Introduction and Guest Welcome

Hello, everyone. Welcome again to the Prostate Cancer Summit, where we have another amazing episode with our special guest, Doctor Paul Anderson. Doctor Paul Anderson is a naturopathy oncologist renowned in the space of naturopathy oncology.

Been in it for a while, right, Paul, you've been you've been in it for are we senior people in our profession? What's considered a senior member of naturopathic medicine?

You know. I, I think I think now we are. Yeah. Wait, you're saying we why are you including me? I well, why why are you including me in this scenario?

What's what's the number before you become, I don't I don't know the number, but what, what I look at is who who is left, who is, you know, been around longer, which there's some, but it's getting to be a smaller number also.

So, by default you become. That, right? Okay. Okay. If it's 20 years, then that I'm in that category because I think, oh three so we're. Yeah, 21 years in, so.

See and and if also, you know, we have a small profession, but it's so much larger now compared to 20 years ago and certainly compared to 30 or more years ago.

Right. That just just by a numeric default, you, you're, you're in the, you know, one three standard deviations away from the median. So. Right. Exactly.

You're rare regardless of what, well, I, I'm fine. I remember we're looking up to the doctor sense in a great year. Like, this is a year for, of our profession.

And, like, I look at Jeff and I'm like, you know, Paisano, I see him all the time. Was like, man, these guys are like legends. Like, they don't consider themselves, like they're just doing what they do.

I'm like, you don't understand who you are. I just amazing that you're still here. And I want to take photos and selfies with these people. Or, you know, it's like, man, hey.

Yeah, you guys were in the battlefields back early. Early in the days, thinking of battlefields you deal with. I mean, it's amazing what you do. You deal primarily with advanced cancers.

All cancers, and certainly prostate cancer. That's advanced. The most people deal with, you know, low risk prostate cancer, you know, low Gleason scores, perhaps intermediate risk, even advanced cases are not that advanced all the time.

So if somebody has an advanced case that's, say, Gleason nine or or something, that's not that advanced. I'm talking about metastases. Metastases, you know, to the bone and beyond the bone to lungs and brain and things like that.

So you deal you deal with those. So let's start here, Paul. Why why you do what you do to me. Like what got you to say? You know what? I want to be challenged.

I want not only cancer cases. I want advanced cancer cases. Why? So it, at least consciously, it was not a, conscious decision to say, oh, this is what I want at least long ago.

The in in those days, you know, like three decades ago, there were so few of us.

How Paul Anderson Entered Advanced Cancer Care

And the normal referral was somebody would go to their oncologist, they would say, we've done all we can for you. Go make yourself comfortable. If you want to seek alternative care, now's the time to do it right.

So the only people we saw were die you know next to death etc. which is not a great, you know sample size but it really makes you learn quickly where the guardrails are and all that.

And, and so literally my early introduction to, you know, clinical medicine in the oncology space was that. And it was not like, oh, here, you know, here's some prevention.

You can do it all that it was like, you're what can we do to help you? You know, be more present and have good quality of life. So, so it kind of started that way.

And then we sort of went in reverse, where people now start to seek out people. You know, earlier diagnosis and prevention all that. Well, I think just it's one of those things, just the, you know, luck of the draw or timing, because that was the primary group of people I saw were very advanced cancers.

Then you sort of reach, well, I'm half or one generation, you know, older than the, the bulk. Then it's like, well, okay, we'll take care of these and we'll send these other ones over to people like Paul.

And there's, there's a group of us that are, you know, kind of they're, and I think that's kind of how it did, how it happened. And then what really cemented it was, and I always get the years wrong because it was kind of a blur of work.

But when I was, I was full time at Boston University for five years, and we had a collaboration with the Seattle Cancer Care Alliance, which is U-Dub, Fred Hutchinson, Seattle Children's, etc..

Big, big stuff, you know, and we had NIH funding and we had a the collaboration was our center was going to work with people who wanted integrative care and then all those other places.

Did, you know, standard of care. And it wasn't that we excluded. It was do they want to add on integrative care? And our only outcome was do they live longer with x, y, z cancer?

Okay. But then within that I was five years NIH funded. And we have so much as many things. This is ended up in 20 right 20 1516 something like that. We have so much data that still has never really been published like they came out of it, but I've tried to like, teach doctors what we found out.

But anyway. I was like, why was that? Is that data not published? Well, what happens, for those who have never been in a research sort of bubble, the so I was not a pi.

I was in charge of a section, but the PiS control everything. So we had a. PiS principal investigator. From the, CCL cancer care side and from the last year side with copies.

And what happens is they're churning and doing all this stuff during while they've got funding. And then there's publications that come out that you know, it's like, what can we get out, you know, the quickest.

And then if you're if you're in that world, you're on to the next thing. When this when this ends. And so what happened was, which they didn't really kind of put in the calculus, which was good for us as far as investigating things with humans was I had the interventional whole part, which included I. V.

therapy and all this stuff and, and the, the, the IRB, which in, Institutional Review Board, which allows you to do human research and what to do was, essentially unrestricted in that sense because they didn't realize what we could do.

But they'll never make that mistake again. So we did like a lot of things that drug companies now have, not because we gave it to them, but because they worked and drug companies saw our data and took them.

So what really happens is we were doing whole practice. So there was acupuncture, nutrition, mind, body, every other thing you can think of. And then there was the interventional stuff with IVs of mostly natural substances.

So what happens is it's easier to publish, you know, basic survival data and these other things. So that's what comes out. But then NIH money ends and your peers have gone on to the next thing, unless someone just takes their own time and, you know, and publishes, which I've tried to do, and, you know, I've written books and put it in there and stuff and talk a lot.

You just don't see the rest of it come out because it's it's all still there. So. But what I got there, though, was because they said, well, your interventions like intravenous therapy is different from primarily different from nutrition and acupuncture and herbal medicine and mind body and all of the other parts.

We had. And I said, what was that mean? And they said, well, you're only going to get stage four cancer patients, right? And I said, why? And they said, well, because it's harder to prove in a sense, in somebody with a lower stage grade cancer, which is true.

But that was my whole career up to that point. So that didn't bother me. It's just that really cemented sort of that reputation as well. This is where those people go, right?

And we had, you know, collaboration with, with people who are involved with prostate cancer. And it was the same thing. You know, if you're if you're at active surveillance and you're, you know, all of that, you're going to stay in this area.

You don't need to see Paul. If you get metastases high stage grade, we're kind of beyond the surveillance thing. Let's see if Paul can help you. And so that really was sort of a turning point.

And for better or worse, having NIH funding to do it and all of that, you know, not in the eyes of a lot of oncologists, which gives you a little bit of cred, you know, to, to to do those things.

So I think and the thing about it was there was nothing terribly remarkable that I learned that I didn't already know. But research forces you to be critical and to keep track of your data and do all of this stuff and that.

That's where I learned a lot of lessons that I've tried to bring into practice now. So I think that's how, you know, I probably wound up getting those, those tougher cases.

Lovely. And it's such a pleasure to call you a colleague and a friend because, you know, your your information is just top quality. I've been at your conferences as a speaker and also as an audience member, and it's just really top notch.

In terms of, you know, the scientific rigor, clinical outcomes and all the things that we're all looking for, from, from a natural or integrative perspective.

So, I always thank you so much for doing what you're doing. We were talking before we started recording. Hey, how's your health now? I'm saying it for selfish reasons.

How's your health? I need you to be around for a long time because I know it's it's. I mean, I my health is better than has been a long time, so. Yeah. That's right, that's right.

My goals are all about staying here for a while. So yep yep. Yep. Good, good. You do it. You do it for selfish reasons. And I'll ask for selfish reasons, too.

Because we need you. We need you and your quality of work for as long as possible. So a guy goes to you with

stage four prostate cancer and stage four three advanced prostate cancer has different definitions, actually.

So even somebody with, for example, a Gleason nine that has, let's say, you know, invasion in the seminal vesicles that's advanced, you know, if it leaves a prostate, it's a advanced prostate cancer.

If it's if it's even Gleason nine encapsulated, it's not stage four, but it's like T3B it's like, right there. Recurrences, obviously, once it leaves, you know, even if it's in the lymph nodes, which if it's in the lymph nodes is not such a big deal as long as you catch it early with imaging and so forth.

But then it gets to the bone and then beyond the bone, it becomes a bigger issue. You know, it's so soft tissue, it could metastasize to the lungs and brain and so forth.

What do we what what's the process with that type of patient? What do you do and how do you do you work in an integrative fashion where they do whatever they do conventionally hormone therapy or chemotherapy.

Or do you just take them along and they say, okay, you do, you know, only natural methods. What's the approach? Right. So, generally speaking, with somebody who's the the cancer has left the area.

It is now, you know, around the body in various places. The each, you know, and we talked about this off line, you get six prostate cancer patients, you have six different prostate cancers. Yes.

You know one. Yeah.

Integrative Treatment for Advanced Prostate Cancer

And and when you get over to the world of advanced prostate cancer, I always tell people it's actually a different cancer. It's prostate cancer that's not outside the capsule is one prostate cancer.

Prostate cancer becomes aggressive, which is the only things I get referred. That's we should call it something else because. I would even break it down like this.

Poor prostate cancer that's encapsulated. That's one cancer. Prostate cancer that metastasizes not yet to the bone seminal vessel vesicle lymph node. That's right. Bone.

That's another type of cancer outside of the bone. That's then that's something even more so there's like four different types of advanced prostate cancer.

Yeah. Yeah. And I would say the only people I get are three and a half and four in that group. Group. Right. Exactly. Yeah. Exactly. Okay. So and I think this is a good because it's the exact discussion I would have with a patient is look, you know, and this is not uncommon X number of years ago when you were in active surveillance.

These you know, you you maybe you change your diet. You do these nutrients. You do this other stuff, you did whatever urologist was doing and you were good to go, right.

Things were cool. And then all of a sudden, boom, you know, it's like this new thing happens. It's spreading. The regular stuff is not controlling it.

We need we need to sort of match the aggressiveness with what we do for interventions. So the first thing is when it comes to, you know, do you mix and match with the standard oncology approaches, etc.?

The answer is usually yes. I mean it depends what it is. And I would say one really, you know, not universally, but a good thing I've seen change over the last three decades is oncologists are getting more realistic with their patients.

And so there comes a point where, okay, now we're we don't even have statistics for how our therapies are going to work here. Because your aggressiveness is at this level.

So we could do these things. They might help, they might not, etc.. And if we do, here's here's the good in the bad of it. Right. And and not always. But I've had a lot of oncologists now tell patients look it up to this point I would do everything from the book right.

At this point you have some decisions to make because you're balancing. I know I can give you a lot of side effects of this treatment. I don't know if I can help with your cancer at this point, you know, and and sometimes there's palliative things that have to be done, such as focal radiation or, you know, other stuff.

That's a whole other follow ups. Yeah. So each person's calculus as far as are we including, you know, the more advanced chemo and and biologics, all that.

Sure. If they have a good chance of working. Because here's the thing. What you and I do can not only make those things work better, but can protect the normal tissues that don't have cancer.

So the person's quality of life doesn't just completely go, you know, down the tubes while they're doing a more aggressive, you know, traditional oncology therapy.

So that's really a very individual discussion. And, and I'm not for or against anything. I'm, I'm for what's best for you right now. So essentially what we are helping I think we're doing two things.

I think we're helping the good cells stay healthy, which is very important. Paul, I do think that we're we're trying to look, I at this point, a lot of prostate cancer patients I see nationally, globally and they go back to their doctors.

How do you treat prostate cancer with these natural methods? My God, they're doing so well. The quality of life is better, I can honestly say, because I have no evidence that I'm treating prostate cancer like I don't know what's happening there.

I really don't know what I think it's happening is that we're treating the healthy cells, but we're also trying to create a micro environment that's hostile to these cells.

Very much so you have to if for cancer cells to spread and move, they need a favorable environment. Well, we try to make it unfavorable so they don't attach to things and move around.

And I think that's one of the elements that, that, that we, we help, you know, maybe the, the radiation that kills the cancer. So I don't know that I kill cancer cells.

I don't know, I have no evidence for that microenvironment. And, you know, keeping healthy cells healthy is what what we do I think. Yeah. Yeah. And I think that that's a real critical thing that, you know, from a patient perspective, I mean, cancer is very confusing.

You know, if you're the patient and also you don't want that diagnosis. So it's overwhelming. What you just were talking about, about the microenvironment is that is literally the battleground.

Even if you have wide metastases where you win or lose or where you gain quality of life and length of life, that's those are the two things that we know can be affected the microenvironment.

And and now it's in the tumor biology literature much more than it used to be. So one of the things that we know, and this is not you know, this is not a slam on certain therapies, but it's very well published, is if I give you radiation therapy or chemotherapy of a traditional type, I will engender stronger cancer stem cells.

I will weaken your regular cancer cells. But the stem cells get stronger. And that's been in the literature all along. And it just gets stronger. In the, doctor, Stinger and I wrote Outside the box, cancer therapies were the first book I know of to actually take that research and summarize it in a, in a textbook.

And the reason that I wanted to make sure that got in there was not to be a bummer to everybody, but like to

underscore, it's great if we knocked down the major, you know, tumor cells.

But this battleground of the cancer stem cells and the microenvironment, that's where long term you win or lose. And what what you and I do affects that in a way that standard therapies can't do.

Right. There is not a biologic drug or anything. It's going to go and undo, you know, what traditional chemo and radiation does. So it's it's it's like everything can be good.

But why not support your microenvironment and keep you as healthy as possible? I always tell people you got way more normal cells in cancer cells or you wouldn't be here.

We're mostly interested in the normal ones staying really healthy and not being recruited in the tumor microenvironment over to the bad side, which can happen.

Right. And so so that is a big target. And I think, you know, we're we're you're saying, well, you know, we can't prove that we actually reverse a tumor process or something like that.

Generally. But integrative therapies like we do definitely affect those things. Keep the cancer stem cells very quiet, not wanting to do anything. Keep the microenvironment against recruitment, against cancer.

You may still have wildly aggressive cancer, but it may slow it down enough and it may open up your normal cells to work better. So your quality of life is better than usual.

You're length of life is better too. So. So that's from a, you know, from a the tumor biology perspective. That's why what we do works. It's just what you might do with an active surveillance or earlier stage person.

We kind of have to kick up the intensity quite a bit when it gets outside in the bones and beyond. Right. And and like I say, that's where that's where my, where my experiences.

So what I notice there though is to, to kind of dial back a little bit, you might see them. Okay. What is it about these more aggressive cases that may take the, you know, the practitioner has to step back and say there's tumor biology that we understand reasonably well, but what else is pushing on that?

Like once it's gone into the bones and beyond, what things can push on tumor biology to, to literally kind of pour gas on a fire. Right. That's when a literal you could call it holistic or whole person or whatever you like term you like to use.

That's where that comes in. And here's the thing that, even, you know, when I'm working with, doctors who do this, etc., practitioners they'll often miss because often they see, you know, the the more surveillance oriented ones in the literature, there are there are pockets of areas that have seemingly nothing to do with cancer that are tied to aggressive prostate cancer, for example.

So, so just one area and I'm glad on the areas I, I like to look at, one area is infections. But what's interesting is there's well over I'm going to pick a low number, just, you know, so I can be conservative, well over 30 peer reviewed publications and is probably 100, but let's say 30, that talk about aggressive prostate cancer and it's not.

And here's the thing. And this is what researchers do because I understand it. You're looking for the holy grail. You know, it's like everyone's, you know, Knights Templar or something, looking for this holy grail.

And you want to find the one organism that causes prostate cancer, but you're doing it all around the world. So if you look at all that, read all that research, which I've done.

It's not one. Everything they look for that is a bad, chronic infectious agent has a relationship to aggressive prostate cancer. And it's not from just bacteria.

There's viruses, there's parasites, there's fungus. And do you know anything bad they look for? They find okay now there's some this is. It's something very similar like say human papilloma virus and ovarian cancer and things like is it something similar to that?

You know. I, I, I think two things got them looking and then it led to this sort of, you know, as you know, with subspecialty research areas, you'll find the same authors involved in half the papers.

Right? So I think what started was, was really two things. One was we know in other cancers there's viral triggers etc., you know, or pylori and you know, GI stuff.

Hap v and and but. You have yeah happy and you know, liver cancer etc.. So we know that cancer. So the first thing was does that exist with prostate cancer.

So they just start hunting in the viruses. I think one of the first places they look, but then they also I, I this is my assumption based on the way they language things they're looking at.

Well, what are other chronic things that prostate has problems or chronic prostatitis etc.. What do we find there? Well, we find all sorts of weird, you know, organisms in the seminal vesicles and stuff.

And do they have any relationship then to advance prostate cancer. So they start looking at that and it just it just mushrooms out from there. But here's what I would tell patients is okay.

So the researchers didn't find the holy grail. There's not one bug we can kill. But there are chronic infectious things that we all carry around. But once our immune system gets beat down because of treatments or, you know, when you have advanced cancer, it's not working the right way, etc..

Those infectious agents just are unchecked. But what they do is not necessarily cause cancer, but they mess up your immune system in a way that is, again, makes it easier to have more cancer.

It makes the tumor microenvironment more pro cancer. So infections are a big area. But what I always tell patients is let's look at the, you know, the more common things.

But let's also look and you know, just see. Or do you have this, you know, super high chronic inflammatory marker rate. There's probably brewing infections.

And it's not that maybe they didn't cause the cancer, but they're permissive. And killing them is not going to make your cancer probably go away. But it's going to take away another guy pouring gas on the fire.

Right. And it's like 20 years ago or more that was considered like lunacy and heresy and all this stuff. And and I didn't care. We just we still did it.

Now we have all these papers and it's like no one reads them except the guys who write them, I swear. But yes, that's true. Yeah. That's true. We have all this research and I'm sure those researchers are probably like, hey guys, you should really listen to this.

You know. What are your thoughts on, and this is like fungal infections as well. Is it is that part of the potential issues? Definitely like every category of infectious agent that they test there's relationships.

Yeah. And and so and this is another thing that it's something that I definitely do nowadays with advanced cancers of any kind, especially prostate. This is an intersection, I think, a good place to bring it up.

A lot of not all, but a lot of the repurposed oncology drugs or off label oncology drugs that are real hot now. And because of the internet, people read about them.

A lot of them are, repurposed anti infectious agents, a lot of them branded parasitic. But here's the thing that, so I

always tell people I'm a recovering, pharmacology professor and biochemistry professor.

So that's dear to my heart. Pharmacology. And it's almost all out of me. But I still think that way. What people miss, and especially now with the internet, it's like you can say whatever you want and people believe it, so, but what they miss is if you look at the mechanism of most of the drugs that are anti-parasitic or even the antifungals or, you know, stuff, yeah, they kill things great.

But they're also immunomodulatory substances. This there's almost no useful repurposed cancer drug that's not immunomodulatory. Okay. So it might be doing two good things at once or or multiple.

One is maybe killing some bugs that are there, but the other is making your immune system has to ebb and flow. When you have cancer, it's sort of ebbs and stops flowing and it's like high here and low here and it's stuck.

So immunomodulatory substances trying to get you back there. If you take the bugs away, it's easier to get back there. But also a lot of these agents, you know, whether it's the, the vendors, all the, you know, then submit is all category, mid-band is all albums, all etc., or any or the albums or the whoever most kill things, but they also are, you know, modulatory.

Microenvironment, Infections, and Toxic Exposures

So that's another, you know, it's another avenue in. And again, what I tell patients is like, there's there's a lot of repurposed cancer drugs. Our goal with you is if we can layer we know you've got these bugs.

How do we know we have these bugs? Well, the largely from largely from testing which is is limited. As I'll also tell patients for every one bug I can find, there's 30 hiding next to it.

We don't even know how to tell exactly. So would that change treatment? Wouldn't you? Do still anti infectious agents, even if nothing. If you if you're one of the people who get referred, you know, to someone like me, at this point I'd probably just empirically do it anyway.

Okay. This is like the research is, is big enough now to say you've got something. Okay, but why don't we choose things that we know also have an anti-cancer immunologic effect, and we'll kill somebody at the same time?

And and usually we do that in a particular way and all that. So, so that's a big area like immuno modulation. And you can imagine if you have chronic infectious things that are going to not let you immunologically, because your immune system is twisted towards infections, and then you got cancer and switched it over to cancer.

So infections are a thing, you know, and but the treatments are more than killing. But the treatments are also helping your immune system. And to your point earlier about the microenvironment, that's one of the things that keeps it anti-cancer is getting the immune system back to being employed and not going too far up and too far down.

Right. So that's one big area. And, you know, I was thinking earlier today because I knew we were talking and I, I meant to ask you off camera, so we'll see if we we'll see if we have the same experience.

Another area with my more advanced prostate cancer patients is not all, but most. If you look hard enough, you'll find a either occupational or other environmental exposure, especially to solvents and other chemicals.

In the more aggressive cancers. And it was it was always more obvious if they were, you know, painters and contractors, when people that worked in, you know, oil fields or whatever.

But also this because I'm in the northwest, we have a lot of aerospace folks, real aerospace engineers, who you think, well, they're working on, you know, CAD designing and stuff, but the facilities they work in are full of aerospace, chemistry and a lot of like, I, I can't remember the last advance to truly advanced prostate cancer person I met who didn't.

Once we dug deep enough, didn't have occupational exposures to these things that people say, well, a lot of people do, and they don't get prostate cancer.

Well, sure, people are exposed to all sorts of stuff. A lot of people have infections. They get cancer. Right now. A lot of people smoke and they don't get lung cancer.

It's it's it's it's did you did you stack up all the wrong things in the wrong places? And then it's like, okay, we've got enough pressure here. Your prostate is going to be where we express, you know, cancer because we screwed up the genome, etc..

So, so toxins are a thing. Now here's and again, as opposed to ten, 20, 30 years ago, you can test more for toxic things. Now that we used to be able to.

And also that leads to we now have research to show these things definitely don't help many cancers, especially prostate. But at that point it's kind of like the it's like the infection discussion where okay, who knows if it caused it was it was not helpful okay.

To have these chemistry around. Why don't we do things at the very least that just keep the door open so your body gets rid of these things at a faster rate?

Maybe you've had 20, 30 or 40 years in a profession or even marinated in chemicals. You're not going to get those, you know, out of a person you know, in their lifetime, probably, but not quickly.

But why don't we make it so that that is less of an issue in your body? Okay. And kind of like with the the infection discussion, a lot of the things that we might do to help your body get rid of or just keep up with the chemistry it's got, are also, you know, potentially anti-cancer or helpful with cancer, but it's because they're doing all these other things, you know.

So on the infectious side, you've got the repurposed oncology drugs, which are an infectious enemy in a budgetary in the world of of the toxicity type things, you'll often get people that will come in and they'll say, hey, you know, I've been, you know, not great with my prostate, but it's been stable for years, right now.

It's not. And they don't know what to do. And, you know, they say it's it's moving. They will come in and say, I want, I want high dose vitamin C therapy or I want, you know, some other, injection type therapy or something.

Well, it another thing that a lot of those therapies, especially vitamin C do is they really support your body, eliminating a lot of junk. Like there's the there's the known kind of name brand reasons used to identify them and see which might be the, great, you know, peroxide surge and, you know, assault and cancer cells.

And it turns out that the same vitamin C is helpful of normal cells. Great dream. But it also does a lot to help your body get rid of junk. It makes it harder for the bugs to live there.

You know, it covers a lot of bases. So, so I think that like, and there's other areas too. But if if I just look at every prostate cancer patient, you know, every guy who came in that it was like, and usually it was stable, stable, stable.

And then, you know, it blows up. Toxicity was almost universal. Infectious things and immunologic damage is almost universal. Or you can't have that sort of cancer.

And so why not do things that help your body with that fight, right. To take as much as possible? So, you know, there's other things that we see with folks who have had that.

But but if I had to pick the top to like comorbid things that, you know, that that keep the fire going, I think by the time you get to advanced prostate cancer, those are the two big ones.

So we talking anti infectious agents. And we can get deeper there in a second. And IV vitamin C not just oral.

Right. So there's a, there's nothing wrong with oral vitamin C, but to get to these biologic effects that that would create and oxidative, you know, space.

And what happens is and this is, this is why I say it's sort of a nice therapy, with cancer, if I give you a traditional cell killing cytotoxic chemotherapy, like doxorubicin or anything, it goes to your body, it will kill all the cells, whether they have cancer or not.

It it encounters. Right. So it's it's good, but it's also not good for the normal me. All right. Vitamin C a high dose within some perimeters will create this peroxide surge.

And with a lot of cancers they don't have the enzymes to take the peroxide away whereas my healthy cells do. Right. So all my healthy cells get is some vitamin C and some antioxidants support my liver, get some detox support.

Boom. The cancer cells, on the other hand, become weakened in a way because of the peroxide, because they can't deal with it. But with this is something that we we now know because we've watched enough people over time that we it's not a caution, it's more of a informed consent thing.

It if if you were to, for example, come in and you had surveillance of all, you know, low stage grade prostate cancer, I would have you focus on all sorts of things.

And you don't really need these sort of high level interventions. Normally, your high grade prostate cancer, it's it's great to do these things. But high dose vitamin C has this way of normally causing what you and I know, a pseudo progression, which is the labs start to look worse in the beginning.

Right. And it's because suddenly there's something going in there and there's an immune war now going on. So we have the cancer cells are weakened. The immune system says, oh, I should maybe look at these guys and beat them up.

The cancer can actually swell and the PSA can spike and go up a little bit for a while with high dose vitamin C, it's not because it's made a cancer worse.

It's actually it's reacquainting the immune system with the fight it should have had ten years ago. And so we always tell people look, the a lot of times though your PSA is follow like they should.

But in a lot of people if you have a lot of cancer burden or your immune system's really been kind of asleep at the wheel, the vitamin C is going to reacquaint your immune system with this.

And and even to the degree you know and with modern scans now we see a lot of stuff we didn't used to, but we'll have people have local nodes light up on a Pet scan that weren't lighting up before, you know, and they get really worried, of course.

And a lot of times it's just, oh, there was, you know, there was metastatic disease there. The vitamin C has injured the cell enough that the immune system doing this beat up job, and this happens in the prostate and or wherever you're got it.

And it will actually it will actually look like a bigger tumor for a bit. Now again, this is something that I learned 25 years ago from, you know, pioneers in this world who are all, you know, dead and gone now.

But, it was really a fringy thing, like radiologists knew about sort of progression. And in quiet rooms, oncologists would talk about. But what I mean, in a situation, I mean, in that situation, everybody's freaking out, including the oncologist, right?

When they see these things lining up. So I don't think either they know about it or the what to know about it or they because they going in even stronger in these.

And if they're saying, well, this happened from some vitamin C who prescribed this guy Doctor Paul and that guy is you know, it's like how sorry this is going the wrong direction.

Honestly. It's so I guess learning the hard way. Always the best. Right. These are now conversations that we have on the front of the people, and we explain all of this, but the only thing in our favor really is about somewhere between 7 and 10 years ago, a particular category of biologic cancer drug was developed, and it causes pseudo progression.

And so suddenly oncologists had to be taught about pseudo progression. So they didn't freak out when they gave the biologic drug. And when I teach this to in and I wind up nowadays, you know that some of the barriers are broke down.

I teach to medical doctors and, in doctors, but all kinds of practitioners. Right? I use pseudo progression slides from the company that made those biologic drugs, because they're the most beautiful things you've ever seen.

And they show it's like, yes, the tumor got bigger, but it's mostly immune inflammatory response against the tumor. And they have these different colored things.

And and I give them credit of course. But it's like now it's not a fringy thing. It's like oh that pseudo progression. So now at least we can say, okay, dear patient, this may happen here.

This is known in the world of, of targeted therapies with certain drugs that happen also. But we've known about with vitamin C forever. So if this does happen we need to use specific terminology.

It's called pseudo progression. And people will say, well, how do you know if it's pseudo progression or real progression, which is a legit question. And the answer is and this is another thing like, I mean, I have to give them credit in order to keep selling those drugs.

They had to educate everybody about this. So they came up with these little charts and it's like and it's sort of basic medicine 101. But okay, I my imaging looks worse and maybe my PSA looks worse, but are all the rest of the physical and lab characteristics of the patient improving or not.

You know, are they getting sick or are they having negative things. It's probably real progression. Are they just having this imaging and and PSA anomaly.

But everything else is getting better. That's kind of pure pseudo progression. It's still a fight though because like you said earlier and believe me I've heard exactly what you've said.

It doesn't matter that now we know that the A category of drugs do this. They will still look and say, well, the vitamin C is not that biologic class, right?

So it must divine is he must be making prostate cancer worse. So you have to do this ahead of time. You have to talk them through it. And the other thing is, the more toxins you have sequestered and the more infectious agents that you don't know you have, the more the inflammatory response is.

And if you if you think about it, you know, and this is all cancers but breast and prostate are really good examples. The in in some cases now especially you can start to prostate.

We have infectious data but glandular tissue loves loves chemicals chemicals love them. And they just stay there. You know they'll marinate. And so imagine the poor prostate cells trying to do the right thing.

And the you know, they've got all these solvents and things hanging out. Well, now I'm giving you something that helps your body, you know, to recognize and deal with these problems.

Of course, you're going to dump more PSA and you're going to, you know, things are going to swell up, etc.. So so

it's a conversation you have to have ahead of time because as we all know, if you tell a patient before something happens that, hey, this, this thing that looks scary but happy, okay, it's less of a problem if you don't tell them.

They're not going to believe you. If you come back and say, oh, that happens all the time. The other thing is that they cannot work with medical doctors in that situation because they're not going to play along.

So it gets tricky for the patient. They have to choose their doctor. Are you either going to go with Doctor Anderson or Doctor Espinosa or the oncologist?

Yeah, it's it it becomes and I mean, you and I both know there are instances of colleagues we have in the medical oncology world that, you know, have developed trust and, you know, might go with it.

But by and large, yeah, if you have a just a patient with the rest of the 98% of medical oncology, they're just going to freak out and say whatever. And so the discussion that I usually have is, okay, how how far along the trail are we considering?

My patient started a pretty far end of the trail. If you're in a place where all they might have are experimental treatments and other stuff like that, you know that they're going to be a little more hands off on the medical oncology side.

If you're still under active, say, traditional chemo or some, therapeutic radiation or whatever. It's going to be a different conversation. And the way I deal with it after all these years is like, it's it's still your body.

I'm going to explain to you why these things might happen. You got to decide whether you want to do this or not, because it might happen. But if it comes down to it in your oncologist says, well, this is why you shouldn't do all these things.

That's that's not that specific advice. And it should be your body. You decide how you want to move forward. A a portion of our patients are the oncologists aren't doing it time.

You know, they're doing energy deprivation. Maybe, they're doing, you know, a couple things, and they're watching the thing. You know, they're getting at least, you know, their imaging done.

And then there's people at all other places.

Vitamin C, Pseudo-Progression, and Patient Communication

So, yeah, it's, that is a and I guess I for, you know, I just don't think about it that much because that's been my only reality is advanced cancer. Pretty much.

That's part of dealing with it is the fact that, you know, we're kind of beyond the window of what traditional oncology can do at this point or if they are doing something, you really want us doing our thing to protect the rest of you from it.

But yeah, those sort of discussions, I just make sure the patient knows. I tell them exactly what you know, College is going to tell them. Yeah. And, you know, the logic that will be used or not used.

And then we just, you know, move on. And and this happened in the research thing because we were partnered, I had way more traditional oncology people working.

I was working with some folks like us and there were only two categories. One were people I could share data with and they would say, And this was like to the chief of oncology somewhere, and they're like, I didn't even know that data existed.

Okay. Go ahead. You know, it seems seems like you know what you're doing. And the others were just sort of

morally, literally had one person say they were morally opposed to what I did.

And it was like, well, you know, and we got in this kerfuffle one time and I was like, well, wait a minute. Like, how much data do you have for this fifth line treatment that you'd recommend.

100%? Yeah, exactly. And I was like, well, so we're on the same footing, you know, let's let's at least be honest about it. Yeah, exactly. We came up with some other reason they didn't like me, but, I mean, it was, but they they called me privately, like, literally on my cell phone.

This is off the books, right? We have the big fights on the books. And they were like, all right, I still don't agree with what you do, but I will tell you, the patients I share with you are much healthier than all the other ones.

And I'm intellectually curious. But then they retired two years later, so they got to retire with their. Yeah. And look, I think it's a generational element.

I am cautiously optimistic. Now, urologists, they are my friends. These people we ride and die. Yeah they are. They love what I do. They send them to me.

They do. Well, no problems with your oncologist. That's a tough nut to crack. Yeah. Now, there's a newer generation there. I'm thinking that, they just think differently.

And a lot of the younger people just are more holistic. Just from whatever. From their life, from reading, from the internet, from whatever. So I'm cautiously optimistic that there's going to be a lot more of integrative oncologists, even if they don't call themselves that.

So there could we could we can at least have better conversations about and be real with each other like, yeah, yeah, we're all trying here. And this is a tough thing to, to to know, to treat.

So let's just figure out how to work together or what are. And we'll end here because, man, we can talk. We can talk for a while. What are some of those and, anti infectious agents antiparasitic, both natural and, and pharmaceutical that, you'd use.

Yeah. So, there are, there are so many categories now. So there are the, the ones that have the most press in the standard oncology world started out more, insulin manipulating, you know, like metformin etc..

And then we, you know, we might see someone using berberine or hydro berberine, the active form, for a similar reason. And those are not, they're immunologically modulating through, through the insulin channels, etc., but they're not as much an infectious agent.

But then you look at like and then on the other end you've got, autonomic drugs that we might use for blood pressure or neurological things, and they don't have a ton of, you know, you know, like an infectious effect.

Everything in the middle are repurposed, some kind of ineffective drug. So most people at this point have heard doxycycline, a common antibiotic, family from the tetracycline family.

It turns out it also, does some manipulation with the way that we metabolize, in our cells. And it turns out that that could be used to, to aggravate cancer cells in some cases.

So that's was before it was thought of as primarily anti-infective. And then I think largely from urology and dermatology, we knew it was also an inflammatory, but it's an immunomodulatory in addition to killing bug.

So but it's also, it's a metabolism manipulator. Okay. So that's an example from the antibiotic world. But then you get to the antiparasitic, which are a big category. And the in in the US, the bends the midsoles, which includes, knee benders all in albendazole and then in Europe and then dissolve it in the US.

That's an animal only drug. But really they're very similar. They're, they're just made in different generations. Yes. They kill, they, they kill parasites in a few other types of organisms, but they also are really immunomodulatory.

Then there's a category and it's it's always interesting, like, if this was pre-COVID, I could say this category. No one would have ever heard of it. Covid is cause everybody hear about it with really weird connotations.

But the the, category is called the AVR ivermectin family. And it includes ivermectin. Okay. But other things, there is a, cousin of ivermectin that is not used in the US but is used in many other countries, specifically for cancer.

It was developed as a anti-parasitic drug because it was supposed to be like the the better ivermectin based. And I know, you know, now like you, you know, now we talk to people all over the world, people are using this drug.

And it was primarily like it, you know, it was like, well, how many parasitic infections are we going to have that we tried on cancer. It really works well, that category.

And there's other relatives there. That category. Yes. Kill some some bugs. But I truly think it's the immunomodulatory effect of it. So this, this sort of next generation better, you know, ivermectin mostly is used for cancer.

And it's because again, it brings immunological agent in and then you. Get what's the name of that drug, of that. It's called in it's real similar name to another cancer.

Drug that is not the same at all. So it's so endo mycin. Which sounds a lot like about three other drugs, but. Yeah. So I know my CIA, I believe, and it's it's actually structurally related.

It's an inactive. Drug and no selenium in it. The name would imply that. No. Okay. No, it's, it's just the way, it's, it's the biochemistry of the way it looks.

Okay. So it and again, it was it was made to kill bugs. Right. And then they thought, well, this is a real big immunomodulators. Let's put it in. And then you have, you know, you have some antifungals in the tri Asal class that, work in there.

And again, they so these trials, what most people have heard of, so, you know, like keto or, Keto keto, keto. Right. Which is which is used in prostate cancer.

Yeah. Actually more as a anti androgen. Yeah. It's so you look at that whole triangle family like keto and it's recognizable and you know, it's got even stronger cousins.

They initially and this is this is like so yeah they kill fungus. But they also do this androgen blocking thing that we sort of discovered after we learned they killed, you know, fungus.

But also it turns out that they do they do some beyond their hormonal manipulation, which is stronger than most people believe. They do some, immunomodulatory action as well.

And so again, in, like in, in your world, they might use it, you know, in the prostate cancer setting and more on, you know, looking at the androgen manipulation.

But they're probably getting immuno modulation as well there. And another that's not it's, it's definitely, you know, off label sort of thing, but it's very common in the world, but it's not as effective.

Is using instead of high dose naltrexone like used for addiction and stuff using low dose naltrexone. And that is now we know a lot more about it at low dose.

It actually goes in. So at high dose it just suppresses opiate receptors. And and it has a real heavy hand which is not what you want with cancer at low dose.

It actually goes in and goes to the the T cells the cell mediated system. And there's all these families that are supposed to bring this orchestration of immune response in cancer to the T cell sort of shift over one direction.

Well, naltrexone at low dose can go in and just sort of push everybody back into where, you know, so they're all working, like they're supposed to. And there's there's actually not as much in this country, but in Europe, there are hardcore medical oncology researchers that are using what us now track.

So the research quite a bit. And it my experience with it is it's like the other things it's good to bring in to help out. It's not going to it's not going to pull all the weight on its own.

Nothing is. Yeah. But it, it's like the, the, the repurposed drug world is only going to get bigger. The idea is a lot of these things are off pat and they're fairly cheap.

We can, you know, mix and match and we can do layers of them. But all of them have usually an immunomodulatory effect. Some have hormone effects, like you mentioned.

And then somehow, you know, like nervous system effects, which actually affect cancer as well. So the, the. So these, these, these drugs do the natural in the botanical world can if somebody wants to go completely natural can they compete.

So warm warm wood. Oregano. Oil or oregano capsules. Berberine any of those things. Can they compete. You know, the short answer is yes. There's a little bit of emerging data, like people actually trying to use them, maybe head to head or looking at that sort of thing.

Repurposed Drugs and Botanical Therapies

I would say definitely if you go to the, the, the sort of OG repurposed drug metformin, which is the only one you see in research a lot of times, you get berberine or hydro berberine.

It can be just as effective. It's sort of an equal transfer. You get two antifungals, so you know, oregano with time and, you know, all the other sort of aromatic herbs, they also like we think of them as antifungal agents.

They kill other infectious agents too, and they actually have some immunomodulatory effect. I'm always cautious with that because they don't. It's often not a 1 to 1 transfer.

It's like the to the drug in the herb might both kill the same bug, but their immuno modulation may be different. So but again it's it's always in in my experience with advanced cancer, it's about sort of layering them so that they have synergy.

And you can do that with botanicals and you can do that with drugs and you can mix and match. And it's never about like one or just these three are always going to work for you.

And that's not how it works. You know, the one of the most hilarious things that I've had in my career was reading a, a fairly big textbook about repurposed drugs.

And in the introduction, two chapters I was reading and I thought, this looks really familiar. And they had they had reprinted, they give me credit, but they reprinted, something I published somewhere about, treating cancer from a metabolic point of view.

And I didn't even know I was in the book. And as the author, you know, put it in there, and it was like they had all of these sort of things that had been published, written about, etc., and the whole lead in was, you have to do these other things to get the metabolism to be body friendly, cancer averse, you have to do these things to maybe, you know, beat up the cancer and then all of this repurposed drug business makes more sense, you know, and you you mentioned, Wormwood.

So one of the things that we got to do was, there are constituents of wormwood, like artemisinin or testnet, etc., and those can be used really intermittently.

We had some really amazing results with advanced stage four breast cancer. And combining that and then high dose vitamin C with just survival, which to an advanced breast cancer patient, that's what they're after.

Like they want to feel good and they want to live as long as they can. And similar with prostate. But because of the pseudo progression thing, like when you add artemisinin or test innate, you get a, you get a, much harder punch, you know, because our testing it used for malaria that it kills a bunch of other stuff.

Well, it's what people miss is it's famous for killing, but it has more research in rheumatology as an immune modulator. So what I'll tell people is, yes, the first 30 minutes in your body, it's going to kill whatever's there and it's going to create redox, surges.

But the next day it's in your body. It's going to work more like curcumin, where it's leveling out your immuno. And now we think maybe the reason we kept those patients alive longer was the bony and brain metastases, etc..

What keep what makes them grow faster is an out of balance, inflamed immune system. Well, it turns out that like the the vitamin C, yes. But also the, Pakistani was having this 1 or 2 day long immunomodulatory, you know, kind of haze afterwards.

So it it's, you know, it's never one thing. It's obviously I've been doing this thinking about it for most of my life. And so it seems real, you know, obvious to me.

But when you try to talk to patients and try to say this why we're doing these things, yes. Your oncologist is probably not going to buy into it. They're not going to understand why we're doing it.

But here's, you know, my goal is to make all your healthy cells so healthy and make the tumor microenvironment so chill that it doesn't want to do any more cancer business.

That will make you feel better. It'll make you probably live longer. And when you have advanced cancer, that is, those are the two goals most people have right now.

So, you know, and I, I mean, we do 80% more stuff now and we know 80% more than we did 15 years ago. And thank God, you know, we're learning. Yeah. It's a it's an endless process unless processed.

Paul. Another masterclass by you. And you have so much more to offer. Parting thoughts. And how can people find you or your work? So I think because I'm certain, a portion of the people watching this or loved ones or people with advanced prostate cancer, you know, it's it's tough.

It's there's no cancer. It's not, it's it's tough. And when it gets to the point where, you know, it seems like it just is a whole different animal. It is, and it's these other things that if you can work with somebody to, you know, work on these underlying things that are, as we talked about, were gas on the fire through on your immune system off and sometimes that takes maybe a couple or 2 or 3 practitioners because everyone does things differently.

But if you can bring that into your team, I from my own experience with my own eyes and watching people, the more you can do their, you know, length and quality of life are all of our goals.

Final Advice and Where to Find Paul Anderson

But once we have cancer, they become very, very acute goals that we want to look at. And I've really never seen anybody, even if the cancer kind of kept, you know, pushing.

We're improving quality of life, definitely the length of life and better quality and all that. So the more of these things you can look at, the more people you can work with.

You know, it's not that the standard system of oncology, medical oncology, radiation, they're great. They do. They have their place. All of these things have their place.

And if you're dealing with it, your loved one is and you're willing to kind of step into this world, it can add a lot of depth to that. So I think that's that would be my parting final thought is, you know, you want to do everything you can to make yourself as small a target for the cancer as possible as you, you know, once you have advanced cancer, it's not going to go away, barring a miracle, you know, but you can make yourself so you're less of a good host, right?

That's right. And where can you be found? Or your work or. Yeah. The. So, I, I had help with my, online person personality. I have a hub website. So if you, you do a lot of YouTube and podcasts and writing and stuff, just go to a doctor a, you know, w a doctor now.com and there's links to pretty much anything I do there.

So that's easy. Doctor A now.com. Yeah I love it. Paul, thanks so much for being on and for really educating us in a, in a such a high level that I, I'm always appreciative to, to listen to you.

So thank you so much. Thank you for having me as fun. It's always fun talking to you. Absolutely. Yeah. All right everyone, thank you so much for listening to this.

Another just amazing episode of the Prostate Cancer Summit with our guest, Doctor Paul Anderson. Stay tuned for more. We have more coming. I'll see you next time at the next, prostate cancer episode.

Prostate Cancer Summit episode. So long.