Origins of Oasis of Hope

Well, it is absolutely my honor to have Doctor Francisco Contreras here Thank you so much for for spending some time with me today. Thank you. It's a pleasure and an honor.

Well, you have been in the integrative cancer field for a long time. Can you do you do you mind kind of telling me a little bit what what kind of drove you into that direction?

Okay, well, I was born into it. My father, founded this clinic in 1963, and I started working, within a, since the 70s. And, when he passed away, I took over, and he worked until he was 88.

Full time. It was incredible. So he really loved what he what he was doing. And he's the one that introduced to the world the holistic approach. He felt that the reason for the failure in medicine, he was a pretty renowned, oncologist and pathologist, and he felt that the reason for the failure was that we just became mechanics of the human body and forgot that patients needed emotional and spiritual support.

And that's really how we started. The opportunities came later when a patient from San Diego participated in a clinical trial in Canada with Latrell, the famous B-17.

And when she came back, nobody in San Diego wanted to touch her. And one of the pathologists at work with my father, you know, told her, well, I know this oncologist into one.

And maybe he he is willing to help you to continue with your therapy. My father looked at it and saw no harm. I mean that the lady had stage four very advanced breast cancer and to my father surprise, she just continue to improve and improve and improve.

And then this lady is the one that started calling everybody on the, on the, trial that, nobody wanted to continue. And that's how my father began using alternatives.

And since then to now, the therapy has evolved, tremendously, to what we have now. But that's the origin. And so, I was tremendously influenced by my father.

I went to do my, you know, completely by the book training, my own logical training in Vienna. I did surgical oncology there. And then I came back to work with my father.

And he has always been, he was always an intuitive, doctor. So, whatever he felt that was the best for the patient. Conventional or non-conventional? He he had the possibility of offering that therapy, to patients.

Cancer as a Metabolic and Immune Disease

And, and you mentioned when we were talking before we started, if there were several clinics here, just about every one of those, alumni of my father, they, you know, and we're happy because there's so many patients that need, care.

And so that's very briefly the the story of the Oasis and my story within the other oasis. And that's the thing is that, you know, that cancer, it's such a it's truly a pandemic.

So we need more and more like you. Yeah. We need more people, more doctors that are thinking and and your direction, you know, to be able to take care of patients, you know, and in a much more comprehensive way than it's offered.

Yeah. Through just plain traditional oncology. That's so true. In, in, you know, oncological need that I was presenting my cases, of breast cancer. One of the oncologists was a little bit upset and said, well, why don't because I was using, you know, some conventional some of those.

He was. Well, what are you really an alternative doctor or a conventional doctor? I said, well, I know I just want to be a good doctor, okay. And so I'll choose whatever is best for my patient.

Yeah. And that's the thing, is that, you know, we we're not here to pick sides. You know, we're not here for our own sake. Yeah, we're here for the best of the patient and whatever the best of the patient is, that is what we want to offer, you know, not married to certain therapy.

But we bring in therapies that we feel, you know, could really move the needle for, for patients, you know, so, especially in cancer, cancer's a very complicated disease.

And, some of the pieces of the puzzle are offered by conventional medicine. And, a lot of the pieces of the puzzle are offered by alternatives and, and non-conventional means.

And so we have to be very open to use whatever is the best for our patients. And when we say cancer is a complex disease and that's a thing, cancer is kind of like this, this enigma that people are trying to figure out, what it truly is and what's driving it.

Then in order to be able to find the solutions. I mean, in your from all your reading and all your, you know, practical, you know, research and well, what is your view on cancer, what it truly is?

Well, there's no question that cancer arises from, genetic mutations. And, and and that's why, you know, the thrust of research now is and in finding targeted therapies, honing in on, on some of those mutations and the benefits that those mutations bring to the tumor.

And if you can target that mutation and block the protein that is produced by that mutation, well, then you are going to affect the cancer. Unfortunately, most humans have hundreds of mutations and you would need hundreds of targeted therapies.

And they're not cheap. They're around $1,000 every 3 to 4 weeks. And so let's say you need 100 of them, you know, the $1 million every 3 to 4 weeks. But on the other side, all of those mutations have a very significant, metabolic impact.

And in the metabolic, common denominator factors for all tumors are really quite limited. And so we approach, cancer as a metabolic disease because it's much easier than then, to treat it as a generic disease.

But in truth, there is no long term benefit of the therapy if you do not address the immune system. So one of the things that I, that I tell my patients is that if your immune system is 100%, it's up to par.

People cannot develop cancer. And, that's not possible. Well, everybody knows the little lady that lives in the corner, you know, 99. And she drank all of her life, smoked, ate only McDonald's.

And then she sells shoes healthy with no cancer. That's because she was born with an incredible immune system. Most of us have a, you know, a not up to par immune system, and we have to take care of it.

And so we come we we, develop cancer because our immune system failed. And if you do not work on the immune system, you're not going to be successful long term.

And so at the Oasis of Hope, we've been working for the immune system since the beginning. So a lot of our therapy is to improve the quality and quantity of the immune system from the very simple things like laughter, joy, being spiritually strong music to the very complicated, like the dendritic cell vaccines that we've been doing now for many, many years.

We're very, very, encouraging results in, in in the cell therapies based on dendritic cells have evolved significantly in the last decade so that we have more and more tools, immunologically, to help our patients fight their cancers.

And, and we're very, very excited about that. But I think, that the more we learn about how the immune system can attack a tumor and how to bring down the barrier is a very effective barriers that tumors develop to protect themselves from the immune system.

The better results we're going to, we're going to get. So cancer is just very difficult to, to, to describe to, to define more than describe. But it is a combination of an immunological and a metabolic disease.

That's very, very ingenious, very resourceful and resilient, very stupid, because it kills itself with it when it kills the the host. But still it's, it's it's just a, a significant foe that we cannot, minimize and, and, and simplify, like, you know, cancer's a piece of cake if you just eat carrots, you know, that's that's not it.

But, more and more, we're finding ways to to undermine cancer so that we can be more successful. Yeah. And that's the thing, is that, like, like you're saying, you know, looking at it genetically, you get 100 different genetic mutations or targets and, you know, one breast cancer versus another breast cancer.

Dendritic Cell Therapy and Personalized Immunotherapy

They will have different types of genetic mutations. So you can't just say, you know, these are the ones that are always for this one person. And then you you block.

You know, you mentioned you can do some immunotherapy and you block, you know, certain certain receptors. And then you're able to put stress on the cancer.

But then you know yes you blocked one, but then you have 99 others. Yeah that the cancer can use. So it becomes a very complex, you know, strategy you have to bring in.

And that's why it's so beautiful then to really kind of lean more on the, the immune system, lean on the metabolic aspect, lean on the immune system. And we know cancer creates a confusion within the immune system.

You know, where it actually use this immune system for its own benefit and cloaks itself. So that's why, you know, that's why you've moved, you know, with using that dendritic cells and that kind of having that vaccine.

In fact, that that is a very kind of powerful strategy to kind of reeducate the immune system. Yes, yes. And one of the biggest advantages that we have in mixed well, you know, dendritic cells were developed and discovered in America.

In fact, the the discoverer obtained a Nobel Prize. And yet patients cannot have access to it. And the Mexican government opened up many years ago to, cell therapy against cancer because it's autologous, meaning that we obtain all of the elements from the same patient and we only apply that quote unquote vaccine to that specific patient.

So there is no, there's no safety issues whatsoever. And that's why Mexico said, well, why not? You know, these are patients that have a very poor prognosis.

And, so we have been able to develop this. And then the cost of the therapy here in Mexico, because it's, you know, even though the, the, the equipment is it's expensive here, there the, the, the the scientists that do this are not as expensive as in America.

We don't have as many lawyers. So you don't spend a lot of money protecting yourself from, you know, lawsuits. And so the therapies are, are much more, accessible in Mexico.

In fact, one of our goals is to be able to do Car-T cells within probably a year, a year and a half. It's a very

complicated, process. But the cost in America is about a half a million per dose.

Here in Mexico is going to be 50, about $50,000 per dose, you know. So that is going to make it available for a lot of people. And then the beauty of Car-T cells is that many in many cases with one shot you're cured.

And those are cells that continue reproducing themselves. So they stay in you forever. Some patients will need 2 or 3 dosages, but imagine that a half $1 million is just very, very few people have access to that therapy.

Yeah. And here you then have to play that insurance game. And then, you know, obviously half a million is, is, unattainable for the normal person. I think that most insurance companies are not going to pay for it.

That's why it has not progressed. In America. Yeah. And then to, to be well, I mean, 50,000 is something that, you know, if you are really needing it, you know, that's something that a person could potentially do, you know, that's not out of reach.

And so that's, that's that's amazing to me. But talk to me a little bit more for the end. Yeah. So the audience can understand what dendritic cells are, what they do and how they impact cancer.

So our immune system is very well orchestrated and, and regulated. And so when, when and when an invasion comes from whatever, bacteria, viruses, the dendritic cells will acknowledge that foe.

And it's going to present that foe to the specific agents of the immune system to attack them. So they're called antigen presenting cells. And that's all they do.

They're the most important element of the immune system. But they kill nothing. They destroy nothing. They only present the, the, the aggressor to these specific agents.

And and so we have in our immune system, the what are called the killer cells. And they are specifically there to kill malignant cells and viruses. They don't do anything else.

And and so you you were mentioning that the immune system, uses the immune system to, you know, to protect itself. So they, they upregulate the immune system so that the immune system is virtually blinded.

They don't see it. And so what we do is that we get malignant cells from the patient. And these malignant cells are then, destroyed. And from there we obtain the antigens of the, of the tumors specific to that patient.

And now that we have the antigens, we can activate the dendritic cells with that antigen. And now the dendritic cell can see the tumor and go to the natural killer cells and tell them, hey, listen, there's a cancer there.

And now it will attack it. And there are variations, a number of variations to, to achieve that. In but basically that is the activity of this dendritic cell therapy.

We are now calling it dendritic cell therapy. Our name our proprietary name is impact, which stands for immune. Autologous, immune a personalized autologous cell therapy because in the internet now you use vaccine and they block you.

It's become very complicated. But but at any rate, it is a cell therapy. And, so we can do the dendritic cells, we can also obtain natural killer cells from the patient and activate them without being presented by the dendritic cells.

So we bridge that. So we we can we can produce millions of these cells that will directly go and attack the tumor. We can create a vast amount of antigens so that we can use that really as a vaccine.

So inject the antigens in subcutaneously so that all of the dendritic cells in the system can be aware that there's a cancer there. We can do only natural killer cells.

These are more complicated to expand, expand in, in, in in illogical terms means to clone them to produce from 100,000 tens of millions in the lab so we can expand them.

It takes a long time. And the closest we have now to to Car-T cells are what are called tumor infiltrating lymphocytes. In this case, we have to remove a part of the tumor or a whole tumor from the patient, and we obtain killer cells that are already in the tumor.

So these are cells that were able to break all of the barriers. And so if if the killer cells are like soldiers, the natural killer cells are like the seals.

The Navy's seals or the Delta Force. They're very, very aggressive against the tumor. And we can also expand those. But again, the that's the most complicated because we have to operate on the patient.

We have to obtain the sufficient tissue. But whenever we're able to do that, the results are fantastic. And so as I tell you, with time things have been evolving.

The, the number of of, devices, that we have now have evolved significantly from ten years to now so that we can be more efficient in lower cost to, to produce the cells.

So it's a very, very exciting, time for us. And, in developing these type of immune, products that have, a tremendous positive impact on patients. Nontoxic, completely nontoxic, because we're using the cells from the patient and expanding them and mixing, making them more aggressive.

And then we we infuse them in the patient. So in a nutshell, in a very simplistic way, that's what our immune therapy is for, our impact therapy. I mean, that that that's incredible.

I mean, you have and that's, that's kind of my I know this is, on the mind of a lot of listeners, that, you know, why doesn't traditional oncology research, you know, why is it going in this direction?

I mean, this direction. Yeah. Like you're saying, it is nontoxic. It is specific. And you're then utilizing the information from the patient. So it's not just some kind of generic template, it is the, the exact, you know, tissue that, you know, we want the immune system to recognize and to go after.

Yeah. It is not just something that's been expanded, you know, in a lab, you know, from a, you know, from a mouse or from something like that. It is specifically for that individual recognizing that, you know, genetic mutations is is different from each individual.

Exactly.

Clinical Results, Safety, and Lab Innovation

So to be able to do this so it's targeted and then, you know, then that like you're saying your Navy Seal natural killer cells, these are the ones that were successful.

Yeah. You mentioned they were the ones that were able to get into the tumor to get three through that cloaking device. You know that that that a tumor has that makes it harder for the immune system to see it.

And they were able to get through that and then, you know, start to attack the killer cells. So obviously those are the winners and those that are the ones that want to have a lot of correct.

The main reason why it has that progressed in any part of the world is because this is not a moneymaking machine. And what they're trying to do in America, and I think is going to be very complicated.

Why don't convert it into a drug? So they want to have dendritic cell vaccine for breast cancer. And that's going to be like tiny therapies because every woman has a different type.

And this is just going to address a few mutations. And it's not going to work. It and so doing a patient by patient is is is is not effective from the economical point of view.

And that is why I think it's going to be very difficult for, for anybody to, to adopt this. We you know, here in Mexico things are not so expensive. We're able to survive with, with, therapy like this, but as I told you, is not a moneymaking machine, but it's it's a miracle, gene.

And and and that's more rewarding it than anything else. Some some. I'm curious, what have you seen? Because you and you mentioned this, this is something that has evolved over time.

You've gotten better and better. Obviously there are other places that do dendritic cells, but you, you have been in the game for a long time. And and it's not just all didn't really cells are the same, you know, in one location they say dendritic cells.

But the way they do it is quite different from the technology of G and the evolution that you brought forth. So, so it is really fascinating to see how you gotten to this point.

So what have but the dendritic cell therapies that you're offering now, what what are you seeing? What kind of impact are you seeing, on patients. So let me let me tell you statistics that we have in in breast cancer stage four, the survival rate in America is around 13, 14%.

Five year survival, our survival rate and stage for patients that have received chemotherapy, radiation, surgery, everything is about 50% instead of 13%.

And when a patient comes to us version to treatment, the five year survival is 75%. Major, major difference. And and you have to consider that the, the 13, 14% five year survival rate in America is for patients that arrive to them virgin to treatment.

The ones that we're treating are the ones that were sent home to die. So that's why the the difference when they come into treatment to us is is so massive.

And and so it is very exciting. We, we believe that, again, the more we work on the immune system, the more we learn, the better we're going to get at it.

I think that, you know, it is not impossible to make dendritic cells, but it's a complicated, process. And you need very specialized type of people. And, and I know for, for a fact that a number of people in Mexico that are doing dendritic cells, most of them are, hematologist and yes, hematologist can learn, but no, we we have cell culturing specialists here for every part of the for every part of the process.

And that's why I think that the quality control that we have here is very, very, extensive. And that's why I feel that we have a very, very good product.

I'm sure that there are other labs and there might be some that have the same, the same capability as our lab. But we're we're very committed to to immunology.

And our lab is really state of the art first world, and that's it. I mean, you can use you know, we all know, you know, with technology how fast it advances.

You know, just take cell phones, for instance. I mean, you can say that, yes, we sell cell phones, but, you know, am I selling the one that existed, you know, 20 years ago, or am I selling the one that is now newly developed?

And obviously the the, the, the functionality is going to be a vast different. And that's the same with any kind of technology that that evolves, you know, like dendritic cell therapy, the safety issue is a big thing as far as not getting the cells contaminated first, because you can lose them in the lab.

And it's it's a waste of money and time. And second, if you contaminate the patient is not a good thing. So the newest thing that's coming up, and we're very excited and hopefully we can, obtain it is that, there's a company in America that is developing now, cassettes.

And with this cassettes, it's one per patient, and then you have to throw it away. But the beauty is that you don't need, for instance, the cost of, controlling the air quality in a lab like this is immense.

So the air in, in our lab is 100,000 times cleaner than the normal air that we breathe. Okay, with this cassettes. You don't need that. It's amazing. So, yes, as you said, new technology is coming out, and it's faster.

You know, the cassettes. I know that they're going to be very expensive, but, you know, the safety and not needing the clean air and all of that, I think it will not impact the price so much.

Or the cost, the price of the patient. But we're very excited about this new toys that are coming out. I love toys, you know, toys. Yeah. They're our friend.

Yeah, yeah, yeah, man will be man, right? Yeah, exactly. And yeah, so do the same. My clinic, just bringing toys. Yeah. Because I know the benefit of the patient.

So. And I want to just kind of reiterate the point that you were making in regards to, you know, the survival rate of stage four breast cancer, you know, being in, you know, in the teens.

Yeah. And, with traditional oncology and you're, you're making the point that these are patients that have not been treated by other things, you know, that having failed anything.

And so they are like virgin patients in a way. They're untouched. And then patients that are coming to you, with stage four breast cancer, these are the ones that have failed.

The majority of them have failed all these different therapies. So they are living, correct? You? Because I think we state things wrong as doctors. We want to feel that we didn't fail is where the therapy failed.

The patient. They will. You usually say the patient failed to chemotherapy. Well no it's the other way around. Sorry. Yeah. No I appreciate that I appreciate that that is a very important distinction.

Yeah. So so you get the ones that have you know, really have nowhere to go. But. Right. They were virtually no to that. Yeah. And with those you have a much better success rate than traditional oncology.

You know, that have had people that are virgin patients you know. So so I just want to make sure that that point is valid. So those it's about three times to four times the average with the other one is about 5 to 6 times the average.

Yeah. That's amazing. And and we talked a little bit about and obviously you do a slew of other things as well there. Yeah. And then I mentioned this.

It's it's very expensive to do prospective clinical trials with small institution. And we, we fund those studies and they're not easy to do. A five year study takes ten years because, you know, everybody's as well as five years know by the time you gather, you know, a number of patients that are old, you know, homogeneous so that you can make statistical analysis.

It can take 2 or 3 years and then, you know, you have to follow them for all of those years until you reach five years for everyone in the study. And so it is very expensive.

But we're, we're, we're very happy that we've been able to do in some of the most common tumors. We haven't been able to do that in all of the tumors in our our sense of mostly retrospective.

But they're they're very, very good results. And, and with this because because people always are concerned

about, you know, also cancer stem cells you know, so here you are able to, you know, shrink the tumor and can I have the immune system go after the tumor and, and cancer cells.

But is it also effective then against, you know, the there's no sermon yet to prove that.

Integrative Treatment Strategy and Patient Access

But we cover ourselves and we provide our patients all of our patients take, metformin, because the performance has been proven to kill stem cells. There is these two products by gel Cincy.

So the answer is yes. Yeah. We're studying that. And they have very compelling information that we believe is well produced that, that and they've been able to prove in the laboratory that kills malignant cells is natural.

So, we are we are close to making a decision to change to this, to natural products in the very near future. Yeah, yeah, I yeah, she she's a dear friend of mine, silver bull Jansky and.

Yeah. Yes. Yeah. And they, they send us information very compelling, very well done. And so I think that soon we're going to do that because we the nobody has studied and it's very difficult to study whether a product will kill the stem cells.

We know that chemo radiation most natural therapies don't. And so the the the science behind metformin is very solid. But if we can use something that is natural, that's what we're going to do.

Yeah. Yeah. No it's it's phenomenal. And they're using well-respected you know Columbia University. Yeah. Well respected universities to to run these studies and yeah.

So that that's amazing. Another point you're making kind of earlier in our conversation is that. Yeah, we, we are not all this or that. You know, we're not all, you know, holistic we're not all, you know, traditional oncology.

Right? We've we found the appropriate path for the patient. So how how do you determine, you know, because you use some chemotherapy. Yes at Oasis as well.

So what does that look like. And is it there. There's several criteria. The easiest one is where a therapy shines. Lymphomas, non-Hodgkin's lymphoma. Even in stage four, the curators around 90% with chemo.

Why should I think about anything else in a patient with lymphoma? Now, if they do not respond well, well, then we have a backup. But so that would be one where, a therapy that is established conventional, that has proven to be very effective.

We're not going to be fooling around. The other one is how, threatening a tumor is to a patient in in how short of a time? So if we have a large tumor, that's blocking the main airways, the patient can't breathe.

And I'm going to say I'm going to give you this dendritic cell vaccine, which takes about three months to work. Well, the patient is going to be dead in three days or four days.

Radiation therapy may open. That may open up those airways within a couple of days. So I'm going to do radiation. And once I the patient is breathing, well, now I go to the alternative because I know that the radiation is not going to save that patient long term, but it's going to help me get the patient breathing the same.

If I have a patient with a colon, I can't give him the diet. That would be the best because the patient is going to die. So we're going to do it resolve the plumbing with surgery.

And in and so the criteria is very easy. But if you don't have the tools, well then you lose the patient. Yeah. Yeah. Exactly. That's one of the things here at the Oasis.

We have everything available. Yeah. And there are a lot of ways to then administer chemo, for instance, you know, there, you know, you have where you kind of do the full dose all at once.

You have, you know, metronomic, you have IPT and so there are a lot of different ways. I mean, what are your thoughts in regards to the best way of, of utilizing chemo?

We use, low dose chemo. It's not metronomic. It's low dose in, in for instance. And the the product that we use for all patients is capecitabine. And we've been criticized by many oncologists because they don't get it.

Why are you using capecitabine in, in in cancer of the ovary where it there's no studies that prove that it helps. Well, what happens is that when you use a low dose chemo, all tumors are going to be a little bit affected by it.

And that's like the the tumor is hiding in the tumor suddenly, you know, brings up the head and now the immune system can see it. So we use it more for that purpose than anything else.

We use metronomic chemotherapy, cyclophosphamide. Because it's proven to reduce the amount of T regulating cells which the tumors produce to fend themselves from the immune system.

They use the immune system to protect them. And so if, if we're able to make the tumors show up with, with some chemotherapy and with other chemotherapy, reduces the to regulating cells, well, we're going to be more effective.

We use it for the purpose of prepping the patient for the vaccine. We did like ten clinical trials with IPT using, you know, the conventional, combination in metronomic dosages with very, very poor results.

So we stopped that. So another way to use chemotherapy, is, the metronomic with lower dosages, not a 10th a lower dosage, but for instance, capecitabine where you have to give it for, periods of 15 days with seven days of, of rest.

We use a metronomic and metronomic comes from from the metronome. You know, when you study piano or music like that so that it's constant. So we use a lower dose of capecitabine every day.

Most of the patient is a 90, maybe 85% of the is well tolerated. Very well at those so visitors, you know, and then the conventional way. But preconditioning the patient beforehand.

So we do detox, we do immune stimulation. We do a lot of preparation so that the patient will have less collateral damage when you use the chemotherapy.

Because for instance, in, in, in, in, lymphomas, we use the full dose conventionally because it's been so effective. But in our hands, as the patients suffer less, so they have less side effects, better results.

Yeah. And that that's the beauty of when you have an institution that's able to kind of recognize the importance of, of the immune system and prepping that and cleaning up the terrain, you know, so that when you go after the cancer, then with with chemo that you're going to have less damage.

You know, the body's going to be more protected and you have more effect. And then then on the cancer at the same time. Yeah. So so then after we, we do a game therapy to repair the collateral damage.

Yeah. Yeah. Exactly. And so you know with that so it seems to me when you're talking then about the chemo, it's almost like you were, you know, when when you use, you know some of the, the metronomic.

So you're using, you know, some that you're using it almost to educate the immune system to, you know, to kind of stipulate that a little bit to show itself.

Yeah. Yeah, yeah. So it actually becomes almost like an immunotherapy. I mean, you're, you're always this is part of the immune therapy. Yeah. Yeah. That's that's fascinating.

And then you can then build on that. Then with the dendritic cell therapy that, that that you're doing. Right. So they can kind of build, you know, up on each other.

They work synergistically. Yeah. And then you also have I mean, in addition to all of that, obviously you have the, you know, the vitamin C IVs. Yeah, I even I mean, B17 we have hypothermia.

We use all of those, ozone therapy. We use a lot of ozone therapy here. But the main anti-tumor therapy, direct anti-tumor therapy is vitamin C. High dose vitamin C has proven to be very effective.

And I'm curious, since since the whole journey started with B17, I mean, what is what is your thought about B17 and what do you it is very effective. In when when my father started, our five year survival rate in stage four was about 1,718% in comparison to to at that time.

But the question was always, well, if we're effective in 20%, what's what were the other 80? So we've been, you know, developing our therapy and adding things to our therapy and chipping away into that.

So we're now close to 40% all tumors, all or all stages, five year survival rate. And and I want to, you know. Erode that percentage is still very high.

The patients that you can't help but so that's why this is exciting. And we never stop developing our therapies. Yeah, I love it I love it then. And for, for people that are, that are interested, I mean, that, that are needing your help.

I mean, how, what is kind of the process that they need to go through in order to be able to become a patient? You can call us or visit our website. It's Oasis of hope.com.

And, they will guide you. And then you can call us and, and we have, an admissions department with doctors that we will consult with you. The the first consultation is free.

And, once we know you, then we will propose a, a protocol that we believe would be the best for you. And of course, once the patient comes here, then we do the complete evaluation.

And sometimes we are we are just what we said, on, on on the letter or the phone because we have the patient and we have, you know, true information or, or or very, very, good information about the patient that we might, you know, adjust some of the elements of the therapy according to what we see.

Yeah. So wonderful. And obviously, in addition to going to the website, you know, they can always get your book, Thank you. Yes. Yeah. Is the art and science of undermining cancer strategies, you know, to slow control, reverse.

Yeah. So, yeah, it's it's a phenomenal book. Yeah. Well, thank you very much. And if you don't mind and if you have your viewers call you, we can offer them as many books as you want to give away.

You send us the name and the and the name of the patient. I'll sign them and we'll send them, to them within the United States. That's their job. But we have people looking, you from many parts of the world, but for free within the United States.

Yeah, that's very generous, very grateful. Well, Doctor Contreras, it's been amazing. Thank you for all the work you're doing for, you know, driving science and, you know, and and the art of addressing cancer or, you know, and because it's truly an art and and thank you for driving that forward.

Thank you very much.