Introduction and Guest Welcome

Welcome back to the summit. I'm your host, Dr. Jenn Simmons. I have a very, very, very special person here for you. Next, I'm going to welcome Dr. Nathan Goodyear to the summit and tell you that you have something really, really special ahead of you.

Dr. Goodyear is medical director of Brio Medical in Arizona. He is board certified in OB-GYN and he has a story very similar to mine in that he had his own personal experience that opened his eyes to the shortcomings of our conventional medical system.

And he has been on a journey of self-exploration, both for his own benefit, but now for the benefit of his cancer patients who he treats. So he is a revolutionary, cutting edge guy, and I'm so delighted to have him here today to speak to our audience.

Welcome. Well, Jenn, you know, I don't believe in coincidences. I believe in divine intervention. Or I think. We I think we were destined to meet each other at that conference just a couple of weeks ago.

And, you know, your story is very similar to ours. And I think those traumatic events in our life have taught us how to be better physicians. And clearly, we've taken different trajectories from that standpoint, but we're following the same path.

We're learning from what it means to be an actual patient or, you know, being able to provide a perspective from the other side of that desk that you just can't, you know, the thoughts, the questions, the emotions, you know, what's going to happen to my family and you don't.

And you can't imagine what that's like until you're there. But here's what I would say about that. It is by far been the best thing that's helped me as a physician.

Yeah, and it definitely gives you a perspective that you could have never, ever otherwise gone. For me, it was a defining point of I need to take care of patients with cancer.

So from my perspective, it was clearly the calling on my career. It had been me before that. Were you just practicing OB-GYN in the very traditional sense?

Yeah.

Lessons from Medical Trauma and Mesh Litigation

So I actually had a company pharmacist during residency that was talking to me about about hormones, you know, and I would always say, well, show me the double blinded, randomized, placebo controlled trials about transdermal progesterone, you know, blah, blah, blah, blah, blah.

I was an intern. I didn't know what I was talking about. And so then when I got out into private practice, I was primarily a pelvic floor surgeon, so I was dealing with prolapse, incontinence.

I did, as I mentioned, abdominal cyclical complexities, both open laparoscopic, but what I really like to do was the vaginal approach to surgery, because the patients had quicker outcomes, they recovered better.

And I think it provided a much better solution for women. But what I discovered there is I got caught up in that vaginal mesh stuff that was so prominent about 20 years ago.

Yeah. And I start that. That was my first eye opening experience to what is the business complex that is medicine

versus what is the practice of medicine and who really controls the direction of medicine.

And it's business. Yeah. And so for people that don't know what you're referring to, can you describe that whole situation that that happened? It was probably in the like nineties somewhere.

Well, actually. Maybe a little later. The dementia started in the nineties, especially the trans urethral slings. And you know, most of those have not really presented any issues.

And of course that mesh has been used in abdominal hernia for a long time. A long time yeah. And it was called a secret exit where you have a prolapse of of the area of the top of the vagina, where the uterus used to exist or even the uterus itself.

And you would go in surgically and re support it and you would use this artificial construct, this fact, this mesh well coming out of France, they said, well, you know what we can do, let's take that mesh and then let's approach it through a safer route that agile because we're already doing it with the sling to protect against urinary incontinence.

If you call it leak and it works very well with minimal side effects there. And so they said, well, let's just take that that abdominal mesh and just use it badly.

And that's where just problems arose because not only was the research limited there, but now when they when we got into the litigation part of things, they knew they had a bad product from the beginning.

I actually ended up being a witness, an expert witness against the manufacturer of the mesh because of the harm that was done to the patients. But what what was a problem was the assumption that the bacteria and the environment of the abdomen is the same as the vagina.

Now, it's a little bit of a, you know, people going, why are we talking about this? Because I think it highlights one of the things that we as physicians need to be better advocates for our patients and better critical thinkers.

And it's experiences like these that inform really hurt patients. But it's taught us a lesson that I will never unlearn. My job is to be the most critical thinker for my patient, that there is not a group thinker, but critical thinker.

Yeah. So what what basically came of that is that. No, these environments are not the same. Yeah, of course they're not. And so we had massive inflammatory responses, massive side effects, erosions, the mesh, the tissue didn't heal.

Well, what's about it is when they went in and removed those meshes, the inflammatory response continued even after it was removed. So the foreign body response to of course, massive lawsuits and legalities that was actually eventually settled sometime in the early 2000, I think was 2012 or so.

And but they made their billions. They made their billions, yet millions of women were negatively impacted because. They really suffered. They really suffered.

And, you know, it's through these experiences, as you said, that you you learn to approach the patient far more critically and in the confines of conventional medicine.

And you know this very well, we really are not taught to critically think in that. We are trained that everything that they taught us is true. And when you question it, you're difficult.

And that goes for the doctor and the patient, right? So the people that don't want to just follow that that pre-planned paradigm for everyone, they're considered difficult patients and so many, so many cancer patients, breast cancer in particular, they really, really struggle with what's the right thing to do.

So I would love to hear your approach to the breast cancer patient and how you individualize it and talk about the things that you have found to be really valuable in helping people to heal from a breast cancer diagnosis.

I mean, what you're really talking about there is the paradigm shift that we're undergoing, which is the last 100 plus years or so. The one size fits all approach.

Yeah, that is 6.6 and 5.2 patients are the size and they're not. They intuitively know that we try to put them into the model that does that that says that they are the same to individualize care, which is the right treatment for the right patient at the right time.

And that's where we're going. It's the when I say it's the multiple mix, it's the genomics, the epigenome, it's the transcriptome, it's the proteomics and the tableau.

It's it is the pure precision nature and individualize therapy for that patient with cancer. So talked about breast cancer, of course. I mean, we've got five patients with us right now with triple negative breast cancer.

It's like this is INSIGHT. So each one of those five patients with triple negative breast cancer, which is of course, one of the worst forms, is very unique in their story, in their presentation, their built, their lifestyle, everything.

So though they may have the same, quote unquote diagnosis, they are very much unique individual. And this is something that I'm very specific to cover in my book because so if traditionally we have thought about breast cancer in terms of the what people see underneath the microscope, but that is not the important issue.

The important issue is what caused those changes, what led to that cellular transformation.

Personalized Breast Cancer Care

And nowhere in the confines of conventional medicine are they talking about that. No, they are not. And I think that's a topic for another day about why they're not talking about that.

I think there's the question of ignorance, whether it's willful or not. But, you know, what I focus in is trying to help patients and trying to advance healing for patients because we can get ourselves caught in some rabbit holes and create some enemies there that we really don't want.

Intent. I was always taught, you know, be careful. You pick a fight with you. Pick a fight with somebody that has that holds all the cards. You're going to lose every time.

So my job is to help patients. And so I've chosen to be aware of those areas, but focus on the patient. And so as you talked about the individuality of the tissue, looking at it from a perspective of what's underneath that microscope, the first thing that I do when a patient comes to me is I say, look, I want to connect with you as a mother, as a wife, as a sister, as an aunt, as a as a business owner, as a colleague, because that's what defines you before you obtain this diagnosis.

That is, the individual or the person that is that is going to open the book that allows me to explore the events, the environment that has allowed the cancer to develop and then prosper.

People may say, well, that's kind of esoteric. How's that going to help you? It's going to help you a lot because you can you can unmask trauma. The psychological and emotional side of cancer breast in particular, is enormous.

And fact. I think the physical side of cancer is the one that we see and we focus all of our attention on. But I think the capacity to develop or heal from cancer really begins with the psychological, emotional and spiritual.

You know, I was just doing a podcast earlier, just an individual podcast where I just kind of take these deep dives. And the premise there was actually had somebody on social media said, Are you a real doctor?

You're being sarcastic. Don't you love that question? Oh, I love it. So I love to engage with them on that. And I was like, so I said, What? What is a real doctor?

M. D., Naturopathic Medical doctor, Homoeopathic Deal? What's a real doctor? I said, because, I mean, I fit two of those. So does that make me a real doctor?

But, you know, one of the quotes that I then use to provide a different angle was you're focused on, look, our job, Samuel Henman said, is really one and one alone.

It's to heal. That's our job. And so healing is an individual prospect. It cannot be fit into a protocol. It cannot be fit into a one size fits all approach.

Healing is individualized. And so you have to begin in understanding the individual, connecting with the individual, developing that patient physician bond that I think is one of the most unique beyond marriage that exists, period.

And then say, now let's dove into the specific effects, the genomics, the epigenomics, because you can take these five women with breast cancer e r pr HER2 negative, but they can actually have massive differences in the genetic expression.

The immune dysfunction maybe could be just simply in the HER2 expression. One could be considered HER2 plus one with immunohistochemistry. And then, you know, with fish it's negative, but they respond somewhat to her to therapy.

So, you know, it's there's such nuance. And also, I also think that we assume that the biopsy is representative of the complete tumor, but I think there's heterogeneity in the tumor.

And so that's why that's why these treatments are so unpredictable, because you're not treating just one thing. Yeah. You know, I think we try to we try to make simple what we can't understand because it's human nature.

And we oversimplify it. Bingo. And we don't do it justice. That's right. And so I actually had a patient one time tell me. Well, but brevity is the soul of wit.

I said, exactly. Not trying to be witty, that trying to be accurate. And so if you just look at the immune effects of cancer, it's insane. I mean, I just did an individual podcast where I talked about the impact of Tylenol on the immune system in cancer, how a retrospective study showed completely negation, complete elimination, any benefit from the immune checkpoint inhibitors in patients because of Tylenol.

So, you know, people go, how is that possible? Well, it's individual meaning if you had if you were on immune checkpoint inhibitors, could you have a PD, one, 111 or other immune checkpoint and you take Tylenol that is going to completely negate the effect of that therapy.

So that's individual eyes. It's a very precise manner of expression, but it's very individualized. It's being aware of that. But I believe your experience my experience is what has taught us some very tough lessons that we've taken to heart for the benefit of our patients, to become advocates for our patients and our patients alone.

Yeah. And I think it's a calling your it's your calling. It's my calling. And there's many other wonderful doctors out there. And, you know, we always seem to find each other in that.

Interesting. Yeah, absolutely. Yeah. The laws of attraction. Yeah. So can you just lay out how you then approach the patient in that individualized way?

The the things that you're looking for, that the triggers that you're looking for, and then how do you help them to mitigate those those triggers for their for their breast cancer?

And how do you combine that with the therapies that, you know, work and they need? Yeah. So 90% of the patients that come to us are stage four. So they're, you know, well in, you know, the progressive state of disease and some of them decline.

I just had a patient, 31 years old, 31 years old, with stage four pancreatic cancer. Oh, I mean, it's insane. Insane. And things that we really did not see 20 years ago. I couldn't even thought about it.

Yeah. Yeah. But so in those patients, we do focus on causation because it's important, because eventually we're going to reach a point where we transition to healing.

But in those patients, we kind of do a dual track because they come in, they come in and they're they're off the rail, so to speak. So obviously we do evaluation as it relates to genomics, epigenomics, nutritional genomics.

We look at the immune system and we do a lot of conventional labs with them. We do a lot of specialty testing. We, of course, look at the gut, the gut, I believe, more and more the gut and the microbiome and its interaction with the tumor microbiome.

Is that signal in there is going to be, I think, very key. So we look in all of this and of course, we're looking at metabolic issues, we're looking at acid based issues, we're looking at redox issues.

All of these through testing, evaluation, examination and got to touch the patient, kind of examine them. All of these help us to not only look at the current status of the individual, but it helps us to start the foundation of looking in at causation of this issue.

And of course, everything begins with nutrition. Everything begins with nutrition. Yeah. So what's your current nutritional status and how do we implement a strategy of nutrition that heals but also weakens and and stresses the kids are and sets it up for other therapies to stack on top and work with that.

So there's an initial evaluation phase that the patients come to us that we do through the first 3 to 4 days of the first week. And then once we compile that data and have a chance to really assimilated, then we can really start to push in in the initial phase of treatment strategies.

Now some of that's based on what the data tells us from a natural, holistic, integrative strategy to treat breast cancer. In this case, I've talked about five patients with triple negative.

Yeah, but but then as we start to get some of the specialty testing the roles in the immune system, you're looking at the innate immunity create CD4 cells, natural killer cells.

And then we start looking at the genomic expression of the cancer. We start looking at the epigenetic expressions of the immune system. We start to really hone in and and really become precise and targeted in our therapies.

So we start out broadly based on the evidence naturally, holistically and innovatively. But then as that data comes in that allows us to become targeted and precise, we really narrow in on that with therapies.

And the key is one thing do not cause cancer. Likewise, one thing cannot treat cancer. We must we must stack therapies together in a precise manner, in a precise and targeted manner for that individual.

And that's and that's the broad approach and how we do that. Individualized, whether that be, you know, ketogenic diet, hyperbaric hypothermia, local full body, you know, mistletoe, whether that be intratumoral I. V.

low dose metronomic came out I think procurement ideas, vitamin C loaded, whatever that is, we use that based on the expression and behavior of the cancer and the individual.

Yeah. I wonder where you stand on fasting. Oh, yeah, I stand on it. I mean, I think fasting is critical. I mean, the research from the conventional world, the conventional medicine agrees with us on this.

And one of the things that you and I, as conventional doctors need to recognize that we are medical doctors, we come from that conventional world. So I always try to reach across the aisle.

They are our colleagues and the more we can work together, the better patients could benefit. This is not a battle. This is not a war. Everything's about the patient.

So if we can build bridges, we build bridges. But the conventional literature supports fasting with full dose chemo, with radiation that it augments two sided toxic effect.

The cancer killing effects of those therapies. So with that, we bring in fasting with many of our therapies. For example, we don't do full dose chemo because that destroys the immune system.

Yeah, that's it. The cancer is never get it beyond that. It's the immune system. And in fact, when you look at the literature as it relates to CD4 and maximal tolerated, maximum tolerated dose chemotherapy, there's a question about whether those T lymphocytes ever recover, ever.

So when you take actually a low dose form of chemo, typically defined at about 10 to 30%, I like to use the lower of that amount in 80% and dose it more frequently metronomic.

Testing, Nutrition, and Treatment Stacking

It now becomes immunomodulatory, it becomes immuno stimulatory to dendritic cells, natural killer cells, cytotoxic t lymphocytes. So what we do is then combine that with the fasting to augment it as much.

So if I absolutely stand on fasting now, we have to recognize this is where the individualize comes in, right? We have somebody sitting in front of us.

Let's take exit. And you know, they have massive muscle loss, which that's how you diagnosis. And you can tell they're very, very advanced in their stage.

They're not getting that. That is that is the an end stage of cancer. Most most people even stage four won't be kick hectic. It's that that's a very late finding.

So in that individual right it would be silly to say oh that's fast. Yeah. Because that would be detrimental seriously to that individual if excuse me could be something that helps precipitate the end.

So we have to recognize who is sitting in front of us. And so if the person is metabolically able to fast, then I will absolutely eliminate. Yeah, I want to switch gears a little bit because I know that you do a lot of work with cannabinoids.

So I'm curious to the work that you're doing and where you find this to be advantageous for the cancer patient. Wow. You know, there's probably not a more misunderstood therapy out there than if I do cannabinoids and I call it kind of you know, it's the fog of the Cheech and Chong era because, you know, hey, dude, you know, it's.

Great. That you did a podcast once where I had on a Cheech and Chong thing, but because everybody looks at cannabis through that prison, they look at it through the prism of the make love, not war from the 1960s and early seventies.

And so it's that history that always comes up when we think about it. But what we're talking about here with phyto cannabinoids, of course, marijuana, medical cannabis, it's coming from the cannabis plant, marijuana.

But phyto cannabinoids are all the cannabinoids that come from that plant. The part that gets you high, the Cheech and Chong effect, if you will, is the THC, the Delta Nine tetrahydrocannabinol Cannabinoid.

So there's also a Delta eight which comes from him, which that's the 2018 farm bill that has allowed that process. Now, Delta eight, THC, which is Delta nine, actually has, you know, psycho activity and hallucinogenic and high properties, all that you would see with marijuana from a classical sense.

But it's lesser and it's more tolerated than the Delta nine, which classically comes from marijuana plant. But but so these are phyto cannabinoids. But then there's other phytochemical.

It's CBD, cannabidiol, CBG, cannabis. We're all CBD. And then there's the CBD, a forms of THC forms, a cigar forms. There are so many different phyto cannabinoids within that plant, and then all the other components within the plant in whole body and whole plant extract and how they interact together.

And an entourage effect. I really believe this is one of the frontiers of where medicine's going, just super excited. So when when you actually look at cancer liberal waste saying that these are cannabinoids that come from plant it's phyto the major anti-cancer benefits are from CBD, not THC.

And that's one of the things that I think a lot of people get confused about is like, no, no, you do not have to get high and so will use high dose CBD to actually treat a lot of the symptoms associated with cancer.

Of course, one of the biggest is pain, one of the biggest is pain. And then but we'll also use it because the anti-cancer effects of CBD are well published.

Now what's interesting about that is that the anti-cancer effects of CBD published in the literature in Europe and in the US curiously or differ. I don't know why that is, but it is.

But nonetheless, that's a again, a topic for another day. That's interesting. Oh, yeah. So just just Google. Not Google, just PubMed, CBD cancer and then do that same thing in the your form Europe PMC and you're going to see a different volume of evidence that's significant.

And why do you think that is? Because I think some of the best research in the world is coming out of Europe on this. It's more open and consistent with their cultural approach to to health care.

So, for example, in Germany, they have a true integrative approach as it relates to the physician and the doctor with the patient. And then that is also that also bears out in other cultures over there in the United States, we built a medical culture that is that is built on a foundation of of pharmaceuticals and medical manufacturing.

And so what happens is anything outside of that is deemed, well, let's say, quote unquote, alternative, marginalize. So the problem is, today in the United States, people just don't know what they don't know.

Yeah. So you have to be open to the idea that you may not know something. And until you know that you're not going to be able to unlock it, break out of the ignorance that you've self-imposed on yourself.

So if we just look at it from a noncancer perspective, for example, CDC, CBD, not CDC CBD actually has sedative properties. So it can help us sleep. It has it has an appetite suppressant property.

It's anti-nausea, works great for dry mouth, it's great for fatigue, can actually be used for treatment, for gastrointestinal upset, could be great for migraine, post-traumatic stress disorder, depression, anxiety.

I mean, these are just general non, you know, non-cancer benefits. Yeah. But if you look at specifics related to CBD and cancer, wow. It's entire anti-India genic.

It's it's pro cytotoxic, it's pro apoptotic. I mean, it becomes broad. One of the big benefits of CBD is it's immunomodulatory, so it stimulates the right parts of the immune system at the right time, but it reduces pain.

Now people would go, What are you talking about? Well, when you take opiates for pain that suppresses urinate immunity. Yeah, and that occurred. And that's a huge problem, especially in the stage four population because you you take someone who already has significant immune challenges and you basically take their immune system out of the picture with opioids.

You couldn't have said that more clearly.

Fasting and Metronomic Chemotherapy

The problem when you have people that are in advanced cancer, you're trying to avoid a return that strong, that final straw that breaks the back of their immune system.

Yeah. And so constantly working to keep people off of opiates, the cannabinoids, the phyto cannabinoids help us to do that. And what's great about it is we can add in a therapy that actually can be used to treat the cancer but actually alleviate one of the primary adverse side effects and quality of life measure issues in cancer.

And that's pretty. Yeah, because it is so hard to get better when you're suffering, when you have pain, when you're in pain, it is so hard to heal. It's hard to do anything that promotes your health when you're suffering.

When you're already been told that you're not going to survive. I actually had a patient that a patient that came in. She wasn't just told she had three months to live.

She was told the day that she was going to die in. Canada was Nostradamus. I guess so. Or God or one of the two. But, you know, I found that I've never had a patient.

Let me tell you what that was ingrained in that patient's mind that day. It was October 20. A patient was told that was the day. That would probably be the end of that patient's life.

So what we have to do is recognize that patients come with a pre taught idea that this is a this is a battle they will lose and they will lose in quick order.

Yeah, so we have to fight that. So they're already down and depressed and their moods affected because of that. And so if they're dealing with chronic pain, that makes it worse.

So if we can just shed some light with pain relief, but do so in a way that doesn't compromised immune system. Now you can start to get just a glimmer of hope like, wait a second, I don't hurt as much.

I can walk. I can be the woman with brisket, I can be with my husband, I can be with my family, and I can be lucid and within my right mind and I can at the grocery store and see that simple concept live as you heal.

Yeah. We do that. We go to war on the body by going to war cancer. The problem is we turn the body into the battlefield. But CBD, I believe I do. Cannabinoids, I think are the next frontier.

But they allow us in that patient population to not present that final straw, actually remove things that are hurting the immune system, but actually give them that glimmer of hope that we can build upon, but then also help their immune system at the same time.

So it's the problem. How do you how are you dosing it and how is it delivered? Yeah, that's the problem. So when you look at let's take CBD because again, that's the one that has the broadest effects.

But I would tell you CBG and CBD C to come are going to be more potent and I think CBG Cannabidiol is going to have a huge impact in inflammatory bowel disease.

I think it's going to be huge. I think it's gonna be huge in brain cancer. Glioblastomas brain mets. But that's coming but CBD so the majority of research is CBD.

So it's bioavailability from an oral route is only about 6 to 8%. So when you take it orally, which is the predominant use and method of delivery in the United States, it's oral.

So if you take it with food, six, 6% of 18% will be absorbed because it's it's lipid, it's lipophilic, it loves fat. Take it with food, you improve the absorption of it.

So 18%. But if you take it fasting, the absorption, the bioavailability is 6%. So the problem is at its best it's 18%. So you typically have to dose very, very high with CBD at around a range of ten milligrams per kilogram per day, which is a lot.

Yeah. And so you can get some more side effects with that. So you get, you know, you get a £200 individual that becomes a very high dose but a very costly dose because CBD is not cheap.

So then there's techniques of, you know, rectal suppository, vaginal suppository, inhalation or intranasal sprays, transdermal. So we employ all of those.

So take, for example, intranasal, you get a increase in bioavailability, upwards of about 38 to 40%. So that's really nice.

Cannabinoids in Cancer Care

And so if you have somebody that has brain Mets that has a glioblastoma, then you can actually do intranasal CBD, get it right through that clip from play right into the brain at a lower dose with a much higher bioavailability than that with the oral.

The great thing about looking at the toxic effects of CBD, the toxic genetic studies is you have to dose it. It's almost you can almost say that there's not a dose level that is toxic.

I'm sure there is a toxic dose. But, you know, right now it's not been clearly identified in animal studies, in human studies. What that does is I think you're going to reach a point on dosing of CBD orally, that you get adverse events like with diarrhea where you're taking too much sedation, where you're taking too much appetite suppression because you're taking too much.

And it's not really a toxic effect. It's just it's the, you know, the build up of those of that effect. It's not really it's like it's actually an intended effect.

It's just too much. So what we are now doing is I'm working with a group out of California where we're actually taking this lipophilic molecule and putting it actually into solution and giving it IP.

Because when you look at cancer, it is a systemic process from day one, from day one. It was really interesting. I was reading an article actually last night where it was published from University, Oklahoma Group.

There you check it out. It was just published in the journal Cell. I'll send it to you. 2000, December 19, where they actually showed that the by got a biopsy, promoted a pro metastatic change in the tumor.

So there's this great debate can biopsy spread the cancer. Well this study these they looked at this cell culture study and these tumor models and they go yeah, yeah, it actually can.

And so they talked about the mechanism. Are they measuring circulating tumor cells or how were they making that connection? You know, that's a good question.

I don't know. I don't think they were looking at circulating tumor cells. I have to go back and reread that. But what they were looking at was within the tour, within the tumor itself, looking at the.

So they found like transformation in the genetic profile like you know and stuff like that. Is actually can hear and change expression these markers that we would see affected where you're going to actually get epithelial mesenchymal transition where the tumor becomes mobile.

I do not believe in I read in late last night that they looked at tumor circuiting tumor cells. They were just looking at the tumor itself, the biopsy and changes associated their it. Yeah so but the point there is that, you know, this is very cutting edge that you know surgery biopsy here can spread the cancer.

So what we want to do in the treatment of cancer is recognize it's systemic from day one and most of the patients coming in have had a biopsy. So that means already it's mutated or been forced into a change that has made it systemic.

So we have to recognize this. This is a systemic process. And so with the limitations of CVP delivered orally or even intranasal or transdermal or trans rectally or inhalation, we you know, I've is the only way that that gives 100% bioavailability.

Yeah. So with that we can deliver it in a very safe and tolerated way and take advantage of its relatively long half lives and really augment treatment of symptoms that are associated with cancer.

All of the quality of life issues that you think about, think about if you have somebody with stage four cancer and they're depressed, lift the depression.

Now, it's possible. Yeah. Really anything but you can actually alleviate the pain but target the cancer at the same time. I'm I'm curious as to the appetite suppressant because we usually see we usually see the use of cannabinoids for appetite appetite stimulation.

That's a THC. Yeah, that's that's the THC. Yeah. But so what I'll typically do as well is I'll couple CBD with CBD of course this is oral CBD is an appetite stimulant, great for neuropathic pain, great for GI symptoms by the way, I think again for this I think CBG and IBD that's Crohn's and ulcerative colitis one colorectal cancer.

Watch out. I think really exciting stuff coming. That's again. Being with this group. It's super exciting, but so I'll use CBG with CBD if I'm concerned about maybe early kick XA or already an appetite issue that will wait.

So I'll couple those phyto cannabinoids together to counteract that and that seems to actually work really well. But yeah, if I want somebody that's really dealing with major could get the appetite suppressant.

Yeah, I'll give them THC like in a 1 to 1 with CBD. And that works really well to actually keep appetite stimulated and controlled. I'm curious as to how this compares with Rick Simpson oil, because I have found that people who utilize that therapy, it really just knocked them out and they're not able to live their life while they're healing.

Wow. That's Pandora's box there. You know, Rick Simpson. Rick Simpson, the well is, you know, high dose THC, a high dose, very concentrated form of THC.

That's why it's called our ASO. And so typically the dose there and it's it's usually SteveA it's a different plant type versus indica but it's typically about it's dosed in one rice grain and it's about 60 milligrams.

I can tell you a funny story about that. We're actually the very first patient I prescribed medical cannabis to when I got to Arizona in 2018. She went to the she went to the dispensary and he told her to tip the tip to me to dip the tip of a teaspoon into this this this jar of THC gel that was all right.

So she did the whole teaspoon. It literally she was out for two days. Yeah. I mean, I've never seen anything like it, but I've actually seen it induce psychosis in two patients.

So what you have here is something that has medicinal value, but you have a, you know, the the Internet creating the persona of something that is partially true but mostly not true.

Does THC have a lot of benefits? Oh, yeah, it does. Is it the primary benefactor in the treatment of cancer from a phytochemical perspective, no, that's what the research says.

It's CBD and others. THC is definitely the lesser, but it's the people that are. They're looking for any hope. They're looking for any therapy. Yeah. So I'm across this and again, as I said, I've actually seen it induce psychosis.

Oh, me too. For sure. That is not an effective therapy as it relates to cancer because they're not functional. Yeah.

So you said, well, we're going to cure your cancer, but now you're nonfunctional, you're psychotic.

How's that beneficial? Yeah, I'm wondering about things that are synergistic with the phyto cannabinoids. So because it is an immuno modulator, I'm thinking about low dose naltrexone or today have synergy with one another.

Absolutely they do. And of course, you know, we use a lot of low dose naproxen with our patients of course because of the immuno modulation in cancer doesn't create anything new.

It just adulterate what's there and the immune system is key in that. Yeah. And so anything we can to modify the immune system, to help the immune system to do its job and low dose no tricks on helps there.

Yes there's synergism there there's there's synergy between CBD and low dose metronomic chemo. There's synergism between CBD and hyperthermia. So really the synergism is broad.

Yeah. Is the immuno modulation and how do we match those together. And the problem there is we can't write adequately evaluate what the immune system is in the tumor microenvironment and the collected tumor microenvironment as exists in patients or cancer has spread.

Again, as you talk about within a tumor, things are very heterogeneous. People look at tumors and they say, well, it's hypoxic. Well, some parts are some parts are actually normal oxygen or what's called normal.

So parts are acidic, parts are alcohol. So this concept that it's one size fits all in the tumor is very heterogeneous. Likewise, the tumor microenvironment that they exist when cancer spreads, they are equally heterogeneous.

And so that's the beauty of natural therapies. Natural therapies have a knack. Vitamin C, CBD, hyperthermia, photodynamic therapy. They have a knack. Curcumin is another one for targeting abnormal cells, but protecting and elevating healthy cells.

So it's just I call it the Trinity Effect, but it's it's really interesting how natural therapies really target that which is abnormal but helps to protect that which is normal and CBD fits right in that picture as an immunomodulators, it'll modify the immune system in a way that is beneficial to the individual but detrimental to the cancer.

Yeah. So anything that is modulating in a similar manner is going to be likewise synergistic. So another peptide, thymus and alpha 1t1 is very synergistic with CBD.

Of course the other five cannabinoids are as well. But I mentioned just a few there. The Photodynamic the little is metronomic, chemo, hypothermia, hyperthermia, a body local.

So all of these would be synergistic. And with regard to hypothermia, are you talking about sauna or are you talking about more than that? You know, I'm talking about real hypothermia.

So, you know, when you look at hypothermia, it's really mimicking the fever. And the fever is the manifestation of the immune system. Yeah. Again, going back to the answer is the immune system.

And Dr. William Coley, a surgeon back in the end of the 19th surgery. Thank you, surgeons, for giving us such innovative thought. It was treating sarcoma and he was seeing terrible results.

And so he discovered that, wow, what if I induced an infection or a fever response and he killed some bacteria and then noticed that, wow, a patient got better.

Yeah. And he actually had one patient live for 47 years after stage four cancer diagnosis as melanoma case. I think so he was a surgeon and he then said, well, let me mimic a fever.

Now, he did it by injecting, you know, he killed bacteria. Yeah, hypothermia saying, well, let's control this.

Hyperthermia and Core Treatment Strategies

A heating from outside again. So we do this both in a whole body perspective where we're using, you know, radio frequency to heat the bodies. Of course, we have to sedate.

It's a 5 to 6 hour process and it's a very tolerable process, I would tell you, for the treatment of bone metastasis, there's not a better treatment. Of course, we use medical cannabis to sedate.

As I mentioned, we'll give vitamin C and human why they're getting that as well. We, of course, monitor their core temperature. Okay. So we're monitoring the core temperature, not the surface, where they have a fully catheter.

We're measuring it in the now measure. You know, it's a very detailed process and we're targeting per what the German literature describes as hypothermia, which is somewhere between 100 and 406 degrees Fahrenheit.

You heard that, right? Yeah, 106 degrees Fahrenheit. We need you there for 2 hours. This is a very detailed and specific procedure, very safe. It's one of the safest we do.

But it requires preparation. It requires monitoring. We have to cardiovasc monitor monitor that. Very safe. Yeah, but highly effective. And then there's local hypothermia.

That's much more ablative going up to 108. And so it's much more of an a blade of approach to the to the hypothermic approach. So each one of those are good devices.

Each one of those are good therapies. Yes, that's a good point. People will say, I'm doing sauna, I'm doing hypothermia. No, you're not. I mean, you people can raise their internal temperature, just not enough.

You know, and here's you're right. Because they can't tolerate. Yeah. And they're not monitoring. So they don't know what temperature there was actually a study and I don't have it in front of me forgive me.

But where they actually looked at people that were heating up to less than 39 degrees Fahrenheit, it's 20 Celsius. And so between 35 and 39 degrees Celsius, they actually found that that propagated the cancer growth.

That was a cell culture study, I remember correctly, but it probably propagated the replication of the cancer cell. It was only when it got above 39 degrees Celsius that the cytotoxic effects started to really kick in.

The chaotic effects and the heat shock proteins and everything that came with it started to kick in. So actually at a lower temperature, for a shorter duration, the literature at least that study suggested it actually propagate the cancer growth.

So I think it's very good. Considering that we're telling people to do summer. But it gets back to the R. That's why I don't tell people to do something anymore.

That's why it gets back to it gets back to the art. So there's a piece of it that's true. Yeah. But then there's a part of it that's definitely not true.

And so our job, you and I, your and my job as physicians, which that means healer doctors, which that means teacher is to be critical analyzers of the data to bring back to the general public to empower them.

Yeah. So remember, let's do it right. Yeah. You're right. And I think that, you know, that is all part of your individualized approach and looking at the person and determining what's going on, what got them to this point, because what we see under the microscope is a very small part of the of the person and a very small part of the story.

And the story is what got them to that point, what led to those changes. And you're looking at all of those elements that someone to that point, and then you're helping them with diet and low dose chemotherapy when it's

appropriate and you're you're using ozone and hyperbaric oxygen and immunomodulators like mistletoe and LDN and of course, the phyto cannabinoids and. Supplements and repurposed medications and all these other things.

Yeah, yeah. We could actually go on forever. But is there are there are there go tos that we haven't covered today that you think are important for people to know about at least so that they can start the conversation with their providers?

Yeah. I mean I think, you know, I have a couple of go tos as it relates to stage four cancer. And so I'll put it in that context. Definitely hypothermia is go to.

So say it this way. If I was stranded on an this is kind of out of how weird I am if I was stranded on an island with three therapies, would I take with you?

So I take nutrition, I take hypothermia, I take high dose vitamin C and I take low dose metronomic chemo. I know that's for. But that what. Will give you a fourth.

That's right. I didn't take math in college. I think those are for stage four breast cancer. Those are for critical. But but here's how the individuality comes in it.

Let's say that I get back a genomic mutation from circulating fragment DNA on the patient. So one of these very precise testing methods we have now available and we go, wow, you don't have a cross mutation or this cancer does not have a mutation.

So that limits the impact of the vitamin C, but you have the cancer has a C MC mutation are we can target that with artists tonight curcumin and quercetin.

So that shows you right there this this paradigm shift where we're not just using a one size fits all approach, but we're now actually using natural therapies in a very precise, targeted way based on what the cancer is showing us.

Closing Thoughts and Where to Find Dr. Goodyear

Yeah. Yeah. And I left an hour. I looked at artists today. I absolutely adore artists. And as a therapy incredibly safe. It is the gold standard treatment for malaria, but it is a powerful anti-cancer therapy immuno modulator as well.

Coupling artists with vitamin C together is a powerful combination. Therapy in cancer. Amazing. Where can people find you? Well, you can I can have a big mouth.

As you can see. I tell patients that, you know, the word physician means healer, the word doctor, and that means teacher. Just as you're taking on the next aspect of your career because of what you learned, you're going to be a teacher and you're forcing and pushing the arena of ideas to.

Empower patients. That's where I'm going in the next phase of my career as well. You can find me on my personal brand website that is drgoodyear.com, my podcast, which is practicing with Dr. Nathan Goodyear.

You can find that on my website, but you can also find that wherever you download podcasts, I take deep dives individually. But then I love to interview and have dialog with other innovative practitioners like yourself because you're going to be on my podcast and I can't wait to come out.

I can't wait to talk about surgery and do some deep dives on that and the immune system. Talk about biopsies, talk about surgery, not to not to look at it from a perspective of ridicule, but to learn.

Yeah, to learn. Of course, you can find me at brio-medical.com, where I'm the medical director and wherever you social media's, I am there. No. Check me out there.

That's where you can find me. Terrific. Dr. Goodyear, thank you so much. This was an amazing insight into

personalized medicine, which is as we both know, the wave of the future.

And gone are the days where one size fits all and one treatment fits all. So I thank you so much for the work that you do and for the contribution that you're making because you're changing the world for these people.

Well, thank you for the platform and honestly, the courage that you bring to the table to share this information. Because without courage, guess what?

We wouldn't have a platform. So your courage is contagious. Thank you. Thank you for being unafraid of mentioning your past and learning from it, because that's what you and I have in common.

I think you're I think you're anointed to do great things. So it's my pleasure to get to know you. Well, thank you so much. You bet, It's Dr. Jenn. Bye for now.