PERSPECTIVES

The Gonzalez Best Case Series Presentation to the NCI: 25 Cases, 25 Years Later

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The publication of the monograph *Proof of Concept: 25 Best Cancer Cases Presented to the National Cancer Institute* by New Spring Press provides another facet of the accomplishments of the remarkable man who wrote it, my long-time colleague and friend, the late Dr. Nicholas Gonzalez.[1] Gonzalez had been successful in the world of journalism before he decided, in his late 20s, to become a physician. While in medical school, he encountered the work of Dr. William Donald Kelley, an orthodontist who had developed a nutritional method for the treatment of cancer and other illnesses, involving individualized diet and supplement protocols, high dose pancreatic enzymes, and various detoxification routines. After reviewing Kelley's records, Gonzalez dedicated his life to preserving this treatment method and to trying to get it properly scientifically evaluated.

Gonzalez' findings about Kelley's practice would eventually be published, 25 years later, as the book *One Man Alone*.[2] But at the time Gonzalez finished his investigation of Kelley's results in 1986, no journal editor or book publisher was willing to accept that the case reports were real, to examine the medical records supporting the cases, or to take the risk of antagonizing others in the medical world. I was already working with Gonzalez at that time; I remember the numerous submissions of case reports and manuscripts, and the disappointment building as the rejections came. Finally, Kelley began to mistrust us, and it became clear that Gonzalez and I could no longer work with him. Since Kelley was no longer seeing patients, Gonzalez decided that he should try to recreate the protocol, in the hope of collecting more data to further document the treatment's potential, and that someone other than Kelley could implement it.

In the fall of 1987, Gonzalez began seeing patients in New York City, in the office of a physician friend. I helped out administratively until I resumed my internal medicine residency in June 1989. Those were difficult times, with limited resources. Gonzalez wrote instructions for diets and detoxification protocols, decided what supplements to use, and figured out how to get them distributed. He got publicity through contacts from his journalism days such as Dr. Robert Atkins. Most challenging of all was patient care. We had to learn the hard way the limitations of the treatment method and of our own stamina. In the early days, Gonzalez was making house calls on patients who in retrospect were simply too ill to benefit. Both Gonzalez and I were tempted on many occasions to quit, but invariably, when we were despondent over one poor outcome, shortly afterwards we would get good news about another patient who was improving.

In 1991, I finished my internal medicine residency, passed my boards, and rejoined Gonzalez, but there was no room for me to see patients in the office he rented. While Gonzalez saw patients, I reviewed his charts, looking for remarkable outcomes and incomplete records, and sent out release forms to other treating physicians, radiology facilities, and hospitals. All this proved invaluable when Gonzalez was invited to present a Best Case Series in 1993 at the National Cancer Institute.

For his presentation, Gonzalez was determined that every detail would be in place. We felt a single bit of missing data could provide an excuse for someone to criticize his selected cases. It became my mission to track down actual X-ray and CT films, to get pathology slides, and to be sure every relevant document was included. Meanwhile, Gonzalez continued to work long hours seeing patients and returning phone calls, while writing a monograph describing the cases in his presentation. We had it printed and bound, and distributed it to the attendees at his presentation, with patient names and identifying information intact in the medical records included.

In his introduction, Gonzalez discussed supporting evidence for the treatment, including the work of Dr. John Beard, who first suggested that pancreatic enzymes could be used to treat cancer.[3] Beard's thesis centered on the similarity in appearance and behavior of cancer cells to the trophoblast, the earliest stage of the mammalian placenta. Beard had observed that the trophoblast moderated its aggressive, invasive nature around the time the fetus began making pancreatic enzymes. He speculated that pancreatic enzymes

could also moderate the behavior of cancer, which he felt arose from "aberrant" trophoblast cells that were retained in adult tissues as a reservoir for repair – similar to the function of what are now called stem cells.

At the time of Gonzalez's NCI presentation in 1993, little of this was corroborated in the scientific literature, and a common criticism was that the treatment method did not fit with what was known about cancer at the time. Gonzalez believed that the lack of a detailed rationale for the mechanism of action of Kelley's treatment method did not invalidate the findings among Kelley's patients or his own. Since then, the similarity of the trophoblast to cancer has become more widely recognized,[4,5] and modern science has shown that the fetus does in fact make enzymes early in development.[6,7] On a molecular level, receptors for proteolytic pancreatic enzymes have been found on both trophoblast and cancer cells.[8,9] Even without the knowledge of Beard's unifying theory about pancreatic enzymes, research is proceeding that may eventually bring modern science to the same conclusions that Beard made more than a century ago.

Gonzalez also included references about the therapeutic use of enemas in his presentation; a recent article documents the usefulness of coffee enemas in stimulating bile flow, corroborating what Kelley and others had claimed as the mechanism of action of this detoxification technique.[10]

Looking back after 25 years, I am amazed that Gonzalez was able to put together this case series after only six years in clinical practice. We have never seen high volumes of patients; it takes time to collect the information needed to design protocols for our patients, time to explain it, and time to return the phone calls to answer patients' questions. And the patients included were not the only ones doing well. There were some who simply were not far enough out from diagnosis in 1993 to be reportable cases.

The scientists in attendance at Gonzalez's presentation suggested a pilot study looking at pancreatic cancer, though no funding was provided to facilitate it. He and I began seeing patients for that project in 1994. What happened next has been documented elsewhere; the results of the pilot study were published in 1999,[11] followed by the flawed clinical trial that concluded in 2005, a bitter disappointment to both of us.[12,13] There was an epidemic of poor adherence among patients on our arm of the study, which was never discussed in the published article which used an intent-to-treat analysis.[14] To quote an article in the *New England Journal of Medicine*, "When there is incomplete adherence, intention-to-treat analyses … may result in an effective intervention appearing to be ineffective if the poor adherence was due to misplaced concerns about effectiveness or toxicity."[15] Gonzalez and I had assumed that the medical community would be supportive of our patients who were entered into the trial. Instead, other treating physicians seemed to feel a moral responsibility to be as negative as possible. One prominent academician even told a patient that the trial was a devious way to scam money from him, even though he told her he had paid nothing. Thirty of 39 patients on our arm of the study followed their treatment incompletely, briefly or not at all. To quote from a letter from one of the supervisors of the trial after a particularly contentious meeting:

> We discussed at considerable length his [Gonzalez] concerns about the probable accrual of patients unable to comply fully with the nutrition arm of the protocol. It was our impression that everyone in the room basically agreed that, despite best efforts, there is in fact, reason to be concerned about this issue, and that it clouds interpretation of the data.[16]

Meanwhile, a patient with pancreatic cancer who was deemed ineligible to enter the NCI-sponsored study by the trial supervisors was treated by me off-protocol and is still alive with good performance status, now 18 years from her diagnosis. Her pancreatic tumor was biopsied and the slides sent to the Mayo Clinic for a second opinion, with confirmation of the diagnosis of cancer of the exocrine pancreas. She has never had surgery, radiation or chemotherapy.

Throughout our time in practice, even as our formal research efforts bogged down in a miasma of mismanagement and indifference from the academic world, many of our patients continued to do well. We published a collection of case reports in 2007,[17] and Gonzalez was working on a large collection of them at the time of his death, subsequently published in two volumes under the title *Conquering Cancer*.[18,19] Some of the patient stories described in *Proof of Concept: 25 Best Cancer Cases Presented to the National Cancer Institute* are continued in those books. Some of the patients are still alive.

Gonzalez was frequently infuriated by the rapid approval and acceptance in the orthodox medical world of treatment methods with far less documentation of good outcomes than he had provided with his investigation of Kelley's work and his own presentation to the NCI in 1993, a total of 74 remarkable case reports. As an example, in 1992, interleukin-2 was approved by the FDA for use in metastatic renal cell carcinoma based on the results of pooled data from seven Phase II studies, despite high expense and toxicity, and a fairly low overall response rate of 15%.[20] That era also saw the widespread adoption of bone marrow transplantation for poor prognosis breast cancer before properly done clinical trials showed it to be no more effective, and far more toxic, than standard chemotherapy.[21]

Gonzalez was not against proper evaluation of his own work, far from it. He just expected the same standards to be applied for all. He wanted his own work to be evaluated in a properly run trial, where patients were able to comply with their treatment and encouraged to do so, not subjected to harassment by other treating physicians. And he wanted to see orthodox therapies properly tested before widespread use, not given a pass because the treatment methods used made sense to the oncology world.

It is still hard to believe, four years later, that Gonzalez is no longer here. But I continue seeing patients, as I know he would want, and I continue to see patients do well. I plan, in

due time, to continue to publish case reports, in the hope that someday the work that Kelley, Gonzalez and I did will get the vindication Gonzalez never received during his life. And I find encouragement to continue from the passionate gratitude of the patients, both his and mine, whose lives have been transformed by the methods Gonzalez dedicated his life to preserving.

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