Introduction to Donald Yance

Donald Yance It's such an honor to have you on this segment of cancer breakthroughs. I mean, you're you're a man. It's just tremendous amount of knowledge.

And you train practitioners from all over the world in regards to to, you know, dealing with cancer and how to how to address it. Well, thank you for having me.

So far for everyone out there. And Donald, also, Donnie is a clinical master herbalist and certified nutritionist, renowned for his extraordinary knowledge and deep understanding of the healing properties of plants and nutrition, as well as epigenetics, laboratory medicine, oncologic pathology and molecular oncology.

He lectures nationally and internationally on his pioneering work in the field of botanical and traditional medicine and cancer. He is a professional member of the American Herbalist Guild and the National Association of Nutrition Professionals.

He's the founder and president of the Metairie Center, a nonprofit 51C3 organization for patient care, professional education and clinical research and holistic medicine, Integrative Oncology.

He's also the president and Formulator of Natura Health Products, a line of advanced botanical nutritional products for health care practitioners. Donnie conducts as clinical practice at the Metairie Center in Ashland, Oregon, utilizing his a unit of integrative model known as Metairie Care, which evolved over more than 20 years of successful patient care.

The Metairie care model elegantly combines his passion for the latest scientific research and the wisdom of ancient healing traditions, resulting in compassionate, creative, intelligent and effective approach for healing.

As a visionary, leader, mentor, teacher, author and healer, Donnie's mythology has transformed thousands of lives and has taught to health care practitioners worldwide through the Metairie Academy, an online program of modular courses focused on whole systems integrative oncology principles, clinical applications.

Therapeutics is the author of Herbal Medicine, Healing and Cancer and Adaptogens and Medical Herbalism, Elite Herbs and Natural Compounds for Mastering Stress, Aging and Chronic Disease.

It publishes a weekly blog at Donnieyance.com well that I'm really excited about this interview this is going to be so cool. Thank you, Michael. My pleasure.

And so so tell me, I mean, you've been working with cancer patients for for for so many years. So when when a cancer patient comes to you, you know, what do you look for?

I mean, where do you start that journey? Well, I like. To. Look at the situation through three distinct lenses. So one lens has nothing to do with the cancer.

One lens is all about the host or the person with the cancer.

Three-Lens Approach to Cancer Care

So we start there and that lens is more based on traditional methodologies, interviewing, letting the patient give you their narrative about their health, you asking all your questions, you are observing things, whether it be their eyes, whether it be their tongue, their skin health.

So you take in this big you do this big interview and you develop a relationship. And because really everything is based on relationship. So this is a little bit more subjective, but this is a big piece because often I say make your patient healthier and forget about the cancer and your patient will live longer and better.

So that's the first lens that we do. So we call it a host lens, and it's based predominantly in traditional modalities like traditional Chinese medicine, the Western medicines, like eclectic medicine, physio, medicalism, and a little bit of Ayurvedic medicine.

And so it's none of those in and of itself, but it is a convergence of those and also bringing those systems of medicine into a real life contemporary model.

So that's the first lens, the second lens that we look at is all the laboratory tests we might take on a patient. And there's two ways that you look at laboratory test.

One is you're looking at it in relationship to the host. So how does the how does this blood work lab tests that we're looking at reflect the health of the person?

The second way we look at it, how is this blood work conducive to the onset of disease and most notably cancer? And the third way we look at it is in more aggressive or advanced or active cancer.

Has the cancer hijacked what we call the microenvironment? Because that second target is the microenvironment. And if it has, what is it manipulating, which we can determine in the lab test that we need to change so now we're looking at how do we maximize the health of the person of the host, how do we alter the microenvironment to make to maximize it to the health of the host, make it the least conducive to cancer, or analyze it in relationship to the cancer and then change it.

And then now the third lens, main lens we look at is the disease itself, and we're going to look at cancer, which includes all of that, looking at it through all the typical pathology but now also doing a more in-depth look at what we call the molecular characteristics of the cancer.

What is driving this cancer? What mutations does it have? What growth factors does it have, and what does that have to do with the optimal way to treat this patient?

So now where we have looked at it through their host, through the microenvironment and through the disease itself, and then we're going to apply six toolboxes.

And those toolboxes are the first toolbox is botanical medicine, which is the heart or the soul of Mediring Care. The the system of medicine. The second is supplemental nutritional medicine.

So what you give your patients to take in the way of a supplement, that might be a combination of nutrients. The third toolbox is dietary or food as medicine.

The fourth toolbox is lifestyle as medicine. The fifth toolbox is is modern pharmaceutical medicine. So that's its own toolbox. How do we utilize drug therapies and different things that are are present?

That toolbox that most people are leaning on is the predominant toolbox and immediacy care. We're often using it in a different way than maybe standard of care would recommend it.

And then the sixth toolbox is what we call spiritual care. And spiritual care is both how do you meet the needs of somebody? Because often somebody will come to our center or come to me that's had cancer a long time, that has exhausted a lot of different treatments and it's very aggressive and they have a deeper need to go with regard to the relationship we have with that person.

So spiritual care is really nourishing the patient in that spiritual way, but it's also applying your own spirit to how you decipher how to support that patient.

Because their mind, there's so much complexity when you start looking at it through all these different lenses that the mind itself can't figure it all out.

So what I often tell people is fill your mind with as much information as you can and then go to your heart. Like Einstein says, the the intuitive mind is the sacred gift.

The rational mind is the humble servant servant. So I always say wisdom and courage and love are the are the great healers, not fear. So often patients are fearful.

Often the system of medicine is all fear based. So we have to kind of pave our way away from that. We have to start with a place where we're fearless and that we're filled with love, and that's kind of it.

The overview in a nutshell of how we start to go about things. And so those are the thematic elements. The first element is the philosophical elements.

The first is wisdom, which is ancient and comes through traditional medicine. The second is knowledge, which is modern and scientific. The third is common sense and logic, and the fourth is musical intuition.

And then we have, most importantly, prayer and love. And what we would say is providing faith and hope as well in a realistic way to our patients, and always knowing that the most important thing is not eliminating the cancer always, or having the most effective way to shrink the tumor or eliminate the tumor.

People get too impressed with that. The most important thing is helping people live longer and helping them live better and sometimes taking a very aggressive approach.

For example, my eradicated cancer only to see it come back and put a patient in a very poor state of health and have them live a shortened life span rather than ultimately having them live long and in a very healthy way, possibly never eliminating their cancer.

Yeah, and that's the thing is that with with traditional oncology, they're very good at shrinking tumors. They may not be so good, adding creasing longevity, increasing quality of life, but they're very good at shrinking tumors.

So that has them become the focus that they that really want to project on to the patients as a measure of success. And, you know, coming from where you're coming at, at the end of the day, and we see this in animals.

I mean, we see an animal that that that that die from a long, healthy, you know, long life and enjoyable life. And then you do an autopsy and you see that died with a bunch of tumors and the animal.

But it didn't really affect their quality of life and their length of life. They just live with those tumors. And that was not a big deal. So, you know, so then to look more exactly what you're doing at that at shifting the focus away from the tumor and then shifting towards more longevity and health becomes so important.

Unified Toolboxes in Integrative Oncology

Yeah. And every you know, I always tell people every cancer is a unique disease across the board. There are there are no two types of cancer. There are identical.

Like it's so there are so many types and subtypes of cancer. And then every patient is unique. So you have a unique patient, a unique host, and you have a unique disease.

And so don't get too caught up in anything that in a in a pattern way. Every time you go from one patient to the next, you've got to kind of start all over again.

And maybe you think you apply some of the same things and you'll find that you need to go a different direction with with one patient and every way, even how you talk to them.

One patient's very emotional center, another patient's very intellectual. They've done a ton of their own research. Wherever you need to meet them, you meet them because I'm a, you know, a research fanatic.

I spend 1 to 2 hours every single day of my life compiling, research, studying, compiling, writing papers. I have a monograph on every single plant I use some with for 500 citations now, mostly centered around cancer, but not entirely centered around cancer.

Because, again, when you're dealing with an aging population, you you're not going to just treat cancer, you're going to maximize their health. I mean, a lot of people with cancer die of heart disease.

And they had cancer and they the heart disease is what got them. So our ultimate goal, like I said, is making people healthier, keeping them healthy and helping them live as long as possible.

That's always the goal. Now, sometimes you have to forget, not forget, but you you do need to shift the emphasis on the cancer. You know, I deal with pediatric cancers idea with very, very fast, aggressive, fast growing tumors.

I don't have time to say we can ignore your cancer and just work on you. We have to put all these pieces. So I always see it like a puzzle. You put all these pieces together and that's what you need to do.

And part of the initial pieces are our targeting the cancer. And often that might be utilizing the modern pharmaceutical toolbox. But again, maybe in a slightly different way, maybe, maybe the standard of care way is not the best way.

The first line that is often given for a type of cancer isn't always effective in every situation. And how do we determine what people are going to benefit from, what treatment and what people aren't going to benefit?

So part of what I do, because to tell you the truth, I learned a long time ago, 30 plus years ago, I mean, I've been working with cancer almost four decades now, but I learned a long time ago that I can do everything right.

I can give people the best diet, the best herbs, if they're on a treatment, an aggressive treatment that is doing no good and only harming them, the outcome still isn't going to be great.

The only way the outcome is consistently great is when all the pieces are unified. That's why I call my dairy care. Not a integrative system, not a collaborative system, a unified system.

Everything is purpose really put together to work in a unified way to synergize. And it is through that harmonization. We go to the musical terminology that the outcome is great.

So it's not any one thing we do. It's because we use a lot of what we call sort of non cancerous, even drug therapies at very low dosages, whether it be an mTOR inhibitor, a Cox two inhibitor and H2 inhibitor.

So there's different ways or metronomic chemotherapy that's very different than using standard of care chemotherapy. It's a very low, constant dosage of a drug that is no longer meant to be cytotoxic, but rather it's psychosomatic.

It's it's angiogenic regulating and it's immune regulating because cancer hijacks the body almost every part, every system of the body cancer needs to manipulate to grow.

So we're talking predominantly the immune system. So cancer takes over your own immune system. It suppresses the cells that are going to be advisory to it.

And it and it helps produce all of those chemokines, those different cytokines, the neutrophils, the macrophages that enable it to thrive and grow. So we have to do, like I said, we have to do all kinds of things to see that consistently.

You can see people over and over again that aren't supposed to be getting well get well. That's what that's what that's what motivates me more than anything is just seeing applying this this system and seeing people get well over and over and over again.

Well, when do you because a lot of a lot of patients say you have some patient that say, I just want to do natural things and that's all I want to do.

And then they are not unifying all these different therapies like you're talking about, but they're doing wheatgrass juice, a plant based, they're taking some herbs, and then all of a sudden they come to somebody like yourself, myself, the doctors that work in this field and they get stage four and it's all over the place and they.

So when do you feel that an individual like that should look at things like chemotherapy and some of the using that that toolbox that you're talking about?

And maybe can I lean on more of the traditional oncology to just to shrink the tumor and then at the same time support with leads all other factors? Well, we have to look at that toolbox in relationship to all the other toolboxes and know that everything in that toolbox is more a sledgehammer and for the most part has very a concept of blocking something.

When you look at modern pharmaceutical medicine, it's very strong and anything but harmonizing and unified and works, like, I will say, like a sledgehammer.

And the way botanical medicine works is in a network fashion. It's doing any one compound and one or well will be metabolized in the body of orally ingested into a multitude of new compounds.

And so this bio transformation, one compound creates a dozen new compounds that enter into our bloodstream and act in hundreds to maybe thousands of different ways.

So this concept of network medicine is really beautiful that we can look at plant medicines, how it affects organ systems, how it affects cellular networks, how it affects molecular networks.

And it's endless. It's like, and then you put lots of plants together. It's even more endless. So I always tell people herbs are supporting your body in an endless way, trying to regulate, trying to create better efficiency, trying to help the body auto regulate, be epigenetic, modify, modify modifiers.

But, but drugs are very specific and they're very functional. They're not harmonizing. They don't they don't have a way of bathing with our body and communicating like plant medicines do, but they will serve a purpose that frequently natural medicine won't do.

Sometimes you need something strong to get in place while everything else starts to work. But you have to be sure that you're picking the right kinds of drugs and giving them at the right dosage.

So most of the time in modern medicine, they're using the wrong drugs frequently, or they're giving them at dosages way too high. You take a great drug like everolimus that was approved.

Maybe ten, ten or more years ago for breast cancer. It was approved at ten milligrams. It's it's an mTOR inhibitor, mostly a Tau one inhibitor because there's tau one and two or two, very strong tau one inhibiting.

And it was approved at ten milligrams a day for breast cancer. And no women can tolerate it. You know, they get mouth sores, they're bought, you know, they just couldn't take it.

It was too toxic. And then the CDK four and six inhibitors came out like Ibrance and all the colleges abandoned ship with the with Everolimus. And they made a big mistake because it's a very effective drug, particularly with people with specific mutations, like a pick three mutation.

But even without that mutation, it can be very effective. I often get to try to get people to get on either 2.5 milligrams and take it only three times a week, which is less.

It's a seven and a half milligram per week rather than a ten milligrams per day. You only need a little bit. And it when it when they finally did research on two and a half milligrams, it was just as effective as ten milligrams with none of the adverse effects.

But all the doctors abandon ship because they got the CDK four and six and six inhibitors and none of their patients can tolerate it.

When to Use Pharmaceuticals and Surgery

So whenever I recommend it and I talk to it in colleges, oh, my patient can't tolerate it. I said it's dose dependent. I said they were they were given an overload.

And remember, when you take a pharmaceutical drug, one day like an aromatase inhibitor, I often have people recommend rather than not take it because they're getting too many side effects, which often happens.

O'Donnell I can't take that, you know that. LETROZOLE It it just messes with my body in every way and my joints, all her. I said that's because you're taking too much.

It can still be very effective. Let's dose challenge your system and find it. The only mechanism is to lower your estrogen by by blocking the aromatase enzyme pathway once that's blocked, it doesn't need to be blocked more and more and more and more.

And every time you take a drug, you take a drug. Today at 9:00, you take the drug tomorrow at 9:00. That drug wasn't cleared out of your system. Letrozole takes up to a week to clear out.

So now you're piling drug on top of drug on top of drug. And it's it people are toxic with these drugs. And so when you find the right drugs, you have to dose them.

And as people get older, they need even less and less drugs. But a doctor isn't free to do that. That's the crime of our system. When a drug is approved at a certain dosage, as an oncologist, you have to prescribe and tell your patient to take it at that dosage.

That's just the way the system set up. If you say, oh, tried challenging it like I do them, they now are liable, you know, legally now they're can be held accountable and and all sorts of stuff starts to be drummed up.

But that's why our system has to change. We have to be able to adapt our medicine better to the patient. We have to be able to know what patients are going to benefit based on various testing methodologies that we have.

Certainly we have ones now, you know, you test for her too, but even that's not even that accurate. There's all kinds of deletions within her, too. There's the sometimes a tumor is heterogeneous.

It has a heterogeneity, which means that particularly in more cancers that have been treated a lot, you can take a sample from one tumor and take it from another.

And you have two different types of cancer. You have three different kinds of cancers. So even within a person, particularly with advanced cancer, they can have three, four or five different types of cancer.

And their first type of cancer is still present. They're virgin cancer. But now it's been it's mutated a multitude of times and it's gone through different stages.

And what it's become is completely different or very different from that first cancer and what we have in some cases, and more advanced cancer in older people.

I do I like them to think about a concept called competitive release, where you're actually not trying to eradicate their cancer because believe it or not, they're virgin, slow growing cancer.

That's still around is competing against their aggressive cancer. Like I often say, it's like, you know, sometimes you have to make friends with, you know, the like the work that the enemy.

That's not the worst to get rid of the worst enemy. So I said sometimes, you know, and it's a whole concept in oncology called competitive release where like take prostate cancer, you know, in an advanced case in an older man you over they are over treated all the time they're giving heavy hormone blockade agents just in a disease that's not that aggressive, that's accentuating all the other diseases they're getting neurological disease, heart disease, bone disease, depression, all the things that you wouldn't want, like an 80 year old man to be getting because they're over.

Treating their cancer when they're cancer is not going to kill them. It doesn't mean you ignore their cancer, but you have to be very gentle on how you treat it and not overtreated.

So, you know I know, I know. I've gone, you know, done a big circle around around everything. But hopefully I'm I'm covering what you were asking. You're doing great now on all of this is fascinating to me so one one of the components that it's been talked a lot about is that when you remove you're talking about the slow the original slow growing cancer and let's say you do surge your you remove that, and then all of a sudden you have all these daughter cancers that pop up that become very aggressive.

So the just cutting out the cancer is not the solution. But like you're saying, you know, become friends with it and then support the environment that it exists with then.

Yeah, immediately care you. It's never optimal to do surgery as an upfront therapy. So sir, if we look at the surgery toolbox, we want to treat cancer systemically, always first, whenever possible, unless it's an emergency.

And there are three main reasons and I actually wrote about this in my book 25 years ago. There's three main reasons why you want to do that. And since then, neoadjuvant, neoadjuvant therapy has become more and more popular.

25 years ago, nobody was doing it. Now it's becoming more of a of an approach to cancer. But there's three main reasons why. Number one, you treat a systemic disease systemically.

First, because it is a systemic disease. Nobody's ever died of breast cancer. Nobody's ever died. It's always metastatic disease to the brain, the lungs, the liver, not so much the bone anymore.

But those are the the main sites where breast cancer metastasized. So, again, you have to treat the systemic disease systemically. That's number one. Number two, if your systemic approach is working, guess what happens?

Your tumor shrinks. Sometimes it disappears. Often it disappears. When I, when I, when people and all the pieces are put together in a and and over two or three months therapy.

It's not unusual for me to have a tumor just vanish. It's gone. Now you just say, do you have surgery or not? You know, is the question. And that's, you know, so that's the second thing that happens.

The third reason why is if you've shrunk your tumor or 50%, you have a far less invasive surgery now. So now your surgeries are much simpler. And surgery in and of itself is cancer promoting? Why?

Because you're weakening the host. And so the host is is weakened now and cancer's already weakening the host. Second, you are causing an inflammatory environment and a pro angiogenic environment, which is just what, cancer loss.

And so, you know, you have to be very careful. So often in media, we care, we say let's treat systemic early. Let's

see what happens over the next two or three, four months, maybe even longer.

Once we feel like things have really regressed, well, then I think it's permissible to do surgery. And in some cases, if you can get your tumor small enough.

I am a big fan of Cryoablation, which is basically freezing the tumors. I've had a lot of people do that like a breast tumor. If you can get it down to 1.5 centimeters or smaller, they just stick a needle in it and freeze it and that has a it.

Not only is it noninvasive, but it has a localized immunological effect. And after six months or a year, that ice ball that's left disappears and you have a breast that looks like it was never touched.

And so I'm a big fan in many situations of cryoablation, but not without the right systemic approach. To me, systemic treatment is the most important thing.

People have had great, great surgeries. I got everything. It's all gone. Six months later. They're dealing with with cancer everywhere. So that's you know, that's a common theme that I've that I've heard often.

Yeah. I just spoke to a patient actually. Right. Right before you that did the surgery, did a lumpectomy and then two weeks after was just big tumor, just grew on her sternum and then hip and then serve.

I mean it's just like two weeks after the surgery, so but the surgery was successful. It was all gone, you know, clean margins, all of these things. So yeah, so what?

So we talked about kind of the danger of these daughter daughter cancers. So if you you were treated systemically and you've been able to shrink the cancer, make it like a smaller target, there's not as much risk than for things to take place distal for metastatic activity at that time.

Correct? Correct. So now you've got a much healthier patient. You've positioned them with a really good protocol and already we've seen that things are extremely quiet systemically based on maybe the regression of the tumor.

Now you've reanalyzed the microenvironment, maybe you saw it. We saw all kinds of things. We saw like to me, a simple CBC is maybe the most important thing to be looking at a cancer patient.

And people don't understand how important a CBC is, because if your patient has high neutrophils say and they don't have a bacterial infection, they are in an in a in a hot, inflammatory state because cancer can be hot.

It can be cold, it can be intermedia, it can be in between. But whenever you have high neutrophils and low lymphocytes, you know, you have a bad situation in a cancer patient.

Again, unless they have unless they're fighting some acute infection, that's the only case. But if there's none, then, you know, their bodies are pro flattery.

Tumor associated neutrophils are big promoters of a cascade of events and cancer. You have tumor associated macrophages you have, you know, all these collaborative cells that are really promoting the cancer.

So you have to see those things improve. Maybe you've done some angiogenic markers like fibrin pigeon and D-Dimer and Plasminogen activator inhibitor.

Those were elevated. Now they're not elevated anymore. Maybe we did growth factors like a sperm HER2 new like a vegetable, maybe a tumor marker as well.

All of those were elevated before when we first got the patient. Now they're all quiet. They're all right where they need to be. So I'm pretty confident that if I've gotten all the blood work looking the way I want it and it's all getting moving, everything's moving in the right direction, then I am I am totally fine with surgery taking place at that at that

time.

And yeah, and that was my next question as regards to add to patient, they're doing all this care. They're seeing that there's still the tumors there.

You know, maybe it's shrinking, but it's always that kind of in the back of your mind, you know, what's what's happening in the rest of my body. Is it is it ending up elsewhere?

Is it treatment successful? Are we moving in the right direction? And medically, it's usually it's it's imaging, you know, that that's where the always go.

Blood Markers, Microenvironment, and Liquid Biopsies

You know, where you have to deal with all the die that obviously is toxic in itself. So what are what are you mentioned on CBC? You mentioned neutrophil lymphocyte.

I know there's like a neutrophil lymphocyte ratio that are optimum. And then also you also many people do like lymphocyte monocyte ratios that are optimum.

Can you talk a little bit more about the different things that you look at over and above what you just expressed? And kind of what are some of the numbers to to be between to add to know that you are doing better?

Well, one thing is that all of it has to be adapted to the individual. Nobody knows what their perfect balance is. So we each have our own ecosystem. I mean, everyone's microenvironment, two thirds of your microbiome are unique to the individual.

Only one third all humans share. So when we're looking at bloodwork, we're not trying to look at it like we're like a machine. Like, like, like everyone has the same perfect blood work.

So the first thing we have to do is when we start to look at baselines, we have to ask ourselves what is what part of the bloodwork is just part of the.

I have patients with with white blood cell counts of two for 3040 years. Everyone I would ever want to even wants to keep sending them to a hematologist.

They're totally fine. I've had a person with MDs with hemoglobin that fluctuates around seven and a half to eight. He has got more energy than anyone, so we can't just always interpret, you know, bloodwork like it's everyone's the same.

We we start, we take our baseline and we look at things. So we'll look at the neutrophil lymphocyte ratio. And I always look for the trends is the most important thing.

So we get a baseline know we can tell when things when cancer is active and things are definitely reflecting that. But sometimes we can't always. So now we're going to start looking at the trends.

What are the trends? Tell us about this. Also platelets. It's not good to have really high platelets are also cancer promoting a lot of the angiogenic dependency is around platelets and aggregating platelets and then even inflammatory cells of say histamine that that can be some cancers are like neurofibromatosis type one is a very much a histamine driven tumor.

Some mast cells are involved in even breast cancer. So every every thing we have to look at based on the individual. So it's not even anemia. Some people have a fair ten or 15.

They're completely fine. Another person that's always there ferritin has been 50 or 100 and now it's 15 and now they're severely anemic. So, you know, people have different blood works, vitamin D, levels of vitamin someone's,

vitamin D was ten and now it's 20.

It's far better than it was. So it's not like we don't have to get everybody, you know, up to this perfect range. We're just looking to see if things are moving.

And often we're not in a hurry to move things either. Sometimes we are in acute situations. When some things happen acutely, then we need to change that acutely as well.

When something is part of a chronic pitcher, to me, slow, steady wins the race. We don't have to like give people hot massive dosages of of of vitamins because they're been deficient we want to nurture them slowly back up and let them keep adapting like even people with methylation defects.

I think there are always overtreated. People with low thyroid are overtreated. You know, some people have, you know, everyone's test is in a different range.

Everyone is a little bit different. We just see what does this tell us, this blood work in relationship to what the patient's health is like and what does this have to do with their disease?

And now how what do we really want to move and how much do we want to move it? And these are questions that we're asking ourselves all the time. But generally, I'm a vital estate practitioner.

Overall, I'm interested in building the life force and doing things as gentle and as slowly as possible, knowing that sometimes I have to abandon that and not do that because we have to be always adapting everything to each situation that we see.

We don't we you know, our philosophy is one of adaptation. You know, it's like sometimes we have to be very aggressive right up front sometimes. But generally speaking, I, I follow that because every system of medicine follows that same premise.

Why, why is every system of medicine built on building the patient's vitality as the most important thing? And we keep abandoning that. We keep people ask me o.d where, you know, when are you going to give me cytotoxic herbs, you know, and I do, I, you know, I do really.

I said, I need to build you up first and foremost. We'll get to that. Don't worry. You know, it's like that's the thing I said, that's I want to get you stronger than ever imaginable because part of, you know, cancer is a catabolic disease.

Aging is a catabolic is is catabolic. You have surgeries, catabolic, chemo catabolic, radiation's catabolic. So if you don't do some anabolic restoration, you're not going to get to where you need.

So these are very fundamental things that I that, you know, that I focus on and then I layer things in. You know, we get to different herbal formulas that are more designed to be either alternatives are very specific.

I mean, I have a formula that's based in chemotherapy and that, you know, you have Madagascar periwinkle, you have the Pacific, you you have the Kanto thing, too, where I really can until protein can come from.

So, you know, I do. And those plants have like you take the Madagascar periwinkle that's got like 80 alkaloids in it all with antitumor activity. But now we've made three drugs from that one plant.

Vanilla beans and Kristen have been blasting and we isolate compounds but the plant is got so many other compounds the Pacific you 27 toxins alone in that plant all with antitumor activity.

But we just isolate one and then make Taxol tax a tier Abraxane and other, you know other related toxins now that are available. So you know I will give people whenever someone's on a chemo that is a plant origin I frequently give them the whole plant extract to go along with that and other synergize and supporting herbs.

But again I'm always asking what am I doing to make the patient healthy? I'm analyzing their microenvironment and I'm constantly looking at all these parameters in relationship to the tumor like we can do circulating tumor cells can do liquid biopsies, of which there's a numerous labs.

Now, they all have a little bit different technology. I have my favorites. I think, you know, it's like the Wild West with these labs testing nobody. There's not great oversight.

So people are often making mistakes by going to labs where their methodology does not translate over to what's what we really need to focus on. So I question a lot of that.

But I'm, you know, I am fond of certain, certain testing methodologies. I'm always doing tumor tumor testing as well. So you have tumor testing, you have liquid biopsies.

Now, you circulated in tumor cells, then you have have the standard tumor markers, you have the microenvironment markers. So by the time we look at this, it's better than looking at scans.

You had mentioned scans before because scans can miss things as well. And scans sometimes can't differentiate always what's a tumor, what's not a tumor?

If there's a lot of fluid, if there's a lot of air like in the GI tract, scans can't see very well all the time. And scans don't pick up micro disease or stem cells because really it's the stem cells.

Chemotherapy doesn't kill cancer stem cells. So if you have if you have a smart intellectual cancer, it's going to have a stem cell population as soon as that as soon as the coast is clear, that's going to re differentiate through essence.

I'm all messenger. I'm all transit transformation, where the EMT occurs, where it recruits the epithelial cells and all of a sudden you have cancer growing again in your body and that's resistant what you often did before.

So if you did Platinum and Taxol now, that's not going to work again. You need to go to your strong, your next strongest line of chemotherapy and then your next strongest.

And that's definitely not a good place. So you have to identify your cancer stem cells. And again, the natural toolbox actually addresses cancer stem cells.

And so that's why we need to do a lot of a combination and things. We need that we need this unification to see all of our patients getting well and staying well.

So what and you mentioned then the liquid biopsies and I know there's a bunch of different labs you want to test for the CTC what is and I recognize this doesn't mean that other labs are bad but but which which one is your favorite out of?

You know, from all your research, you know, which one is your favorite? Well, I am fond of near genomics, where they do both pathology testing and then some liquid biopsies.

The way the system is working now that everything in medicine today is very profit driven, it's it comes down to money. So if I am if I've got a liquid biopsy and I've got a big sales force and I got a lot of money invested in my sales force, like gardening 360 does or foundation one, I go knocking on the door to the hospital and say, Let me give you a presentation now.

Look at how much money you can make on this testing. And then the hospital adopts it and that's their testing. So they're going to pick, you know, like there's lots of things that are done that should never be done.

Patients should not be given these growth factors, these bone. Our growth factors say new last in a new project. They just promote cancer growth, too.

I mean, it's a travesty. But the hospitals make 10 to $20000 on every shot that they give to stimulate the neutrophils. And that's what it's doing. They're stimulating neutrophils and suppressing the lymphocytes, and they're cancer patients with it with these shots because they and and I mean, I wrote a whole paper, so I write papers on everything.

Like, if you want to like you want to understand fibrinogen and cancer and why, that's an important biomarker. I have a 200 page paper with well like 150 citations on fibrinogen and cancer level copper zinc ratio in cancer.

Cancer. Why? That's important like ever every thing. Neutrophils I have a whole paper on that. So I write papers on every single thing. VEGF and Cancer Vegetable levels in cancer galectin three and cancer.

Why these biomarkers are so essential. Why serum her to do is better than pathology her two new so I like new genomics. There are other ones. I don't mind looking at the other ones, but the methodology of, you know, well, it's called next generation gene sequencing through RNA technology is not as good as DNA technology.

So there's, you know, these different things. Even the old cell search, the FDA approved CDC, I still think is a very good it's been it's you know, it's really been.

But that's only approved, I think, for breast long, maybe coal. And so it's so I, I mostly go but there are there are there is the there are there are numerous other labs that are out there that are pretty that are pretty good too.

I'm not interested in that what's called agreat testing and a lot of that testing. I don't feel that that translates at all to reality and is often tell people to do things that don't work and they've they've steered away from the right things to do.

So that testing. I'm not I'm not for at all. No, no. And you mentioned yeah. So you mentioned a bunch of different things like fibrinogen. And I know we've talked about ferritin as so there are a lot of these other markers that are easily available, you know, through CBC Scampi and yeah, C-reactive protein said rate you mentioned d-dimer yeah.

So so all of these said that are very simple numbers and an analysis like base of cells in interleukin six, you have asana fills, you have so there's so many different numbers that you can look at that are easily available. The yeah LDH is another really good looking at lactate dehydrogenase that's really important.

Sometimes it's done in a standard cancer patient, but most of the time it's not. But I think that that's really important. I do p urine first morning because I really want people keeping their page up at around seven.

So I frequently give people potassium bicarbonate as a part of the treatment protocol that we do these are, you know, very straight, more straightforward things that I you know, that I do I use for fibrinogen and d-dimer.

Of course, a lot of botanicals, blood moving. But botanicals are really important.

Nervous System, Music, and Spiritual Care

I like heart rate variability and looking at the nervous system. So my feeling is the most important thing you can do for a patient. The number one most important thing, and it comes back to that spiritual care, is nourish the Vega, the vagal system of the vagus nerve.

That's the most important because sympathetic nervous system is the main driver of of cancer, particularly metastatic cancer and cancer reoccurrence. It's not an initiator, but a big time driver.

So I'm also doing a lot of work on the nervous system, the endocrine system. You know, these are part of the core, I think, to where we need to go. A matter of fact, the biggest probably the biggest mistake breakthrough in cancer is that accidental, like many things, is the Association of Beta Blockers and cancer growth slowing down and reoccurrence rates much lower and people on beta blockers only because they're antagonizing the sympathetic

nervous system.

That's the only mechanism there. Yeah. And these are all the things that I that I again, that are pieces to the puzzle that we do. But I would say that's if someone pushed me and said, What's the most important thing to do for a cancer patient?

I would say nervous. Nervous. They're nervous system and help them to understand the importance of that and make sure they're doing things, whether the breathing techniques, prayer, music, chanting, whatever we can do to help them in that way is to me, the most important thing you can do.

Yeah, yeah. I couldn't agree with you more. And I. And I love what you said kind of in the earlier section of of our discussion, you know, that you fill your mind with, with all these pieces of information, all this knowledge, but then you you need it needs to be organized.

And that's kind of a heart component that's more that intuitive. It's beyond your cerebral executive thinking. So you need to allow these pieces of information to to correlate with each other and becomes a network of information.

And each piece will fit and their specific location. And you can't do that with executive thinking. It's more of an intuitive process that that that's kind of a deeper knowing that exist.

So then that's where meditation music being in that parasympathetic state, all of that becomes really important. Yeah, I, you know, I always when I teach, I always tell people I'm a musician first and foremost.

And so and my not only do I think music and sound is a very important modality for healing, but conceptually the application of being a musician and the the complexity of the mind all working simultaneously.

Because let's face it, you're you're listening is a key component. So when you're working with a patient, you're listening to that patient's narrative, you're listening to your own self because you're trying to decipher what am I going to be doing to support and help this patient.

Now, you're also acquiring all this other information at the same time and only, I think, a musical mind can really decipher that, because if you're like a jazz musician, you have a chart, you have melody, you have improvization, you have your own sound, you have your own way of interpreting what's going on.

But you're also listening to all the other musicians kind of working off of them. And that kind of way that the mind and the heart and the spirit all work together.

Because when you go to play an instrument, hopefully you're not thinking anymore and you're just feeling you're just going to your heart because all the work was done.

I always tell people, do all your studying, you know, without your patients. So it just just flows basically it just flows through you and that so that musical mind is very appropriate to medicine, in my opinion.

Otherwise, it's too it's too difficult. And, you know, a musician, all parts of the brain are firing together. Yeah. Is that part of what they call unconscious knowing? Yeah.

Which is kind of the highest level of of knowing. So well. And Donnie also knows. So people can, can listen to your music. I mean, you're also known as as a funk monk, right?

Yeah, yeah, yeah. So I have you can listen to some of my music on all the sites, Spotify, if you just put my name in Donnie Yance, I with Donnie always out there, remember that.

And then you could also go, my CD is called Heaven Awaits. I actually wrote that song as a reflection of all the patients I've worked with that have passed on.

So it's kind of like this meditation song that is, but there's ten songs on that album, and I wrote nine of them. Gino Fanelli wrote the 10th called Hope Valley.

And then I have a new one that will come out by the end of this year, which I call cosmic. I'm finishing the last song on that one, so a lot of them are based melody driven.

Maybe the song Heaven Awaits is actually bass and clarinet. So yeah, music is I. Music is is a very, very important part of my, my being. And it strengthens me in medicine.

So I guess the more music I do, the better I get at medicine for sure. Yeah, I love it. And for people to be able to get have access to all the the research that you've done, where do they go for all of that?

Well, my blog has some think it's a good amount of information. Donnie Anscombe, we have a dairy center, dawg, and in there they people can learn about the academy that we just launched just a couple of months ago, where we have six courses up and online, including three on cancer.

And that's where I teach this methodology. And I have we have students right now from all over the world, from pretty much every continent in that academy.

For the last 25 years or so, I've been teaching like week long courses that people have come here to Ashland, Oregon, but I have way too much to share.

So it's overwhelming. So we've developed, hopefully what will be a two year program, but it's set up in a modular way so people can go at their own pace, they can jump in whenever they want, they can even pick and choose what courses it's it wasn't my vision.

My vision was really to have a classroom and have people all going through the program, a full two year program together and then certifying them and Medicare.

So I hope to get there. But right now there is a there's some great courses up and so people can get a lot of information that way. We have about 35, 40, what I call ATMs practitioners that are part of a network that I do teach and send a lot of data out every two or three days to this this group, but they've all taken the courses that I've done.

So I think once people take the courses, then they get access to a lot of my information. But as it stands, the best way is through my blog website, which is Donnie Anscombe.

Resources, Research, and St. John's Wort

I've lots and lots of stuff on botanicals and cancer and cancer metabolism and you know, all the misconceptions that diet misconceptions, everybody's, you know, I think often going down the wrong road, you know, putting people on aggressive ketogenic diets, you know, things like that really aren't this isn't the way we want to be going, you know, you want you want to.

And so I write about all this stuff and glucose and cancer. I've got one that I haven't published yet on glutamine and cancer. And, you know, cancer is hijacking these things.

So you have to take you know, that's where the blockage is. So you can't eliminate all the energy sources of cancer and get anywhere because it keeps finding new energy sources.

And so you have to find a new way. And in this combination way, you're able to do that. I often tell people, people are often looking at the baseball and not the pitcher.

So when a pitcher throws a ball and hits a batter in the head, does the batter go running after the ball and tries to punch the ball? I said, No, it goes it goes to the source.

So I said, You have to go to the source. You know, you have to go out to that cancer. So anybody that's a little bit of an overview on things and we have published recently a breast cancer retrospective study, which is published now that people can get through our Web site.

I'm going to do a blog on it as well that gives an overview, but it's, I think, 35 breast cancer patients. And then we're about to launch a study on dogs.

We've tried so hard, Michael, to launch clinical trials with big institutions like Ohio State, only to have the final IRB, not the tap, not knock it down and say, no, we can't do this because we're quote unquote concerned of this theoretical herb drug interaction.

Even though I like with Ohio State, I said, give me your sickest patients. I only want stage four cancer patients that have failed everything. And now this is going to be a clinical trial waiting for them to go into.

And even then they all said all the oncologists said, yes, this is great, we can do it this way. We can do a lot of botanicals in the drugs because they're buying into this.

And and then and then they get to the final. IRB after seven years trying and the pharmacists, not the ecologists, knock it down. The pharmacist are more problematic than the oncologist actually, because they all go to the same website and re read information.

That's not accurate and true. It's it's theoretical information, not accurate information. So It's all based on theoretical pharmaco kinetics that has nothing to do with pharmacodynamics or pharmacokinetics.

And in real world, what really happens. Yeah, it always fascinates me kind of as a simple example. As for patients, I just want to get off antidepressants and then you're suggesting something like St. John's wort and then they read on a site that, well, I'm not a depressant, I can't take that St. John's wort, you know?

It's going to I'm going to have a serotonin storm and I'm going to die. And so it always fascinates me because exactly what you're saying, it is a theoretical assumption because it has been used in in that area.

So then they think they function in the similar fashion when they don't. Well, I love St. John's wort and I really go with that one because that it's an amazing, amazing plan for so many things, including cancer.

And I could tell you right now, for 35, 40 years I have used St. John's wort to get people off SSRIs and always with great success in all research. Even in the last two or three months, meta analysis research compared St. John's wort either is equal or outperforms all SSRIs with a much better safety profile.

So St. John's wort is an amazing, amazing plant. And what they worry about, not so much the serotonin storm. They worry about the fact that it's such an a headache detoxify through the 2d6 pathway in the 3a4 pathway that you diminish your drugs, your blood levels of drugs.

But the interesting thing is that probably 30 to 50000 women died because of a drug drug interaction of you using an SSRI in combination with Tamoxifen because SSRIs inhibit 2d6 and tamoxifen is metabolized through 2d6 So all women put on tamoxifen and SSRI is we're not benefiting from their tamoxifen.

They weren't getting any benefit. And the ticker or of that is that St. John's wort is a 2d6 inducer. It would have been able to correct that. That's the funny thing about it.

It's like you're avoiding St. John's wort and taking your SSRI with your tamoxifen when the SSRIs is the problem. And and in every way, like with with one last thing I'll just say because I know we're ending, but the the irinotecan is another one.

When you take high dose St. John's wort, 900 or 1500 milligrams with a standard dosage of irinotecan, which is a UD21a1 metabolite using enzyme pathway that herb will upregulate that and eliminate that drug from the blood

maybe up to 30% more.

So you'll say, oh my gosh, interaction, this is terrible. And you know, it does send out maybe a potential interaction, but just because blood levels are diminished doesn't mean a drug isn't working.

And in the case of St. John's Wort, there's no study that shows St. John's Wort diminishes the beneficial effects of I really can. And if anything, the study shows that it mitigates the adverse effects and potentiate the action of the drug, even in even in the light of it, bringing down blood levels of that drug.

Yeah, see, and that's, that's, that's what I love about the work that you're doing is that you're, you're bringing in the science, the real science instead of just assumptions into the picture.

So yeah, that and that, that's huge. Well, Donnie, that's been such a pleasure and thank you so much for everything that you're doing. Thank you so much.

So thanks. Wonderful to be with you. Thank you so much too.