a synergistic therapy hyperbaric can synergize almost any of the other immune therapies that we do.

It also can help people recover from the damage of, say, chemotherapy or surgery or radiation, which is very useful as well. And we use it a lot too. Synergize oxidative therapies as well.

So hypothermia, hyperbaric, UV, you know, like you see this sort of body wide, they don't really so much care what's wrong in the body. They try and get the immune signaling system to go back in the right direction.

So I think those are major synergies. Another one, which is both global and specific in therapy, be photodynamic therapies. And so you might have a global photodynamic therapy where you're using a specific wavelength generator on maybe the whole body or maybe the brain or maybe a particular organ system externally.

And those, again, are commonly used in other parts of the world. A lot of photodynamic therapy is relegated in North America to dermatology and couple other things, although it's certainly known about.

But again, I see that as another another way into the immune system that's very just like heat or hyperbaric. It's a very elegant way and it gets really forces from nature.

If you think about light that we already, you know, we know now interact with our cells and interact with our immune system. So I said Photodynamic can kind of be a global or a specific therapy.

So, you know, light beds and light arrays and, you know, light helmets and other specific pacific superficial things. That's sort of the global.

Global and Botanical Integrative Therapies

And then there are things that, for example, you know, you and I were at a conference recently about more specific internal, you know, indoor laser applications and using the laser to bio activate either a natural substance or maybe even a drug, etc..

So I think Photodynamic therapies are another really big synergistic layer that we can add on. And then, you know, there's sort of an interplay between immuno modulating substances which most of the plant world is.

You know, we think sometimes people say, well, it's an immune stimulant or, you know, something that is an immune suppressant. In most cases with plants, they're more modulating.

They may have an initial stimulation and then modulation. So even something which we think of as an immune stimulator like this mistletoe therapy, it sort of has that upswing, but more of it is immuno modulation.

A lot of the other herbal and botanical treatments, whether it's curcumin or Boswell. Yeah. Or Egcg or resveratrol, etc. those are also modulating different parts of immunity. And people will often think, well, if I have cancer, don't I want my immune system just upregulated so it goes and you know, beats up the cancer and to a degree you want some of that.

But one of the things that we miss sometimes is that what keeps us alive when we have, you know, stage three or four cancer is how well how well does the body manage?

The downstream drivers of metastasizing cancer will it turns out that most of the drivers that drive metastasizing cancer, which is what will kill you, are our slowed or sometimes stopped by immuno modulation.

And so you know, there there are synergistic therapies we've done over time and we just sort of observe that those people lived longer even with stage four cancer.

And it turns out that biologically what those therapies did probably more had to do. Yes, they had a little initial part of kicking the immune system up, but their longer term effect was modulating the immune system.

So the metastases, what we called metastatic drive, was slowed down. That's what keeps you alive longer. So I really think that, you know, when you get past the global things like hyperthermia, hyperbaric oxygen and photodynamic, which are little more specific, then you get into botanical types of interventions, whether it's mistletoe or one of the many other botanical interventions then you're moving towards, yes, we're going to make your immune system, you know, spunky and active.

But really what we want to do is take away the drivers of the cancer so it can be calm and quiet. And what I would say and then I'll stop talking so you can tell me where we want to go next.

But what? I was curious. Okay, good. What I see now and I think we're we're coming to although, you know, many people have been already doing this, but I think we're getting to a a more maybe a little more wisdom around the way to implement these things is sometimes what we see.

And I'll just take the case of botanical therapies. I think that what we see is you certainly can have like a lot of one botanical therapy and it can do things, but I think a better way to go for many people would be lower amounts of maybe two or three or four botanical approaches that are sequenced as a therapy and maybe then activated by, you know, photodynamic therapy or something, or synergize by heat or hyperbaric.

I think that that's really the next step that we're moving into. It's not that we don't do that. It's more knowing what's the most appropriate to put together.

So, for example, could I do a lower dose of, say, curcumin and egcg and, you know, maybe buzz while you're or some of the other agents and they would all kind of come at the problem from a different place.

But I wouldn't have to use so much of the therapy. And one of the things that led me to that actually was necessity back. You mentioned the cancer interventional research.

My part was all the injection I. V. therapies, things like that. And the the whole clinic was doing everything, you know, diet and if they wanted acupuncture and Chinese medicine and we had psychology, we had mind, body, everything going on and botanicals and stuff.

Well, one of the things that we were researching was extremely high doses of intravenous curcumin. But in order to do that, you have to have very particular type of intravenous curcumin, which unfortunately is not available anymore for a number of reasons.

What we saw in about a group of 15 people with they had to get into this group that have stage four cancer. It had to have failed all other therapies, including natural therapies.

And so they had no other options. And so we did extremely high doses of intravenous curcumin. And in the first few patients we did, they would go get, you know, an imaging study, CT scan, MRI, something, because it was part of their follow up.

And the radiologist would think that they were on a chemotherapy agent. And so they would say that, well, it's positive chemotherapy, it effect where the metastases stop growing or in some cases they reversed in, you know, the bones, etc., and that really got our attention.

But in order to do that, we had to put so much curcumin into that person. It was kind of like marinating them, you know, in order to get it to all the cells.

And, you know, it obviously worked real well when that form of curcumin became unavailable. The other forms, it's just not practical and not safe to do those high doses can't do it.

So that led us to the next phase of, well, is there another way into the same effect? And that would be maybe lower doses, but with different basically medicines made from botanical, you know, chemicals, extracts and and that's kind of what we're seeing.

And then the next step after that, you got to keep in mind this all started ten years ago, so we had time to work on it. But the next step after that is, could I do those things?

And then would hyperthermia make that work better? Would hyperbaric sequence then make that work better or any of the other things? And that indeed I believe so what we're seeing and I think that's really that's really the frontier is not so much things we don't know about, but the elegant application, those things mixed together.

So, yeah, we're looking for that one thing and and it just didn't exist. I mean, it's so it's not that one thing, it's how they interplay. And like you're saying, if you're driving with just that one thing, then you need to hit it so hard, that one thing.

But then when you look at hit the different drivers in a very elegant way, and that's when we're able then to kind of address it much more efficiently because and you go at all the different escape mechanisms.

So to say that the cancer has and you don't need to hit so hard in all areas, you just kind of tighten type and the borders, so to say and what it can do and so that I guess that is the intelligence and you know we're not bringing more tools to the table is how to use them, when to use them and what combination to use them.

And that's kind of the phase that we're at right now. Yeah. And I think that, you know, sometimes patients know this and sometimes they they you can lose sight of this even at whether it's a standard oncology treatment or integrative or both cancer is a very, very wily or, you know, informed process biologically.

And so if you keep hammering it down in one direction, you might gain, which is fine, but there's ten or 100 or a thousand other directions that can kind of come back up because it it has that ability to use its tumor biology and switch it, you know, which is why I feel like we've seen much better outcomes when we have multiple points of the compass covered, you know, like we talked about, that includes dietary things, that includes lifestyle things, etc..

And then these other therapies, I think, you know, maybe we might want to do like a lot of something on the front end, maybe a lot of missile too, or a lot of oxidative therapy, etc.

But then as we gain ground, we want to look at what's going to keep all the other doors that might open up, you know, closed for it. So I really think that's that's really the the direction that I see us, you know, refining in the coming years.

Well, Dr. Anderson, it's always such a pleasure. And I it's so I'm so honored to to kind of to to get to read your research, to be to to learn from you, too.

It just makes people like what I do so much easier to have somebody like you with so much knowledge and understanding and kind of guide us along. So I really appreciate everything that you're doing in this field.

Thank you. Thank you so much.