NATIONAL CANCER RESEARCH FOUNDATION

Additional Testimonials

The following are some of the many testimonials not yet entered into the main testimonial booklets. After we build this up, we will then update the main "Testimonial" booklets to include these.

Page **Topic** *Updated: November 20, 2008*

This is far from the complete list of people and the various types of cancer and non-cancerous conditions.

We are very proud of our work and hope you can see how these people improve and regain their lives again.

In the future, we hope the volume to help many more people will increase.

PO Box 131 St. James, New York 11780-0131

Main phone (631) 584-3100 (Toll Free) 1-877-CANCER-FREE Fax (631) 584-4833

Web Site: **www.NCRF.org** *NCRF is a Registered 501(c) (3) & ST-119.1 Not-For-Profit Corporation* Email: **Fred@ncrf.org**

Lung Cancer

Better breathing after 2 hours

On Tuesday, September 9, 2008, Abbey came to us very weak. Her husband and friend had to help her walk and helped her to sit down, clenching herself tightly and with a tense grim look on her face trying to control her pain. For a few weeks before coming to see us, she had shallow breaths and spoke in a soft voice because it hurt too much to speak. Her body was tight and very tense due to her pain. She was on terminal leave from work because she was expected to get worse and soon to die. Her husband and friend went to a meeting. When they returned two hours later, she was sitting on a couch totally relaxed and with her arm across the top of the couch. After a short while, she got up, felt comfortable with almost no pain. Then, in front of her husband, she did a 360 degree spin on the front part of her shoe and went "Taa Daaa", with a smile on her face. That night, she walked around, felt good, not totally pain free, but a lot better than she had been feeling and spoke with a strong voice again because he pain was gone and she could take a deep breath again. The following Monday, Sept 15, she returned to work and, as of Mid Nov 2008, her lymph nodes also are now normal again and she said she has no symptoms of any problem, she has not missed a day of work since. Her life is back to normal.

Her Sept 24 letter written to her friend that brought her to us:

RE: Saving my life

Dear Robert,

I just want to thank you so much from my heart for what you have done for me. I also want to thank you for introducing me to Fred. Since then, no relapses, I'm feeling great and I have been spreading the news ever since to anyone who is suffering or knows someone that is. Again, thank you so much. Abigail

Brain Cancer

2 years post surgery still "No Evidence"

Previous surgery to remove brain tumor in 2005, after which a short period of radiation, in effort to provide a few months survival. After that, Nick came to see us to see whether we could help him. The July 2007 showed no reoccurrence, which surprised all doctors, they were extremely happy and were not expecting Nick to survive beyond a few months after surgery. From there, in December 2007, he went for another scan, again, showed no evidence of progression. Everyone was happy. The doctor stated that the blood work indicated that he was low on potassium. He went to s different hospital for potassium infusion. I felt that was not necessary, all he had to do was eat more foods with potassium and take potassium supplements. We do not know the details except that where ever he went for the potassium, which was not Stony Brook, who ever administered, gave him something else by error and that error caused his body to have a fatal reaction, he died from the complications of what ever was given to him by error. It was extremely sad, he was such a sweet man who fought so hard and did well, he was doing great and it was fully documented that he was clean with no evidence of cancer when he passed away. Just before Christmas 2007. Our hearts are with his family.

See next page for detail

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Pet Tumor , NICHOLAS - 30321205

* Final Report *

Not Official Copy:	Pet Tumor
Flowsheet Date:	11 July 2007 12:28
Result status:	Final
Result title:	PET TUMOR IMAG METABOLIC
Performed by:	CLAROS -SAMANTHA, on 11 July 2007 12:28
Encounter info:	010038902325, UHMCSB, OP Private, 7/11/07 - 7/11/07

* Final Report *

July 11, 2007

PET TUMOR IMAG METABOLIC
PET imaging

HISTORY: Brain tumor, post surgery in 2005 2006, radiation and chemotherapy. FBS by fingerstick is 93 mg/dl.

TECHNIQUE: On 7/11/2007, patient was given 6 mCi of FDG intravenously while resting semisupine. Approximately one hour post injection of radiotracer, tomographic images of the brain were obtained using Siemens Biograph LSO with CT attenuation. Fusion of PET and CT images was performed for anatomical correlation. There is previous PET scan from 3/26/2007 available for comparison. Previous MRI scan was also available for fusion and comparison.

Please note that CT scan is used for attenuation correction and fusion.

FINDINGS: There is again mild hypermetabolic rim corresponding to contrast enhancement on MRI surrounding focal area of absent metabolic activity in the left frontal region. This appears somewhat larger in size but without significant change in metabolic activity.

Also, persistent diffusely decreased metabolic activity throughout the left hemisphere, likely related to effects of radiation therapy.

No obvious evidence of focal hypermetabolism to suggest recurrent tumor activity.

IMPRESSION:

MILD HYPERMETABOLISM SURROUNDING SOMEWHAT LARGER FOCAL AREA OF ABSENT METABOLIC ACTIVITY IS UNCHANGED AND MOST CONSISTENT WITH POST THERAPY CHANGES AT THIS TIME.

Impression shows no recurrence of tumor after more than 18 months post surgery

Attending Radiologist:	FRANCESCHI, DINKO
Ordered By:	MEEK, ALLEN
Order Date:	July 11, 2007 10:15 AM
Completion Date:	July 11, 2007 12:28 PM
Encounter Number:	010038902325
Accession Number:	2625718

Images were reviewed and interpreted by Attending Radiologist: Dr. FRANCESCHI,

Printed by: JOHANNESEN, KARI
Printed on: 7/11/07 15:16

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Fibromyalgia

Nurse - Walking up stairs in 3 hours

Laurie, in her early 40's, was stricken with Fibromyalgia. She had difficulty walking and required help. To up any stairs, she needed to hold onto the rail and have someone help stabilize her as she slowly moved rigidly, one movement at a time. It was a long process. Consequently, it was rare that she would go up the stairs. She also had multiple pains in her body, limiting her movements.

Her family came to see us, her father, mother, brother and her 16 year old daughter. After about 2 – 3 hours, her father and I went up to the second floor to the printing room. After a few minutes, she came walking in to see what we were doing, she was by herself, nobody had helped her. He was surprised and said, "How did you get up those stairs?????" She looked back at the stairs and said, "Oh, yeah did." She did not even realize it. Her daughter was yelling up the stairs, "mom, how did you get up here ??" Obviously, they were all excited by this. Her overall body pain had reduced.

As time continued, she eventually no longer has any evidence of body pain nor Fibromyalgia. I am sure that she probably has some but not a noticeable amount. Over time we anticipate that it will resolve itself completely, as others have found to happen. Prior to seeing us, she was scheduled to see a doctor regarding her pain. Her brother called a few days after the scheduled appointment. She did not go to the appointment because she had no pain.

Multiple Sclerosis

4 years Quad-pelagic - Functions returning

Laura is in her mid-40's, was stricken with MS 4 years ago, with no feeling or sensation from the neck down, totally depressed. We know that is a frustrating and debilitating position to be in. As soon as she started the first week of Sept, her left arm started to regain sensation on the third day, her mental attitude and clarity improved as well. After a week, she had full use of her left arm and 50% use of her right arm. She was able to feel her dog lick her toes. She then was able to get a voice activated program for her computer so that she could talk, which would activate to type for her.

After another week, she was able to wiggle her toes and play with the dogs with her toes, she was able to lift her leg a little with some help, and her speech started to improve. A week later, we received an E-Mail from her, it said "I typed this email all by myself" which meant she no longer needed the voice activated program because she had enough use of her entire left arm and hand to type.

As of the end of October, she can type with both hands, she has 100% use of her entire left arm and hands, now has 100% use of her right arm and hands. She can now lift both legs and move them around up in the air, bend and move them around with out any help. She was hoping to start walking within the first month. After the first two weeks, she tried to walk on her own but did not get far. Her husband found her in the middle of the room on the floor, she was laughing, happy that she was able to accomplish what she did, and she knew it was simply a matter of time. She is set to walk on New Years Eve and will dance with her husband, but her father wants the first dance with his daughter.

Her cognitive abilities are restored, memory is actually great now. Her balance is greatly improved. She has no depression at all and her mental outlook is great. The pain she had in her feet and legs are totally gone. Her body is extremely flexible and no longer brittle. Her handwriting has improved dramatically, she can easily use the computer now. She has had no setbacks nor relapses. She has been filming and documenting everything to show the path she has taken and to show the evident improvements as they occurred.

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Lung Cancer

InOperable - Chest pressure gone after a few days

Rachel was diagnosed with advanced lung cancer, with a mass over 5 cm and multiple small lesions, as well as other masses and lesions in her chest. She was told by the USA doctors that they cannot save her life but they could possibly add time by a few months with the chemo/radiation/surgery therapies. She was not interested in that. She went to Canada to be with her family.

While there, her family contacted us in August 2008, she started this program.

By a week or so, the pressure was no longer evident and she was able to speak normally again. After two months, the huge mass was no longer there. Some of the smaller masses were still evident, but the cloudiness and basic masses were gone. She continually feels improvements as time continues.

Bile Duct/Pancreatic Cancer

After a month, scan "No Evidence"

We did not expect the results as fast these tests showed. However, the following pages document the information. Joe came to us about September 10th. Previously, 7/26/08, CT scan showed numerous tumors: pancreatic tail 1.8 cm, gall bladder – 4.8 cm, lymph node – 1.8 cm. in addition, a 6 mm cyst on pancreas, and 4.9 cm aortic aneurysm. Bilirubin was 18.6, up to 1.2 is normal, ALT/AST/Alk Phos was 48/49/361, norm is 40/37/129. the gave him a stent to help bile flow and to reduce his yellow jaundice. By 9/15, bilirubin was down to 1.7, close to normal. However, AST/ALT rose to 55/64, Alk Phos reduced a little to 311.

They came to see me a few days after that, despite the reduced bilirubin, he was still jaundiced. After two hours, his jaundice was gone, and joints were no longer painful. He felt better, not 100% great, but much improvement. As days continued, he continued to improved.

On October 5, he had a pain and was concerned, went to hospital. To be cautious, they did blood work and a CT scan. To their surprise, his bilirubin reduced to 0.8, and the ALT/AST/Alk Phos reduced to 43/58/218. they were quite happy and surprised because they never expected to see that. The CT scan showed no evidence of gall bladder nor pancreatic tumors, nor the lymph node, all clean. The 6 mm pancreas cyst and aneurism was reduced a little, not significant though.

On Oct 29, the Ct sowed improved results again, the aneurysm reduced a little as well., Bilirubin was 1.1 which is a normal fluctuation, ASTALT/Alk Phos reduced even further down to 34/39/195, they were quite excited.

He felt so wonderful, on Friday, Nov 7, he went to Spain for 5 weeks. He feels great !!!!!!!!!!

Update: Feb 10, 2009 - (see page 14 & 15) PET scan of entire body showed no evidence of any cancer anywhere. See top of page 15 for accurate one sentence summary stating this.

See next pages for reports

NATIONAL CANCER RESEARCH FOUNDATION

ST. CATHERINE OF SIENA MEDICAL CENTER
SMITHTOWN, NY 11787
RADIOLOGY DEPARTMENT

July 26, 2008

PT NAME: ,JOSEPH
DOB: /33
CI D/T: 07/26/08 0938
TRANS DT: 07/26/08 1043
RELEASED: 07/26/08 1044

ACCOUNT #: S0820700282
MR/RAD#: S0003746696
PT TYPE: SIP
LOCATION: 3SS-307-01

SHARMA,RAKESH
122 PORTION ROAD

LAKE RONKONK NY 11779

Chk-in #	Order	Exam	
3617526	0004	20148	CT ABDOMEN W WO CON

Ord Diag: R/O OBSTRUCTION

History: R/O OBSTRUCTION

Technique: CT of the pancreas was performed utilizing 97 cc of Omnipaque-300. A noncontrast CT was performed prior to administration of the contrast.

Comparison: Previous CT 3/30/2006

Findings: Lung bases are clear. The heart is mildly enlarged.

The liver is small. There is intrahepatic bile duct dilatation. The extrahepatic bile duct is poorly visualized. Portal vein is patent. The pancreas is atrophic. In the pancreatic tail is a 1.4 cm low density lesion which was not previously seen In the region of the gallbladder, is an area of decreased enhancement. This measures approximately 4.8 cm. This is a common area of perfusion abnormality. MRI can be performed to further exclude mass.

The gallbladder is abnormal in appearance. The wall is thickened. Areas of high density is seen within the gallbladder wall. There is an enlarged periportal lymph node measuring 1.8 cm. This is new. Kidneys are symmetrically without hydronephrosis.

Incidentally noted is an aneurysm of the aorta measuring up to 4.9 cm.

Adm Date:07/25/08 1614 Dis Date: FINAL

(Continued)

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NATIONAL CANCER RESEARCH FOUNDATION

Saint Catherine of Siena Medical Center
50 Route 25A
Smithtown, NY 11787
Director of Laboratories: Pratima Savargaonkar, M.D.

Patient: , JOSEPH
MRN: 0003746696
FIN: 0820700282

DOB/Sex: 1933 Male
Admission: 07/25/2008

Location: 3SS 307 01
Physican SHARMA, RAKESH

July 29, 2008 Final

General Chemistry

Routine Chemistry

Collected Date	07/30/2008	07/29/2008	07/28/2008	07/27/2008	07/26/2008		
Collected Time	06:25 EDT	06:00 EDT	06:15 EDT	06:00 EDT	06:00 EDT		
Test						Units	Ref Range
Glucose		**150 H**	**139 H**	108	98	mg/dL	[83-110]
BUN		18	**22 H**	15	18	mg/dL	[6-20]
Creatinine		1.2	1.2	1.1	1.2	mg/dL	[0.5-1.2]
BUN/Creat Ratio		15	18	14	15		[12-20]
Sodium		139	140	140	140	mEq/L	[133-145]
Potassium		3.5	3.6	3.8	3.8	mEq/L	[3.3-4.5]
CO2		25.3	25.7	26.9	24.9	mmol/L	[22.0-29.0]
Chloride		107	106	107	107	mEq/L	[96-108]
AGAP		**7 L**	8	**6 L**	8		[8-16]
Calcium		9.2	8.8	9.5	9.4	mg/dL	[8.8-10.2]
Total Protein	6.4		**6.3 L**		6.5	gm/dL	[6.4-8.3]
Albumin.	3.4		**3.2 L**		3.5	gm/dL	[3.4-4.8]
Bilirubin Total	**-----> 18.6 Cf**		**-----> 13.6 H**		**6.9 H**	mg/dL	[0.0-1.0] <-----
Bilirubin Direct	**13.4 H**		**9.2 H**		**5.4 H**	mg/dL	[0.0-0.3]
ALT	**-----> 48 H**		**-----> 62 H**		**86 H**	unit/L	[10-40]
AST	**-----> 49 H**		**-----> 58 H**		**63 H**	unit/L	[0-37]
Alk Phos	**-----> 361 H**		**-----> 343 H**		**359 H**	unit/L	[40-129]

Special Chemistry

Special Chemistry

Collected Date	07/26/2008		
Collected Time	06:00 EDT		
Test		Units	Ref Range
CEA f	2.1	ng/mL	[0.0-3.8]

07/30/2008 06:25 EDT Bilirubin Total:
Results confirmed, panic value range.
Notified k geick rn on unit 3s at time 0925 .
Read back to j vanscoy

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NATIONAL CANCER RESEARCH FOUNDATION

Saint Catherine of Siena Medical Center
50 Route 25A
Smithtown, NY 11787
Director of Laboratories: Pratima Savargaonkar, M.D.

Patient: , JOSEPH
MRN: 0003746696
FIN: 0825200016

DOB/Sex: /1933 Male
Admission: 09/08/2008

Location: 3NS 334 02
Physican SHARMA, RAKESH

Sept 8 - 15, 2008

Cumulative

General Chemistry

Routine Chemistry

Collected Date	09/15/2008	09/12/2008	09/11/2008	09/10/2008	09/09/2008		
Collected Time	07:15 EDT	06:00 EDT	07:20 EDT	07:22 EDT	07:05 EDT		
Test						Units	Ref Range
Glucose	108	108	**144 H**	**126 H**		mg/dL	[83-110]
BUN	12	11	13	10		mg/dL	[6-20]
Creatinine	1.0	0.9	0.9	1.0		mg/dL	[0.5-1.2]
BUN/Creat Ratio	12	12	14	**10 L**			[12-20]
Sodium	142	143	139	140		mEq/L	[133-145]
Potassium	**4.8 H**	3.7	3.8	3.6		mEq/L	[3.3-4.5]
CO2	27.8	25.0	**21.2 L**	24.4		mmol/L	[22.0-29.0]
Chloride	107	**109 H**	**109 H**	108		mEq/L	[96-108]
AGAP	**7 L**	9	9	8			[8-16]
Calcium	9.5	**8.6 L**	**8.7 L**	**8.7 L**		mg/dL	[8.8-10.2]
Total Protein	**6.2 L**	**5.9 L**	**6.1 L**	**6.2 L**	**5.9 L**	gm/dL	[6.4-8.3]
Albumin.	**3.2 L**	**3.0 L**	**2.9 L**	**3.1 L**	**3.0 L**	gm/dL	[3.4-4.8]
Bilirubin Total	-----> **1.7 H**	**2.1 H**	**2.5 H**	**4.4 H**	**7.2 H**	mg/dL	[0.0-1.0]
Bilirubin Direct	**1.0 H**	**1.2 H**		**3.0 H**	**5.7 H**	mg/dL	[0.0-0.3]
ALT	-----> **55 H**	**50 H**	**60 H**	**82 H**	**116 H**	unit/L	[10-40]
AST	-----> **64 H**	**40 H**	**39 H**	**64 H**	**140 H**	unit/L	[0-37]
Alk Phos	-----> **311 H**	**279 H**	**332 H**	**392 H**	**461 H**	unit/L	[40-129]

Collected Date	09/08/2008			
Collected Time	08:42 EDT			
Test		Units	Ref Range	
Glucose	**137 H**	mg/dL	[83-110]	
BUN	16	mg/dL	[6-20]	
Creatinine	1.0	mg/dL	[0.5-1.2]	
BUN/Creat Ratio	16		[12-20]	
Sodium	141	mEq/L	[133-145]	
Potassium	4.2	mEq/L	[3.3-4.5]	
CO2	24.4	mmol/L	[22.0-29.0]	
Chloride	105	mEq/L	[96-108]	
AGAP	12		[8-16]	
Calcium	9.1	mg/dL	[8.8-10.2]	
Total Protein	7.4	gm/dL	[6.4-8.3]	
Albumin.	4.0	gm/dL	[3.4-4.8]	
Bilirubin Total	**4.3 H**	mg/dL	[0.0-1.0]	

This blood work was taken 6 weeks after a stent was placed. Bilirubin came down considerably, but not down to normal levels.

Alk Phos Reduced a little
AST & ALT increased instead of reduced

The program was started the week after this bloodwork

LEGEND: *=Abnormal C=Critical f=Interp Data !=Corrected L=Low H=High @=Ref Lab f=Footnote

8

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NATIONAL CANCER RESEARCH FOUNDATION

Saint Catherine of Siena Medical Center
50 Route 25A
Smithtown, NY 11787
Director of Laboratories: Pratima Savargaonkar, M.D.

Patient: , **JOSEPH**
MRN: 0003746696
FIN: 0827900083

DOB/Sex: /1933 Male
Admission: 10/05/2008

Location: TES 242 02
Physican SHARMA, RAKESH

Oct 6, 2008

Cumulative

General Chemistry

Routine Chemistry

Collected Date	10/06/2008	10/05/2008		
Collected Time	06:00 EDT	07:52 EDT		
Test			Units	Ref Range
Glucose	100	**196 H**	mg/dL	[83-110]
BUN	16	20	mg/dL	[6-20]
Creatinine	1.1	1.2	mg/dL	[0.5-1.2]
BUN/Creat Ratio	15	17		[12-20]
~~Sodium~~	~~141~~	~~140~~	~~mEq/L~~	~~[133-145]~~
Potassium	4.0	4.1	mEq/L	[3.3-4.5]
CO2	26.4	26.4	mmol/L	[22.0-29.0]
Chloride	107	104	mEq/L	[96-108]
AGAP	8	10		[8-16]
Calcium	**8.7 L**	9.2	mg/dL	[8.8-10.2]
Phosphorus		3.4	mg/dL	[2.7-4.5]
Total Protein	**5.9 L**	6.9	gm/dL	[6.4-8.3]
Albumin.	**3.1 L**	3.6	gm/dL	[3.4-4.8]
----->Bilirubin Total	0.8	1.0	mg/dL	[0.0-1.0]
Bilirubin Direct	0.3	**0.5 H**	mg/dL	[0.0-0.3]
Uric Acid		4.0	mg/dL	[3.4-7.0]
----->ALT	**43 H**	**44 H**	unit/L	[10-40]
----->AST	**58 H**	**64 H**	unit/L	[0-37]
GGT	**143 H**		unit/L	[8-61]
----->Alk Phos	**218 H**	**235 H**	unit/L	[40-129]

Cardiac Tests

Collected Date	10/05/2008	10/05/2008	10/05/2008		
Collected Time	23:00 EDT	14:51 EDT	07:52 EDT		
Test				Units	Ref Range
Troponin-T	0.010	0.010	0.010	ng/mL	[<=0.030]
CK MB	2.7	3.1	3.2	ng/mL	[0.0-5.0]
Total CK	**23 L**			unit/L	[38-174]
~~Myoglobin~~	~~30~~	~~29~~	~~30~~	~~ng/mL~~	~~[28-72]~~

All results showing reduction, Bilirubin in normal range
Alk Phos reducing better
AST & ALT reducing

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ST. CATHERINE OF SIENA MEDICAL CENTER
SMITHTOWN, NY 11787
RADIOLOGY DEPARTMENT

PT NAME: ,JOSEPH
DOB: /33
CI D/T: 10/05/08 0950
TRANS DT: 10/05/08 1042
RELEASED: 10/05/08 1043

ACCOUNT #: S0827900083
MR/RAD#: S0003746696
PT TYPE: SIP
LOCATION: DIS - SIP

Oct 5, 2008

OSHAUGHNESSY,PATRICK
88 ARKAY DRIVE

HAUPPAUGE NY 11788

Chk-in #	Order	Exam	
3745407	0002	20148	CT ABDOMEN W WO CON
			Ord Diag: ABDOMINAL PAIN
3745408	0002	20075	CT PELVIS W CON
			Ord Diag: ABDOMINAL PAIN

Delayed images were also obtained CT of the abdomen and pelvis with intravenous contrast

Clinical History: Abdominal aortic aneurysm. Cancer hepatic ducts cholangiocarcinoma or Klatskin tumor liver

Technique: Helical scanning was performed of the abdomen and pelvis from the lung bases to the ischial tuberosities following the administration of oral contrast and intravenous administration of 97 ml of nonionic intravenous contrast. 5 x 5 mm cuts were used. Non intravenous contrast images of the abdomen were done prior to the administration of IV contrast delayed images of the abdomen pelvis were also obtained in equilibrium
.Post processed reformatted 2D images were obtained in the coronal planes.

Comparison study: CT abdomen pelvis 9/8/2008

Findings:
There is evidence of a infrarenal abdominal aortic aneurysm which does not extend to the bifurcation. The abdominal aortic aneurysm measures 4.4 x 4.9 cm and image 50 on the prior aneurysm measured 4.65 x 4.5 cm

See next page for comparison

Adm Date:10/05/08 0720 Dis Date:10/06/08 1755 FINAL

(Continued)

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ST. CATHERINE OF SIENA MEDICAL CENTER
SMITHTOWN, NY 11787
RADIOLOGY DEPARTMENT

PT NAME: ,JOSEPH
DOB: /33
CI D/T: 10/05/08 0950
TRANS DT: 10/05/08 1042
RELEASED: 10/05/08 1043

ACCOUNT #: S0827900083
MR/RAD#: S0003746696
PT TYPE: SIP
LOCATION: DIS - SIP

OSHAUGHNESSY,PATRICK
88 ARKAY DRIVE

HAUPPAUGE NY 11788

Oct 5, 2008

Checkin-Exam Code Summary
3745407-20148,3745408-20075

online measurements the measured 4.6 x 4.75 cm. There is a crescent area of low attenuation seen in the left side of the abdominal aortic aneurysm and the calcium is not displaced most likely mural thrombus. The aneurysm is about 2 cm below the renal vessels. There is no extravasation of contrast. Both common iliac arteries demonstrate atherosclerotic calcification without evidence of aneurysm there is mural thrombus of the left common cautery. There is no retroperitoneal hemorrhage. The celiac and supra mesenteric vessels and renal vessels appear patent

The lung bases demonstrate mild pleural thickening. There is scarring seen at the inferior aspect of the lingula The spleen is unremarkable The gallbladder are is mildly distended. The tail of pancreas 6 mm low attenuation lesion on image 30 which is unchanged

The common duct is not dilated however there is intrahepatic biliary tree dilatation with a stent in the in the duodenum entering the common duct and the distal aspect is seen in the periphery of the right hepatic ducts. In image 25 there is abnormality at the confluence of the right left hepatic ducts most likely a Klatskin tumor or cholangiocarcinoma There is new air within the biliary tree

----> The liver is normal size and no focal masses are demonstrated within the liver parenchyma. There are no enlarged lymph nodes

The 1.8cm lesion on the pancreatic tail and 4.8cm on the gall bladder are no longer seen.
The 6mm cyst on the pancreas is still seen.
The 1.8 cm enlarged lymph node is no longer seem.
The aortic aneurysm was reduced a little from 4.9 cm.

Adm Date:10/05/08 0720 Dis Date:10/06/08 1755 FINAL

(Continued)

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NATIONAL CANCER RESEARCH FOUNDATION

ST. CATHERINE OF SIENA MEDICAL CENTER
SMITHTOWN, NY 11787
RADIOLOGY DEPARTMENT

PT NAME: ,JOSEPH
DOB: /33
CI D/T: 10/29/08 1323
TRANS DT: 10/29/08 1356
RELEASED: 10/29/08 1358

ACCOUNT #: S0830300267
MR/RAD#: S0003746696
PT TYPE: SER
LOCATION: DIS - SER

TROPE,SHLOMO
88 ARKAY DRIVE

Oct 29, 2008

HAUPPAUGE NY 11788

Chk-in #	Order	Exam	
3789849	0002	20148	CT ABDOMEN W WO CON Ord Diag: ABDOMINAL PAIN
3789851	0002	20075	CT PELVIS W CON Ord Diag: ABDOMINAL PAIN

CT abdomen pelvis.

History: Abdominal pain.

Multiple sequential axial images were obtained from the domes of the diaphragms through the liver following administration of oral contrast. Following the administration of intravenous contrast, multiple sequential axial images were obtained from the domes of the diaphragms through the pubic symphysis. Coronal reconstructions were obtained.

The liver demonstrates normal size and contour. There is intrahepatic bile duct dilatation. There is pneumobilia. If a intrahepatic biliary and extending to the duodenum is identified. The spleen is normal. There is no evidence of pancreatic mass or pancreatic ductal dilatation. The adrenal glands are normal. There is no evidence of renal mass, hydronephrosis or calculus. There is no evidence of ascites or adenopathy. There is a 4.6 cm infrarenal abdominal aneurysm.

Impression:
Biliary stent. Pneumobilia. Intrahepatic bile duct dilatation.

There was no evidence of the previous 4.8 cm bile duct tumor, nor the 1.8 cm pancreatic tumor, nor the 1.8 lymph node. The only thing evident was the pre-existing aneurysm.

Date:10/29/08 0821 Dis Date:10/29/08 1530 FINAL

(Continued)

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NATIONAL CANCER RESEARCH FOUNDATION

Saint Catherine of Siena Medical Center
50 Route 25A
Smithtown, NY 11787
Laboratory Services
Phone/Fax Number: 631-862-3050/631-862-3178

Patient: , JOSEPH
DOB: 1933

Location: SLAB

Saint Catherine of Siena Medical Center
50 Route 25A
Smithtown, NY 11787

Dr. CARFORA, ROXANNE

Nov 2, 2008

General Chemistry

Routine Chemistry

Collected Date 11/02/2008
Collected Time 10:05 EDT

Test		Units	Ref Range
Glucose	**123 H**	mg/dL	[83-110]
BUN	**23 H**	mg/dL	[6-20]
Creatinine	1.1	mg/dL	[0.5-1.2]
BUN/Creat Ratio	**21 H**		[12-20]
Sodium	140	mEq/L	[133-145]
Potassium	**4.9 H**	mEq/L	[3.3-4.5]
CO2	26.7	mmol/L	[22.0-29.0]
Chloride	105	mEq/L	[96-108]
AGAP	8		[8-16]
Calcium	9.6	mg/dL	[8.8-10.2]
Magnesium	2.07	mg/dL	[1.60-2.60]
Total Protein	7.3	gm/dL	[6.4-8.3]
Albumin	3.9	gm/dL	[3.4-4.8]
-----> Bilirubin Total	**1.1 H**	mg/dL	[0.0-1.0]
-----> ALT	34	unit/L	[10-40]
-----> AST	**39 H**	unit/L	[0-37]
-----> Alk Phos	**195 H**	unit/L	[40-129]

Glucose was not during "Fasting" therefore that is a good result.

Normal Glucose is generally 80 - 125, not to 110.

Cardiac Tests

Collected Date 11/02/2008
Collected Time 10:05 EDT

Procedure		Units	Ref Range
CRP High Sens	0.90	mg/L	[<=5.00]

The AST, ALT and Alk Phos All dropped cosiderably Bilirubin is at high normal, but that is still a great reading

Lipid Studies

Collected Date 11/02/2008
Collected Time 10:05 EDT

Test		Units	Ref Range
Chol	200	mg/dL	[0-200]
Trig	**251 H**	mg/dL	[0-200]

Cholesterol is reducing without meds - Great
Triglycerides are reducing as well without meds
Great improvements !!!!!!!!!!!!!

Legend: *=Abnormal C=Critical f=Interp Data !=Corrected L=Low H=High @=Ref Lab f=Footnote

Report Printed: 11/3/2008 14:21
Chart Request ID: 1427617

Patient: , JOSEPH
MRN: 0003746696
Admit Age: 75 years

Page 1

Director of Laboratories: Pratima Savargaonkar, M.D.

Page 1 of 7

PET/CT Imaging Torso , JOSEPH - 30226240

* Final Report *

Feb. 10, 2009

Not Official Copy:	PET/CT Imaging Torso
Flowsheet Date:	10 February 2009 15:28
Result status:	Final
Result title:	PET CT IMAGING TORSO
Performed by:	FRANCESCHI, DINKO on 10 February 2009 15:28
Verified by:	FRANCESCHI, DINKO on 10 February 2009 15:28
Encounter info:	010045240594, Stony Brook University Hospital, OP Private, 2/10/09 - 2/10/09

* Final Report *

PET CT IMAGING TORSO

"This document may contain an image. PLEASE BE AWARE: You are about to open the patient image folder. Be sure to review and select only the desired image sets prior to clicking DISPLAY."

PET/CT imaging

HISTORY: Cholangiocarcinoma for restaging. No history of therapy provided.

FBS is 106 mg/dl.

TECHNIQUE: On 2/10/2009, patient was given 13 mCi of FDG intravenously while resting semisupine. Approximately one hour post injection of radiotracer, tomographic images were obtained from the base of the skull to the upper thighs, using Siemens Biograph LSO with 40 slice CT. Fusion of PET and CT images was performed for anatomical correlation. There is previous PET/CT scan on 8/5/2008 available for comparison.

Please note that CT scan is used for attenuation correction and fusion. Oral contrast was utilized.

FINDINGS: There is physiological radiotracer distribution.

No abnormal hypermetabolic foci in the head and neck region.

No evidence of hypermetabolic lung nodules. Atelectatic changes noted at bilateral lung bases, greater on the left side. No hypermetabolic adenopathy in the chest and axillary regions.

No abnormal focal hypermetabolism in the abdomen and pelvis. Diffuse bowel hypermetabolism may suggest diarrhea associated disease. Again evidence of biliary stent and aortic abdominal aneurysm up to 5.5 cm in diameter.

IMPRESSION:

See Next page for the summary - "IMPRESSION"

Printed by: GANNON, DOLORES
Printed on: 2/20/09 15:11

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PET/CT Imaging Torso , JOSEPH - 30226240

* Final Report *

Feb. 10, 2009

--> NO ABNORMAL HYPERMETABOLISM TO SUGGEST NEOPLASTIC ACTIVITY. <--------

Attending Radiologist: FRANCESCHI, DINKO
Ordered By: BEST, HENRY
Order Date: February 10, 2009 2:00 PM
Completion Date: February 10, 2009 3:28 PM

Encounter Number: 010045240594
Accession Number: 3192377
Images were reviewed and interpreted by Attending Radiologist: Dr. FRANCESCHI, DINKO

Electronically Signed On: February 11, 2009 10:29 AM by Dr. FRANCESCHI, DINKO

STONY BROOK UNIVERSITY HOSPITAL
DEPARTMENT OF RADIOLOGY
STONY BROOK, NY 11794-7300

Completed Action List:
* Order by BEST, HENRY IV on 04 February 2009 15:54
* Perform by FRANCESCHI, DINKO on 10 February 2009 15:28
* VERIFY by FRANCESCHI, DINKO on 10 February 2009 15:28
* Assist by on 10 February 2009 15:28

Printed by: GANNON, DOLORES
Printed on: 2/20/09 15:11

Page 2 of 2
(End of Report)

Brain Cancer

No Longer Evident

OK, how do I explain this one, hmmmm

John lives about 10 – 15 miles from me. He had brain cancer, in the base of the stem, non-operable because it was so large.

He started this about Jan-Feb, by May, there was no evidence of cancer. He stopped, figured he was cured and no longer needed it anymore. I cannot tell anyone what to do, it is their choice. A month ago, there was evidence of a recurrence, his doctor wanted to do immediate surgery while it was still small.

He refused and started 6 dosages immediately, felt better and was not concerned. His doctor continued to call numerous times, he gave in and had the surgery even though he was feeling better.

He had the surgery last Friday, Nov 11, 2005. Upon surgery, the surgeon found that at least half the cancer cells were dead and it was mush. He really did not need the surgery.

He was home in two days, up on his feet and getting around easily. This past Saturday, Nov 19, he come out to see us, he walked and acted totally normal as if he was never sick.

He took off his hat and the scar was already skin color. One week, healed and scar was normal skin color.

Needless to say, this very sweet man was very happy. His doctor had no interest in this.

Freddie

Update:

It is common to have swelling as a result of brain surgery, but John had virtually no swelling of any kind. A few weeks later, although he did not have swelling, the doctor wanted to insert a stent “Just in case” he gets any swelling, and assured him that it was a standard preventative measure and an easy procedure. As a result, he got a massive staph infection which infected the brain, he died as a result of the infection, yet, he did not have swelling and did not have cancer. We were absolutely distraught. This man and his wife are so sweet, it was a terrible shame.

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Hormone Imbalance correction / Restored energy

Hi Fred, I just wanted to let you know I really love what it has done. I truly believe that it saved my life. My hormones were so imbalanced that I could not get out of bed for days at a time, I had no period and I started to feel like I did not want to live anymore. This has not only balanced my hormones – it has also given me my strength and energy back. My moods are **SOOOO** much better and my skin looks smoother. I also had quite a few skin tags on my neck that have completely disappeared !!! I have recommended this to a lot of my friends and I only do that when I really believe in a product. Thank You and stay Strong – you have helped countless people and are doing great things for this world.

Sincerely,

Jennifer

Uterine Fibroids & Ovarian Cysts

Dear Fred,

I received your card and Newsletter. I was very happy to read all of the good things happening for you & family.

Previously, a scan was done on Jan 19, 2004, a D & C was done Jan 28, 2004. On Feb 5, 2004, Dr. Jean diagnosed that I had uterine fibroids in the uterus wall and left ovarian cysts, bleeding & clotting, suggested a hysterectomy.

A second scan was done on March 25, 2004, which showed no change in sizes of fibroids or cysts, however, heavy bleeding and clotting continued.

In May 2004, Dr. Kenul told me about your work, I first came to see you on June 12, 2004, I brought my scans and blood work with me. The next day, I decided to start at dosage 3, it helped me very much. July 2, we went on a boating vacation for 7 days, there was "NO BLEEDING" !!! during August 2004, there was sporatic spotting, no pressure, no clots, I did not miss any days of work the entire summer.

Sept 9, 2004 Dr. Jean did a full internal exam. The fibroids - almost none were palpable and no sign of any cysts. He was surprised. He then told me that if I can live with the spotting, he'll see me in April 2005.

I will keep you updated. Thank you so much,

Debbie

Liver Cancer

see scans on pages 4 & 5

Tests on October 6, 2007 documented that Wendy had liver cancer in 2 locations, she was given a few months to live in Oct 2006. She said that they demanded that she immediately start chemo and radiation to offer her additional time to live. She changed doctors and chose one more familiar with her chosen goals.

In January 2007, they could not find anything, the radiologist still wondered if it was an infection, except that the previous tests verified that it was cancer, only because they are not accustomed to witnessing these results. She is fine, currently shows no evidence that she ever had a problem, however, the previous records document that she previously did have a problem back in October 2006. 6/30/08 - She is fine today

BAB Radiology

Paul Bonheim, M.D., F.A.C.R.
Michelle Multz, M.D., D.A.B.R.
Philip Beuchert, M.D., D.A.B.R.
Barbara Moriarty, M.D., D.A.B.R.
Ron Mark, M.D., D.A.B.R.

Jeffrey M. Warh , M.D., D. .B.R.
Melissa Sapan, M.D., D.A.B.R.
Stuart Katz, M.D., D.A.B.R.
Elizabeth Schult , M.D., D. .B.R

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PKWY
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FAX: (631) 205-5588

10/07/2006

October 7, 2006

RE: , **Wendy**
DOB: /1956
Date of Exam: 10/06/2006

De r Dr.

MI I OF THE ABDOMEN

CL NICAL HISTOI .Y: Abdominal pain, abnormal CT, abnormal ultrasound, focal liv lesion.

The examination was erformed with a GE 1.5 Tesla High Field Superconductive Magnet.

Cor ment: MRI of the abdomen was performed using axial T1 weighted images, axia T2 wei hted images, axia inversion recovery images, axial T1 weighted gradient echo images in and ut of phase, and a xial T1 gradient echo images obtained following the dynamic adm nistration of intra enous contrast.

The e images demonst ate two lesions in the liver, both of which have MR sig al cha cteristics most co sistent with metastatic disease. One of these lies at the lateral a spect of t the right lobe of the liver, near the junction of the anterior and posterior segments, a d is best lepicted on axial at saturated pre contrast T1 weighted image # 20 in seri s 7, 1.4 x 1.8 cm. This lesion would be amenable to percutaneous sampling.

Add ionally, there is a lesion in the posterior segment of the right lobe hepatic dome, a xial fat s turated pre contra t image # 15 of series 7, 1.3 x 1.5 cm. No other suspec focal l ver lesi n is seen. The spl en, adrenal glands, pancreas and kidneys are unremarka ble, wit the exc tion of a 9 mm ri ht anterior innerpolar renal cyst. No primary tumor is s en in t e abd nen.

Foll wing the admini t ation of intravenous contrast, both liver lesions enhanc with cont uous rim enhanc ment, also consistent with metastatic disease.

There were two liver lesions:
1.4 x 1.8 cm & 1.3 x 1.5 cm - extremely high concern.

Also a kidney cyst 9 mm. The kidney cyst is common and not of any concern.

BAB Radiology

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Melissa Sapan, M.D., D.A.B.R.
Stuart Katz, M.D., D.A.B.R.
Elizabeth Schultz, M.D., D.A.B.R.

January 9, 2007

01/09/2007

Roxanne Carfora, M.D.
353 Veterans Memorial Highway
Commack, NY 11725

RE: , **Wendy**
DOB: /1956
Date of Exam: 01/09/2007

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FAX: (631) 205-5588

Dear Dr. Carfora:

MRI OF THE ABDOMEN WITH CONTRAST

Clinical History: 50 year old with pain and two liver lesions, for follow-up.

15 cc of Gadolinium contrast was administered and MRI imaging was performed utilizing multiple sequences. Comparison is made with a prior MRI dated 10/6/06.

Bilateral breast implants are seen. The heart and lung bases are unremarkable. The spleen and kidneys appear unremarkable. The spine, aorta and IVC are unremarkable. The previously noted liver lesions have almost completely resolved. There is subtle heterogeneous signal seen along the lateral aspect of the right lobe on axial images 7-12 and best seen on the post-contrast enhanced study. These lesions are smaller and significantly less well identified on today's examination. The possibility that these represented areas of infection is a consideration. Another area of enhancement is seen in the posterior segment of the right lobe above the right kidney near the right hepatic vein. The possibility that these represented other forms of hepatic disease is also in the differential. The gastrointestinal tract is grossly unremarkable. I do not see any adenopathy, aneurysm or bowel abnormalities.

IMPRESSION: The two dominant liver lesions are significantly smaller than on the prior study and are only well seen on the early post-contrast images. The primary differential considerations included focal areas of infection or possibly neoplastic lesions which are being treated and continued follow-up and clinical correlation is suggested.

Sincerely,

Philip Beuchert MD

Philip Beuchert, M.D.
PH/iw
Philip Beuchert, M.D., electronically signed this document.

As notated in "IMPRESSION", there was no evidence of Cancer Evidence could only be seen on the images on the prior 10/7/06 study.

Additional testing after this scan verified that it had been cancer.
As of March 2008, all tests still show no evidence of cancer.
Her health has been back to normal as though nothing happened

AWARDED ACCREDITATION IN DIAGNOSTIC RADIOLOGY BY THE AMERICAN COLLEGE OF RADIOLOGY
If you have received this report in error, please notify the imaging center immediately at the telephone number provided

Double Carotid Artery Blockage 85% & 95% - 3 strokes 2 heart attacks

Background:

Cesar, born 1923, had 2 heart attacks in 2001, then triple colon cancer in January 2002, Flushing Hospital gave him 45 days (at best) to live at that time. He refused all conventional treatment (refused surgery, 5FU and radiation) he did get colostomy.

He started mineral program January 2002, and was documented "No Evidence" as of June 2002. Additionally, cardiac issues resolved with no residual problems. However, he stopped the program the fall of 2003, as he decided that he was cured and no longer needed it.

On the week of March 25, 2004, he suffered 3 strokes and 2 heart attacks, Dr. Batoon at Flushing Hosp declared him totally brain dead with no activity and that he would pass that night. He did not die, April 9, he went to a nursing home. On April 15, Dr. Wahid agreed to install a feeding tube and Jr. gave him 10 - 15 doses daily. April 20, Jr. called to tell me that Sr. was pinching the nurses. Talking normal by April 24. By April 29, he went home because he regained almost everything back to normal: speech, comprehension, eyesight, gag-reflex, eating, etc. Feeding tube came out in mid May 2004, he ate on his own without difficulty, no coughing. He did not re-gain his use of the left arm back, and because he has two carotid artery blockages, 95% in one and 100% in the other, we needed a surgeon to take it out.

The doctors he dealt with, including the visiting doctor, all state that he is the only person they ever saw recover from “totally brain dead”, they’re afraid to perform surgery because they have absolutely no idea what to expect.

Jr was able to wean Sr off all medications and all vitals were middle - line normal, BP was always stable at 130/64 and pulse ranged between 60 – 74. All his bodily functions were fine.

Due to their financial stress, we gave them the minerals at no cost, I did not want to see him die. In January, 2005. he ran out, he was too embarrassed to tell me, we immediately sent it to him but he was out of it over a week, BP went up to 280+, and pulse 200. The minerals arrived. While the visiting doctor was there, he monitored and documented a stroke in progress, during that, Jr. started the minerals, and this doctor watched the stroke regress and diminish. He did lose some muscle tone as a result, but everything else restored and he was eating normally in two days. A portable radiology tech came, they documented that he still had no evidence of any cancer anywhere in his body.

Again, he ran out last Friday, February 4. On Monday, BP was 245/114 and pulse was 174. The visiting doctor refused to come when called because he had no idea why Sr. stayed alive, he was confused and wanted no part of it, and no interest to learn from it.

The Minerals arrived on Tuesday, February 8. After getting the minerals in him, BP dropped to 180/90, then 150/ 85 and after a short while, he stabilized at 130/64 again with low pulse again, and been fine since.

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Heart failure and quad bypass

Paul

I had a different person age 68, in Germany, who was refused a bypass because of his advanced condition, this program helped his condition, 5 months later, he flew here to Pennsylvania, quad by-pass on Monday, released on Thursday, flew back to Germany on Saturday. He has been fine since, 6 months later, the scar was pencil-line thin, hardly noticeable. He is fine today, now in process of purchasing Maagdeborg Airport in Berlin.

Multiple Myeloma

From: Forinda
Sent: Friday, October 08, 2004 9:29 PM
To: Fred Eichhorn
Subject: Update and Order

Hi Fred and Lora,

Just wanted you to know that Mom's platelet count went up from 46 to 110 in 2 weeks. What an improvement!!! Her red blood cells are no longer dropping. For the past 2 weeks, the count held at 2.70. Many of the other levels, i.e., sodium, calcium , potassium , etc., are in the normal range.

However, ALk. Phos jump 16 points. Should we be concern? We'll get her Lambda Free Light chain numbers next week. I hope they are also down. The doctor wants to start her on Valcade in 3 weeks.

Forinda

Pancreas and Liver Cancer

see scans on pages 8 & 9

Previously Lorena, 50 years old, had many biopsies to confirm her very advanced pancreatic and liver cancer. In March, the scan showed 6 cm pancreatic cancerous tumor and 7 liver lesions. Her doctors told her that there were no options for her, none of the previous chemo treatments worked, they told her to contact hospice for the remainder of her time left. Previously, she was told that she had no choice but to take chemo to add time to her life, she was given a short time to live. Because of her intense pain, she was taking daily: 60 mg Oxycodone, Morphine, Fentanyl patches, plus muscle relaxers. She had no appetite and lost so much weight that she was down to between 75 – 80 pounds. She lived in Vancouver Canada, her sisters went up to help her. After a week at dosage 6 - 8, she was feeling better and could walk, she came down here to New York. By May, she was off the Morphine and Fentanyl patches and reduced to 10 mg Oxycodone every other day. By June 15, she totally weaned off all pain medications. May 5, the PET scan was done at Roosevelt/St. Lukes Hospital in NYC, it showed that the tumor reduced from 6 cm down to 1.4 cm during that 5 week period. The doctor at Roosevelt was a true gentleman, he was also confused and told the family that he never saw anything like this happen before because pancreatic cancer is aggressive. Today, she is back in Canada, continues to improve and is living her life the way she knew it previously. **11/20/08 - She is fine today**.

March 28, 2008

BC Cancer Agency
Vancouver Centre

DIAGNOSTIC IMAGING REPORT

0613073

March 2008

LORENA,
9854 013 757
1958

DATE: 26 March 2008
DIAGNOSIS: Pancreatic Ca
REQUISITIONED BY: Dr. S. Gill
PARTS EXAMINED: CT Chest, Abdomen & Pelvis

CT CHEST, ABDOMEN & PELVIS:

INDICATION: Locally advanced pancreatic cancer.

Technique: Study performed post I.V. contrast.

Comparison: Previous CT abdomen & Pelvis, November 29, 2007.

CT ABDOMEN & PELVIS:

A hypodense pancreatic mass is again identified which appears to be arising form the posterior aspect of the body. This encases the celiac axis and splenic artery and remains stable in maximum transverse
6 cm --->> dimensions at 6 cm (image 109/ series 601). The left renal vein is no longer visualized, likely completely compressed and there is extensive varices seen in the region of the left renal hilum. There has been interval placement of common bile duct stent with resultant pneumobilia. The remaining solid organs are unremarkable. No significant retroperitoneal or pelvic lymphadenopathy is seen. No bony metastases are identified.

CT CHEST:

No discrete pulmonary nodules are seen. No significant axillary mediastinal, hilar or retrocrural adenopathy is seen. A right-sided port-a-cath is in situ in a satisfactory position.

IMPRESSION:

The moderate size pancreatic mass remains stable in size. However, there has been interval complete compression of the left renal vein with multiple collaterals now present at the left renal hilum. No evidence of distant metastases seen.

Dr. H. O'Dwyer
Radiologist

D: 26 Mar 2008
T: 02 Apr 2008
/lt

c Dr. RAUL CARVALHO
Dr. ALAN WEISS

Daily Pain Medications taken at this date:

Oxycodone - 60 mg
Morphine
Fentanyl Patch
Morphine Syrup

Signed electronically by:O'Dwyer, Helena 02 Apr 2008 15:34

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NATIONAL CANCER RESEARCH FOUNDATION

Patient Loc: CCMR
Status: O
MRID: D0569179

D0569179
LORENA,
DOB: -1958 Sex: F

COLOMBUS CIRCLE PET
ROOSEVELT DIVISION

Radiology Consultation

May 5, 2008

Physician: WANG, JOHN

3325867 5-May-200810:55 AM Requested by: WANG, JOHN
PET MISCELLANEOUS TUMOR IMAGIN

There are subcentimeter nodes in the AP window measuring up to 6 mm in short axis. There is very little fat in the mediastinum. There are no definite hilar or mediastinal or axillary lymph nodes. There is no pulmonary mass or nodule or infiltrate or pleural fluid.

Abdomen:

There is gas noted in dilated bile ducts with a stent running from the common hepatic duct into the duodenum. There is very little fat in the abdomen. There is a large mass in the region of the pancreatic head and body with partial obstruction on the stomach in the region of the pylorus. Corresponding functional images demonstrate heterogeneous multifocal hypermetabolic activity, maximal SUV values ranging 2.4-3.2. Contrast material does reach the jejunum. There are no focal masses in the liver or spleen. The kidneys show no obvious masses. There are multiple lymph nodes in the region of the celiac axis and SMA that cannot be accurately measured due to lack of intravenous contrast and paucity of fat. They measure approximately 1.4 cm. Corresponding functional images demonstrate mild hypermetabolic activity, maximal SUV ranging 2.4-2.6. There are hypermetabolic left paraaortic lymph nodes measuring up to 1.2 cm, maximal SUV up to 3.1. There are peritoneal nodular soft tissue densities in the left lateral abdomen (for example images 164-167) which demonstrate mild focal hypermetabolic activity, maximal SUV up to 1.4. In addition, there are several nodular foci of hypermetabolism in the periphery of the liver and in the anterior abdomen to the left of midline, maximal SUV ranging 1.8-2.2.

<<--- 1.4 cm

Pelvis:

There is no obvious pelvic adenopathy. There is fluid in the cul-de-sac. The sigmoid colon is distended with stool. The small intestine looks normal. There are nodular hypermetabolic foci in the pelvis, maximal SUV ranging 2.1-5.0. These foci are not confined to physiologic bowel pattern and are suspicious for metastatic implants. The uterus is present. Ovaries are not seen.

Daily Pain Medications taken at this date:

Oxycodone - Reduced from 60 mg down to 10 mg
By June 12, she weaned off Oxycodone completly
Morphine - off completely
Fentanyl Patch - off completely
Morphine Syrup - off completely

Update: July 10, she is feeling great reagained a lot of the weight she lost
She feels normal as though she was never previously sick, with no problems

Patient Loc : CCMR **UPDATE: July 21, 2008** D0569179
Status : 0 LORENA,
Loc at Sched : CCMR DOB : 1958 Sex : F
ROOSEVELT DIVISION
COLOMBUS CRICLE PET

Radiology Consultation

Physician:
WANG, JOHN
426 WEST 58th St.
GROUND FL.
NEW YORK NY 10019

3372530 21 - Jul – 2008 12 : 23 PM Requested by: John Wang
PET MISCELLANEOUS TUMOR IMAGIN / LOCM 100CC

Clinical Information : **Metastatic pancreatic carcinoma**. The patient received chemotherapy (February 2008) . Prior PET/CT in **May 2008 revealed the hypermetabolic mass in the head and body of the pancreas, hypermetabolic abdominal lymph nodes and metastatic peritoneal implants**. A follow-up evaluations.

Description:
Approximately 60 minutes after the intravenous administration of 13.5 mCi of FDG, whole body PET/CT imaging was performed. The patient's blood glucose level was 91 mg/dl at the time of injection of FDG. IV Contrast was not administered prior to the CT portion of this examination. The patient received oral contrast.

Images from prior PET/CT dated 5/5/2008 are available for review.

Unless otherwise indicated, any anatomic image numbers referenced below represent axial CT images on PACS.

Unless otherwise indicated, any functional image numbers referenced below represent axial PET images on MIM PET/CT Workstation.

Head/neck:

There is **no abnormal hypermetabolism involving the parenchyma of the brain**. There is no midline shift, or mass effect on this

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nondedicated evaluation. The orbits are symmetric without abnormal preseptal or retro orbital soft tissue.

There is **no evidence of any hypermetabolic or radiographically significant lymph nodes in the neck.** Evaluation of the visualized aerodigestive tract is unremarkable. The thyroid gland again appears heterogenous in attenuation. The skull base appears grossly unremarkable. Sinuses are clear. The major salivary glands are symmetric in appearance. There is **no focal abnormal hypermetabolism in the neck.**

Chest:

There is a portacath to the superior vena cava. The superior mediastinum has **no mass of enlarged lymph nodes.** Hila and heart size are normal. The central tracheobronchial tree is patent. There is no consolidation or focal mass. There is **no pleural thickening or pleural effusion.** There is **no focal lateral hypermetabolism in the chest.**

Abdomen:

The **liver is normal in size**. Evaluation for focal mass is difficult in absence of intravenous contrast. There is air in the bile ducts and a common duct stent from the porta to the duodenum. The intrahepatic ducts are mildly dilated. The gallbladder is moderately distended, up to 3 cm in width over a length of a 7 cm similar to the prior examination.

The spleen is mildly enlarged, unchanged. There is redemonstration of extensive soft tissue density in the region of the pancreas, which is difficult to define due to the absence of surrounding fat. It involves most of the pancreas, most apparent in the body and neck region with intraperitoneal extension anteriorly and posteriorly obscuring the fat around the celiac axis and central mesenteric vessels. On the functional images,

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there is again heterogeneous **multifocal hypermetabolic activity**, maximal **SUV** ranging **1.8 - 2.1, previously 2.9 - 3.2**. In addition to decreasing SUV values, the **metabolic activity is less extensive in the current examination.** Anatomic measurement and comparison with prior study is difficult due to the poorly defined margins but the anteroposterior diameter is between the anterior aspect of the mass and abdominal aorta is 4.4 cm compared with 4 cm, image 143.

There are enlarged perioaortic nodes that appear larger; for example, a left periaortic node measures 1.2 cm compared with 0.7 cm, image 163. **This lymph node is non-hypermetabolic now, in comparison to maximal SUV values of 2.7 previously. There is an 11 mm left perioaortic lymph node, image 155. which was inseparable from the decending thoracic aorta in the previous examination** but measured approximately the same size, image 156.

Oral contrast reached the colon. There appear to be nodes in the celiac axis region that indent the gastric wall near the EG junction. There is some infiltration along the proximal root of the mesentery with multiple nodes. There is minimal abdominal ascites.

The kidneys are prominent but no contour deforming lesions. A lower pole small calculus on the right is unchanged. Left kidney is malrotated, unchanged.

Pelvis:

The bladder was empty at the time of the scan. There is some ascites in the floor of the pelvis. The uterus is not enlarged. There is **no adnexal mass on anatomic images**. **Previously identified hypermetabolic foci suspicious for metastatic peritoneal implants are no longer seen now**. Left common iliac nodes are larger and there may be proximal left external iliac nodes as well. However, these **lymph nodes do not demonstrate focal abnormal hypermetabolic activity**. Metabolic activity seen in the

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pelvis bilaterally is simply related to physiologic activity in the ureters.

Skeleton:

There are again degenerative changes of the thoracic and lumbar spine. There is **no discrete lytic or blastic skeleton lesion**. There is **no focal abnormal hypermetabolism in the skeleton**. There is again slightly prominent metabolic activity in the bone marrow.

IMPRESSION:

1. There is again **heterogeneous multifocal hypermetabolic activity associated with a mass in the pancreatic head and body,** consistent with known pancreatic carcinoma. When **compared to the prior examination dated 5/5/2008, this is less extensive in less severe,** as described in detail above.
2. There are **hypermetabolic lymph nodes** in the celiac axis, **SMA** and **left paraaortic lymph node chain**, consistent with metastatic lymphadenopathy. **When compared to the prior examination, there is evidence of interval improvement**, as described above.
3. **Previously identified metastatic periotoneal implants in the abdomen and pelvis are no longer seen now**.
4. There is **no anatomic or functional imaging evidence to suggest metastatic diseases in the soft tissues of the neck or chest**.
5. There is **no definite anatomic or functional imaging evidence to suggest skeletal metastatic disease. There is again prominent metabolic activity in the bone marrow, most likely benign, such as due to anemia or a medication effect, such as due to chemotherapy or bone marrow stimulants**.

This study was jointly interpreted by Dr. Munir Ghesani, and Dr. Benjamin Bashist.

Double Kidney Cancer

Summary UPDATE Sept 12, 2006

From: Patricia D
Sent: Tuesday, September 12, 2006 8:12 PM
To: Fred Eichhorn
Subject: PET SCAN results!!

Bottom of Page 14 shows normal PET scan

Hi Freddie,

Well, I finally got my Pet scan approved! I went down to the Cancer Treatment Centers of America's Philadelphia facility. When speaking with them beforehand, they seemed confident that they would get the insurance to cover the cost as they said it is all in the way it is coded. They where right!

Additionally, I really liked the place because they are open to all the elements that help people heal, conventional oncology, diet, naturopathy, mindbody, spirituality. I however, went for the Pet scan and met a wonderful doctor who was very interested and excited about the program. He once was with the National Institute of Health and said he was not one to look outside the box before coming to CTCA but now he is very open to alternatives. He was anxious for me to meet with their doctor of Naturopathy.

Ironically, the Dr. of Naturopathy disapproved of the amount of A&D and vitamin E in the program.. I said, "would you like to read over the literature I brought with me, this has helped so many people..." She replied, "I'll stick with the literature that's out there which backs up my concerns with these dosages. You only have one kidney and this is very hard on the liver." I told her I'd been on the program for well over a year and was doing great. I listened to her suggestions and said adios! . As it was just my initial interview , I didn't have my glowing bloodwork results in front of me.

When I got my test results, I did not want to meet with her again. I can't waste my time on close minded people. Undoubtedly, she would rather I prescribed to the regimen she offers what ever that is. The oncologist, Dr. Willis, was very happy with my results and told me to keep doing what I'm doing and return in 4 months at which time the insurance will cover another PET and we can monitor things. I left him the manuscript.

The tumor on my adrenal and one lymph node lit up but it doesn't seem to be thriving or growing and is not affecting gland function. I'm going to increase my dosage and consistency taking more and see if I can knock it out by my next visit. I've also attached my blood work results and am still waiting for a copy of a morse, moss ??, blood test which is more accurate regarding tumor changes/markers.

I need to let Dr. Diaz know of my decision to travel to Philadelphia rather than L.I. I really liked her and wished she was closer but I need to take the path of least resistance right now. Would you send me and email address or forward this to her if you can.

The work you've done on the house looks amazing and I see wonderful things ahead in that environment. God bless your plans and work.

I've still a lot of work here including unpacking, but it's all good.

Love and blessings,

Patti

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NATIONAL CANCER RESEARCH FOUNDATION

Copy of a letter sent to a person asking for help

Hello,

I have been on the program since April of 2005. I was diagnosed with kidney cancer in September of 2002, and had my left kidney and adrenal gland removed in Dec. '02.

In July of "03 I started a trial of Peg Interferon at Sloan Kettering Cancer Center. I was on the interferon for one year. It made me depressed and my hair got thin and dull, I lost my appetite and 20 lbs. I was happy to stop it as it did not kill the tumor that was on my remaining adrenal gland. It did not grow while I was on it and it did not get smaller. My oncologist at SKCC said there were some promising drugs on the horizon and agreed that I could stop the weekly injections.

In Sept. of 03 I had surgery on a benign tumor that was on the outside of my brain. The surgeon that removed it said it would never give me a problem. He attributed the breaking down of the tumor and my subsequent illness to my being on the interferon. My oncologist said it could not be proven to be the result of the interferon.

In March of 05 I was told I had tumor growth in my remaining kidney. I was advised to go on a trial medication call Iressa and Surgen. Two drugs that had not been used together before. Iressa had been used on lung cancer patients and two weeks after I was offered the new trial, I read the Lung cancer trial was discontinued as it was not prolonging the patients lives. I was concerned about the side effects on the trial medications ie: heart problems, weight loss, eye problems, burning palms and feet, itching of skin. etc. My son is getting married in October and I wanted to be feeling well for that occasion. PLUS, I did not have any peace about using the trial medication. I had little faith in it and I knew that would affect the outcome. I knew from former experiences that a lack of peace about something is God's way of showing me it is not his will.

I was upset to hear of the new tumor growth in my kidney, but I did not want to die from a drug as I had seen my mother in law and father in law do. I decided to call Fred after a friend had his information sent to me. Fred was most generous with his time and gave me the number of a man name Joe who survived a worse fate than mine. Joe is 82 years old. He was also very encouraging as he is now cancer free. Another man name Jim had Kidney Cancer and used the program and he called me after Fred contacted him. He was also very encouraging and generous with his time, He too is cancer free now. I started program on April 4th at six doses a day. I experienced diarrhea, and found that to be a minor inconvenience compared to the side effects of the doctors medications. I thought it was from the cod liver oil. But recently I stopped the cod liver oil for a week and it made little difference so I suspect the minerals contribute to the problem of watery bowl movements.

My recent blood work shows my thyroid is functioning normally. It was almost not functioning in Jan. 03. Fred explained that there is a link between the thyroid and cancer. My pH is now normal at 8 and my tumor markers are in the normal range (they indicate whether you have tumor activity or not), mine showed no activity. I find this encouraging and will have another scan in a few months. The constant dull ache in my back (my kidney) subsided in early July. I feel it only occasionally not all the time as before.

You must take the program faithfully throughout the day. I just mix the plain double scoop of minerals with water and drink it down. It is the easiest way for me. The more one gets in to the system the faster it is going to start doing the work.

I hope your friend has the courage to try this and believe in it. I will pray for her.

Sincerely
Patricia D

Dateline of events Sept 2002 – July 2006

Sept. of 2002- after a scan for Osteopororis a 9cm tumor was discovered on my left kidney and a smaller tumor on my right adrenal.After an MRI a meningioma was found in my head. Initially, I was told it was a matetesis. (Please excuse my spelling on medical terms.

December of 2002, the kidney and left adrenal was removed. Ironically, the adrenal was healthy but too entangled to save. The right adrenal remained with its mass. I had been to two doctors before deciding on Dr. Russo at MSKCC. and I went with him because he did not want to remove any of the adrenals.

January 2002, I started seeing a Oncologist at MSKCC, Dr. Motzer. He monitored my adrenal with cat scans and suggested a trial of PEG INTERFERON.

July 2003, I started the trial. After a year of weekly shots, low blood counts,20 lbs lost and depression, the tumor was still there and about the same size Dr. Motzer said I could stop the trial. I decided to take the summer off from trips to NYC and bi-monthly Cat scans. I said "See you in September." I was so happy to get away from it all that it became my theme song-but not for long..

August 2004 I began having dizzy spells and vomiting which escalated and landed me in the local emergency room. I was thinking I had a tooth acting up-but after two visits to the E.R. in one day they admitted me and told me I had a tumor in my head that had to come out. After a month on Dexamethzone, the drug from hell, I returned to Dr. Gutin at MSKCC, a neurosurgeon who asked what I had done to disturb a meningioma which should never have bothered me. I said, " I've been on a trial for Peg Interferon.", Dr. Gutin said "that's it!".

September 2004-surgery by Dr. Gutin at MSKCC.

December 2004- I returned to see Dr. Motzer and had another scan, I was told once again that growth of the tumor was minimal. I had been off the interferon for five months. He mention a promising drug "coming down the track" that he was very excited about. He also said there was no evidence to implicate the interferon in the break down of my meningioma. (I went with Dr. Gutin's expert opinon.)

March 2005- I returned with a new cat scan to Dr. Motzer who informed me, much to my shock, that the tumors in my kidney had grown. I had never been told I had tumors in my kidney before and expressed my dismay. He looked at me like a deer in headlights. Anyway, he suggested I had no time, because I didn't have a lot of time to waste until this new trial would be approved. I felt pressured and didn't want to start on the trial which was very involved with my getting into NYC and the possible side effects grabed my concern. When expressed, the nurse said "don't worry it won't happen to you." I replied "everything happens to me!" I had adverse reactions to my anesthia and morphine after my first surgery. The promising drug which was "the best thing to come down the track in 20 years" was a combo of Surgen and Iressa. When I returned home, I called and told the nurse, that I had decided against the trial. A few weeks later I saw on T.V. that a trial of one of the drugs, I believe the Iressa which had been run on lung cancer patients had been stopped because it did not prolong life.

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April 2005, I called Fred Eichhorn, my friend Joan told me she got a call from a friend on L.I. whose brother had cancer and who tried a program he developed and his cancer was gone. I began 6 doses daily, as soon as the overnight package arrive.

July 2005 I started seeing Dr. Diaz, as she believed in the program as well, she saw great results in others. My insurance company denied two PET scan request from Dr. Diaz as well as my letter of appeal.

April 2006- I had a CAT scan (the first in a year), It showed little change. But Fred and Dr. Diaz stressed a PET scan was needed to determine if the spots in my kidney where indeed dead or live cancer cells.

July 2006-I emailed the Cancer Treatment Center of America in Philadelphia. They said they used PET scans and I made an appointment to see Dr. Willis.

I had a pet scan and it shows that the adrenal is cancer, but has not grown and one lymph node behind my kidney also lit up.

The Doctor was amazed at my blood work and general health and happy with the scan- he offered no other plan.

I am doing GREAT !!!!!!!!!!

Wyoming Valley PET Associates, LLC

190 Welles Street, Forty-Fort, PA 18704
Phone: 570.331.7702 Fax: 570.331.7704

Naresh Shah, M.D.
Ron Konecke, M.D.

Patient Name: Patricia D
Date of Birth: 10/ /48
Date of Study: 08/24/06
Ordering Physician: Rudolph Willis, M.D.

1190

TYPE OF EXAM: FDG-F18 WHOLE BODY PET SCAN

CLINICAL INFORMATION: Renal cell carcinoma with left nephrectomy in 2002. Multiple nodules on CT scan involving the right kidney. Rt. adrenal mass and enlarged retroperitoneal lymph node.

TECHNICAL INFORMATION: Examination is performed on a full ring dedicated PET scanner with intravenous administration of 2.9 mci of FDG-F18. **Whole body rotational images as well as multiple axial, coronal and sagittal images were reviewed. Attenuated corrected and non-attenuated studies are obtained.**

INTERPRETATION: CT scan dated 4/11/06 performed at Marian Community Hospital reveals multiple nodules in the right kidney with a right adrenal mass and enlarged retroperitoneal lymph node.
PET scan reviewed and shows no definite focus of abnormal FDG uptake suggestive of metastases or malignancy.
There is normal appearing right kidney and collecting system. Please note that small neoplasm may be difficult to evaluate due to normal physiological FDG activity within the renal collecting system. There is no abnormal intense activity within the right adrenal gland.
There is normal physiological activity within the pharynx/mouth and no abnormal activity in the neck, chest, abdomen, or pelvis suggestive of abnormal lymph nodes.

CONCLUSION: Normal PET scan

Naresh Shah, M.D.

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Headaches – disabling

Broken neck in previous years

From: Anthony
Date: Friday, March 26, 2004 20:23:55
To:
Subject: Headaches

I thought you might be interested in knowing that although not a scientific statement I can attest to the fact that when I do not take the vitamins my problem returns within a few days. The problems that I had been encountering were severe stiffness in my neck and headaches that ranged from mild to disabling. I recently ran out (thought I had another bottle, oops), and the constant discomfort has returned. It is definitely not a coincidence.

I apparently broke my neck when I was younger. I had visited the Dr. and was referred to several specialists. The course of treatment was to be cortisone shots in my neck. I was also taking 1000 mg of Napersin a day to ward off the headaches. If I didn't take the Napersin I would get a headache without fail.

A friend of mine suggested I give you a shot. I did and like anyone else you think I feel better and you skip a day here and there. I can get away with a day here or there but not 2 or 3 in a row.

Well enough of my babbling. I just wanted to say thanks. I am one happy camper. My problems are small to most of what you must encounter and for that I should be thankful. I did think you would find it interesting to know the effects it is having on my pain. I don't know if it eliminates the pain or effects the transmission from the nerves or simply allows the muscle to relax. All I know is that I feel better!

Thanks again

Anthony

Lung Cancer

see pages 12 and 13

Nell, 78 years old at that time, was diagnosed with 5 cm lung cancer on December 22, 2006. The doctors told her that she had no choice but to take chemo to add time to her life, she was given a short time to live. She refused and did not want their treatments. She started with 4 doses daily, sometimes 8 when she could. When she returned the next month, she felt fine, the tests could not show any mass. The doctors were confused and told her that they never saw anything like this happen before. They added that they never saw lung cancer improve, therefore, they can only believe that they must have incorrectly diagnosed her in December and that instead of lung cancer, and that the biopsy had to have been incorrect because it resolved itself and went away, it therefore must have been pneumonia. Although they never saw pneumonia do that, they can only draw that conclusion because they have no other explanation. 6/30/08 - She is fine today

Feb 06 07 01:02p

JOHNSON REGIONAL MEDICAL CENTER
1100 EAST POPLAR STREET
CLARKSVILLE, ARKANSAS 72830
RADIOLOGY DEPARTMENT
PH: 479-754-5304 FAX: 479-754-5325

PATIENT NAME: , NELL
UNIT #: J000088490
DOB: /1928 AGE: 78Y SEX: F
ACCT#: 7345870
LOCATION: RAD

ORDERING M.D.: GATELEY, SUSAN A
ATTENDING M.D.: Gateley, Susan A

Dec 22, 2006

DATE OF EXAM: 12/22/2006
HISTORY: MASS

EXAM: CT CHEST

==========

TECHNIQUE: Standard protocol with IV contrast.

FINDINGS: There is a right infrahilar mass present measuring 5 cm. It extends along the right heart border. It encases multiple right lower lobe bronchi and pulmonary vessels. There is some pericardial effusion or thickening which is nonspecific. There are prominent prevascular, pretracheal, and right infrahilar lymph nodes present. These are suspicious for adenopathy. There are low attenuating lesions seen in the liver. Please see separate CT report regarding them. No axillary adenopathy is seen. Great vessels are unremarkable. Tiny 3-mm noncalcified pulmonary nodule is faintly seen in the base of the right upper lobe anteriorly, image #177. Follow-up could be obtained to document stability.

--->> IMPRESSION: 5-cm right infrahilar mass suspicious for primary lung carcinoma with several prominent mediastinal and right hilar lymph nodes suspicious for adenopathy and pericardial fluid or thickening.

Dictated by : ERIC MAGILL, M.D.
d: 12/22/2006 15:23:47
t: 12/23/2006 09:51:24
sa

VID#: 182247
DID#: 131692

They found a 5 cm mass and wanted her to start chemo that day. They said that she had to start chemo immediately because of the large size of the mass. She refused all treatments and went home. She took this program and returned to the doctor a month later.

Meanwhile, the doctors were calling her often and told her that she was endangering her life by refusing chemo and that she needed to reconsider her choices.

She still refused their treatments.

Page 1 of 1

ORDERING PHYSICIAN'S COPY

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Feb 06 07 01:03p

Sparks
REGIONAL MEDICAL CENTER
131 South I Street • P.O. Box 17006 • Fort Smith, AR 72917-7006 • 479-441-4000

Jan 23, 2007

Medical Imaging Consultation

MRN: 000592581
Patient Name: , NELL

Patient Number: 01164458
Patient Location: **OPDS**

Admitting Dr.: JOHN C DUNHAM, MD
Ordering Dr.: JOHN C DUNHAM, MD
Admit Date: 01/23/2007
Discharge Date: 01/23/2007
Patient Type: Outpatient
DOB/Age/Sex: /1928 78 years Female

PET

Accession Number:	Exam:	Exam Date/Time:	Ordering Physician:
PT-07-0000053	PET-CT Skull Base to Mid Thigh	01/23/2007 10:30:00	DUNHAM, JOHN C

Reason for Exam
CHEST MASS, LYMPH NODES IN CHEST POSSIBLY IN LIVER

REPORT
CLINICAL HISTORY: A 78-year-old female patient with chest mass, lymph nodes in chest possibly also liver mass. This was performed in correlation with prior CT scan dated 12/22/06 and CT abdomen and pelvis dated 12/18/06.

13.5 millicuries of FDG-18 was administered intravenously. Images were obtained from the base of the skull through midthigh followed by noncontrast CT scan and fused images.

Patient with an infrahilar mass suspicious for primary carcinoma on CT scan of the chest dated 12/22/06.

There is no abnormal increased metabolic activity in the right hilar, perihilar or subcarinal regions. On the noncontrast CT scan through the chest this area appears to have resolved. The findings on prior CT scan most likely are related to infection i.e. pneumonia.

-> IMPRESSION:
No abnormal increased metabolic activity within the chest that corresponds to the CT abnormality detected on 12/22/06. The findings on prior CT scan most likely related to pneumonia that has resolved. Clinical correlation is recommended and follow up CT scan of the chest with IV contrast is suggested also.

DD: 01/24/2007 1:08 P
DT: 01/25/2007 8:14 A
000136583

The doctors were confused because they could not find any evidence of her cancer, it showed "No Evidence of Cancer" after one month. Because they never saw cancer like that disappear, they tried to cover up their confusion by stating that they must have incorrectly misdiagnosed her and that it was must have been pnuemonia that resolved itself and not the cancer that they originally diagnosed.

Their reason was that cancer like that does not ever show improvements

Final Report
Dictating Physician: Al-Refai, Fareeda
Signing Physician: Al-Refai, Fareeda
Transcribed by: SP
Transcribed on: 01/25/07 8:28

Patient Name: , NELL
MRN: 000592581
Chart Request Id: 3849426
Run Type: Cumulative

Copies to: JOHN C DUNHAM, MD
Print Date: 01/25/2007
Print Time: 01:15 PM
Page: 1 of 1

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Main phone (631) 584-3100 (Toll Free) 1-877-CANCER-FREE Fax (631) 584-4833
Web Site: www.NCRF.org *NCRF is a Registered 501(c) (3) & ST-119.1 Not-For-Profit Corporation* Email: Fred@ncrf.org

Lung Cancer

May 13, 2006

Hi Fred and Lora,

I have met with the both of you before, I am a friend of Suzanne.

My husband Lou is the one with the osteogenic sarcoma w/metastasis to the lungs.
He is recovering from a lobectomy (left lower lobe).

As of 3/30, the physicians told us the chemo was not working and the tumors had in fact grown.
That's when I started him on the program. Needless to say, when the pathology report came back after the 4/19 surgery, the tumor was 80% necrotic.

Yeah…..

Anyway, the program has been going well.

Thank you

-Heather

Update: December 10, 2006, Latest PET scans show "No Evidence of cancer".
He is doing fine.

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Double Lung cancer

To Whom it may concern:

I am Jean. My husband Ray was diagnosed with lung cancer in both lungs at the VA in Northport. After talking to one of his doctors who said that if Ray were his father, brother or son, he would say, “Do Nothing.”

The other doctors wanted to crack his chest and we were not in favor of anything so radical. Ray, by the way, at the time, he weighed 142 lbs, from a normal weight of 175 lbs. You know of course that it is common to lose weight with cancer.

So, we went to Freddie, Ray tried the program and felt that he wanted to do it, as, after taking the first dose, he felt a little alive.

After about 4 days, he was in much better spirits and was feeling better. He is also a converted skeptic……

Needless to say, he is doing very well at this point in time. He has gained all his weight back plus 5 more pounds.

It is very hard for me to be very cut and dry about the program because I have seen in this past year many changes in not only my husband, but also many people that I have had the honor of talking to and meeting through Freddie. I myself use the program because I know that if you are going to do vitamins/minerals of any kind, this is the one to take, hands down. I have over the years walked many paths to get to a point then when I awake in the morning, it is not an effort to get out of bed.

Well, now after all this being said, if you want to contact Ray or I, please feel free to do so.

By the way, Ray is 78 and I will be 72 just before Christmas 2005….So, if we can do it, anyone can….

I wish you only the best for you and others.

Jean

Autism

I'm the very proud parent of 8 year old boy, Sam. Sam is a very bright, sweet boy. Since kindergarten, teachers noticed that Sam had problems relating to other children and very often he would prefer to be alone, along with other behaviors like not understanding non verbal communication. We thought that having siblings a lot older was part of the reason. With time, Sam started to display other behaviors, like a very high level of anxiety that most of the time would bring to a meltdown(anything would start it, and the worst part is that no matter how I handle it, reassuring him, calming him, nothing would work). Most of the time, I would walk away crying.

Sam also developed a fixation over certain things, it was extreme compared to just having a particular interest.

Another problem we encountered with Sammy was with his motor skills. For a very long time, we tried in vane to teach him to ride the bicycle, even with the training wheels, Sammy had a very hard time, he could not do it. Sammy could not catch or throw a ball, despite the many times his brothers tried to help him.

On August 2005, he was diagnosed with Asperser's Syndrome (high functioning Autism) and was recommended to take 3 different medications: Ritalin, Seroquil and another one which I do not remember the name. I did not want to put my son on these drugs that would just mask somewhat his symptoms(ritalin is 99% molecularly similar to cocaine).

A month later we met Fred. Sam started to take a mineral/vitamins program (Sam's favorite flavor is chocolate). Within a very short time, I saw a big change in Sam.

After trying for years to teach him, Sam finally is riding his bicycle, WITHOUT training wheels.

Now Sam plays football with his brothers. They can't believe it either, how well is throwing and catching the ball. Just recently he started playing hockey, he loves it and expressed the desire to join a team just like his older brother.

Also, Sam 's anxiety diminished greatly. Meltdowns do not occur as often as they used to, and they do not last as long either. Definitely, Sammy is a lot calmer.

I can 't really explain in words the feeling that I have from seeing my son accomplishing so much, especially after experiencing so much pain. I know that meeting with Fred and starting his program has been a lifesaver for my son.

Thank you, Fred and Lora for the great work and for all you have done for my family!
Best to both of you!!

Sincerely, Rossana

Nov 11, 2005

Hello Fred, thank you very much for your email! I just wanted to let you know about something else about Sammy. Few days ago a friend was over and suddenly Sammy (who was sitting down and reading) told her: "My life changed forever since Sept.13th!" My friend asked why and his reply was : " On Sept 13th I started taking the mineral program". Besides the fact that he made such statement, which sounded more like a statement from a much older child .I could not believe that he recorded the exact day that he started the program!! He 's doing also really well in school and started playing football with is older brothers. They can't believe how well is catching and throwing the ball (things that he was not doing before). I can't thank you enough for all of your help. I always tell people about you and always tell them about Sammy accomplishments. Priceless. I also started taking the drink and feel a great increase of energy. We will see you soon! Please say hello to Lora and Mark.

Sincerely, Rossana

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ADHD

I thought you'd like to read the response from the mom of a 9 year old girl with ADHD and learning disabilities. They came to us in September, as the school did not want to deal with her because she was so troublesome. The girl is soooo cute and adorable, and she knew she had a problem and wanted help.

This is a great letter. I get so excited when I read these type letters, I hope you do too.

Fred Eichhorn

Hi Fred,

I just wanted to share with you that I think the turning point has finally arrived for Jaclyn. Steve couldn't remember for sure, but he thought he told you the story last week about Jaclyn hitting the boy in the playground and accepting the consequences only to come home and tell us exactly why she hit him.

I went back to the school and told them her version of the story including the part where she feels she was wronged by one of the teacher aides. Not only was I apologized to, but Jaclyn received all of her privileges back. I spoke with the school psychologist for nearly an hour listening to her tell me how remarkable the change in Jaclyn has been since she returned in September.(Remember when we met!) She went on to comment how clear her speech has become and how clearly she can now express her thoughts. It is necessary for them to make immediate changes to her behavior plan because the one from last year does not apply any longer. We may also be looking forward to a new classroom setting for the next school year.

All the good things that are finally happening for her and how good she feels, now we will really see her story start to unfold.

Thanks for encouraging me to hang in there. I think we are starting to see the benefit!

Thanks again for everything.

Prostate Cancer

Plus: Diabetes, High Cholesterol, High Blood Pressure
Dia, Chol, BP normal in one month, Prostate cancer gone in two months

Summary

Charlie, 56, was diagnosed early April 2005 with advanced prostate cancer extending past the capsule. The only option given him was lupron and to consider a prostatectomy to prevent further spread. I did not agree with the options at all. See report in first two attachments.

Charlie wanted to try this protocol first. I usually recommend at least 4 dosages daily. Charlie decided, on his own, to do between 8 – 10 dosages daily in order to give it a head start.

He started April 20, at dosage 8. He was also diabetic, high cholesterol, high blood pressure. While on this protocol, his blood pressure reduced which allowed him to wean himself off his meds. His glucose also dropped, allowing him to reduce his meds according to his glucose levels. Because of his reduced cholesterol levels, he weaned off his cholesterol meds also. I was not aware at the time. See chart summary above.

Charlie's wife Julie charted his progress. His doctor was concerned about the 5/2/05 chart showing that he stopped all his meds, she ordered bloodwork. Results shown in "Lab 1" and "Lab 2" show dramatic reduction showing normal results after he weaned off the medications.

Because multiple issues were resolved, he went for a color doppler and MRI on June 17, 2 months after the previous showing extensive cancer. The 6/17/05 tests showed "No Evidence" of cancer. The swelling reflected the damage caused by the 12 biopsies in April.

Today, 6/6/06, recent testing continues to show that he is fine with no problems, no medications and never sick.

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CHARLES **REVIEW ON**

What	Date:	Results:
Blood Test Done:		PSA 4.8
Blood Test repeated:		PSA 4.8
Biopsy Performed:	March 28, 2005	
ordered:	April 01, 2005	
Biopsy Results:	April 05, 2005	1 of 12 Highly Suspicious, 2 of 12 Abnormal
Started	April 05, 2005	
Met with Fred	April 07, 2005	
Biopsy 2nd opinion:	April 11, 2005	John Hopkins - same as 4/5/05
Doppler Color Sono w/ Dr. Bard	April 18, 2005	Low flow tumor-small - wait and watch 4 months
MRI after Dr Bard	April 18, 2005	small but aggressive-bulging through the capsules - cannot wait 4 months
Met & spoke with Fred	April 18, 2005	Take in as much as possible
		Blood sugar has dropped from 148 & 139 to 116 and now 93 Blood pressure decreased from 140/90 to 124/77 Skin color is great and dryness decreasing, nail beds have improved and toenail fungus decreased Flexibility and leg strength has improved Numbness and cramping in hands have disappeared Taste has partially returned; sinuses clear No allergic reactions to pollens and grass Sight has improved ; more alert, more energic, Appetite had increased; has lost weight

EASTSIDE DIAGNOSTIC IMAGING, PLLC
106 EAST 61ST STREET
NEW YORK, NEW YORK 10021

TEL: (212) 751-9090
FAX: (212) 751-9089

ARIE L. LIEBESKIND, MD

ROBERT L. BARD, M.D.
121 EAST 60TH STREET, 6TH FL.
NEW YORK, NY 10022-

Patient Name: CHARLES
Date Of Birth: - -1949
Identification#: 622
Accession Number: 2052336
Exam Date: 04-18-2005

Dear Dr. BARD,

**** ORIGINAL REPORT ****

MRI OF THE MALE PELVIS:

CLINICAL HISTORY: Prostate carcinoma.

TECHNIQUE:

MRI of the pelvis was performed at 1.5 Tesla. Sagittal, axial and coronal T2 small field of view, as well as axial T1 and axial T2 spin echo large field of view images were acquired.

Correlation with the patient's prior endorectal sonogram.

FINDINGS:

There is diffuse hyperintensive T1 weighted signal noted throughout the outer gland which represents hemorrhage following the patient's recent biopsy. This does limit the examination for evaluation of intracapsular disease. Within the region of the right prostatic base, extending into the angle between the capsule and the right seminal vesicle as seen on axial image 11 and coronal image 15, there is a focus of extracapsular extension measuring approximately 0.8 x 1.0 x 0.7 cm in AP, transverse and craniocaudal dimension. The seminal vesicles are otherwise unremarkable.

The capsular margins are otherwise intact.

The urinary bladder is unremarkable.

Identification#: 622; Accession Number: 2052336; CHARLES

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NEW YORK, NEW YORK 10021

TEL: (212) 751-9090
FAX: (212) 751-9089

ARIE L. LIEBESKIND,

There is no pathologic adenopathy or ascites.

No focal abnormal T1 weighted marrow signal to suggest the presence of osseous metastatic disease within the pelvis.

IMPRESSIONS:

EXTRACAPSULAR EXTENSION OF PROSTATE CARCINOMA AT THE RIGHT BASE. NO PELVIC ADENOPATHY, ASCITES OR OBVIOUS METASTATIC DISEASE WITHIN THE PELVIS IS NOTED.

Date/Time Transcribed: Apr 18 2005 9:18PM
Electronically Signed By Arie Liebeskind, MD **Apr 19 2005**
9:50AM

Identification#: 622; Accession Number: 2052336; CHARLES

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CLIENT SERVICE 800.877.7525

PATIENT INFORMATION
,CHARLES
DOB: /1949 AGE: 56
GENDER: M

REPORT STATUS **FINAL**

ORDERING PHYSICIAN
ROXANNE G. CARFORA, M.D.

CLIENT INFORMATION
L893377 8962792
CARFORA, ROXANNE G., M.D.
353 VETERANS MEMORIAL HWY
COMMACK, NY 11725-4325

SPECIMEN INFORMATION
SPECIMEN: 74319759
REQUISITION: L8933770007491

COLLECTED: 05/02/2005 07:53
RECEIVED: 05/02/2005 13:23
REPORTED: 05/03/2005 06:38

Test Name	In Range	Out of Range	Reference Range	Lab
COMP METABOLIC PANEL				LI
GLUCOSE	116	148↓	65-125 mg/dL	
The glucose reference range is based on a non-fasting state.				
SODIUM	140		135-146 mmol/L	
POTASSIUM	4.6		3.5-5.3 mmol/L	
CHLORIDE	105		98-110 mmol/L	
CARBON DIOXIDE	23		21-33 mmol/L	
UREA NITROGEN	19		7-25 mg/dL	
CREATININE	0.9		0.5-1.4 mg/dL	
BUN/CREATININE RATIO	21.1		6.0-25.0	
CALCIUM	9.4		8.5-10.4 mg/dL	
PROTEIN,TOTAL	7.5		6.0-8.3 g/dL	
ALBUMIN	4.6		3.5-4.9 g/dL	
GLOBULIN,CALCULATED	2.9		2.2-4.2 g/dL	
A/G RATIO	1.6		0.8-2.0	
BILIRUBIN,TOTAL	0.67		0.20-1.50 mg/dL	
ALKALINE PHOSPHATASE	70		20-125 U/L	
AST	21		2-50 U/L	
ALT	28		2-60 U/L	

We received your handwritten test order for a chemistry panel containing 14 or more analytes. We performed the AMA defined Comprehensive Metabolic Panel. If this is not what you intended to order, please contact your local client service representative immediately so that we can adjust our billing appropriately. You may also inquire about alternative or additional testing.

needs u/a + urine cls
urology referral for PSA

HB 5-3-05

,CHARLES - 74319759

Page 1 - Continued on Page 2

Phone # not in service
Please send contact letter
5/3/05

mailed 5/4/05 ®

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QUEST DIAGNOSTICS INCORPORATED

PATIENT INFORMATION
,CHARLES
DOB: /1949 AGE: 56
GENDER: M

REPORT STATUS **FINAL**

ORDERING PHYSICIAN
ROXANNE G. CARFORA, M.D.

SPECIMEN INFORMATION
SPECIMEN: 74319759
COLLECTED: 05/02/2005 07:53
REPORTED: 05/03/2005 06:38

CLIENT INFORMATION
L893377 **89627922**

Test Name	In Range	Out of Range	Reference Range	Lab
LIPID PANEL				LI
CHOLESTEROL,TOTAL	179		<200 mg/dL	
HDL CHOLESTEROL	51		>/=40 mg/dL	
CHOLESTEROL/HDL RATIO	3.5		<5.0	
LDL CHOL, CALCULATED See footnote 1	108		<130 mg/dL	
TRIGLYCERIDES	101		<150 mg/dL	

We received your handwritten test order and performed the AMA defined Lipid Panel. If this is not what you intended to order, please contact your local client service representative immediately so that we may adjust our billing appropriately. You may also inquire about alternative or additional testing.

TSH	1.13		0.40-5.50 mIU/L	LI
CBC W/ DIFF & PLT				LI
WBC		**11.5 H**	3.8-10.8 Thous/mcL	
RBC	4.69		4.20-5.80 Mill/mcL	
HEMOGLOBIN	14.7		13.2-17.1 g/dL	
HEMATOCRIT	42.5		38.5-50.0 %	
MCV	90.5		80.0-100.0 fL	
MCH	31.4		27.0-33.0 pg	
MCHC	34.7		32.0-36.0 g/dL	
RDW	12.7		11.0-15.0 %	
PLATELET COUNT	247		140-400 Thous/mcL	
MPV	9.0		7.5-11.5 %	
TOTAL NEUTROPHILS,%	74.6		38-80 %	
TOTAL LYMPHOCYTES,%	15.5		15-49 %	
MONOCYTES,%	8.2		0-13 %	
EOSINOPHILS,%	1.2		0-8 %	
BASOPHILS,%	0.5		0-2 %	
NEUTROPHILS,ABSOLUTE		**8579 H**	1500-7800 Cells/mcL	
LYMPHOCYTES,ABSOLUTE	1783		850-3900 Cells/mcL	
MONOCYTES,ABSOLUTE	943		200-950 Cells/mcL	
EOSINOPHILS,ABSOLUTE	138		15-550 Cells/mcL	
BASOPHILS,ABSOLUTE	58		0-200 Cells/mcL	

DIFFERENTIAL
An instrument differential was performed.

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JUN-23-2005 10:18 AM

ZWANGER-PESIRI
RADIOLOGY

Plainview
680 Old Country Road
Plainview, NY 11803

Phone: 516-681-8400
Fax: 516-433-7201

To: **Roxanne G. Carfora, D.O.**
353 Veterans Memorial Highway
Commack, NY 11725

Name: CHARLES
MRN #: 521205
Phone:
DOB: /1949 **Gender:** Male
Exam Date: 6/17/05
Referring Phys.: Roxanne G. Carfora, D.O.

Exam: TRANSRECTAL PROSTATE SONOGRAM
Clinical Indication: Patient has prostate cancer

The visualized prostate measures 5.89 x 4.69 x 3.6 cm with total volume of 52 ml which is moderately enlarged. Peripheral zone appears unremarkable. Small calcification in the left apex is noted measuring approximately 1 cm. Doppler evaluation of the prostate reveals normal flow pattern.

Impression

Enlarged prostate.
The peripheral zone appears homogeneous with no abnormalities.

Interpreting Radiologist

Parviz Khodadadian, M.D.
Electronically Signed: 6/17/05 2:28 pm

Page 1 of 1

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RADIOLOGY

Plainview
680 Old Country Road
Plainview, NY 11803

Phone: 516-681-8400
Fax: 516-433-7201

To: Roxanne G. Carfora, D.O.
353 Veterans Memorial Highway
Commack, NY 11725

Name: CHARLES
MRN #: 521205
Phone:
DOB: / /1949 **Gender:** Male
Exam Date: 6/17/05
Referring Phys.: Roxanne G. Carfora, D.O.

Exam: MRI-PELVIS WITH AND WITHOUT CONTRAST
Clinical Indication: Follow-up examination.

MRI of the pelvis was performed with gadolinium with multiple sequences in sagittal, coronal and axial planes.

Comparison is made with a prior MR examination performed at an outside facility on 4/18/05 and prior prostate sonograms, the most recent performed on this same day.

The prostate gland is enlarged measuring approximately 4.7 x 4.0 x 6.0 cm in the longitudinal, AP and transverse dimensions.

There is marked enlargement of the central zone. On the current study, no discrete solid nodules are identified within the peripheral zone. The prostatic capsule appears intact.

The seminal vesicles and surrounding soft tissues appear normal.

No enlarged lymph nodes or fluid collections are seen in the pelvis. The visualized bowel and mesentery appear normal.

Impression:

Prostatic gland enlargement, predominantly the result of central zone enlargement. No discrete solid nodules are identified within the peripheral zone. The prostatic capsule appears intact.

Interpreting Radiologist

Glenn E. Rabin M.D. / Steven L. Mendelsohn, M.D.
Electronically Signed: 6/17/05 6:31 pm

Prostate Cancer - Advanced

Hi Fred,

On my second visit to Dr. B's office, he was pleasantly surprised at my improvement. It appears the size of my prostate has decreased in size by about 20% and the color doppler showed 'decreased vascularity on the right side lesions' as well as the left base tumor. And no evidence of anything spreading.

He said there was no need to come back for another six months.

My question to you is what I should do about the volume of the program. I would expect you to say to continue using the full amount that I've been using, but is it really necessary? I am also using many other supplements recommended by other Drs. and organic, home cooked foods. I also get oxygen into my body primarily with aerobic exercises.

I thought you might be pleased to hear the good news.

Charlie (A different Charlie from previous testimonial)

UPDATE: 12/12/06

As per Color Doppler testing - Stable, no evidence of cancer

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2/25/03

California Pacific Medical Center-San Francisco, California
Pacific Campus (415) 923-3232 California Campus (415) 750-6025
Davies Campus (415) 565-6180

1 OF 2

RADIOLOGY CONSULTATION REPORT

Name: ,RITA DOB: 10/07/ MR#: 05025041

Report Status: Final
Location: OUTPAP Exam Code: C05260 C05105 C05195 Order#: CPC0304243 CPC0304244 CPC0304245

ACCT#: OP03551268PRIVATEX

MR: 05025041 Patient: ,RITA
Exam Date: 02/25/2003
02/25/2003
Test taken → 02/25/2003
Exam: CT ABDOMEN W IV CONTRAST ROUTINE
CT CHEST W IV CONTRAST (ROUTINE)
CT PELVIS W IV CONTRAST

colon cancer mets to liver and lungs

CLINICAL INFORMATION: Rectal CA. Follow up examination.

COMPARISON: CT exam of chest, 10-1-02 and CT chest, abdomen and pelvis, 7-12-02.

TECHNIQUE: Spiral CT acquisition obtained through chest, abdomen and pelvis. Oral contrast and 150 cc Isovue 300 intravenous contrast administered.

FINDINGS:

Since the CT scan of the chest performed on 10-1-02, new masses have appeared in the left hilum and the aorticopulmonary window. Substantial volume loss is now present in the left lower lobe and the most inferomedial aspect of the left lower lobe has an unusual appearance where the lobe is atelectatic, poorly aerated, and multiple rounded lucencies are embedded in the collapsed lung which could represent either tumor or mucous in the obstructed bronchial tree. No comparable finding was seen in the left lower lobe on the prior study, however, the left hilar mass was present. The size of the tumor and inferior hilum as increased substantially compared to the prior examination. In addition, tumor tracks down through the left posterior CP angle and results in some thickening of the left upper psoas margin inferiorly to the level of the left mid kidney. Several nodules are present in the left lower lung at and below the level of the hilum which were not present on the previous study. No other substantial changes are seen in the chest. There is no evidence of pleural effusion. No definite metastatic lesions are visualized in the right lung on the present exam.

In the abdomen, scattered hypodensities are present in the liver which are less than 1 cm in diameter for the most part and which are

---

T: 02/25/2003 SB
Physician(s): Tuan, Bertrand Y
Meyer, Sharon C

Ord. MD:Tuan, Bertrand Y

(Page 1 of 2. Continued on next page)

FRED: THAT WAS THE CAT SCAN THAT I HAD ON FEB. 25, 2003.

2/25/03
2 OF 2

RADIOLOGY CONSULTATION REPORT

Name: ,RITA DOB: MR#: 05025041

Report Status: Final
Location: OUTPAP Exam Code: C05260 C05105 C05195 Order#: CPC0304243 CPC0304244 CPC0304245

ACCT#: OP03551268PRIVATEX

---

likely to represent small cysts. Similar hypodensities are present on the CT scan of the abdomen performed on 7-12-02 and there is no substantial change in their size, number or appearance since that time. Spleen is normal. The pancreas is normal. The kidneys and adrenal glands are unremarkable. There is no evidence of retroperitoneal mass or lymphadenopathy. Upper abdominal bowel loops are unremarkable.

In the pelvis, the bladder is distended. Low density ovoid structures are seen in the right and left adnexal region which probably represent ovarian cyst. The right sided hypodensity measures approximately 2.2 cm in diameter and the left sided hypodensity 1.9 cm. No other pelvic abnormality is identified. A normal amount of free fluid is present in the pouch of Douglas.

IMPRESSION:

Interval increase in size of mediastinal and left hilar neoplasm. Questionable subtle neoplasm in right hilum.

Several nodular metastases in left lower lung.

Interval appearance of obstruction of left lower lobe with volume loss and consolidation/atelectasis of the medial aspect of the left lower lobe and multiple low density rounded/tubular structures embedded within the collapsed lower lobe, probably fluid filled dilated obstructed bronchi.

Multiple low density foci in liver, probably cysts. No change compared with prior exam.

Mild thickening of the left upper psoas margin, probably an extension of the process in the left posteromedial costophrenic sulcus.

Small cysts in adnexal regions bilaterally, probably ovarian cysts.

Bladder distention of uncertain origin and significance.

No other substantial abnormality identified.

Dictated By:
Kirk Moon MD

T: 02/25/2003 SB
Physician(s): Tuan, Bertrand Y
Meyer, Sharon C

Ord. MD:Tuan, Bertrand Y

(Page 2 of 2. Continued on next page)

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MAY. 1. 2003- 1:49PM PHOA FROM: CPMC Radiology NO. 238 P. 1/1

TO: 9284640

4/14/03

California Pacific Medical Center-San Francisco, California
Pacific Campus (415) 923-3232 California Campus (415) 750-6025
Davies Campus (415) 565-6180

1 OF 1

RADIOLOGY CONSULTATION REPORT

Name: ,RITA DOB: MR#: 05025041

Report Status: Final
Location: OUTPAP Exam Code: D65001 Order#: CPR0333989
ACCT#: OP0362359 0MOBXPACI

MR: 05025041 Patient: ,RITA
Exam Date: 04/14/2003 ← test last week
Exam: Chest 2 Views

Indication: COLON CA ,METS

CLINICAL INFORMATION: Colon cancer with metastases.

FINDINGS: Compare 6/2/01.
The right lung is clear. The left upper lobe is probably clear. Pleural thickening and mild haziness is present in the left lower hemithorax which could represent pleural scarring. No mass is seen in the left lung. Heart size is within normal limits. There is no vascular congestion.

IMPRESSION:
Decreased volume in left hemithorax with density in left posterior inferior hemithorax, possibly a consequence of prior surgery.

Pleural effusion or pleural scarring is an alternate possibility.

No pulmonary masses or nodules are identified.

No other definite abnormality is seen.

Dictated By:
Kirk Moon MD

D: 4/15/03

Electronically Signed
04/18/2003 16:04

Summary
no evidence of cancer

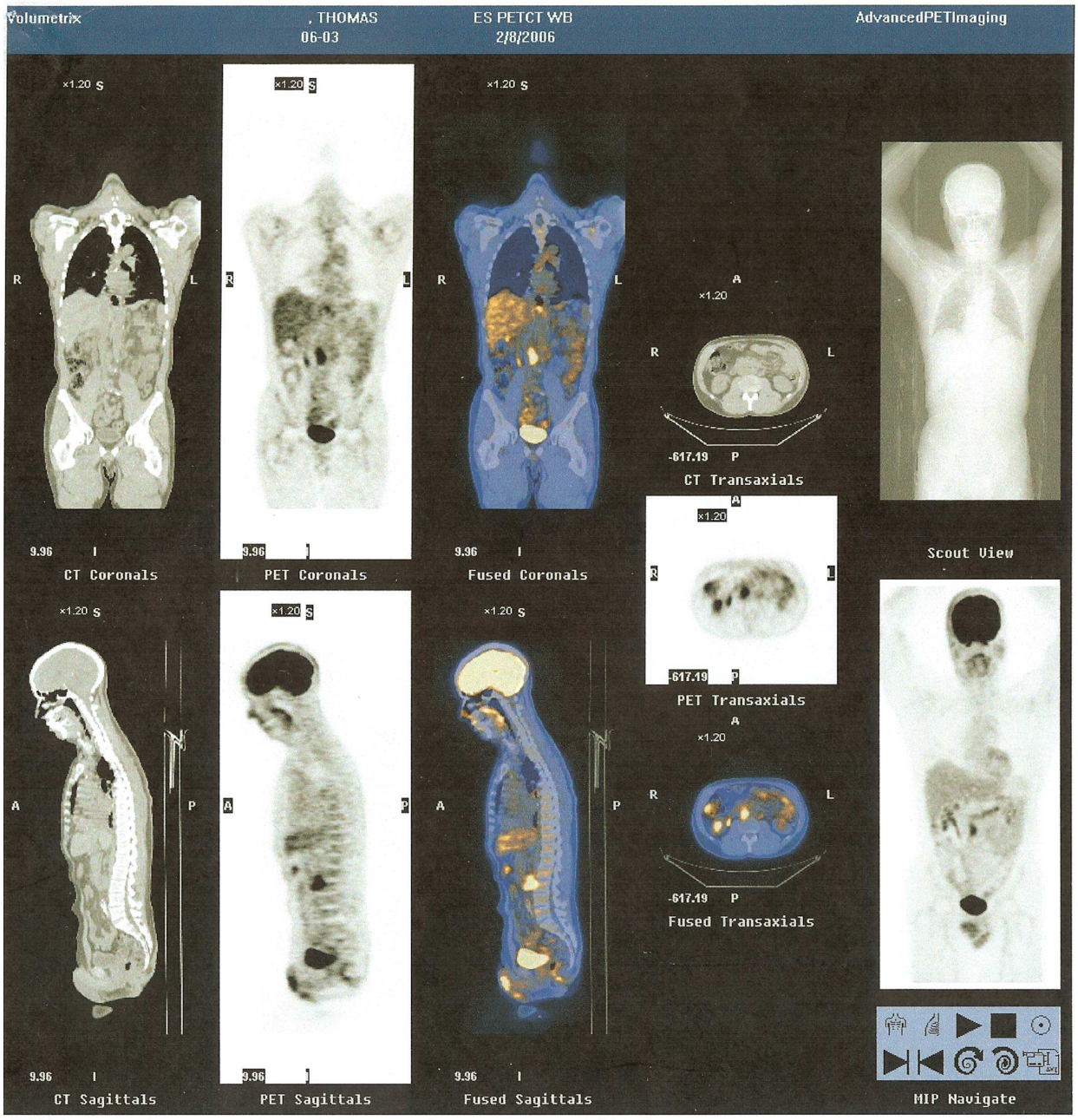
Fred
(631) 584-4833

T: 04/16/2003 LP
Physician(s): Tuan, Bertrand Y → Ord. MD:Tuan, Bertrand Y
Meyer, Sharon C

✓

TUAN, BERTRAND

Esophagus & Liver Cancer
Tom - February 8, 2006 pg 1



including: 2 cancerous liver lesions with multiple smaller ones
Given 2 months to live at that time

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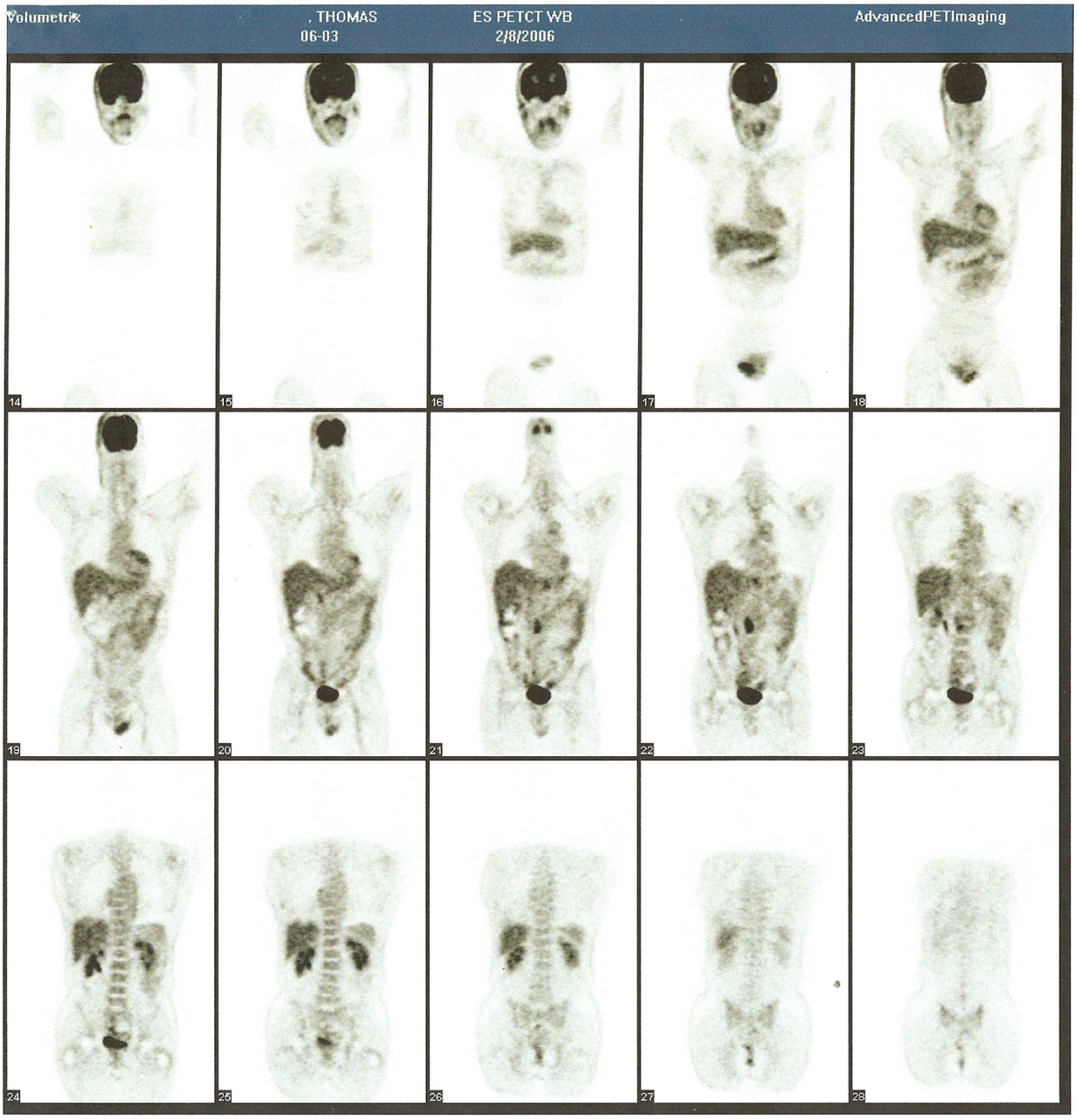
Esophagus & Liver Cancer
Tom - February 8, 2006 pg 2



including: 2 cancerous liver lesions with multiple smaller ones
Given 2 months to live at that time

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ADVANCED IMAGING
POSITRON EMISSION TOMOGRAPHY
we see further

February 8, 2006

Dr. Lawrence Glassman
410 Lakeville Road
New Hyde Park, NY 11040

RE: , THOMAS
06-219244
DOB:
02-08-06

EXAM: WHOLE BODY PET/CT SCAN

Whole body PET/CT imaging was performed in this 60-year-old male with esophageal neoplasm.

PROCEDURE: Approximately one hour following the intravenous administration of 8.9 mCi of Fluorodeoxyglucose, images were obtained from the calvarial vertex to the upper thighs. Reference was made to recent CT scan of the chest report.

The imaging data was reconstructed in the coronal, sagittal and axial planes. Standardized uptake values (SUV) were calculated for regions of interest. 3-dimensional display of the data was reviewed.

FINDINGS: In the head and neck, normal distribution of FDG was noted.

The 2 mm peripheral nodule noted in the right middle lobe on the CT component is not well evaluated on PET imaging due to the small size of this density; therefore, to further evaluate this indeterminate finding, a close interval follow-up CT scan of the chest in four to six months is suggested. There was no evidence of increased uptake of FDG in either lung.

Distribution of isotope throughout the hila and mediastinum was unremarkable.

Physiologic distribution of isotope was noted throughout the myocardium.

There was no evidence of axillary or supraclavicular uptake of isotope on either side.

Normal distribution of FDG was noted in the liver; the two low-density masses noted in this organ were not FDG avid. The correlative CT appearance and PET scan appearance suggests the presence of hepatic cyst formation. Normal distribution of FDG was noted in the spleen, kidneys, and suprarenal regions. The gastrointestinal tract demonstrated physiologic distribution of FDG; there was no evidence of hypermetabolism noted in the gastric pull-up. The enlarged retroperitoneal lymph nodes noted on the CT component were FDG avid on the PET component. The correlative findings indicate neoplastic lymphadenopathy, most probably lymph node metastasis rather than the presence of a second primary neoplasm such as lymphoma. The most metabolic of the lymph nodes in the retroperitoneum is noted in the interaortocaval chain, SUV max 3.6.

In the pelvis, normal distribution of FDG was noted. There were no findings noted to indicate the presence of pelvic lymphadenopathy.

Distribution of isotope throughout the skeleton was unremarkable, without evidence of increased FDG uptake to indicate osseous metastasis.

Continued

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RE: , THOMAS
06-219244
DOB:
02-08-06

The CT component demonstrated the following incidental findings:

1. Increased number of small middle mediastinal lymph nodes, non-FDG avid, and therefore suggesting a post-inflammatory etiology.
2. Gastric pull-up in the right paravertebral region.
3. Deformity of multiple posterior right ribs secondary to the prior thoracotomy.
4. Hepatic cyst formation.
5. Retroperitoneal lymphadenopathy.
6. A 1.7 mm nonobstructing calculus in the mid right ureter.
7. Calcific aortic atherosclerosis and pelvic vascular calcification.
8. Mild sigmoid diverticulosis.

IMPRESSION:
WHOLE BODY PET/CT SCAN DEMONSTRATED THE FOLLOWING:

HYPERMETABOLIC RETROPERITONEAL LYMPHADENOPATHY. THE FINDINGS MOST PROBABLY INDICATE THE PRESENCE OF LYMPH NODE METASTASIS RATHER THAN THE PRESENCE OF A NEW PRIMARY NEOPLASM SUCH AS LYMPHOMA. HOWEVER, FURTHER CLINICAL EVALUATION OF THIS LYMPHADENOPATHY IS SUGGESTED.

2 MM RIGHT MIDDLE LOBE NODULE NOTED ON THE CT COMPONENT WAS NOT WELL EVALUATED ON PET IMAGING DUE TO ITS SMALL SIZE. THEREFORE, CLOSE INTERVAL FOLLOW-UP CT SCAN OF THE CHEST IN FOUR TO SIX MONTHS IS SUGGESTED.

REFER TO ABOVE DISCUSSION FOR CT FINDINGS.

Thank you for allowing us to participate in the care of your patient.

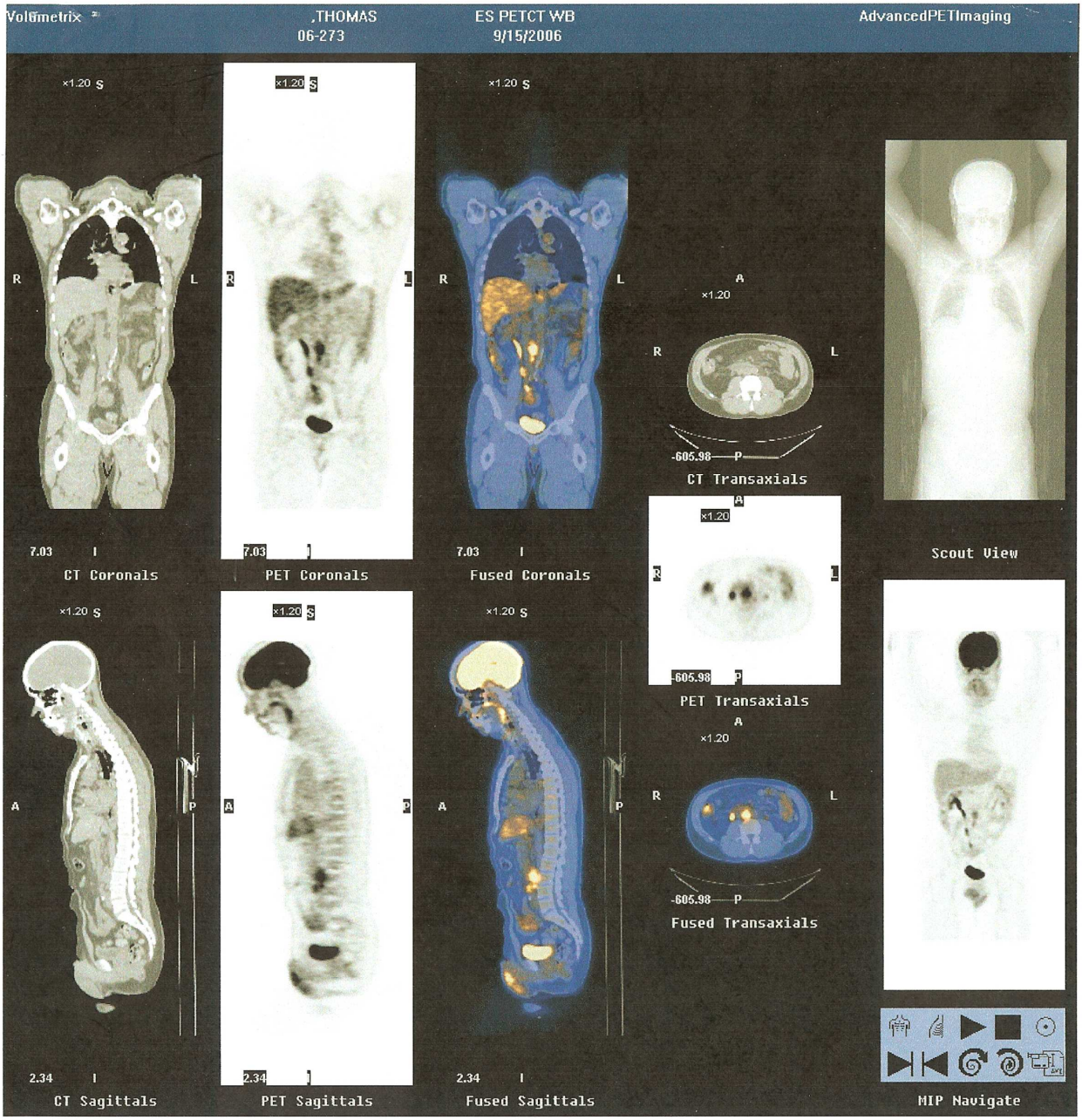
Yours truly,

Azad Anand, M.D.

Long Island Diagnostic Imaging / Advanced PET Imaging

we see further

Esophagus & Liver Cancer
Tom - September 15, 2006 pg 1



No Evidence of Cancer

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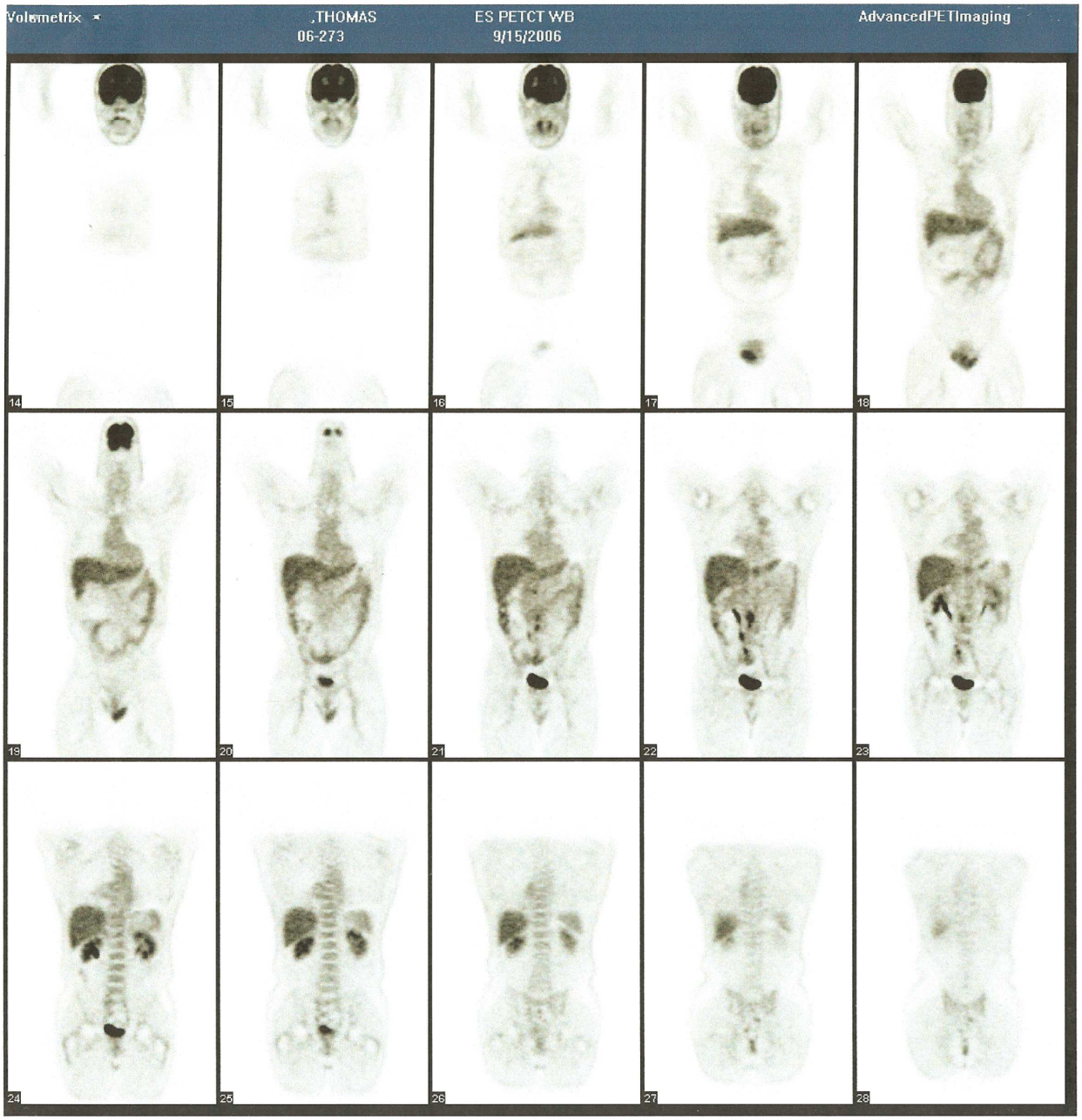
Esophagus & Liver Cancer
Tom - September 15, 2006 pg 2



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ADVANCED P[illegible] IMAGING
POSITRON EMISSION TOMOGRAPHY

we see further

September 15, 2006

Dr. Lawrence Glassman
410 Lakeville Road
New Hyde Park, NY 11040

RE: , THOMAS
MRN: 219244
DOB: /1945
DOS: 09-15-06

EXAM: WHOLE BODY PET/CT SCAN

Whole body PET/CT imaging was performed in this 61-year-old male with esophageal neoplasm.

Approximately one hour following the intravenous administration of 13.9 mCi of Fluorodeoxyglucose, images were obtained from the calvarial vertex to the upper thighs. Serum glucose level at the time of injection of isotope was 120 mg/dl. Reference was made to prior PET/CT scan dated 02/08/06 and to recent CT scan of the chest.

The imaging data was reconstructed in the coronal, sagittal and axial planes. Standardized uptake values (SUV) were calculated for regions of interest. 3-dimensional display of the data was reviewed.

FINDINGS: In the head and neck, normal distribution of FDG was noted.

In the thorax, there was no evidence of increased FDG uptake in either lung to indicate the presence of a neoplastic etiology.

Distribution of isotope throughout the hila and mediastinum was unremarkable.

Physiologic distribution of isotope was noted throughout the myocardium.

There was no evidence of axillary or supraclavicular uptake of isotope on either side.

In the abdomen, normal distribution of FDG was noted in the liver, spleen, kidneys, and suprarenal regions. Patient is status post gastric pull-up; normal distribution of FDG was noted in this region. Again noted is hypermetabolic retroperitoneal lymphadenopathy, essentially unchanged since the prior PET/CT scan. The most metabolic of the lymph nodes in the retroperitoneum are again noted in the intra-aortocaval chain, SUV max 3.6 (unchanged).

In the pelvis, normal distribution of FDG was noted. There were no findings noted to indicate the presence of pelvic lymphadenopathy.

Distribution of isotope throughout the skeleton was unremarkable, without evidence of increased FDG uptake to indicate osseous metastasis.

continued...

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ADVANCED P IMAGING
POSITRON EMISSION TOMOGRAPHY

we see further

RE: , THOMAS
MRN: 219244
DOB: /1945
DOS: 09-15-06

IMPRESSION:
SINCE THE PRIOR WHOLE BODY PET/CT SCAN, THERE HAS BEEN NO SIGNIFICANT INTERVAL CHANGE. AGAIN NOTED WERE HYPERMETABOLIC RETROPERITONEAL LYMPH NODES, WITH SIMILAR METABOLIC UPTAKE. NO NEW HYPERMETABOLIC FOCI WERE NOTED.

NORMAL DISTRIBUTION OF FDG IN THE LUNGS AND IN THE LIVER.

Thank you for allowing us to participate in the care of your patient.

Sincerely,

Scott Sherman, M.D.
Azad K. Anand, MD

LONG ISLAND DIAGNOSTIC IMAGING/ADVANCED PET IMAGING

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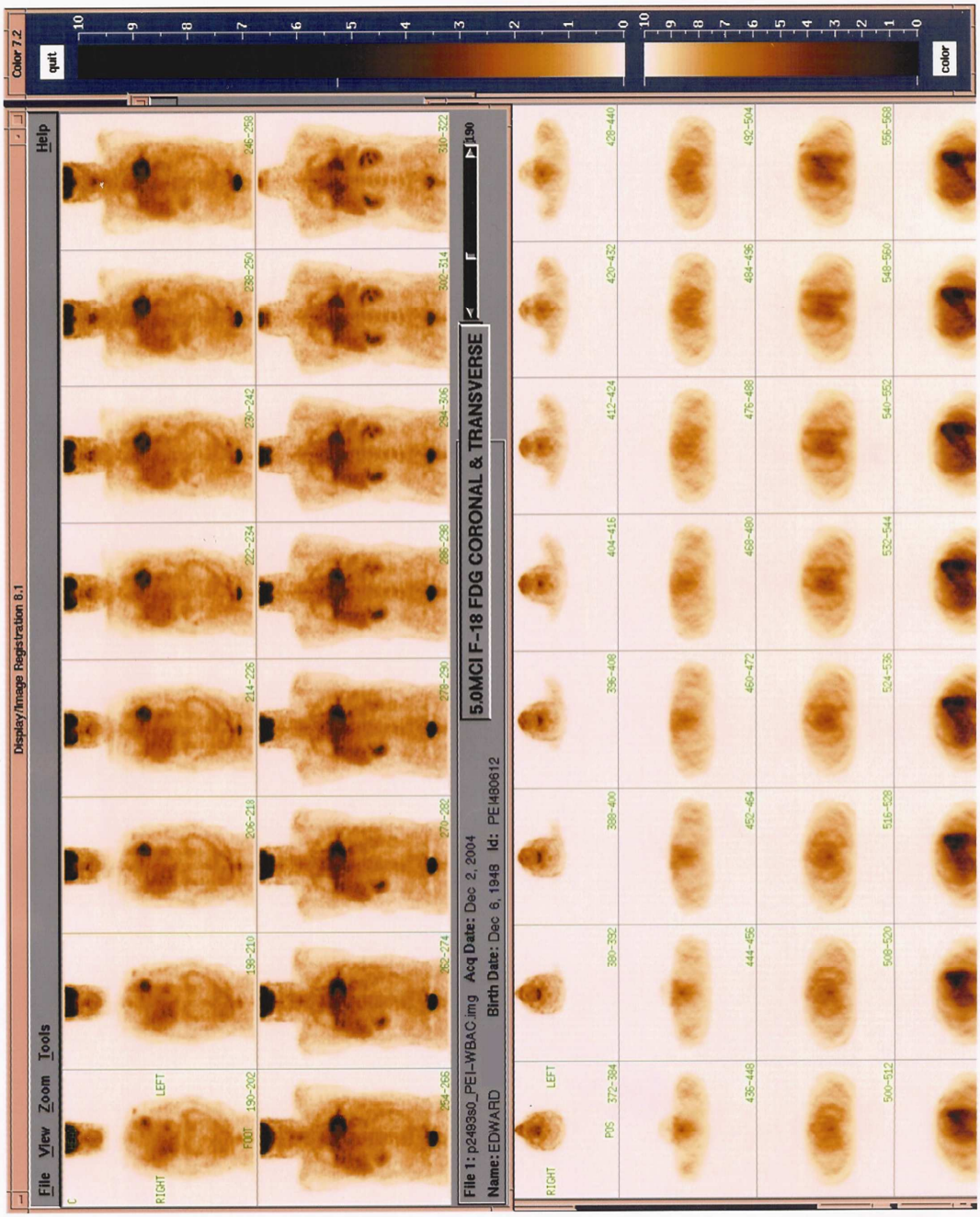
Ed - December 2, 2004



Male Breast cancer quite evident in this PET Scan of December 2004

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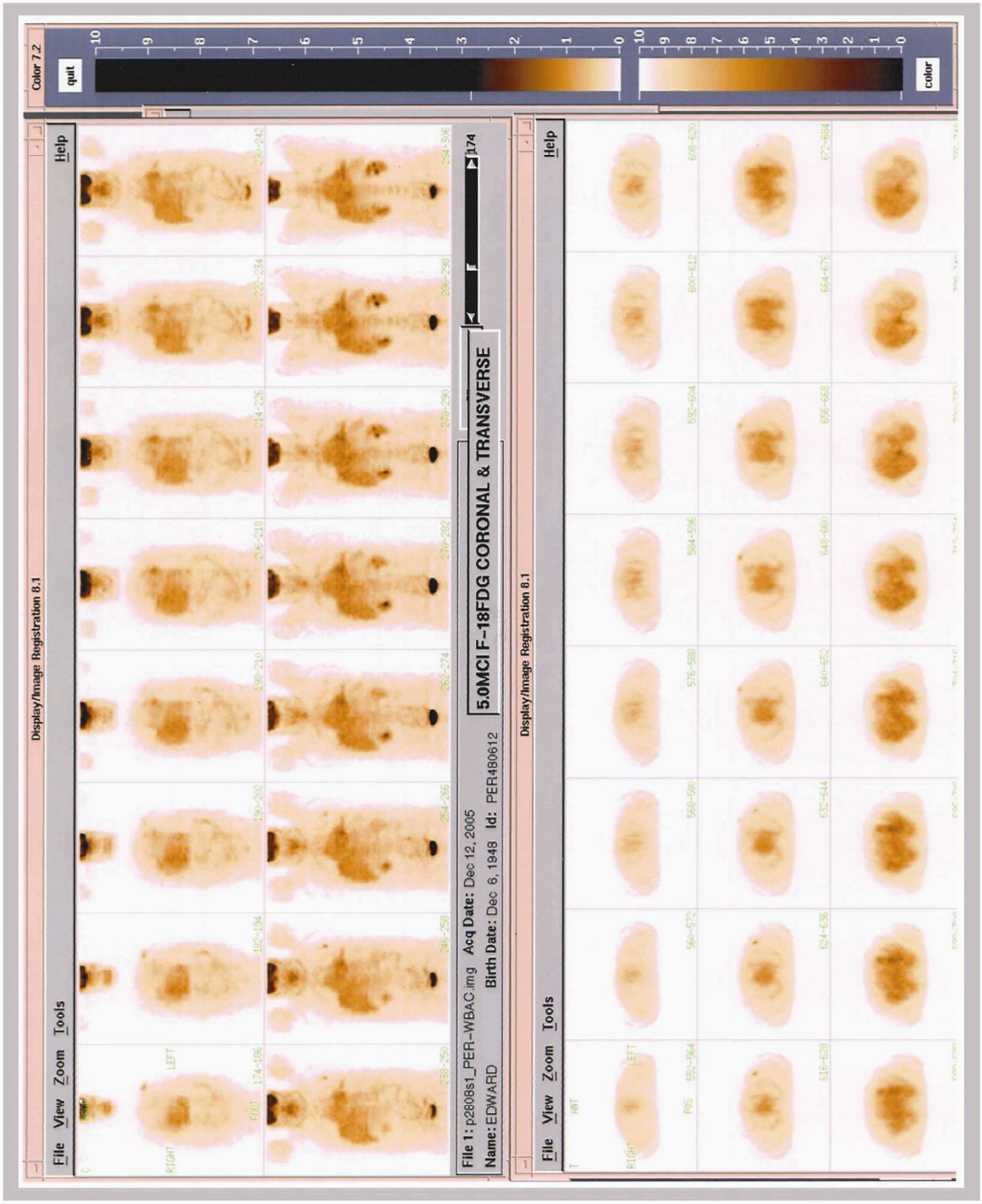
Ed - December 12, 2005



Breast cancer reduction after one year
Self-evident - Almost "no Evidence"

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Cowboy Joe Philips

September 10, 2005

82 year old cowboy who came to me in
mid September 2003 after being diagnosed with:
pancreatic, **liver**, **stomach**, **throat** and **neck** cancer
so severe that there were no treatments offered

In September 2003, doctors told him to go home and call hospice, he was told he had between 3 months and 3 years to live. Basically, the first time frame (3 months) is what doctors truly believe is accurate, second timeframe (3 years) is what they tell the patient so that they do not get depressed or have a heart attack over the first time-frame. In addition to testing, his CA19-9 cancer marker was about 875, (below 33 is normal). By January 2004, it was 310, by Nov 2004, it was "11". As of Nov. 24, 2004, he showed no evidence of cancer anywhere in his body. Late 2005, Joe had a Brown Recluse Spider bite while in Pennsylvania, a huge welt on his foot. Local doctors ignored the welt, assumed it as recurrent cancer. Untreated, the venom caused kidney failure, additional tests indicated "No evidence of cancer", his cancer marker was also at "7"– no cancer evident. He passed away on March 15, 2006 at the age of 82. Joe was a wonderful man of great inspiration and drive and kindness. We miss him terribly.

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Enzo Clinical Labs
An Enzo Biochem Company

Client Service 1-800-371-5227 Supplies, Ext. 243

REPORT NUMBER	ACCOUNT NUMBER	REPORT STATUS
Q0087254	13144	FINAL
DATE COLLECTED	DATE RECEIVED	DATE REPORTED
01/09/2004	01/10/2004	01/14/2004

PATIENT: [redacted], JOSEPH

DOCTOR. RUTH DIAZ, M.D.
1 RABRO DRIVE
HAUPPAUGE NY 11788

AGE	SEX	AREA	ROUTE	PAGE
80	M	200		3

TEST NAME	WITHIN REF. RANGE	OUTSIDE REF. RANGE	LAB REF. RANGE	UNITS
CA 19-9	* advanced cancer → 310 ↑ H M		<33.0	UNITS/ML

Test manufacturer: Diagnostic Products Corp.
Test methodology: EIA
Values obtained with different assay methods cannot be used interchangeably. Results cannot be interpreted as absolute evidence of the presence or absence of malignant disease.

** Note Reference Range Change as of 8/21/03

CEA	1.6		0-5.0	NG/ML

Test manufacturer: Diagnostic Products Corp.
Test methodology: EIA
Values obtained with different assay methods cannot be used interchangeably. Results cannot be interpreted as absolute evidence of the presence or absence of malignant disease.

PROSTATIC SPECIFIC ANTIGEN				
PSA	12.70 ↓ 8.9	H	0-4.0	NG/ML

Test manufacturer: Diagnostic Products Corp.
Test methodology: EIA
Values obtained with different assay methods cannot be used interchangeably. Results cannot be interpreted as absolute evidence of the presence or absence of malignant disease.

PSA FREE AND TOTAL				
PSA	12.70	H	0-4.0	NG/ML

Test manufacturer: Diagnostic Products Corp.
Test methodology: EIA
Values obtained with different assay methods cannot be used interchangeably. Results cannot be interpreted as absolute evidence of the presence or absence of malignant disease.

PSA, FREE	2.58		see below	NG/ML
PSA, % FREE	20.3		see below %	%

Percent free PSA is used to determine risk of prostate cancer;

REPORT CONTINUED ON NEXT PAGE

ANNE B. PLATT, M.D. MEDICAL DIRECTOR & PATHOLOGIST

This is 1/9/2004 Report

02/07/2005 00:42 631

ACCOUNT NUMBER
10161

REFERRING PHYSICIAN/ACCOUNT

Enzo Clinical Labs
An Enzo Biochem Company

Laboratory Locations:

Long Island	60 Executive Blvd. Farmingdale, NY 11735
Manhattan	157 East 81st Street New York, NY 10028
New Jersey (Office)	One West Ridgewood Ave. Paramus, NJ 07652
Client Services	1-800-371-5227
Lab	1-800-522-5052

REPORT STATUS
FINAL

ACCESSION NUMBER
Q4314861

PATIENT INFORMATION
JOSEPH

ROUTE	AREA	DATE COLLECTED	DATE RECEIVED	DATE REPORTED	SEX	AGE	PAGE
	999	11/27/2004 9:05 AM	11/27/2004 7:20 PM	11/30/2004 6:09 AM	M	81	2

Notes:

TESTS	RESULTS		REFERENCE VALUES	
THE CONTROL VALUE FOR PTT HAS BEEN ESTABLISHED TO BE THE MID-POINT OF THE NORMAL RANGE (31.5 SECONDS).				
CONTROL	31.5			SEC.
HEPATIC PANEL				
PROTEIN TOTAL	7.2		6.4-8.0	G/DL
ALBUMIN	3.9		3.7-4.9	G/DL
GLOBULIN	3.3		2.1-3.7	G/DL
A/G RATIO	1.2		1.0-2.0	RATIO
BILIRUBIN TOTAL	0.5		0.3-1.6	MG/DL
AST (SGOT)	14		12-48	IU/L
ALT (SGPT)	13		7-50	IU/L
ALKALINE PHOS	121		25-130	IU/L
AMYLASE	110		25-125	U/L
GGT	20		11-94	IU/L
LIPASE		79 H	7.00-60.0	UNITS/L
CA 19-9	11		<19.0	UNITS/ML

Great

Test manufacturer: Diagnostic Products Corp.
Test methodology: EIA
Values obtained with different assay methods cannot be used interchangeably. Results cannot be interpreted as absolute evidence of the presence or absence of malignant disease.

TYPE & RH	
TYPE	B
Rh FACTOR	POSITIVE

FINAL REPORT

Indicates no evidence of cancer when below 19 he is at 11
he was at 382

Medical Director
Anne B. Platt, M.D.

Date: 11/27/04

PATIENT DIAGNOSED ON SEPT 2003 WITH: PANCREATIC, LIVER, STOMACH, THROAT and Neck cancer

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BER

ERRING PHYSICIAN/ACCOUNT

H DIAZ, M.D.
Rabro Drive
Hauppauge, NY 11788
631-234-7878

Enzo Clinical Labs
An Enzo Biochem Company

Laboratory Locations:

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Manhattan	157 East 81st Street New York, NY 10028
New Jersey (Office)	One West Ridgewood Ave. Paramus, NJ 07652
Client Services	1-800-371-5227
Lab	1-800-522-5052

REPORT STATUS: Final

ACCESSION NUMBER: R3786339 Req: 1576ED207

PATIENT INFORMATION

, JOSEPH A
101147074
631-732-7473

ROUTE	AREA	DATE COLLECTED	DATE RECEIVED	DATE REPORTED	SEX	AGE	PAGE
S/ED275		09/16/2005 07:28	09/16/2005 23:09	09/22/2005 14:10	M	82	4

Report Previously Issued on 09/17/2005 07:33

Notes: FASTING

TESTS	RESULTS	REFERENCE VALUES	
CA 19-9	9.9 ↓ 14.9	<35.0	U/mL

Test manufacturer: Bayer
Test methodology: CIA
Values obtained with different assay methods cannot be used interchangeably. Results cannot be interpreted as absolute evidence of the presence or absence of malignant disease.

*** CARCINOEMBRYONIC ANTIGEN ***

CEA ABBOTT-AXSYM	1.5	0.0-2.5	ng/mL

Test manufacturer: Bayer
Test methodology: CIA
Values obtained with different assay methods cannot be used interchangeably. Results cannot be interpreted as absolute evidence of the presence or absence of malignant disease.

*** PSA, FREE ***

PSA	**12.60<H>**	**0-4.0** (Sam)	**NG/ML**

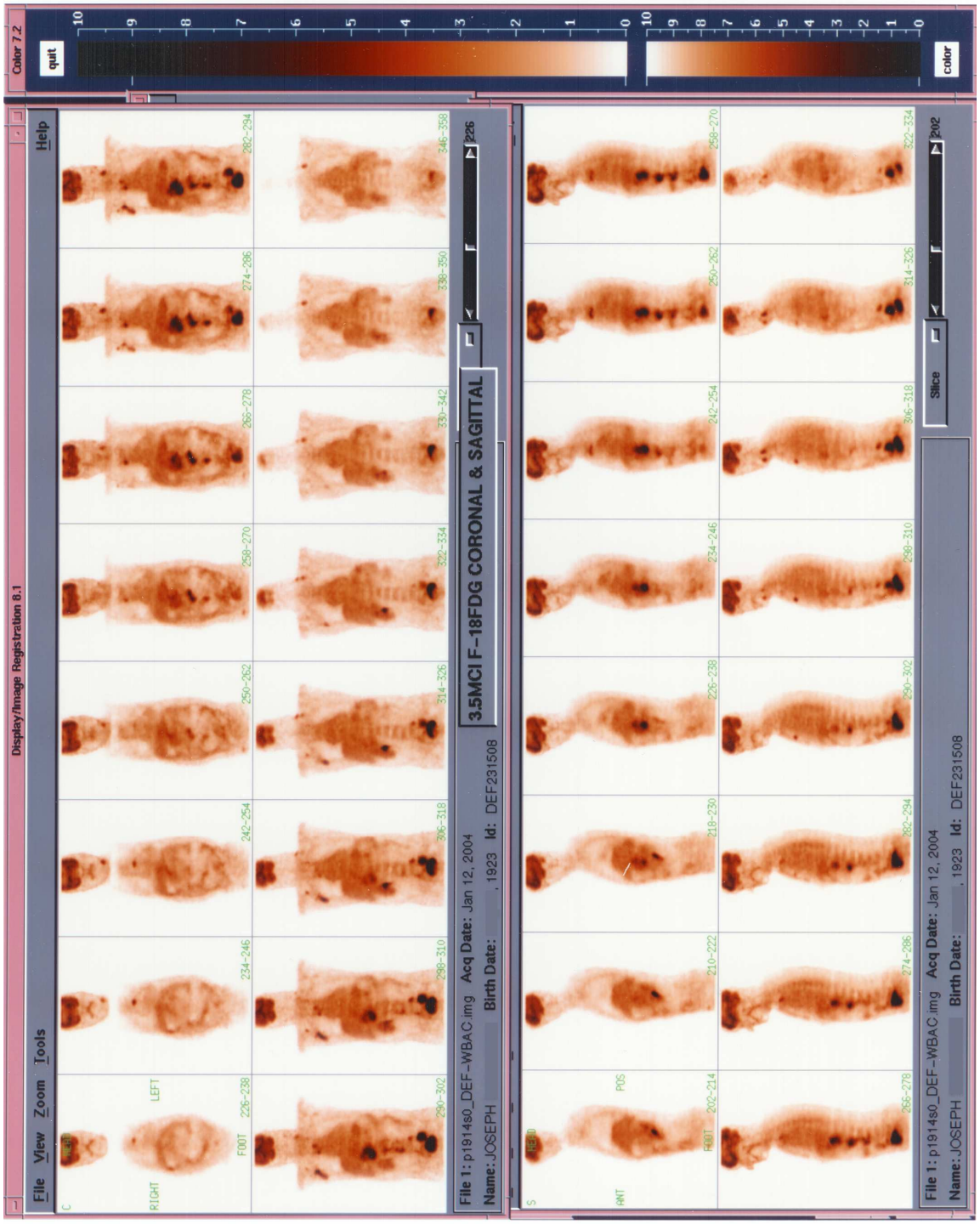
Test manufacturer: Diagnostic Products Corp.
Test methodology: EIA
Values obtained with different assay methods cannot be used interchangeably. Results cannot be interpreted as absolute evidence of the presence or absence of malignant disease.

PSA, FREE	2.63	see below	NG/ML

CONTINUED ON NEXT PAGE

Medical Director
Anne B. Platt, M.D.

PET Scan - January 12, 2004



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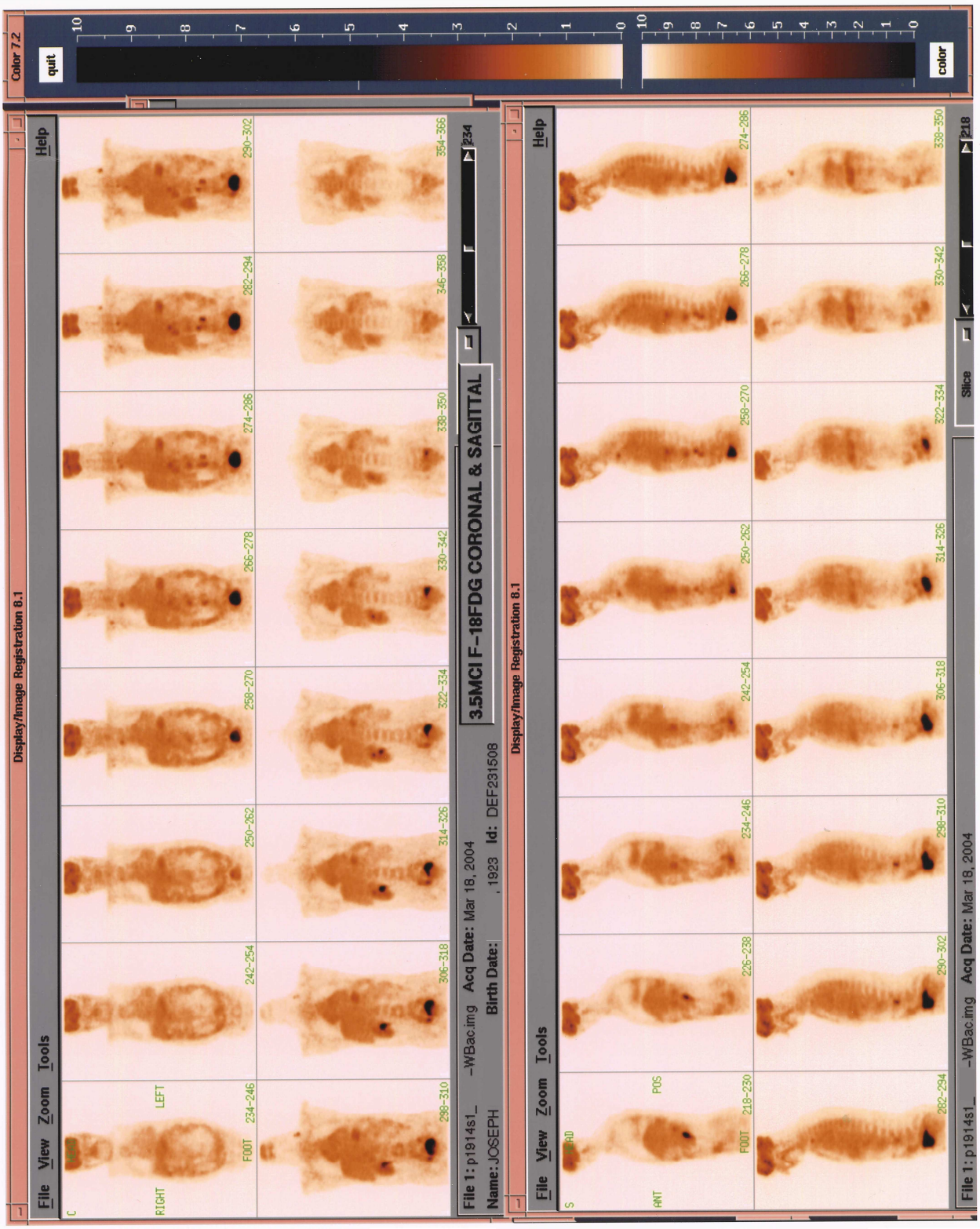
NATIONAL CANCER RESEARCH FOUNDATION

PET Scan March 18, 2004



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Double Lung and Left Hip cancer - advanced 4th stage

Aggressive Lippo sarcoma extremely fast spreading cancer

Coughed up 38 tumors - see last page

Original description

A 49 year old man, named Joe, came to me in Nov 2005 with lung sarcoma cancer and a relative sarcoma tumor on his left hip, but not invading any bone nor muscle. The hip tumor is the size of two large fists. In Nov 2005, his surgeons said that they could not do surgery, and gave him 3 weeks to live, stating that he would not be here for Christmas 2005. They added that even if they could do the surgery on his lung, he would have 15% chance of recovery, so, they refused to do surgery on him. With my program, he is doing GREAT today !!!!!!!!!!!!!!!!!!!

I am including PET scans - Nov 15 2005, Jan 4 2006 and April 10 2006. to show 90 - 95% necrotic dead cancer tissue, especially in hip. And the lower lung lobes are extremely small compared to Nov & Jan.

In Nov 2005, he came to see me, started the program, he decided to take 16 doses daily, his attitude was "Do or Die". I sent him to a different doctor who totally understands this program. By Jan 4, almost half the cancer was necrotic dead. For the past three months, he was coughing up tumors, about 32 dead tumors so far, pathology confirmed dead cancer tissue. He is storing it in a special refrigerator for any doctor who does not believe it. He had some breathing problems a week ago, turned out that it was phlegm from dead tissue in his lung, cleared up again and he is great again.

April 10, 2006 PET scan showed that 90 - 95% of the cancer was dead and over time, they indicated the tumor would probably diminish on its own, and admitted that they never saw this happen before.

The tumor on his hip was also necrotic with 95% dead tissue, and they feel that he should have the dead cancer removed because of the ball on his hip was starting to look like a large pimple forming a head, they did not want it to burst with pus coming out, and preferred surgery before that happens. We are working on getting a surgeon for that.

Attachments (see first three attachments):

1 Nov 15 2005 as noted above
2 Jan 4, 2006 cancer was dying and showed almost 50% necrotic
3 April 10, 90 -95% necrotic tissue ready for surgery to remove dead cancer in hip, lung will resolve itself without surgery, he is fine today.

Tuesday's Update May 8, 2006:

UPDATE:

The surgeon who originally turned Joe down for surgery has now agreed to do the surgery.
On Monday, May 1, the surgeon told Joe:

"This surgery will not change your outcome. It is unclear why the tumor went necrotic like that, how ever, you will not live longer due to removing the tumor from your hip because the lung cancer is so large, your lung has collapsed, and even though you coughed up the many tumors, which is unclear how that occurred, we cannot remove that large tumor and it will only get worse. I will need to give you spinal local anesthesia because you will die on the table if we use conventional anesthesia. This will be a risky and difficult surgery because of your multitude of problems relative to the lung cancer "

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Joe was a bit depressed over that. We explained that the doctor never had any experience using our methods, we needed to educate the surgeon, as I believe the surgeon truly cares and is not an ego nor self-centered person. I liked this surgeon. I told Joe that his job was to help educate this surgeon

Tuesday, May 2, also my parent's 58th anniversary, the doctor said that Joe's lung was not showing much air movement and was concerned. However, Joe felt great and he was at 94% lung capacity, which was good.

That afternoon, Joe started coughing very hard. The tumor popped out after strong coughing. It was hard and compacted from being compressed to go through the bronchial passage. It was 1 ½ +" long, ½ high almost and inch wide. It was that tumor in the lung which surgery was not an option. It came out and he did not need surgery, it was out.

They called for the doctor, nurses said he was gone for the day, and they were not interested, she took it home, took pictures. Wednesday, the surgeon went nuts over it, he clearly said, "In my 25 years as a surgeon, I have never seen anything like this, ever." He ranted and raved over this, and it was sent to pathology. As of this morning, Tuesday May 9, his breathing is great, plenty of air flow in his lungs, his oxygen is 96%, which is great, and they will remove the hip tumor (which is now basically totally dead) in a matter of a day or so. He basically improved so much that all the major concerns went out the window, the surgeon stated it is now just a simple routine surgery.

So, in the next few days, we expect to see some results.

I hope that you are all doing great !!!

Fred Eichhorn

Thursday's update May 10, 2006:

UPDATE on Joe:

Good morning everyone,

The doctors were expecting between 3 – 3 ½ hours, and was concerned that Joe might not be able to come off the ventilator. The anesthesiologist flatly turned him down, indicating that Joe would most likely die on the table. They found a different anesthesiologist who handled it, this one said, "I will approach it with caution, but I believe that we can make it work."

He coughed up a large tumor from his lung 1 ½" long, 1" wide, ½" high, spit it out, confirmed by pathology as dead cancerous tumor. That was his 33rd tumor he coughed up from his lungs, these were coughed up after the April 10th PET. Doctors said " I've been a surgeon 25 years, I have never anything like this !!!" yet, he had no interest to know more about what Joe did.

Long story short, Joe went in for surgery, May 10, 2005 at 6:30 PM. It took two hours and was basically uneventful. Spinal anesthesia, opened up the hip, lots of pus came out, they transfused some blood, the tumor had backed away from everything and was not invading much if anything at all. The surgeon's original concern was relative to amount of muscle would need to be removed and how severe the artery and nerve roots were affected. There was no invasion of anything, the necrotic tumor was 6.5 pounds. The surgeon said he removed just a little bit of muscle tissue, a lot less than he ever would have expected, and everything else was fine. The surgeon said that it would be 3 to 4 weeks before Joe would be able to put his weight on the floor with physical therapy.

Joe was awake almost immediately after surgery was finished and said he felt fine, he wanted to eat dinner. The next day, he ate a full lunch. On May 15, Monday, he walked without assistance to the bathroom and back, went home on Tuesday the 16th. Everybody was happy, it was a great day for Joe and Janice. Healing is fast, no redness, no swelling, no irritation. He is not on any pain meds except Percocet once in a while.

He coughed up another tumor, #34, not quite as big as #33, but still impressive.

Four days later, 5/20/06, he went to his son's College Lacrosse playoffs, sat in a wheel chair to avoid walking in the fields.

Following week update May 17, 2006:

He went to see the surgeon, healing process is extremely advanced, The following weekend, 5/27/06, they drove to Philadelphia, 120 miles each way, for the playoffs again. He was fine.

Update June 2006:

June 2, he went up and down stairs, was tired but did well. He developed a Staph infection from the hospital, not sure of origin.

June 3, Janice called at 11:30 PM to tell me he coughed up #35, it was 2" long and bigger overall than #33. I am waiting for pictures for #'s 34 & 35.

June 5, he was walking throughout the house and outside, he is bored, we need to find things for him to do.

He is getting better every day. July is next PET, that will be interesting. He was fine.

In my literature I wrote:

"When you are diagnosed with cancer,
you are introduced to yourself,
you find out what you are made of."

A few months later, the staph infection became more severe, they gave him strong antibiotics, he had trouble breathing, a common side effect from the anti-biotic. He suffered respiratory failure, not from cancer, but from the overdose of the anti-biotic. He was not able to eat and could not absorb the oxygen, both common side effects from the anti-biotics, and he passed away. I was extremely upset by this. Joe was such a sweet man too.

The following PET scans show where the tumor in the hip was so severe on Nov15, and the lung cancer was quite evident as well.

By Jan 4, it showed almost 50% necrosis, it is darker, which needs to be taken into consideration, the report indicated improvement.

By April 10, it showed about 90% necrosis

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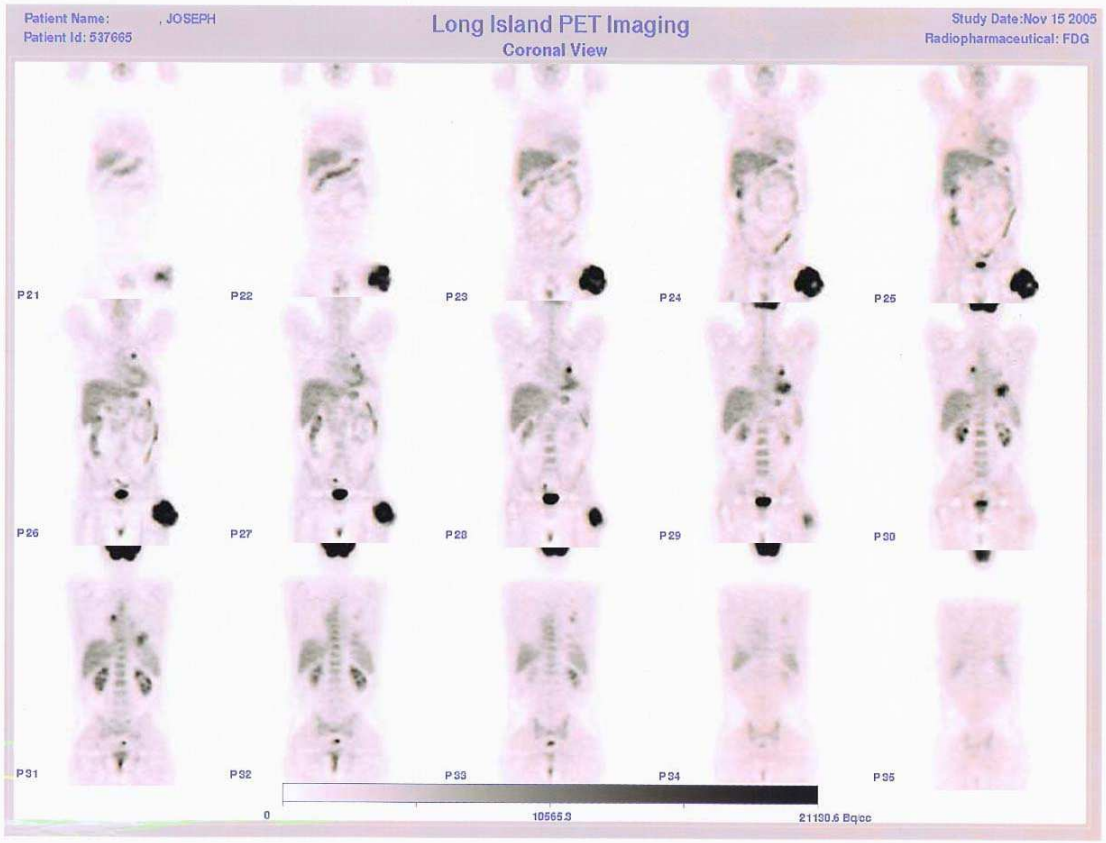
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Patient Id: 537665
Long Island PET Imaging
Coronal View
Study Date:Nov 15 2005
Radiopharmaceutical: FDG
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P24
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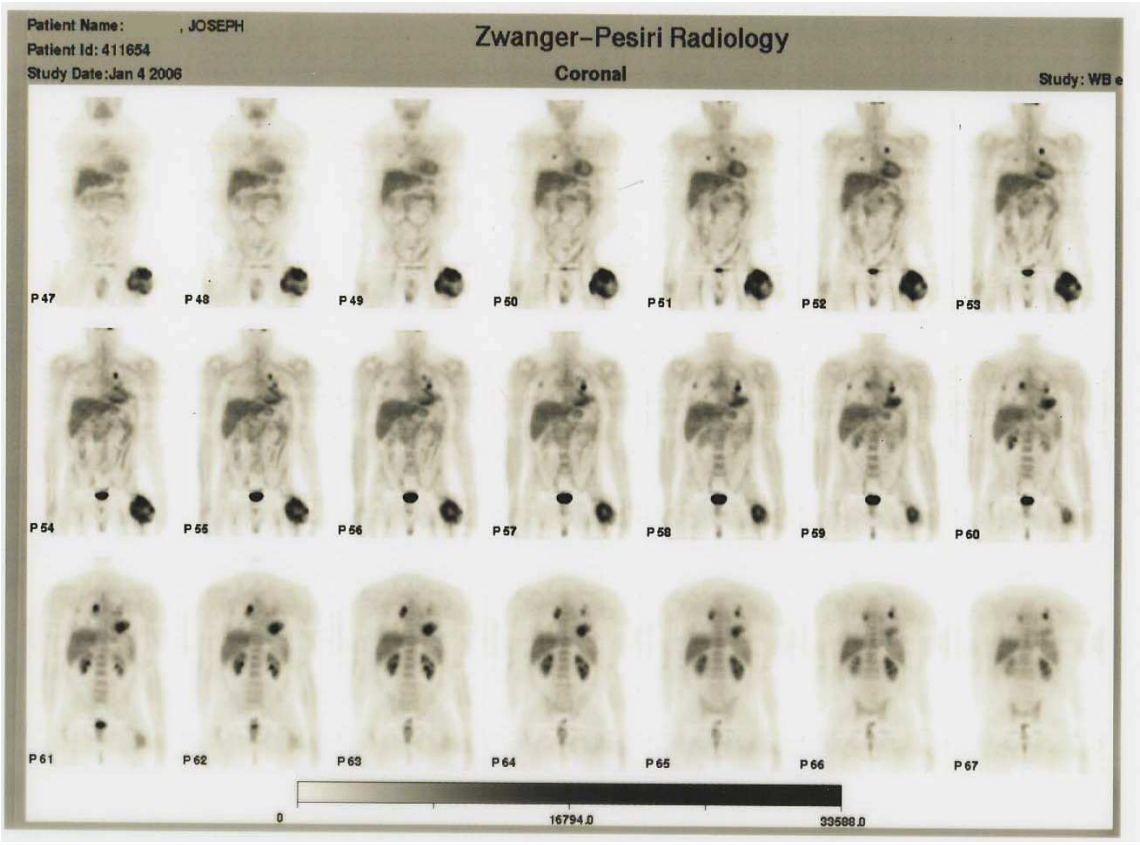
21130.6 Bq/cc


Patient Name: , JOSEPH
Patient Id: 411654
Study Date:Jan 4 2006
Zwanger-Pesiri Radiology
Coronal
Study: WB e
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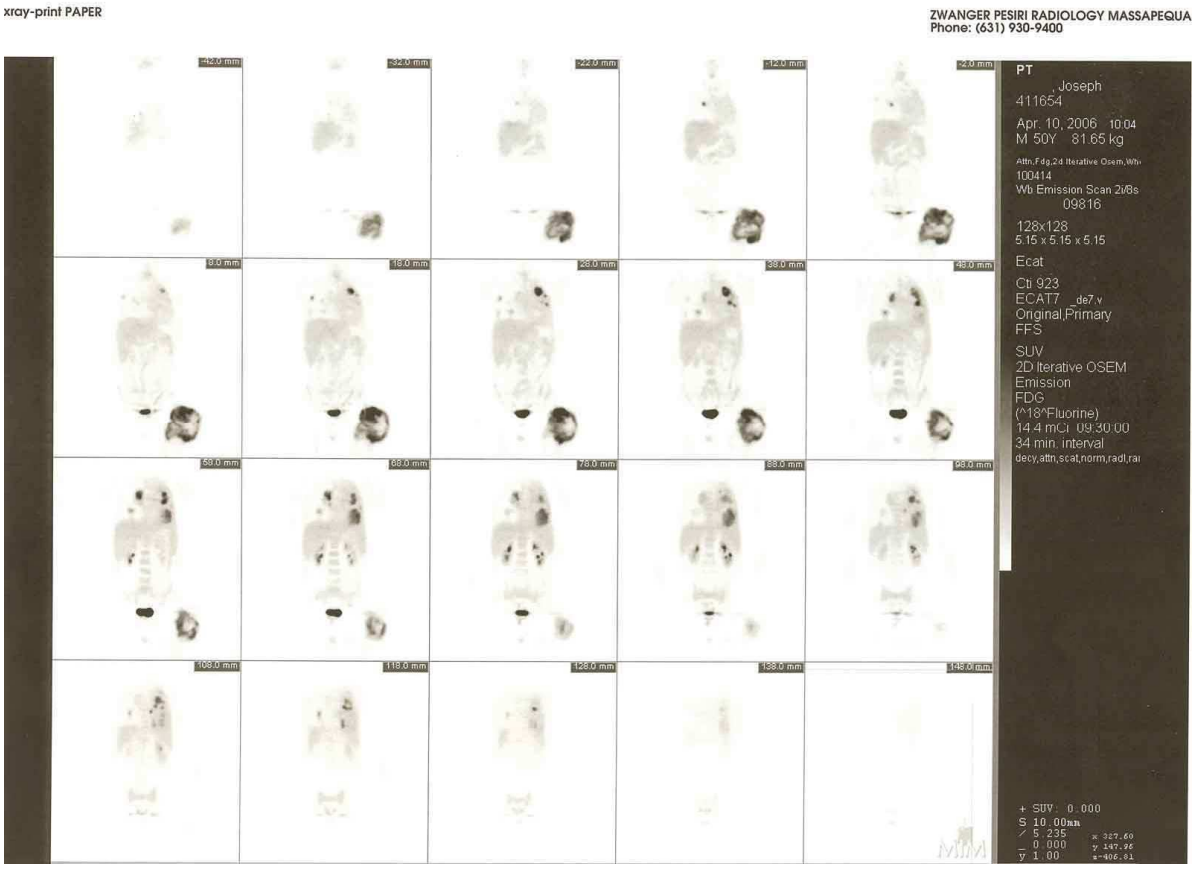
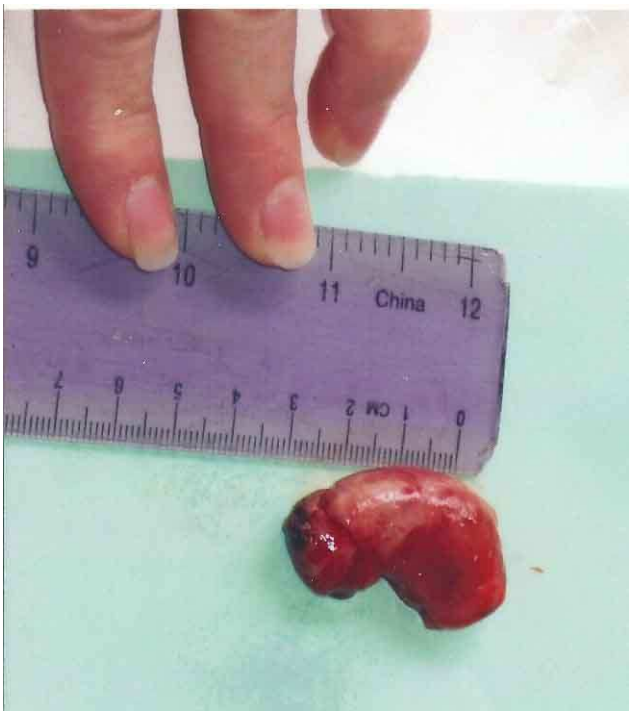
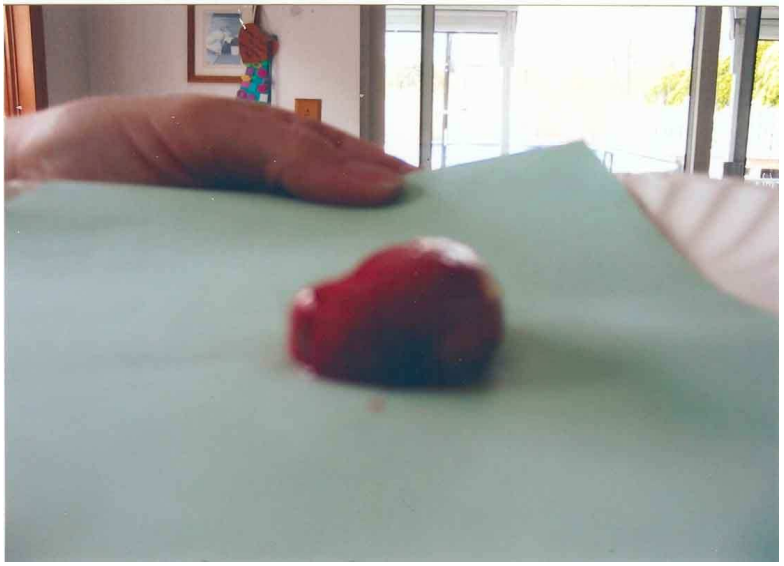




One of 38 Tumors coughed up - Almost 2 " long



Typical tumor showing size compared to surrounding

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