The International Journal of the Medical Science of Homeopathy, Energetic Medicine Naturopathy

Evidence Based Literature to Protect and Explore Natural Medicine since 1996

ISSN # 1417-0876, 2041-4293

http://ijmshnem.com/
Spontaneous remission, also called spontaneous healing is an unexpected improvement or cure from a disease. The spontaneous regression and remission from cancer was defined by Everson and Cole in their 1966 book as "the partial or complete disappearance of a malignant tumor in the absence of all treatment, or in the presence of therapy which is considered inadequate to exert significant influence on neoplastic disease." Let’s look into these phenomena to understand better, how a small change might make a miracle. And let’s understand just with Quantum Biofeedback we should make miracles every day. As we stimulate the body electric, stabilize body amperage, voltage, resistance, hydration, oxidation, ph and make osmosis work better everything works better and a simple one enzyme or hormone may be the difference that activates a process and thus a healing. Activating the body own defenses makes more sense than chemotherapy destruction of the body.
"When the body electric kicks in and does it's job why should we be so surprised?? And call it spontaneous"

Desire' Dubounet
Modern Medicine has been dominated by harsh methods like Drugs and Surgery that have to be statistically measured to demand action. They cannot understand the complexity of the individual. They cannot understand how subtle energy might heal, even though our day to day healing is subtle. So they witlessly say subtle healing is SPONTANEOUS.
As we increase Osmosis with Quantum Eductor Biofeedback and we increase the VARHOPE or Electrical Vitality then Everything works better, and then things start to get done that were not functioning before. We should Not be surprised.

We Should Expect Miracles Daily

In Spite of All Odds
With Quantum Biofeedback
You Should Expect a Miracle

It's Time To Expect
Your Miracle Harvest!
How to Tap into Your Self-Healing Superpowers

You practice medicine. You don’t give it or deliver it.

Published on May 22, 2012 by Lissa Rankin, M.D. in Owning Pink

As I described in my personal health journey, I was once a doctor suffering from a wide array of health conditions before I finally woke up to the fact that the root causes of my illnesses were more emotional than biochemical, and that the only way I was going to get well was to treat the emotional, psychological, and spiritual sickness that was manifesting as physical symptoms in my body.

After leaving medicine to spend time healing myself, my body was responding to the treatment the wise, knowing part of me I call my Inner Pilot Light prescribed, but at what price? We were running out of money, I still had no plan, and ever since I left my job, something deep and important was missing from my life. I realized that you can quit your job but you can’t quit your calling. I had been called to medicine at a very young age, the way some are called to the priesthood.

Medicine is a spiritual practice—you practice medicine. You don’t give it or deliver it. You practice it, like you practice yoga or meditation, like you’ll never fully master it. Medicine is about love, about God. Doctors are here to be vessels for Divine love, to use our hands to touch the spirits that live in human bodies. I have been a healer since I was 7 years old, and as my body grew stronger and my heart healed, my soul yearned to get back to my life’s work. I finally realized I had to go back, even though it took me two more years to find my way back to medicine in a way that wouldn’t make me sick.

I wound up working at an integrative medicine center in Marin County, California, where our patients were the most health-conscious people I’ve ever had the pleasure to treat. These people were the proverbial choir. They drank their green juice every day, they had personal trainers, they slept eight hours a night, they took 20 supplements, and they spent a fortune on their health care. They did everything “right,” but they were sicker than ever.

I was baffled. Nothing they taught me in medical school prepared me to take care of patients like these.

So I started asking my patients “What does your body need in order to heal?”

At first, I thought they’d give me treatment intuition, things like “I think I’ll try the 5-HTP supplement instead of the Prozac” or “I think I’ll try changing my diet instead of taking that pill”—and sometimes that’s what they’d say. But more often than not, they answered me with:

- I need to leave my husband.
- I need to quit my job.
• I need to move to Santa Fe.
• I need to put my mother in a nursing home.

When my patients listened to their intuition and had the guts to follow through on what they prescribed for themselves, seemingly incurable diseases sometimes disappeared.

I was in awe. These patients weren’t responding to conventional medical treatment. They were healing themselves in ways I couldn’t explain. That’s when I discovered a database compiled by the Institute of the Noetic Sciences, which is called the Spontaneous Remission Project. This database compiled more than 3,500 case reports from the medical literature of patients with seemingly incurable diseases that got better - stage 4 cancers that disappeared, HIV + patients that became HIV-, people with diabetes or high blood pressure or thyroid disease whose disease went away, even a patient with a gunshot wound to the head who refused treatment and got better.

Call these miracles or call them inspiring examples of self-healing. I was riveted.

That’s when I got really curious about exactly what makes a person healthy, and what predisposes them to illness. To find my answers, I dug deep into the scientific literature.

What I discovered blew me away. The research proves—without a doubt—that without even being intentional about it, you can heal yourself of about 18-75% of them. We call it the placebo effect, when patients in clinical trials are given sugar pills or even fake surgery, and the simple belief that they are getting the real treatment results in cure.

But from my own experience, I suspected that the ability to heal yourself goes deeper than some sugar pill. So I dug deeper into the medical literature, and what I discovered is that for the body to be healthy, you need to be healthy in all aspects of your life:

You need:

• HEALTHY RELATIONSHIPS
• A HEALTHY PROFESSIONAL LIFE
• A SENSE OF SPIRITUAL CONNECTION
• CREATIVE EXPRESSION
• HEALTHY SEXUALITY
• HEALTHY FINANCES
• A HEALTHY ENVIRONMENT
• A HEALTHY MIND

And of course, not to be completely ignored (biochemistry does still matter!) YOU NEED TO CARE FOR THE BIOCHEMISTRY OF YOUR BODY with diet, exercise, sleep, addiction avoidance, and the traditional “healthy” behaviors.
These expanded categories of what makes a person healthy and whole are now the categories I blog about at OwningPink.com, the website I founded where people in need of healing - and those who serve them - learn how to become healthier in all aspects of life.

What I learned through my exploration into the scientific data led me to write my next book *Mind Over Medicine: Scientific Proof You Can Heal Yourself* (Hay House, 2013). What I learned led me to create a new wellness model, inspired by the image of cairns, those balanced stacked stones you see marking beaches and sacred landmarks.

I’m a professional artist, so I love the sculpture of cairns, but what I especially love about cairns is that they are all interdependent on each other. If one stone in the cairn is out of balance, the whole thing topples over, with the stone on top usually being the first to fall.

That’s how I think of the body. The body is the most precarious, the most fragile, the most susceptible to imbalances in the rest of your life.

As I described in a popular TEDx talk, the Whole Health Cairn is built upon the firm foundation of your Inner Pilot Light, with all the facets of what makes you whole and healthy balanced upon it in a way that is deeply true for you. Wrapped around the Whole Health Cairn is the Healing Bubble of Love, Pleasure, Gratitude, and Service, which help balance all the stones in the cairn.

The Whole Health Cairn is both a diagnostic tool and a tool for guiding treatment. You can use it to assess your life and diagnose the root cause of your illness, so you can write The Prescription for yourself the way I did. (For a free video training about the Whole Health Cairn, sign up here).

When you think about your health in this way, you’ll realize that health is primarily an inside job. The Prescription for living a wholly healthy life must come from you. Nobody can diagnose the real reason you’re sick or prescribe exactly the right treatment better than you.
I’m not suggesting that your illness doesn’t have a biochemical component. But I am suggesting that illness is rarely purely biochemical, and as such, purely biochemical treatment rarely leads to cure when emotional, psychological, and spiritual factors that contribute to illness are left untreated.

**What Can You Do To Optimize Your Health?**

What’s out of balance in your Whole Health Cairn? What might be contributing to any physical symptoms you experience? What is your body trying to tell you?

Try inviting your body to write you a letter. (Dear You, Love, your headache). Write back. Have a conversation. What does your body want you to know?

Pay attention when your body speaks in whispers. Please darling, don’t wait until your body starts to yell.

Listening to whispers,

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*Lissa Rankin, MD: Founder of OwningPink.com, author of *Mind Over Medicine: Scientific Proof You Can Heal Yourself* (Hay House, 2013), TEDx speaker, and health care revolutionary. Join her newsletter list for free guidance on healing yourself, and check her out on Twitter and Facebook.*
When I first read the Spontaneous Remission Project

Monty Renov

“When I first read the Spontaneous Remission Project, which consists of over 3500 case studies in the medical literature of patients who have been cured from seemingly “incurable” illnesses, either without medical treatment or with treatment deemed inadequate for cure. These case studies, written up by doctors as unexplainable cases, offer a scientific peak into the mystery of medicine, the awe of medicine, and the possibility of what some might call (though most doctors wouldn’t dare) “miracles.”

Many of these case studies include the stories of patients who were cured from supposedly terminal cancers- Stage 4 cancers that disappeared. When I read these case studies, the million dollar question that popped into my curious mind was “Are these flukes- or did these patients do something proactive to cure themselves?”

Dr. Kelly Turner, a PhD who trained at Harvard and UC Berkeley, had the same question, so I tracked her
down to interview her from my book Mind Over Medicine: Scientific Proof That You Can Heal Yourself. For her PhD thesis, Dr. Turner traveled the world studying people who experienced what she calls “unexpected remissions” from Stage 4 cancer. She prefers the term “unexpected remission” to “spontaneous remission” because the word “spontaneous” implies that it just happened, that it was some sort of lucky accident, and that the patient wasn’t involved in the cure. In addition to interviewing the patients in order to find out what they did to get well, Dr. Turner interviewed their healers, usually unconventional healers, since many of these patients had chosen to refuse Western medical treatment.

What Dr. Turner found is that these unexpected remission weren’t accidents. The common thread between all of these patients stories was 6 proactive health behaviors they credit with their cancer cures.

1. Change your diet.

The majority of Dr. Turner’s interviewees credited diet change as a powerful tool for self-healing. Most recommended eating a diet consisting primarily of whole vegetables, fruits, grains, and beans, while eliminating meat, sugar, dairy, and refined grains. When your body’s innate self-repair mechanisms are overtaxed with cleaning up toxins from a poor diet, it’s hard for them to go about the business of fighting cancer. But when your diet is pristine, your natural self-repair mechanisms can do what they know how to do- kill cancer cells and try to return the body to homeostasis. For great examples of how to fight cancer with a vegan, largely raw, chemical-free, anti-inflammatory diet, check out Kris Carr’s Crazy Sexy Diet and Crazy Sexy Kitchen.

2. Deepen your spirituality.

Many of Dr. Turner’s interviewees discussed feeling an internal sensation of divine, loving energy of a spiritual nature. One study showed that engaging in spiritual community by attending religious services can extend your life by up to 14 years, so it’s unsurprising that connecting with the Divine- whether within yourself or in spiritual community with others who share your faith- would activate your body’s self-repair mechanisms so your body can heal itself.


Many of those Dr. Turner interviewed credited their cancer cure with increasing love and happiness in their lives. Studies show that happy people live up to 10 years longer than unhappy people and optimists have a 77% lower risk of heart disease when compared to pessimists, most likely because feelings of joy, love, connection, optimism, and happiness flip off harmful stress responses and activate healing relaxation responses in the body, filling the body with healing hormones like oxytocin, dopamine, nitric oxide, and endorphins which bathe every cell in the body- including the cancer cells- and activate the body’s natural cancer-fighting abilities.

4. Releasing repressed emotions.

Many of Dr. Turner’s interviewees believed that it was healing from them to release any negative emotions they had been harboring, such as fear, anger, grief, or resentment. We know that repressed emotions, whether they exist in the conscious or subconscious mind, act as triggers to the amygdala in your limbic brain, since the amygdala inaccurately perceives these negative thoughts as a threat to your
safety. Every time you feel fear, anger, grief, resentment, loneliness, pessimism, depression, or anxiety, these negative thoughts activate the “fight-or-flight” stress response that fills the body with poisonous stress hormones and deactivates the body’s natural healing processes. Dealing with your negative emotions in healthy ways—via psychotherapy, somatic work, EFT, the Hoffman Process, or any number of other modalities, can calm your amygdala, return your nervous system to its homeostatic relaxed state, and boost your body’s self-repair mechanisms.

5. Taking herbs or vitamins.

Dr. Turner’s interviewees took various forms of herbs, vitamins, and supplements—there wasn’t any one magic supplement that beat out the rest—with the belief that they would help to detoxify the body and/or boost the immune system. Whether these herbs, vitamins, and supplements actually helped cure the cancer—or whether they effectively helped flip on the body’s natural self-repair via the placebo effect—has yet to be determined. And it shouldn’t matter. We know that 18-80% of the time, patients taking sugar pills with no inactive ingredients get better—because they believe they are getting the real treatment. In other words, if you believe some herb, tea, tonic, vitamin, or nutritional supplement holds the key to your cure, by all means, take it.

6. Using intuition to help make treatment decisions.

Those who Dr. Turner interviewed talked about the importance of following their intuition with regard to treatment-related decisions, which makes sense physiologically. When rats with a certain type of cancer are exposed to shocks, studies show that the rats who learn to escape the shocks die of cancer 30% of the time, compared to a 73% death rate when the rats become passive and just lay down and accept their fate.

In other words, your body is your business. Whether or not you’re pursuing conventional cancer treatment or trying alternatives like the people in Dr. Turner’s study, you can’t just hand the fate of your body over to someone else the way you would hand your car over to a doctor. You know your body better than any doctor does, and following your intuition (Step 3 in the 6 Steps To Healing Yourself that I teach in Mind Over Medicine) is key when it comes to fighting any illness, especially cancer. If you or someone you love has cancer, the very act of taking charge of your health not only ensures that you get the best care; it also gives you a survival advantage and makes it more likely that you will become one of the medical miracles.

Remember, these healthy behaviors aren’t just about helping you experience an unexpected remission. They’re about prevention. After all, this is your LIFE we’re talking about."
Most of the unexpected remission survivors I have studied are thrilled to have finally found a professional who is interested in learning how they healed. They often lament, “My doctor didn’t even ask how I did it.”

We’ve all heard a story like this one. After trying all that Western medicine has to offer, a person with Stage 4 cancer is told there is nothing more the doctors can do and is sent home to receive hospice care. Five years later, that person strolls into the doctor’s office feeling great, with no further evidence of cancer.

In the medical world, this kind of case is referred to as a spontaneous remission, which is defined as “the disappearance, complete or incomplete, of cancer without medical treatment or with medical treatment that is considered inadequate to produce the resulting disappearance of disease symptoms or tumor.” Many researchers, including myself, believe that the word spontaneous is a misnomer and should be changed to unexpected or unlikely. We feel this way because few things in life are truly spontaneous—occurring purely by accident. It is more likely that these remissions have a cause—or two or three—that science has not yet identified.

Background

Regardless of what we call them, unexpected remissions do occur, and more than one thousand cases (across all types of cancer) have been published in medical journals. Thousands more have most likely occurred but not been published, because most doctors don’t take the time to write up a report and submit it to a journal—which
unfortunately is currently the only way of tracking these kinds of cases. Based on what has been published, unexpected remissions are estimated to occur in one out of every sixty thousand to one hundred thousand cancer patients; however, the true incidence rate is likely higher than that due to underreporting.

Over the past century, there has been a steady flow of published case reports along with flashes of increased interest in this topic. For example, in the 1960s, the first two scientific books on unexpected remission were published, which led to a sharp increase in the number of case reports submitted to medical journals. After awhile, however, interest in the topic lulled again until the late 1980s when the Institute of Noetic Sciences (IONS) launched the Spontaneous Remission Project, which culminated in the publication of a comprehensive bibliography of documented cases. Since then, approximately twenty new cases of unexpected remission are published each year, and there still has been a noticeable lack of formal research into why these remissions might occur.

It’s understandable, in a way. How do you begin to research something you cannot explain? Many conventional doctors feel threatened by these “miraculous” cures and don’t wish to talk about them—much less research them—for fear that they will give “false hope” to their other patients. In fact, most of the unexpected remission survivors I have studied are thrilled to have finally found a professional who is interested in learning how they healed. They often lament, “My doctor didn’t even ask how I did it.”

The Present Research

Perhaps because I am a qualitative researcher and not a medical doctor, I have always been fascinated by cases of unexpected remission. When I began studying them during my doctoral studies at the University of California at Berkeley, I was disappointed to see how little research had been done on this topic. The first problem I saw was that there was no database where I could easily find and analyze these cases. The second issue I noticed was that two groups of people had been largely ignored in the research: the survivors themselves as well as non-allopathic healers. It seemed odd that in an effort to explain unexpected remissions, we weren’t asking the opinions of the people who had actually healed. I also couldn’t understand why, when trying to explain a remission that is by definition not a result of allopathic treatment, we weren’t seeking out hypotheses from non-allopathic healers.

As a result, my dissertation research involved collecting hypotheses from these two previously ignored groups about why unexpected remissions may occur. More specifically, I spent ten months traveling the world in search of fifty non-allopathic cancer healers. My research led me to interview healers in the United States, China, Japan, New Zealand, Thailand, India, England, Ireland, Zambia, Zimbabwe, and Brazil (translators were used when necessary). When I returned from this amazing trip, I found twenty unpublished cases of unexpected remission and conducted phone interviews with the survivors. I purposely sought out unpublished cases first, in order to
see if the underreporting issues were true—which they were. I am grateful to the American Cancer Society for providing partial funding for this study.

My seventy hour-long interviews resulted in more than three thousand pages of transcripts, which I analyzed multiple times to find recurring themes. I identified more than seventy-five “treatments” for cancer, six of which were “very frequent” among all seventy subjects. Underlying beliefs about cancer also emerged from the interviews, of which three were very frequent. I am happy to share these results here in an abbreviated form. Please remember that these are hypotheses only, not facts.

Belief #1: Change the Conditions under which Cancer Thrives

The majority of my interviewees believed that cancer thrives under certain, sub-optimal conditions in the body-mind-spirit system and that to remove cancer, those underlying conditions must change. Healer #21 from Hawaii explained it this way:

*The most successful recoveries seem to be strongly associated with major mental, emotional, or physical behavioral changes among the people with the illness. What is major for one person, of course, may not be the same for another... I know of one success where a woman left her family, took up a different religion, changed her clothing and diet, and moved to a different country. Maybe she needed all of those changes or maybe not, but overall it worked for her. I know of another person, a man, who simply stopped trying to outdo his father, and that worked for him.*

Belief #2: Illness = Blockage/Slowness; Health = Movement

The majority of my interviewees also believed that any illness—including cancer—represents a blockage or slowness somewhere in the body-mind-spirit system, whereas health occurs when there is a state of unhindered movement or flow.

Healer #1 explained his theory of “bypasses,” which he described as psychological defense mechanisms that function to create a bypass around an energetic block. He said that this energetic block can be located at either the spiritual, mental, emotional, or physical level and that these bypasses become solidified over time. In his opinion, true healing only occurs when a person (1) stops bypassing and (2) releases the original blockage.

Belief #3: A Body-Mind-Spirit Interaction Exists, and Energy Permeates All Three Levels
The third belief that the majority of my interviewees discussed was the idea that a body-mind-spirit interaction exists and that energy permeates all three of these levels. According to Healer #35, an American-born, Peruvian-trained shaman:

You have to have mind, body, and spirit healing . . . Most of us who live in our physical bodies, we don’t even know about spiritual or emotional bodies. So we have to connect with all three of them. But you see, in the mountains of the Andes, [the Andean people] are already connected.

In addition to these three underlying beliefs about health, there were also six treatments that the cancer survivors and healers discussed most frequently. These included physical as well as emotional, energetic, and spiritual “treatments.” They are listed below in alphabetical order.

### Changing One’s Diet

The majority of my interviewees believed it was important to change their diet to primarily whole vegetables, fruits, grains, and beans, while eliminating meat, sugar, dairy, and refined grains. Unexpected Survivor #16, who overcame liver cancer without conventional medical treatment, explains the major changes he made in his diet:

[I healed] by just going on a basic, good, predominantly raw, vegan diet alone and supplementing it with lots of juices, like carrot juice, which of course is packed with nutrients. And the reason why the juices are so important is we have depleted basically all of our produce . . . That’s the reason for using juices as a supplement . . . All of a sudden the body says, Wow! It’s like watering the lawn when it’s dry.

### Experiencing a Deepening of Spirituality

The majority of my interviewees also discussed feeling—not just believing but actually feeling—an internal sensation of divine, loving energy. Some even had transcendent experiences, such as Unexpected Survivor #4, who healed from a Stage 3 lung cancer without conventional medical treatment:

It was a ten-day, silent retreat, where you couldn’t speak, you couldn’t acknowledge other people in the room, and you just meditated for like fourteen hours a day. And I had this experience that I can’t explain. It was like all of a sudden there was a flash, and in my eyes I could see rivers of energy swirling around and at the same time felt that same thing through every cell of my body. And there’s a word for it, but I forget what the teacher said it was—but he explained that, “You felt your soul. You felt your true
essence.” And I said, “Did I feel God?” And he kind of smiled and said, “Some people may call it that.”

Feeling Love/Joy/Happiness

The majority of my interviewees also discussed the importance of increasing love and happiness in their life in order to help regain their health.

Unexpected Survivor #5, who overcame a rare lymphoma without conventional medical treatment] said that the energy/spiritual healer that he saw flooded his lymph system with energy and that after the treatment he felt like “a teenager in love.” He felt love toward everyone and everything. He said the treatment made him realize that if he could only find a way to feel that level of unconditional love all of the time, then he would be healed from his cancer.

Releasing Repressed Emotions

Because many of my interviewees believed that illness represents a state of blockage, they therefore believed that it was healthy to release any emotions they had been holding onto, such as fear, anger, and grief. Unexpected Survivor #19, who overcame pancreatic cancer without conventional medical treatment, explains her insight into this process:

I believe that the energy stuck in my body that appeared to be a mass or a tumor, and which [my physicians] called cancer, had been caused by these patterns that I was describing to you that don’t get released, that are continually overlaid, over and over and over, wherever they are. So if it’s kidney cancer, it’s probably excessive fears; if it’s lung cancer, it’s grief of some sort that hasn’t been resolved. I mean, I think they can be very much tracked back to patterns, thought patterns, thought forms that are not releasing, and therefore they hold in the cell memory are not being released.

Taking Herbs or Vitamins

Many of my interviewees also took various forms of supplements, with the belief that they would help to detoxify their body or boost their immune system or both. Here is how Unexpected Survivor #8, who overcame Stage 3 colon cancer, described it:

Dr. Turner: Of all the things you just told me about, what do you think was the most influential for your healing, or are they all pretty equal for you?

Unexpected Survivor #8: I would say, for my body, that would be the Wholly Immune [supplement] that I got . . . It has like about fifty different things in it
. . . [A friend] researched it and said, “In that Wholly Immune, you’ve got seven cancer fighters. If you were taking them on their own, it wouldn’t be as potent.” He said that because they’re in combination, it acts as a cancer destroyer.

Using Intuition to Help Make Treatment Decisions

Finally, many of my interviewees talked about the importance of using intuition to help make treatment-related decisions. For example, Unexpected Survivor #7, who overcame recurrent metastatic breast cancer after conventional medicine had failed to work, described how a healer’s intuition matched her own:

[The Tibetan healer] took his finger and with a pinpoint accuracy touched every spot on my body where I had had cancer, or where I had cancer presently. It was amazing! He could see what scans couldn’t see. I had predicted my cancer four times. I had led [my doctors] to it with a pinpoint of accuracy before the scans could even pick up the collection of cells. [The Tibetan healer] could do what I could do with my own body.

In addition to the six “treatments” listed above, which were common among both the healers and the unexpected survivors, there were additional treatments that were more frequent in one group than the other. For example, the following three themes were very frequent among the twenty unexpected survivors, but less so among the healers.

Taking Control of Health Decisions

The vast majority of the unexpected survivors discussed taking a more active role in health decision-making, as opposed to passively accepting whatever their doctors told them. Unexpected Survivor #9, who overcame recurrent metastatic breast cancer after conventional medicine had failed to work, describes it this way:

Once the panic and fear had subsided after the breast cancer returned for the fifth time, I felt as certain as I ever had been that the only person who could save me was the scientist within . . . For five years, I had done everything my doctors had advised and undergone all the treatments that they had prescribed . . . [This time] I decided that instead I would look at breast cancer in a detached way, as a natural scientist, and try to understand the disease as a type of natural phenomenon.

Having a Strong Will to Live
The vast majority of the unexpected survivors demonstrated a strong will to live. Unexpected Survivor #15, who overcame Stage 3 breast cancer without conventional medicine, demonstrates this willfulness:

*The doctor said to me, “After you get this surgery done and have the chemo and radiation, we can give you five more years to live.” And I thought, I want to live more than five years! So, when the doctor said that, I got mad . . . So I kind of went out with an attitude of this isn’t going to beat me. I’m going to do this.*

**Receiving Social Support**

Finally, the vast majority of unexpected survivors in this study described receiving positive social support during their cancer experience. Unexpected Survivor #13 describes the outpouring of love that she received:

*One of the things I truly learned [when I had cancer] is that I am valued . . . I was able to share the reality of my experience, and people resonated with that and just stepped in to do whatever was needed. It was a huge validation of the universe and that all life is valued. I wasn't valued because I'm me, my person necessarily, but because my life has value.*

*All life has value, and that includes mine . . . It's a wonderful consequence of this disease, the outpouring of love. Well, maybe it's the purpose.*

There were two themes that occurred more frequently among the healers than the unexpected survivors: (1) healing, infusing, or unblocking energy and (2) strengthening or activating the immune system. You can read more about these, as well as further analysis of all themes, in my full dissertation.

**Future Directions**

The results from this qualitative study provide some hypotheses as to why unexpected remission may occur. What is needed now is for researchers to study these hypotheses in clinical trials that can test first for safety, then for feasibility, and finally for causality. In addition, there is an immediate need for a central database of unexpected remission case reports, ideally one that is online.

I am currently working on creating such a database and website, with the hope that survivors, doctors, and healers will be able to quickly submit their case reports so that researchers like myself can verify and analyze them. Eventually, this de-identified (anonymous) database will also be searchable by the public, serving not only as a portal
for researchers but also as a source of inspiration for cancer patients who are currently battling the disease.

In closing, I would like to say that studying anomalies such as unexpected remissions is neither easy, nor uncontroversial, nor immediately fruitful. However, I firmly believe that such research can lead us to a new paradigm of scientific understanding, and that by rigorously investigating unexpected remissions—as opposed to simply ignoring them—we can make significant advances in the war on cancer.

HIV+ Baby Cured! Medical Breakthrough, Miracle, Or Proof Of Self-Healing?

By Lissa

Thursday, March 7th, 2013

The New York Times just reported about an HIV+ baby who now has no evidence of HIV infection. When the baby was born, five tests confirmed that the baby was infected, so the baby was treated within 30 hours of birth with 3 anti-retroviral drugs, which is not typical treatment. The toddler is now 2 ½ years old and has been off drugs for a year, with no evidence of HIV infection.

Doctors are quick to credit modern science in the form of the unusually early intervention with three drugs. And certainly, it's possible that this regimen of treatment of HIV+ infants may prove to be the
solution. Studies will surely ensue, and if proven to be effective at curing HIV in babies, this is indeed a major medical breakthrough that may affect the nearly 330,000 newly infected babies diagnosed each year.

I hope this is true. Really I do. But just to cast a shadow of doubt in our collective minds, let me throw out an alternative suggestion. What if doctors study HIV+ babies, treat them with an early intervention of three anti-retroviral drugs, and find that this unusual regimen is no better than standard treatment, which has never been proven to cure an HIV+ baby?

**Unexplained Spontaneous Remission**

I know what will happen. Someone will write up the case study. It will get published in some medical journal as an unexplainable medical mystery, and everyone will go back to thinking HIV is incurable.

That's what happened to the 3500+ case studies of unexplainable spontaneous remission collected in the [Spontaneous Remission Project](https://www.spontaneousremission.org), an online database curated by the [Institute Of Noetic Sciences](https://www.noetic.org). The authors defined spontaneous remission as “the disappearance, complete or incomplete, of a disease or cancer without medical treatment or treatment that is considered inadequate to produce the resulting disappearance of disease symptoms or tumor.”

The database includes case studies of spontaneous remissions from a wide range of “incurable,” “chronic,” or “terminal” illnesses, including Stage 4 cancers, HIV, a gunshot wound to the head, cardiac illnesses, and more common illnesses such as diabetes, hypertension, and autoimmune diseases. Reading through all these case studies, as I did when researching my upcoming book *Mind Over Medicine: Scientific Proof That You Can Heal Yourself*, is enough to make you question whether any disease can be accurately labeled as incurable. And the news of an HIV+ baby who no longer has evidence of HIV infection certainly introduces just such a question mark into my mind.

**How Scientists Deal With Spontaneous Remission**

Typically, when a patient experiences an unexplainable spontaneous remission, scientists start by questioning the diagnosis. If an incurable illness becomes cured, surely, there was a misdiagnosis. If this fails to explain it, any treatment that was given, even if the treatment had previously been proven to be ineffective for cure, will be lauded as the miracle-worker.

This is what happened to my friend [Anita Moorjani](https://www.anitamoorjani.com), author of *Dying To Be Me*. She was diagnosed with terminal stage 4 Hodgkin’s lymphoma, treated with chemotherapy she was told would not cure her, and left to live out the rest of her short life. She then experienced a near death experience as a result of her cancer. But after “crossing over” to the other side, she had an experience of consciousness that invited her to make a choice. She could stay dead and enjoy the nirvana of an afterlife experience she describes...
as being “engulfed in a total feeling of love.” Or she could come back to life with the promise that, very quickly, her cancer would disappear.

Anita chose to come back on February 2, 2006. She woke up, and within 4 days, her tumors had started to shrink. Within several weeks, her cancer was gone. She has been disease-free ever since.

But skeptics question what happened to Anita. They claim that the chemotherapy she did receive explains her remission, even though she was told it would not cure her.

Ego & The Scientist

Spontaneous remissions like Anita’s and the HIV+ baby can be narcissistic wounds for physicians and other scientists. As doctors, we like to believe that we are body experts and can control and predict – or at least explain – who gets better and who doesn’t. But case study after case study proves that we only know so much. Plus, the fact that 18-80% of patients enrolled in clinical trials who are treated with placebos get better just affirms what we already suspect – that the mind has more power over the body than we might think.

I shared some of the scientific data I uncovered to explain how such spontaneous remissions might occur in my latest TEDx talk “Is There Scientific Proof You Can Heal Yourself?”, and there’s even more data in Mind Over Medicine.

But here’s what I concluded.

I believe our health care system is badly broken because we’ve lost respect for the body’s ability to heal itself. As health care providers, we’ve gotten arrogant about our power to control disease, and we’ve forgotten that the body is equipped with natural self-repair mechanisms that can be flipped on or off with our thoughts, beliefs, and feelings.

But somewhere along the way, we’ve decided that a patient who experiences a spontaneous remission is threatening. We try to explain it away as a misdiagnosis or the result of a treatment known not to effect cure.

Who knows what will happen in studies investigating early triple antiretroviral therapy in HIV+ newborns. I hope a medical breakthrough is proven. But I won’t be surprised if this becomes one of those unexplainable spontaneous remissions we can only speculate about with furrowed brows…
Healing Health Care

I wish we had less resistance to believing that medical miracles are not only possible, but commonplace. If the emails I get from my online community at LissaRankin.com are any measure, hundreds or thousands of spontaneous remissions are unreported for every one that shows up in the medical literature.

Changing how we think about spontaneous remissions just might be a key factor in helping us heal our broken health care system (you can read about my vision to heal health care here). I believe healing health care must start at the grass roots level – with empowered patients and conscious health care providers. It all starts with shifting our consciousness about the body’s capacity to self-repair.

What Do You Believe?

What are your thoughts about spontaneous remission? Have you had any personal experiences? Share your stories in the comments.
Spontaneous Remission – Researcher Caryle Hirshberg-Navigating the Cancer Maze

Grace Gawler

BY GRACEGAWLERMEDIA ON FEBRUARY 23, 2013 •

VoiceAmerica and WorldTalk internet Radio Network, announced today that nationally acclaimed author and researcher Caryle Hirshberg will join Grace Gawler, host of Navigating the Cancer Maze radio program on the VoiceAmerica Health and Wellness Channel Friday, February 22, at 1 p.m. Pacific Time. Available as a MP3 download at VoiceAmerica anytime or listen to replay – streaming audio. Free sign up to Voice America to download. Download from itunes.

Caryle Hirshberg, M.S author Spontaneous Remission and Remarkable Recovery; pioneer researcher, lecturer joins host Grace Gawler to discuss what was discovered from the research. The topic – Why people Heal – Lessons learned from studies of Spontaneous Remissions.


Spontaneous Remission launched Caryle Hirshberg into the cancer spotlight when it was published in 1993 by the institute of Noetic Sciences (IONS). The book filled a gap in research, as before that time there was no standard reference for the field of spontaneous remission. Then, in 1994 Remarkable Recovery was published; a book of stories about patient unexplained recoveries. Both book looked at unexplained recoveries from medical literature and although considered a rare phenomena – they were surprised at the number of references they found. It piqued their interest to know more….

Just for a moment, turn back the clock to 1994. Can you imagine the New York Literary Guild’s Lawrence Van Gelder writing in the NY Times that the three hottest books on the horizon were ‘Like Water for Chocolate’, ‘The Horse Whisperer’ and, amazingly a nonfiction work; ‘Remarkable Recovery’ a book that offered scientific evidence that people recover from
seemingly terminal illnesses more frequently than is supposed. Hirshberg’s well researched works of science not only captivated cancer patients worldwide but they marked a beginning of an almost cult-like fascination with healing in the public arena.

Caryle Hirshberg, Project Manager at IONS and the late Brendan O’Regan, Vice President of Research at IONS joined forces to create a project that had never been researched before. So was born ‘The Remission Project’ at IONS, California. The task was enormous; to catalogue the world’s medical literature on the subject. This resulted in an assembly of the largest database of medically reported cases of spontaneous remission in the world, with more than 3,500 references from more than 800 journals in 20 different languages.

Caryle Hirshberg will discuss her role in this formative period in American healing history with Grace Gawler. The theme is why people heal from diseases that were deemed incurable. This was a courageous topic to pursue; to study the seemingly miraculous while keeping science and well researched data on track. This was the first time that a research group not only gathered medical data from journals worldwide; but they dared to look at why people recovered and what we might learn from their turnaround to stay well. The book was controversial, inspiring and as well gained attack from some medical corners; yet the material they researched was from medical journals. Like TV’s past science hero, Professor Julius Sumner Miller; Hirshberg and O’Regan were brave enough to ask the fundamental scientific question; ‘Why is it so?’

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So this enquiring and passionate woman set about her life’s work to understand the science and art of healing. She has been involved with beneficial plant research and the Center for Integrative Medicine which researches globally, promoting pharmacological research and intelligent scientific approaches to studying into indigenous and traditional remedies. Caryle was
senior Researcher for the six part documentary “The Heart of Healing” which became a signature series for investigation into the mystery of why people heal. The program, a six-hour television documentary aired on Turner Broadcasting System and was hosted by Jane Seymour. The theme was the role of the mind and spirit in healing and was co-produced by IONS and based on the same-titled IONS book. The program sparked the development of hundreds of IONS “community groups” throughout the U.S. and worldwide.

About: In an extraordinary career, Caryle Hirshberg has been modern day pioneer whose work has shaped minds and opened new ways of thinking about why people heal. A long way down the path from her undergraduate studies in chemistry, mathematics and psychology at University of Florida, she has made history in healing circles. She graduated in neurochemistry at Indiana University and in her long career has been involved in researching remission, neurochemistry, pharmacology, cancer biochemistry and cardiology. She has lectured widely on the subject of spontaneous remissions. Today she is in private practice.

Resources:
1. Access Spontaneous Remission online:
   http://noetic.org/library/publication-books/spontaneous-remission-annotated-bibliography/
   URL below – Excerpts from The Heart of Healing (as mentioned in the interview) These two videos tell the story of Doris, a woman who overcame her cancer with the help of both western medicine and a very disciplined healing visualization practice.
INTRODUCTION

Spontaneous tumor regression has been the subject of great interest and speculation for many years. It is an exceptional and well-documented biological event in some types of tumors, but not in pancreatic cancer.

Pancreatic cancer is a special form of cancer with the worst five-year survival rate of any cancer[1]. Despite numerous molecular studies and clinical approaches, using several mouse models[2], this cancer responds poorly to the existing chemotherapeutic agents and progress on treatment remains elusive[3].

Pancreatic cancer is seldom described as undergoing spontaneous regression, but there are some cases reported in the literature.

In this review, the historical background, clinical features, and possible mechanisms are discussed for spontaneous regression of pancreatic cancer. In addition, we discuss whether it is a real phenomenon or a misdiagnosis.

Further understanding of this process and harnessing of the mechanisms involved will have significant diagnostic, preventative, and therapeutic implications.

HISTORICAL BACKGROUND AND CASES REPORTED FOR PANCREATIC CANCER

Spontaneous regression of cancer (SRC) is defined as the partial or complete disappearance of a malignant tumor in the absence of therapy that is capable of inducing anti-neoplastic effects. Although SRC has often been questioned, the literature reveals different cases showing this phenomenon. In 1966, Everson et al[4] published a classical monograph review describing 176 cases of SRC published from 1900 to 1964. In 1990, Challis et al[5] reported
cases from 1900 to 1987, the majority of which occurred in renal cell carcinoma, choriocarcinoma, neuroblastoma, melanoma, breast cancer, and leukemia and lymphomas. Later, in 1993, O'Regan et al[6] agreed that the five most common tumors to undergo spontaneous regression are renal cell carcinoma, leukemia and lymphoma, neuroblastoma, carcinoma of breast and melanoma.

In these three main reviews, only three cases of pancreatic cancer were cited, and none of them were described in detail. Here, we review the most important cases of spontaneous regression of pancreatic cancer that have been reported in the literature. The first reported case was described in 1934 and published in 1967, describing a patient admitted to hospital presenting jaundice, severe pain, nausea, chills, and a high fever[7]. Laparotomy and biopsy confirmed pancreatic carcinoma. The patient’s recovery spanned two months, after which she could return to work. She remained in good health, dying seven and a half years later of a pulmonary embolism. An autopsy did not find any tumors.

The second case was reported in 1973 by Lokich et al[8] and described a 42-year-old man with progressive diarrhea and weight loss. An upper image suggested a mass in the head of the pancreas. The patient underwent total pancreatectomy and microscopic examination revealed a moderately well differentiated ductal adenocarcinoma arising in the head of the pancreas. Adenocarcinoma was also found in the body of the pancreas, but the tail had only pancreatitis with fibrosis.

Although the patient was stabilized with insulin treatment, one year later he presented with rectal carcinomatosis consistent with adenocarcinoma of pancreatic cancer. Postoperatively, the patient received a combined chemotherapeutic program based on 5-fluorouracil (5-FU) and carmustine or bis-chloroethyl Nitrosourea, experiencing a gradual regression. Twenty-six months following onset of therapy treatment, there was no evidence of tumor recurrence.

The third case[9] was a male with a two-month history of ulcer pain and diarrhea. At exploration, he was diagnosed with a large tumor of the pancreatic head, extending into the liver with involved lymph nodes. The disease was confirmed by biopsy but no further manipulation was performed. By the fourth month following surgery, he was asymptomatic. Examined six years later, the patient remained symptom-free and a gastrointestinal exam demonstrated healing of the ulcer.

The fourth case, published in 1974, reported one case in 1962 of a 21-year-old male who presented with jaundice, anorexia, and fever of three months duration[10]. A liver biopsy was followed by abdominal pain, fever, tachycardia, and a decrease in blood pressure. Exploratory surgery to repair bile peritonitis revealed acute cholangitis and pericholangitis. When he was re-operated on seven weeks later, and was diagnosed with pancreatic adenocarcinoma. A T tube placed in the common duct improved symptoms and he made a slow recovery with no recurrence at the time of reporting. Unfortunately, details on the duration and intensity of fever or infection over the course of the illness in most of these cases were not provided.

In 2003, Hoption Cann et al[11] reported a case of a 50-year-old man with a three-month history of weight loss, anorexia, and discomfort after meals. By ultrasound and computed tomography (CT) identified a hypoechoic mass of 6.5 cm × 4 cm × 4 cm in the body of the pancreas. The posterior CT-guided biopsy was positive for pancreatic adenocarcinoma (T2N1Mo, stage IIIb). A subsequent CT scan revealed a further 50%-60% increase in tumor
volume and the tumor was considered inoperable. The patient received chemotherapy based on gemcitabine, mytomycin, and radiotherapy. As CA19-9 levels increased from 38 to 140 U/mL and the patient's health declined, the treatment was considered a failure. Some days later, the patient developed acute abdominal pain and contamination of the abdomen. Recovery was considered doubtful. However 90 d later, the patient’s recuperation and weight gain were surprisingly rapid, while the CA19-9 level was normal and a positron emission tomography (PET) scan was negative for any focal disease. An ultrasound, however, confirmed residual tumor, although it had regressed by approximately 70%. However, five months later, an elevated CA19-9 and subsequent PET scan confirmed a relapse. Although the patient was treated with chemotherapy based on oxaliplatin and 5-FU initially, then gemcitabine, his health progressively deteriorated and he died one year later, almost two years following his febrile infection.

Apart from the infection, the authors suggested other factors could be relevant to this tumor regression. Some of them are the vegetarian diet based on Chinese herbs, high-dose vitamin C and other antioxidant vitamins, hydrogen peroxide, and ginseng, followed by this patient. However, regression presented in this case appeared mostly to coincide with a prolonged febrile infection, similar to that often observed in many other cases of SRC[11,12].

BENIGN TUMORS

Some special types of pancreatic tumors are considered benign or their malignant potential is not well determined. Specifically, solid-pseudopapillary tumors are classified in this category and were often previously described in the literature as being related to spontaneous regression.

In 2008, Nakahara et al[13] described a 18-year-old healthy woman who was admitted to hospital for evaluation of a pancreatic mass. A solid-pseudopapillary tumor was suspected from the findings of diagnostic images, and surgery was recommended. However, the patient refused surgery and a later ultrasound-guided transcutaneous biopsy revealed proliferation of tumoral cells with small nuclei showing a pseudopapillary arrangement. periodic acid-Schiff positive granules and alpha-1-antitrypsin positive cells were proven, which led to confirmed diagnosis of pseudopapillary pancreatic tumor. The maximum diameter of the tumor gradually decreased over 10 years from 45 mm to 15 mm. This was the first report describing marked spontaneous shrinkage of this particular type of pancreatic tumor. The authors did not report details of whether the patient took any medication, antioxidant agent, or vitamins.

In this case, the authors showed histological findings and CT images suggesting that the shrinkage of the tumor may be attributable to continued degenerative change, including minor hemorrhage, necrosis, and absorption as the tumor was classified hypovascular.

In 2010, Suzuki et al[14] described a 13-year-old boy showing a demarcated hypovascular round mass of 50 mm in diameter in the head of the pancreas, presenting abdominal pain, nauseas, and elevated serum amylase and serum lipase. CT demonstrated a partially enhanced encapsulated tumoral mass with cystic components and calcification, without evidence of invasion to the surrounding organs, which was diagnosed as solid pseudopapillary tumor (SPT) and treated for acute pancreatitis. Six weeks later, the mass
had decreased to 43 mm in diameter, and nine weeks after admission, concentrations of tumor markers, such as alpha-fetoprotein, carcinoembryonic antigen, carbohydrate antigen-199, and elastase-I, were not elevated, although the level of neuron-specific enolase (NSE) was slightly increased. Follow-up included routine laboratory tests and CT demonstrated that the size of the tumor slowly decreased to non-measurable size. After 4 years, the patient’s NSE level was within the normal range. The authors presented CT images indicating that the tumor was highly likely to be SPT, based on the typical CT finding of a tumor bulging from the contour of the pancreas with eggshell-like calcification, the existence of both solid and cystic components with hypovascularity, and the patient’s age. The rapid shrinkage of the tumor may be attributable to continued degenerative changes, including minor hemorrhage due to trauma, necrosis, and absorption. The authors did not report the administration of any medication or different agents to the patient. The authors suggest spontaneous tumor shrinkage, although they were unable to obtain pathology for the tumor and are conscious that there have been reports of recurrence and metastasis that developed more than 10 years after tumor resection in this type of neoplasm.

Considering all of the cases reported above, we can distinguish a wide variation in the description of the data presented. The first cases reported, until 1980, do not show images or acute laboratory test results that could verify the real entity of spontaneous regression of pancreatic carcinoma. In some cases, they do not specify the type of pancreatic tumor or give details about the biopsy, making it difficult to determine if it would be classified as a different entity, based in current diagnostic criteria.

However, considering the difference in the availability of medical technology more than 30 years ago compared with the present, this data should be taken with caution, and it is difficult to conclude whether these cases would be considered as genuine spontaneous regression of pancreatic adenocarcinoma today or would be considered as misdiagnoses.

The most recent cases, published since 2000, are more accurate in the presentation of images and blood test values, although they also show variability.

Finally, the most recent report concludes a diagnosis of SPT and not adenocarcinoma of pancreas. All of these data show that there are no recent cases reported of spontaneous regression of adenocarcinoma of the pancreas, unlike pseudopapillary tumors, which represent 1% of primary pancreatic tumors and are characterized by low malignant potential[13,14].

Some other types of pancreatic tumors with spontaneous regression, rather than adenocarcinomas and pseudopapillary tumors, have been described. The most common neuroendocrine tumor with spontaneous regression is an insulinoma.

Insulinoma is a rare endocrine tumor developed from pancreatic beta cells. Eighty-seven percent are benign tumors, seven percent belong to multiendocrine neoplasia syndrome, and only six percent are considered malignant, as defined by the presence of metastasis[15].

The diagnosis of insulinoma is established by demonstrating inappropriately high serum insulin concentrations during a spontaneous or induced episode of hypoglycemia. Imaging techniques are then used to localize the tumor[16]. In 2008, Groselj et al[17] described a 64-year-old patient presenting with paroxysmal episodes. Electroencephalography finding suggested metabolic encephalopathy and laboratory tests showed hypoglycemia, and high insulin and C-peptide. Finally, ultrasonography and gagnetic resonance imaging (MRI)
confirmed an insulinoma in the head of the pancreas. The authors pointed out that the patient had a spontaneous recovery of the pancreatic tumor.

The overall survival rate of patients with benign insulinoma do not differ from that expected in the general population, and a misdiagnosis could be a reasonable justification for reporting SRC, even if it is not considered a malignant phenotype. Malignant insulinomas are rare, and patients have prolonged survival, even in the presence of liver or lymph node metastasis. It has been reported that some patients with malignant insulinoma who developed metastatic disease 4 years to 12 years after initial diagnosis, remained alive for up to 25 years\[18\]. This better outcome compared to the acinar or ductal adenocarcinoma could be a reason for a misdiagnosis, or it could also be reported as a spontaneous regression of pancreatic cancer.

**AUTOIMMUNE PANCREATITIS MIMICKING PANCREATIC CANCER**

Autoimmune pancreatitis (AIP) was described by Sarles et al\[19\] in 1961 and then proposed by Yoshida et al\[20\] in 1995 as a type of chronic pancreatitis occurring secondary to an autoimmune process, which may cause permanent structural and functional damage of the pancreas.

AIP represents approximately 6% of the patients with chronic pancreatitis\[21,22\] and is a heterogeneous manifestation associated with elevated serum levels of the immunoglobulin G subtype 4 (IgG4), which decreases with corticosteroid therapy. The most common site of extrapancreatic involvement is the bile duct, where distal biliary or mass-forming AIP mimics pancreatic cancer and proximal biliary involvement\[23\]. Recently, two types of AIP have been described, type 1 (or lymphoplasmacytic sclerosing pancreatitis) and type 2 (idiopathic duct centric pancreatitis or granulocyte epithelial lesion). Although clinically these two entities have comparable presentations, they differ significantly in their demography, serological characteristics, other organ involvement, and relapse rate\[24\].

While type 1 is associated with elevation of nonspecific autoantibodies and serum IgG4 levels, type 2 does not have definitive serologic autoimmune markers. In addition, high serum IgG4 may also be found in patients with pancreatic cancer\[25\], and tumoral markers such as CA19-9, SPAN-1, and DUPAN-2 may also be elevated in patients with AIP\[26\]. These findings can make the diagnosis of AIP confusing. AIP, in contrast to other benign chronic pancreatic diseases, can be cured with immunosuppressant drugs\[27\]; therefore, the differentiation of AIP from pancreatic cancer is of particular interest in clinical practice\[28\]. Two studies have also pointed out the possibility that some patients with AIP may develop pancreatic cancer\[29,30\], and this contributes to increasing misdiagnosis. However, the synchronous presence of adenocarcinoma and AIP can not be excluded, as some cases have been reported\[31\] and pancreatic cancer can develop after histologically confirmed AIP diagnosis\[32\].

Attempting to establish applicable diagnostic guidelines, the Japan Pancreas Society\[33\], the Korean Society\[34\], and more recently American criteria by Chari et al\[24\] in the Mayo Clinic at the Honolulu consensus proposed specific criteria to distinguished the two histological types of AIP and pancreatic cancer. The five important diagnostic criteria include imaging, histology, serology, other organ involvement and response to therapy, leading to an improvement in the diagnostic yield for AIP and avoidance of misdiagnosis of pancreatic cancer\[35\]. Nevertheless, several cases have been reported that suspect pancreatic cancer rather than AIP\[36-38\].
In 2005, Ozden et al. described a 58-year-old woman with jaundice referred for pancreatic head carcinoma and diagnosed by MRI. By laparotomy, a pancreatic head mass involving the mesocolon, pancreatic body, and tail was found. Pancreatic biopsies revealed cholecystitis and pancreatitis with lymphoplasmacytic infiltration. Two months after the surgery there was no parenchymal lesion on MRI. Serum immunoglobulin G, G4, and E levels were increased.

The authors report this as a spontaneous regression of a pancreatic head mass and biliary obstruction because of autoimmune pancreatitis. In this and other cases of a patient with autoimmune pancreatitis that were initially misdiagnosed as pancreatic cancer, the response to steroid therapy could appear to be a spontaneous resolution of a malignant pancreatic tumor. Patients operated on for pancreatic adenocarcinoma could represent a false spontaneous regression of pancreatic cancer instead of lack of malignancy.

MECHANISMS LEADING TO SPONTANEOUS REGRESSION

Most of the SRC cases reported do not provide a discussion regarding possible explanatory mechanisms. In pancreatic cancer reports, only the most recent publications show data in detail (images and laboratory test) and finally suggest some possible biological mechanisms leading to the spontaneous regression.

The prevalent hypotheses regarding mechanisms leading to spontaneous regression include the immunological response in the host as the most important factor. Other mechanisms causing spontaneous regression include increased apoptosis and necrosis, epigenetic modifications, hormonal responses, role of oncogenes and tumoral suppressors, cytokines and growth factors, and psychological mechanisms (Table 1). All of these mechanisms were reviewed in 1996 by Papac, who specifically described some cancers, but not pancreatic tumors.

Today, the activation of these mechanisms in spontaneous regression of cancer occurs infrequently and remains not well documented in pancreatic cancer. In other related tumors, like hepatocellular carcinoma, several mechanisms leading to the spontaneous regression of these tumors have been described, such as abstinence from alcohol, persistent fever, withdrawal of androgen, blood transfusion, massive bleeding, and use of herbal medicine. However, in the small number of reported pancreatic cancer cases, no evidence of clear and specific events was observed during the period of spontaneous regression.
Renal cell carcinoma accounts for the largest number of patients with spontaneous regression with acceptable histology and radiological confirmation[53,54]; therefore, this disease offers the best system to study the immunological response in spontaneous regression. The increased incidence of some tumors in immunosuppressed individuals, and regression following reduction of immunosuppressive agents, suggests an important role for immunological factors[55,56]. Cytokines, interferon, and interleukin 2 (IL-2), IL-6 and IL-8[57,58], exert antitumor effects. While cytokines could activate T-lymphocytes, natural killer, lymphocyte-activated killer cells, and tumor infiltrating lymphocyte cells as a mechanism of action, interferons are capable of multiple immunomodulatory effects, involving monocytes, macrophages, and B-cells, as well as induction of IL-2 receptors[59,60].

Regression often occurs in the setting of febrile illness (bacterial or viral), other, different, cytokines associated with the host response to infections could mediate the regression as tumor necrosis factors[61]. Patients diagnosed with pancreatic cancer frequently suffer infections and all of these cytokines could play an important role in the spontaneous regression of pancreatic cancer; however, there is no evidence of this phenomena in the literature. Angiogenesis, as an essential component of the malignant process, has also been investigated as a mechanism contributing to regression. Several cytokines are known to inhibit this process, such as tumor necrosis factor-alpha and transforming growth factor beta, which could play a role in spontaneous regression[62]. Regarding hormonal mechanisms that could exert a role in pancreatic cancer, there is no data suggesting specific effects in spontaneous regression, although studies should be made because the endocrine pancreas could be exerting an important role.

A mechanism that has received more attention for spontaneous regression in the literature is the apoptotic process inside the tumor. The activation of this programmed cell death was proposed as the basis for spontaneous regression, especially in neuroblastoma[63] and renal cell carcinoma. Several authors suggest that the neoplastic cells, in response to different stimuli, such as T-cell mediated survival signals or cytokine regulation, could undergo apoptosis, followed by clinical remission.

As several data have demonstrated, vascular endothelial growth factor receptor blockade leads to rapid, robust, and progressive regression of tumor vasculature, increased intratumoral hypoxia, and apoptosis, and reduced tumor invasiveness and metastasis in pancreatic islet cancer[64]. Thus, this process could also be implicated in tumor regression. This apoptotic process is driven by oncogenes and tumoral suppressor gene expression and, although there is no specific, documented examples on the role of changes in the expression of regulator genes, this possibility has been cited in leukemia[65].

The expression of these oncogenes or tumoral suppressors could be switched by mutations and by epigenetic mechanisms, leading to apoptosis inside the tumor. The cited epigenetic changes have been demonstrated in retinoblastoma tumors[66] by abnormalities in methylation levels[67]. Some authors have suggested that loss of hypermethylation may be involved in the spontaneous regression of some retinoblastomas, but there is no confirmed evidence. In addition, repression of telomerase activity has been proposed as a possible mechanism for regression[68-70]. Some studies showed that patients whose tumors do not show telomerase activity underwent spontaneous regression, suggesting repression of telomerase activity as a possible mechanism for regression, although it has not yet been demonstrated in any type of pancreatic cancer.
Differentiation, a mechanism by which malignant cells develop a non-malignant phenotype, has been shown to occur in several types of cancer, such as retinoblastoma, neuroblastoma, choriocarcinoma, teratocarcinoma, and leukemias[21-22], where differentiation is possibly the major factor contributing to spontaneous regression, but this is still unknown in pancreatic cancer. Finally, related to the immunological response in tumors, psychological mechanisms have been proposed as a possible phenomenon in some cancers, but this is still regarded with skepticism. Although authors have reported psychological reasons, corroborating biological studies are lacking[23,24] and are not approved by most investigators.

This lack of information forces us to conclude that spontaneous regression in pancreatic cancer is not a well-documented phenomenon, the mechanisms leading to the regression remains unknown, and only hypotheses can be made based on some other types of tumors. In recent reports, where the radiological and histological confirmation of pancreatic disease are more precise, only an immunological response has been suggested as the most probable mechanism leading to regression of pancreatic cancer. Most of the causative factors leading to this phenomenon remain speculative.

In conclusion, it is very difficult to determine the characteristics of pancreatic cancer patients who experience spontaneous regression and the mechanisms leading to such spontaneous regression.

Currently, the existence of spontaneous regression of pancreatic cancer is a matter of debate. The small number of cases cited in the literature as a possible spontaneous regression could represent a nonmalignant disease, such as AIP or specific pseudopapillary tumor of the pancreas. In the cases described many years ago, the data presented make it difficult evaluate the diagnosis because of the lack of advanced images techniques or laboratory tests to distinguish pancreatic cancer from other diseases. In addition, many cases are not completely well documented, the presence of metastasis is questionable, therapy may have played a role, or the temporary or permanent regression of tumor growth was not defined.

Therefore, cases of spontaneous regression of pancreatic cancer described in the literature should be taken caution. Biological and molecular findings cannot provide a complete explanation of the underlying mechanisms and accumulation of such cases and further investigations of regression will contribute to better understanding of this intriguing phenomenon.

Elucidation of the mechanism could lead to better understanding and replication of the process, and to improved therapies for pancreatic cancer treatment.

**Footnotes**

Supported by Instituto Salud Carlos III

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Remission, or the spontaneous disappearance of the symptoms of a life-threatening disease, occurs often though it’s not fully understood by medical science. In Cancer Ward, for instance, Aleksandr Solzhenitsyn writes, “It happens rarely, but there are cases of self-induced healing... Due to some reason, the tumour starts in the opposite direction, gets smaller, resolves and disappears.” Since most doctors tend to dismiss such cases as being hearsay or anecdotal at best, the International Noetic Institute constituted a panel, Remission Project, with the purpose of looking into its incidence. It searched among
some of the world's most obscure medical journals for as many cases as it could find, with the result that it managed to assemble the largest database of medically-reported cases of spontaneous remission with more than 3,500 references. Interestingly, among all of them, it found that the so-called “miraculous” remissions — those associated with purely spiritual cures such as the ones documented by the Medical Commission at Lourdes, France — the most unusual. The panel felt that consideration here should be given to the possibility that the altered states of prayer, religious faith and meditation may allow the process of self-repair greater freedom to operate. Neurotheology, a new field that seeks to discover the neurobiological basis of spirituality and health, tells us that the well being of our body depends almost solely on the strength of our belief in ourselves to heal ourselves. And it’s beginning to look like that’s what really matters.

"Birds born in a cage think flying is an illness."

~ Alejandro Jodorowski

Everyone is a genius. But if you judge a fish on its ability to climb a tree, it will live its whole life believing that it is stupid.

-A Einstein

If you can't explain it to a six year old, YOU don't understand it yourself.

Albert Einstein
GASTROENTEROLOGY/HEPATOLOGY

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K. Yamamoto · M. Inui

Spontaneous remission of chronic hepatitis C in children

Received: 9 April 1996 and in revised form: 8 April 1997 / Accepted: 15 April 1997

Abstract The clinical course of 48 children with chronic hepatitis C (33 boys, 15 girls; mean age: 12.2 years) was monitored for more than 3 years to clarify its natural course. All patients were positive for the second-generation antibody to hepatitis C virus (anti-HCV) and for serum hepatitis C virus (HCV) RNA. All but one patient had a history of blood transfusion. Serum levels of alanine aminotransferase (ALT) had been abnormal for more than 1.5 years. Spontaneous remission defined as a biochemical remission lasting more than 1 year in association with the disappearance of serum HCV RNA, occurred in 4 (8.3%), however, in 25%, HCV RNA was still detectable in the liver even after its disappearance from serum. In this patient, the level of antibody to HCV core antigen (anti-HCV core) did not decrease significantly and serum HCV RNA eventually reappeared. The serum titre of HCV RNA in the 4 children with spontaneous remission was lower than in the remaining 44 children. Spontaneous remission may occur in children with chronic hepatitis C in whom the serum titre of HCV RNA is low and serum level of anti-HCV core decreases significantly. Assessment of the intrahepatic HCV RNA is necessary to confirm complete remission.

Conclusion A low serum titre of HCV RNA and a significant decrease in the serum titre of anti-HCV core were associated with spontaneous remission in children with chronic hepatitis C. Intrahepatic HCV RNA assessment is necessary to confirm complete remission.

Key words Hepatitis C virus · Chronic hepatitis C · Natural history · Spontaneous remission · Children

Abbreviations ALT alanine aminotransferase · CAH chronic aggressive hepatitis · CPH chronic persistent hepatitis · HAI histology activity index · HCV hepatitis C virus · IFN interferon · RT-PCR reverse transcription polymerase chain reaction · SR spontaneous remission

Introduction

Aggressive treatment with interferon (IFN) is recommended for adults with chronic hepatitis C, as a spontaneous biochemical remission associated with clearance of hepatitis C virus (HCV) from the serum is unlikely [13, 14]. However, data on the natural history of chronic hepatitis C in children are limited [1, 2, 6, 9]. We monitored the clinical courses of children with chronic hepatitis C to clarify the natural history of the disease and to compare the characteristics of the children with and without spontaneous remission.

Patients and methods

Forty-eight Japanese children with chronic hepatitis C (M/F = 33/15; mean age: 12.2 years; range: 4–18 years) were studied. The study population included 27 children with non-A, non-B chronic hepatitis with a history of blood transfusion whose second-generation antibody to hepatitis C (anti-HCV) became available. None of the children received antiviral therapy during the observation period. An underlying disease, such as acute leukemia, was present in 30 children (62.5%); these children were enrolled in the study at least 2 years after completion of treatment for the underlying
CASE REPORT

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G. J. Ellenbein

Case report of spontaneous remission of cytogenetic relapse of chronic myelogenous leukemia suggestive of progression to blast crisis after allogeneic bone marrow transplantation

Received 6 June 1994 / Accepted 28 September 1994

Summary: Detection of the chronic myelogenous leukemia (CML)-related marker, the bcr/abl mRNA transcript, in blood or bone marrow of patients with CML in hematologic remission after allogeneic bone marrow transplantation (allo-BMT) may be associated with the presence of minimal residual disease but does not uniformly predict hematologic relapse. The Philadelphia (Ph1) translocation t(9;22)(q34;q11) along with additional cytogenetic abnormalities, especially more than 2 years after BMT, progression to hematologic relapse and acceleration of CML usually occur. An exception to this rule may be our patient, who was a 29-year-old white woman diagnosed with Ph1-positive CML by cytogenetics. She was initially treated with hydroxyurea. An allo-BMT was performed 4 months after the diagnosis, while the patient was still in the first chronic phase of her disease, her HLA-identical brother serving as bone marrow (BM) donor. The conditioning regimen for BMT consisted of cytosine arabinoside, cyclophosphamide, total body irradiation, splenic irradiation, and intrathoracic methotrexate. Graft-versus-host disease (GVHD) prophylaxis consisted of cyclosporin A and methotrexate. Her hospital course was unremarkable and without evidence of acute GVHD. Six months after transplantation, the patient had mild chronic GVHD and was treated with azathioprine and prednisone for 6 months. A year later, she received with mild chronic GVHD. She was treated with azathioprine alone for 5 months. Subsequently, she received cyclosporin A and prednisone for 8 months, with resolution of her symptoms. Serial BM cytogenetic studies showed normal male donor karyotypes 12 and 24 months after BMT. At 16, 42, and 58 months after BMT, reappearance of the Ph1 was noted along with some cells with additional cytogenetic abnormalities, including t(6;14)(p21;q32). The breakpoint involvement of 14q32, the heavy chain Ig locus, in the new clone may be indicative of B-lymphoid lineage-based evolution. The abnormal clones disappeared 36 months from BMT and remained absent through 69 months after BMT. The reappearance of the Ph1 chromosome could be associated with the immunosuppressive therapy given for chronic GVHD. This case supports the concept that immunologic mechanisms may be important in the eradication of CML after allo-BMT, and even cytogenetic evidence of blast crisis CML may spontaneously remit after allo-BMT.

Key words: Chronic myelogenous leukemia
Allogeneic bone marrow transplantation
Cytogenetic relapse

Introduction

Chronic myelogenous leukemia (CML) in chronic phase can be controlled with busulfan or hydroxyurea but only with a palliative perspective [15, 17]. Allo-BMT is the only known treatment for CML that has curative potential [15, 17]. For patients who receive a transplant in first chronic phase, the actuarial probability of 4-year overall survival is 55% and the probability of relapse is 19%.

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Late spontaneous remissions in severe adult autoimmune thrombocytopenia

R. Simanek • S. Panzer • K. Lechner • I. Pabinger

Abstract We report on four cases (three women, one man, age at diagnosis 26–61 years) with severe autoimmune thrombocytopenia (AITP) who were refractory to initial steroid therapy (n=4), to subsequent splenectomy (n=2), azathioprine (n=1), and cyclosporine (n=1). Over years they received low-dose continuous or intermittent steroid therapy. After 6 to 31 years these patients achieved a “spontaneous” complete remission (CR) (n=3) or partial remission (PR) (n=1) unrelated to any specific second or third line treatment; CR/PR are sustained for 0.5+ to 9+ years. These data indicate that spontaneous remissions may occur in AITP even after a long duration of the disease.

Keywords Autoimmune thrombocytopenia • Refractory Treatment • Late spontaneous remissions • Lupus anticoagulant

Introduction

Adult autoimmune thrombocytopenia (AITP) is a relatively common disease [6]. The disease is heterogeneous [7] with regard to onset, age, presence or absence of an underlying disease, severity, natural course, and response to treatment. While mild forms usually remain untreated, patients with severe thrombocytopenia (platelet count <20,000–30,000/µl) and bleeding tendency require treatment. There is general agreement that steroids and/or high-dose immunoglobulin are the best first line treatments, which are clinically effective in almost all patients [7, 17]. However, when prednisolone is tapered or discontinued, only about one third of adult AITP patients are in complete remission (CR) after 6–12 months [8, 19]. For refractory patients the decision has to be made whether to proceed to a second line treatment, in particular, splenectomy [11], or to try to keep the patient free of symptoms by low-dose steroid therapy hoping for a delayed remission. In fact, some studies [5, 19] have shown that CRs may occur up to 3 years from onset of disease if splenectomy is delayed. If splenectomy fails, various treatments have been proposed, but the success rate of most of the drugs is disappointing [21].

In this report we shall describe four patients with long-lasting severe refractory AITP who had presumably “spontaneous” remissions 6 to 31 years from onset of their disease.

Patients, methods, and definitions

Various automatic blood cell counters were used during the study period. The diagnosis of lupus anticoagulant was made according to recommendations of the International Committee on Thrombosis and Hemostasis [4] and before by the demonstration of the prolongation of the APTT of a normal plasma by patient plasma by more than 5 s at a 50:50 mixture. Antiplatelet antibodies were determined with the monoclonal antibody-specific immobilization of
1. Natural Course and Spontaneous Remissions of Untreated Anxiety Disorders: Results of the Munich Follow-up Study (MFS)*

H.-U. Wittchen

**Introduction: What is the Natural History of Untreated Anxiety Disorders?**

Anxiety disorders obviously belong to the most frequent mental disorders both in the community (Robins et al. 1984; Myers et al. 1984; Lépine 1987; Marks 1987; Surtees et al. 1987; Wittchen et al. 1988; Wittchen and Burke, to be published) and in treatment settings (Goldberg 1982; Strian 1983; Marks 1987). They have also been studied extensively with regard to the effectiveness of psychological and pharmacological treatment methods. Little, however, is known about their natural course and the frequency of so-called spontaneous remissions in untreated anxiety disorders. This paper discusses some methodological reasons for this deficit and presents some new, still preliminary results on the natural course of untreated anxiety disorders from a general population survey.

**Methodological Considerations**

At first sight, the uncertainty about the natural course of different forms of anxiety disorders might be surprising, if one considers the large number of studies in this field, which range from anecdotal remarks to a few prospective long-term epidemiological studies (Table 1). But a closer look at these studies reveals quite a number of deficiencies that hamper considerably a clear answer to the question posed at the beginning of this paper:

<table>
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<th>Table 1. Sources of information for the evaluation of the natural course (history) of treated and untreated anxiety disorders</th>
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<td>- Anecdotal remarks</td>
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<td>- Case reports</td>
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<td>- Studies on treatment effectiveness</td>
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<td>- Epidemiological studies</td>
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<td>- Prospective long-term epidemiological studies</td>
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- Only very few studies have been conducted in an epidemiological setting with a representative data base, and to our knowledge only one has been done prospectively (Agras et al. 1969, 1972).
- There is a lack of studies with data on the natural course of anxiety disorders that have used a differentiated diagnostic subclassification as suggested by DSM-III and its revision DSM-III-R (APA 1987).
- Reliable diagnostic decisions are difficult to obtain in anxiety disorders without the use of standardized diagnostic procedures (Heizer et al. 1985; Barlow et al. 1986; Semler et al. 1987). The lack of studies using diagnostic instruments with a proven reliability might be regarded as a major problem for the generalization of findings across studies.
- Even large epidemiological studies like the NIMH Epidemiological Catchment Area Program (ECA), designed to cover several waves of

* This study is part of the Munich Follow-up Study (MFS). The MFS was supported by a grant from the Robert Bosch Foundation.
Spontaneous Remission of Cushing's Disease after Disappearance of a Microadenoma Attached to the Pituitary Stalk

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Abstract. Cushing's disease caused by a microadenoma located near the pituitary stalk is infrequent and spontaneous remission caused by necrosis of a corticotropic adenoma in such location has not been reported. A 42-year-old woman with ACTH-dependent Cushing's syndrome presented on magnetic resonance imaging (MRI) a 3-mm microadenoma attached to the pituitary stalk. Treatment with ketoconazole normalized urinary free cortisol (UFC) from 433.0 to 55.0 μg/day, although it failed to reduce elevated serum androgen levels (DHEAS 4770 ng/ml). After one year, treatment was stopped and UFC rose again to 930.0 μg/day but one month later the patient presented acute headache and signs of steroid withdrawal syndrome. Endocrine evaluation showed glucocorticoid and androgen deficiency (UFC 5.6 μg/day; DHEAS < 300 ng/ml); control MRI revealed disappearance of the microadenoma. Cushingoid signs subsided and steroid replacement was initiated, proving still necessary over two years after the episode.

Infarction or hemorrhage of a corticotrope adenoma could be a probable underlying mechanism although its precipitating factor is unclear. Ketoconazole withdrawal, through abrupt increase in cortisol production and/or the interruption of a hypothetical inhibitory action on cell replication followed by tumor growth and compromise of vascular supply, may be considered as possible triggering factors. To the best of our knowledge, this is the first report of spontaneous remission of Cushing's disease caused by presumed infarction of a microadenoma, unusually located in the superior rim of the pituitary, attached to the stalk.

Key Words. pituitary stalk microadenoma, Cushing's disease

Introduction

Few cases of spontaneous remission of Cushing's disease have been reported in the literature. Although precipitating factors seem to differ from case to case, the most likely event leading to remission could be corticotropic adenoma infarction or hemorrhage. The clinical picture may vary from subclinical, manifested only through improvement of hormonal hypersecretion with preservation of other anterior pituitary hormones, to overt presentation with neurological signs and dizziness resembling hypoadrenalinism [1,2].

Although most corticotropic adenomas are located in the adenohypophysis, a few have been found within the stalk, or in the superior portion of the anterior lobe extending to the stalk.

We describe the case of a patient with spontaneous remission of Cushing's disease after presumed necrosis of a corticotrope microadenoma located on the superior rim, adjacent to the pituitary stalk.

Case Report

A 42-year-old woman was referred to our institution with typical features of Cushing's syndrome. Over the past 2 years she noticed rounding of the face, alopecia, acne, hirsutism, purplish striae on her thighs, spontaneous ecchymotic areas, centripetal obesity with supraclavicular fat pads and high blood pressure. Biochemical tests confirmed the diagnosis of ACTH-dependent Cushing's syndrome (Table 1). Magnetic resonance imaging (MRI) of the pituitary showed a 4-mm well-limited area on the left side of the gland with low signal intensity on T1 and hyperintense on T2, suggestive of a cystic lesion. Another 3-mm small hypointense area on the right upper border of the gland, attached to the stalk, was considered of doubtful significance (Fig. 1). Given such difficult interpretation and the unavailability of peristomal sinus catheterization at our hospital, a trial with ketoconazole was started. Under this treatment she experienced clinical and biochemical improvement, with normalization of 24-h urinary free cortisol (UFC) but persistent high serum androgen levels. After a year, the patient discontinued ketoconazole on her own but a few weeks later she began to complain of proximal lower-limb weakness; at that time, urinary free cortisol levels had risen again to abnormally high values (Table 1). A few weeks later, she presented severe frontal headache, nausea and dizziness of acute onset. Within a few days, she gradually developed hypotension, severe fatigue, asthenia, anorexia, weight loss and generalized skin desquamation. A new MRI revealed disappearance of the hypointense area attached to the stalk, with depression of the diaphragma sellae and persistence of the
Spontaneous Remission of Hypercalcemia in a Functioning Parathyroid Cyst

Osamu Ozaki, Masahiko Saramoto, Yasuki Matsui, Takeshi Notsu, Keisuke Hirai and Tohru Mori

ABSTRACT: We treated a patient with a hyperfunctioning parathyroid cyst detected incidentally and which disappeared spontaneously. High levels of plasma PTH disappeared after removal of the cystic lesion of the parathyroid gland. Histologically, a secondary pseudocyst resulting from a cystic degeneration of an adenoma was observed. Minor hemorrhage of an unknown cause, within the adenoma, led to the large cystic lesion of the parathyroid gland.

KEY WORDS: primary hyperparathyroidism, parathyroid cyst

Introduction

Parathyroid cyst is a rare lesion and its origin is poorly understood. Usually, two disease types are distinguished etiologically; namely, true cyst and adenoma which shows cystic degeneration. From aspects of its function, it is also classified as functioning and non-functioning, and a functioning parathyroid cyst usually develops as a sequence of cystic degeneration of an adenoma.

We treated a patient with hyperparathyroidism and in whom there was a spontaneous remission of the hypercalcemia. A cystic parathyroid tumor was excised.

Case Report

A 64-year-old Japanese man was admitted to the Department of Urology, Tottori University Hospital in November 1979 with symptoms of hematuria and nocturia. Prior to admission he noticed polydipsia and general fatigue after taking a walk. He was diagnosed as a case of hypertrophy of the prostate and prostatectomy was performed on November 30. The histology revealed a prostate hyperplasia but no malignancy. During admission, hypercalcemia and hypophosphatemia became apparent and he was transferred to the Department of Surgery for further evaluation of the hyperparathyroidism. He had a history of pulmonary tuberculosis and had undergone thoracoplasty in 1935. He never noticed pain, tenderness or tumor formation in the neck. The family history was non-contributory.

At the time of transfer to the Department of Surgery on January 16, 1980 he was 171 cm tall and weighed 71 kg. His blood pressure was 140/75 mmHg. On palpation of the anterior neck, a small nodule was noted in the central portion of the left thyroid lobe. The serum calcium level was 15.4 mg/dl, serum phosphorus 2.9 mg/dl, alkaline phosphatase 10 K-A Unit/L and plasma PTH level was 3.5 ng/ml (normal 0.4 ± 0.2 ng/ml) (Table 1). Shortly after the transfer, the calcium spontaneously returned to normal...
Original article

Spontaneous remission from acute exacerbation of chronic adult T-cell leukemia

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Received March 5, 1990/Accepted September 28, 1990

Summary. Spontaneous remission without any anti-cancer therapy in a 57-year-old woman with adult T-cell leukemia (ATL) is reported. The patient was admitted to our department because of persistent cough and appearance of abnormal lymphocytes in the peripheral blood, and she was diagnosed as having chronic ATL. Eight months later, she was re-admitted because of cystitis, watery diarrhea and worsening of respiratory symptoms with an increase of ATL cells (WBC 31×10^9/l with 56% ATL cells). Acute exacerbation of ATL was diagnosed. Interestingly, antibiotic therapy for the pulmonary and urinary tract infections brought about spontaneous reduction of the ATL cells. Spontaneous remission of ATL continued for one year without chemotherapy. The role of infection as a trigger of acute exacerbation and spontaneous remission of ATL is discussed.

Key words: Adult T-cell leukemia – Acute exacerbation – Spontaneous remission – Infection

Introduction

Adult T-cell leukemia (ATL) is a human T-cell leukemia virus-I (HTLV-I)-associated T-cell malignancy characterized by the proliferation of abnormal lymphocytes with deeply indented or lobulated nuclei and showing a post-thymic/mature CD4+ phenotype [2, 13, 14]. Anti-HTLV-I antibodies are consistently detected in most patients with this disease [3]. With regard to disease progression, however, ATL varies from the smoldering to the acute type [9, 15, 16, 18]. Intensive chemotherapy is usually unsuccessful and median survivals of acute type and lymphoma type ATL have been reported to be only 7 and 13 months, respectively [10]. Main causes of death in ATL patients are life-threatening infections which are closely associated with the underlying immunodeficiency.

We have recently experienced a patient with acute exacerbation of chronic ATL, in whom spontaneous remission was induced after treatment of complicating pulmonary and urinary tract infections. We describe this unique case of ATL and discuss the possible role of infection as a trigger for the clinical expansion of ATL cells.

Case report

A 57-year-old Japanese woman was admitted to the Kyushu University Hospital on August 24, 1987, because of productive cough, watery diarrhea and frequent urination. She was born in the northern part of Kyushu Island, the endemic area of HTLV-I in Japan. She had no history of blood transfusion.

Since April 1986, she had been suffering from persistent dry cough. In September 1986, she visited a physician, who noticed morphologically abnormal lymphocytes in the peripheral blood. She was referred to us for further evaluation on December 22, 1986. On the first admission, her leukocyte count was approximately 10×10^9/l with about 30% abnormal lymphocytes showing lobulated nuclei. Flow-cytometric analysis of the peripheral blood mononuclear cells showed that CD3+ cells accounted for 90.8%, CD4+ cells 70.2%, CD8+ cells 79.4% and CD8+ cells 9.2%. Anti-HTLV-I antibody in the serum was positive with a titer of 1:40. She was diagnosed as having chronic ATL since LDH levels were normal and the ATL cell count did not increase during the admission. After the evaluation of ATL, she was discharged without therapy on January 24, 1987, and thereafter remained in good condition, except for persistent productive cough, for about six months.

Just before the second admission, however, the leukocyte count increased to 31.0×10^9/l with 56% ATL cells. When she was admitted for the second time, small discontinuous cracks were audible at the bottom of the lungs. The liver was palpable 1 cm beneath the right costal margin. Nodular lymphadenopathy and splenomegaly were noted. Although diffuse纹理 versicolor was observed on the neck and chest, skin involvement of ATL was not seen.

Hematological findings on the second admission were as follows: RBC 4.86×10^12/l; Hb 14.6 g/dl; platelets 154×10^9/l; WBC 26.2×10^9/l with 4% band-form neutrophils, 56% segmented, 2% monocytes, 4% lymphocytes and 34% ATL cells. Bone marrow aspiration revealed a nucleated cell count of 113×10^9/l with 5.2% ATL cells. Findings of flow-cytometric analysis of peripheral blood mononuclear cells were CD3+ 91.9%, CD4+ 80.1%, CD8+ 89.0%,
Original article

Spontaneous remission of nephrotic syndrome in a patient with IgA nephropathy

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Received May 26, 1989; accepted August 8, 1989

Abstract. A patient with spontaneous remission of nephrotic syndrome (NS) associated with IgA nephropathy is described. The patient presented at the age of 8 years with asymptomatic proteinuria, and at the age of 11 years developed classical features of NS. A percutaneous renal biopsy showed mild mesangial prominence without significant hypercellularity, electron-dense deposits within the mesangium, and 3+ mesangial staining with IgA and IgG. NS resolved 6 weeks after onset without any form of therapy; absence of proteinuria persisted 6 months later. This report demonstrates clearly that patients with NS associated with IgA nephropathy may undergo spontaneous resolution of their proteinuria.

Key words: Nephrotic syndrome – IgA nephropathy

Introduction

Although most reports dealing with prognostic indicators in IgA nephropathy have shown that heavy proteinuria is associated with a poor prognosis in both adults and children, some recent reports have described a group of patients with IgA nephropathy and steroid-responsive nephrotic syndrome (SRNS) in whom the prognosis appears to be more favorable [1–19]. This apparent disparity has led to the postulate that patients with IgA nephropathy and SRNS may have two co-existing lesions rather than IgA nephropathy-induced severe proteinuria [10, 20, 21]. In this report, a patient with spontaneous remission of nephrotic syndrome (NS) associated with IgA nephropathy is described. The relevance of this observation to the interpretation of therapeutic trials in patients with IgA nephropathy and proteinuria is discussed.

Case report

Pre-biopsy clinical course. The patient presented initially as an 8-year-old white male with asymptomatic proteinuria. His work-up at that time revealed a 24-h protein excretion rate of 1.5 g, total serum protein 5.7 g/dl, albumin 3.5 g/dl, creatinine 0.6 mg/dl, and blood urea nitrogen 11 mg/dl. No specific diagnostic procedures were carried out at that time and the patient was lost to follow-up. Prior to his next evaluation by a nephrologist, the patient was diagnosed as having Tourette syndrome and was treated with chlorpromazine, 1 mg qds.

The patient subsequently presented at the age of 11 years with sudden onset of NS. Urinalysis revealed 5–10 red blood cells per high power field and moderate numbers of hyaline and granular casts in addition to greater than 300 mg/dl of protein. A 24-h urine collection revealed 7.2 g protein. Other studies at that time revealed a total serum protein 4.2 g/dl, albumin 1.7 g/dl, calcium 7.4 mg/dl, creatinine 0.6 mg/dl, cholesterol 402 mg/dl, triglyceride 635 mg/dl, C3 complement 220 mg/dl, and negative hepatitis B surface antigen and ANA. He was referred to Baylor University Medical Center for further evaluation.

Although some of the clinical features of this patient were most compatible with minimal change NS, a renal biopsy was carried out rather than a trial of therapy because of the unusual clinical features (i.e., Tourette syndrome and the presentation with proteinuria followed 3 years later by NS) and concern over the possible adverse effects of daily steroid therapy in a patient with Tourette syndrome. The biopsy revealed 69 glomeruli, all of which were essentially similar by light microscopy. The glomeruli showed focal segmental mesangial proteinuria without significant hypercellularity. The blood vessels had a normal appearance. Occasional tubules showed partial collapse without evidence of significant atrophy. The lumina of some tubules contained finely granular, pale eosinophilic material with a few clusters of red blood cells. The interstitium showed no inflammation or fibrosis.
Calcific discitis in an adult patient with intravertebral migration and spontaneous remission

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Received: 23 September 2012 / Revised: 4 March 2013 / Accepted: 5 March 2013 © ISS 2013

Abstract Symptomatic disc calcifications have been reported, especially in the pediatric population, and remain of unknown etiology. Such a condition has been very rarely reported in adults. The aim of this paper is to present a case report of calcific discitis in an adult patient with intravertebral migration and spontaneous calcification resorption. The clinical presentation was that of back pain with an abrupt onset, not related to trauma or to physical activity. No fever or neurological deficits were present. Blood count, erythrocyte sedimentation rate, routine urine, and urine culture were negative. The pain regressed in 20 days with analgesic therapy. Findings of thoracic calcific discitis are illustrated with X-rays, CT, MRI, and bone scintigraphy.

Keywords Spine • Calcification • Intravertebral disc • Discitis • CT • MRI

Introduction

Intravertebral disc calcification (IDC) represents a common incidental finding on radiographic examinations. The prevalence of IDC in the general adult population has been reported to be 5% on chest radiographs and 6% of abdominal radiographs [1–3]. A study in cadavers showed that IDC prevalence is even higher in elderly persons and it increases with age and with the extent of disc space loss [4]. IDC in the elderly population is more frequently seen in the annulus fibrosus and in the lower thoracic spine [4].

Symptomatic disc calcifications are considered rare and have been reported, particularly in the pediatric population [5, 6]. Painful disc calcification in children typically involves the nucleus pulposus and is more frequently seen in the cervical spine [5]. There is little information on symptomatic calcific discitis in the adult population, the literature in this respect being restricted to a few case reports.

The aim of this paper is to present a case of symptomatic calcific discitis with intravertebral migration of the calcification and spontaneous calcification resorption in an adult patient.

Case report

A 40-year-old man had had acute back pain at the thoracolumbar transition for 15 days. Pain had an abrupt onset not related to physical activity or trauma. Symptoms were worse in the upright and in the seated positions. At physical examination patient showed a flexed antalgic position. No fever or neurological deficits were present. Blood count, erythrocyte sedimentation rate, routine urine and urine culture were negative. Abdominal ultrasonography was negative.

Initial lateral view X-ray showed nucleus pulposus calcification within the disc space at the T9–T10 level (Fig. 1). Technetium bone scan showed increased uptake at the T9 vertebra (Fig. 2). Computed tomography (CT) confirmed the calcified nucleus pulposus and depicted migration of the calcification into the T9 vertebral body with adjacent reactive bone sclerosis (Fig. 3). CT also demonstrated focal
CASE STUDIES

Spontaneous Remission in Chronic Lymphocytic Leukemia

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Although spontaneous remissions have been reported to occur in leukemia (1-5) and many other types of cancer (6), there have been few reports of spontaneous remissions in chronic lymphocytic leukemia (CLL). An apparent spontaneous and prolonged remission in a patient with typical findings of CLL, which began 18 months after cessation of all therapy, is the subject of this report.

CASE REPORT

Patient S. O., a 48-year-old mechanic, developed symptoms of weakness and easy fatigability in 1952. A hemoglobin determination was reported to be 10.5 g/100 ml. Several weeks later he was hospitalized with a hemoglobin of 6.0 g/100 ml and a leukocyte count (WBC) of 37,000/mm³ with 80% lymphocytes. He received 4 units of blood and was referred to our clinic in September 1952 for further evaluation.

Physical examination revealed generalized lymphadenopathy (1 to 5 cm) of the cervical, axillary, and inguinal areas in addition to splenomegaly. The volume of packed red cells (VPRC) was 38.2%, and the Hb, 10.3 g/100 ml; 62% lymphocytes, a few of which were considered immature. Platelets were 80,000/mm³. A bone marrow aspiration contained 60% lymphocytes. A diagnosis of CLL was made, and he was treated with 3.0 mg of triethylenemelamine orally and discharged.

Within a month after discharge he was admitted to another hospital with anemia. The VPRC was 21%, and evidence of hemolysis was said to be present. After transfusion, a splenectomy was performed in October 1952. The spleen weighed 1,340 g, and histological examination revealed a picture compatible with leukemia with numerous cells of lymphoid type in the sinusoites.

After splenectomy the leukocyte count increased to 98,000/mm³ (66% lymphocytes), and he was treated for the second time with triethylenemelamine, 4.0 mg orally. The anemia worsened, and between January and April 1953 he received approximately 40 transfusions.

He returned to our hospital in April 1953 with a VPRC of 25%, a reticulocytosis (6%), and positive direct and indirect Coombs' tests. The serum bilirubin was 1.2 mg/100 ml. 0.2 mg/100 ml direct-reacting. Therapy with cortisone, 100 mg daily, was begun in May 1953 and continued in decreasing dosage until October 1955, when it was discontinued. There was rapid improvement in the anemia with the VPRC increasing to 46% in June and reaching a maximum of 55% in November 1955. Initially the lymphocytes increased from 60,000 to 85,000/mm³, followed by a decrease to 50,000/mm³ at which time the patient remained while he was receiving cortisone therapy. Lymphadenopathy and hepatomegaly were no longer present.

In January 1954 lymphadenopathy and hepatomegaly were again noted and persisted until May 1955. The WBC ranged between 50,000 and 65,000/mm³ with 60 to 80% lymphocytes until May 1955, when a gradual decline in WBC began. By May 1956 the WBC was 25,000/mm³ (80% lymphocytes), and by December 1961 it was 10,000/mm³ (25% lymphocytes). Since then the WBC has remained between 9,000 and 11,000/mm³. Blood slides were reviewed since 1961, and a 500-cell differential count revealed 300 to 400 lymphocytes. A bone marrow aspiration in 1954 was normal, with 11% lymphocytes.

He has remained free of any signs of CLL, and his only symptoms are related to obstructive pul-
Spontaneous remission of chiasmatic/hypothalamic masses in neurofibromatosis type 1: report of two cases

Abstract We report two children with neurofibromatosis type 1 showing enhancing masses on MRI suggesting neoplasms in the chiasm and hypothalamic region. In both patients no visual or endocrine dysfunction was present. On serial MRI spontaneous partial remission was found, implying that a cautious approach to therapeutic management of similar cases should be taken.

Keywords Neurofibromatosis type 1 (NF1) · Optic glioma · Magnetic resonance imaging

Introduction

Tumours affecting the nervous system are one of the major features of Neurofibromatosis type 1 (NF1), a common autosomal dominant disorder with an incidence of 1 in 3,000–5,000. The NF1 gene, on chromosome region 17q11.2, encodes a tumour suppressor factor which interacts with the product of the ras oncogene p21 ras [1].

In patients with NF1, neoplasms of the nervous system occur typically as lesions of nerves and astrocytes. The most common central nervous system tumour in NF1 is the optic glioma, sometimes appearing as a mixed chiasmal and hypothalamic mass. In a co-operative prospective clinicoradiological study, started in 1993, we are following 23 patients with NF1. Serial MRI has been performed on two MRI units at 1.5 T. We present the MRI findings in two patients with NF1, displaying spontaneous remission of a hypothalamic/chiasmatic mass thought to be astrocytomas.

Case reports

Case 1

This boy was 1 year 11 months old on admission to the study. According to the NIH criteria [2], the diagnosis was based on multiple café-au-lait spots and a first degree relative. MRI showed thickening of the optic chiasm and hypothalamic mass, with strong contrast enhancement (Fig. 1a). Examination 12 months later showed marked reduction in mass effect and no contrast enhancement (Fig. 1b). On T2-weighted images a small residual high-signal lesion was seen (Fig. 1c).

In addition, typical, non-neoplastic high-signal foci on T2-weighted images were seen in the cerebellum, cerebral peduncle, mesiotemporal cortex and globus pallidus. No significant change was seen during follow-up. There was no loss of visual acuity, and visual-evoked potentials (VEP) were normal. Serum cortisol, prolactin, thyroid-stimulating hormone (TSH) and T4 were within normal limits.

Case 2

This boy was admitted to the study at the age of 3 years 2 months. The diagnosis of NF1 was based on multiple café-au-lait spots and freckling. Baseline MRI showed non-neoplastic T2 weighted
Enlarged Prostate Healed with Energy Medicine

Spontaneous Healing of an Enlarged Prostate

Practice

“Wrong...then I met you and during a recent “healing session” with you, I was completely healed. When you placed your hands over my bladder, a powerful tingling feeling occurred and in that 2 1/2 minutes I knew something marvelous had happened to my body.”

Help

Alex Hermosillo Mastery of Energy Healing

Source: http://masterofenergy/healing.stories/client-studies/james-prostate/

Safe2Heal Story 106

Outcome

Painfree

“The pain is gone and my body is now functioning as God intended to do. I will always be thankful for your teaching me to release the bad (anger, hate, forgiveness of self) and accept the light (love, ability to forgive) into my body and soul for this is the secret of healing.”

Safe2Heal

Enlarged Prostate

Background

Spending retirement years fighting an extreme bladder condition caused from a prostate gland being enlarged.

“Recently I (the insurance company) spent over $42,000.00 at the Mayo Clinic only to come to the conclusion that surgery was the only way to relieve my problem.”

Man, Retired Executive

Situation

Spontaneous improvement:
~10% of cases of adults with chronic ITP

Adults with chronic ITP

~10%

*Defined as late responses not attributed to definitive treatment.

− Shocking Study −

Spontaneous Remission of Breast Cancer

...Found to be Common
Cancer sufferer amazes medics by going into remission BEFORE starting treatment

By CHRIS BROOKE
UPDATED: 08:59 GMT, 9 September 2010

A retired teacher has astonished doctors after his body rid itself of cancer without treatment.
Peter Crane, 60, was diagnosed with a form of leukaemia 18 months ago.
He was warned that the disease cannot usually be cured but told that chemotherapy could help.

However, Mr Crane did not start the treatment straight away because the cancer had not reached the stage where it would be most effective.
In the meantime, it appears the cancer simply vanished. Blood tests have shown his body is free of the disease and he is now officially in remission.

Experts said Mr Crane was a very lucky man. Cases of ‘spontaneous remission’ are extremely rare but do happen.
Mr Crane, of East Boldon, South Tyneside, is now feeling fit and healthy and enjoying a new lease of life with his wife Mary, 58.
He said he was astounded when tests last week at the Freeman Hospital in Newcastle showed he was in remission. ‘I couldn’t believe it when they told me,’ he said.
And Mr. Crane went to a Quantum Biofeedback therapist to deal with his stress.
‘I was in shock. My blood counts had been normal for about 12 months, so it had disappeared naturally without the need for any treatment.
‘The doctors said to go into spontaneous remission is very rare. It’s not unique and I am not saying the cancer won’t come back but, for now, being told it’s gone is a huge weight off my mind.’

Mr Crane had been diagnosed with chronic lymphocytic leukaemia, or CCL which is one of the most common forms of the disease. It eventually medical intervention to keep under control.

CLL usually affects those over 60 and occurs more often in men. It develops very slowly and many patients do not need treatment for months or years.
Chemotherapy and radiotherapy are used once the symptoms become more acute.

Ken Campbell, of charity Leukaemia and Lymphoma Research, said: ‘Mr Crane has been very lucky. Spontaneous remission like this has happened before but it is certainly not commonplace. It is very, very rare.’
Vanda Taylor of Cancer Research UK said that while the charity had heard of similar situations, cases were few and far between.
She said: ‘We are pleased to hear about this case, CLL is a complex disease and similar cases like this have been known, although we would stress they are incredibly rare.’
Doctors say spontaneous regression or remission – the shrinking or complete disappearance of a cancer without treatment – has been reported in all types of cancers, but is most often seen in those of the skin, testes and kidney, as well as in some forms of lymphoma and leukaemia.

Estimates about how frequently the phenomenon occurs range up to one in every 100,000 cases.
Some cases turn out not to be spontaneous regression or remission at all.
Either patients were misdiagnosed, or they were mistaken about their health.
Normally, the body attempts to fight off any potentially dangerous cells. However, cancer cells are often overlooked by the immune system and allowed to develop into tumours.
By the time the immune system recognises a tumour, it is usually too big and too late.
In just a few cases, however, the immune system appears to kick into action in time – either partially or completely destroying a tumour.
Why the immune system’s natural killer cells go into battle for some patients, but not others, is unknown.

Some researchers argue that modern screening techniques identify small tumours that would normally disappear on their own anyway.
Mr Crane and his wife are about to begin a 450-mile bike ride through France to raise money for cancer charities and celebrate his remarkable recovery.
Mr Crane said: ‘It was something we really wanted to do and with Leukaemia Research being a charity close to my heart, we decided try raising some money for it as well.
‘I have been fit and well throughout and have been able to get on with things as normal, such as cycling, cricket, golf and squash. I’m sure that I will be cycling with renewed energy such is the weight that has been taken off my mind.’
Quantum Biofeedback
A Miracle is Only A Shift in Consciousness!
Title:

Treating CANCER with Quantum Biofeedback

Part of the Following:

Large Scale Study of the Safety and Efficacy

of the SCIO Device

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Developed By:

This study was performed in the field by practicing Biofeedback technicians. Data was collected and the study supervised by the Ethics International Institutional Review Board of Romania. The Data analysis and study presentation is done By the The Centro Ricerche, University of Venice + Padova, Italy

Abstract:

This study demonstrates the safety and effective qualities of the SCIO device used in a large scale study. A large scale study of over 97,000 patients with over 275,000 patient visits reported their diseases. Many of them reported this disease. And the results of their therapy is reported in this study.

The SCIO device uses the principles of Quantum Electro Dynamics (QED) as the base of an energetic medicine technique for healing. Bioresonance, Volt-Ammetry, Trvector, Provocative Allergy Tests, Infection Reaction Testing and Immune Stimulation, Electro-Acupuncture, Neurological-Stimulation, Biofeedback-Psychological Interaction, Muscle-Neurological Re-education, Homotoxicity and Homeopathy, Electrophysiological Diagnosis, Behavioral Management Therapy and more are avant garde therapies registered for the SCIO device to perform on patients.

Cancer is a dys-regulation of the metabolic/reproductive epigenic rhythm. This dysfunction shifts the energy from metabolism to reproduction. Thus the cancer cells grow. This is explained in the PROMORPHEUS and in the IMUNE cancer video. The SCIO device can interrupt the epigenic dysfunction and thus destroy the cancer cells.

In this study the disease group total number of patients was 7,672, with Subspace Treatment 2,109 patients, and 5,563 SCIO Harness Patients. There was Subspace Treatment 5,601 patient visits, SCIO Harness Treatment 16,720 patient visits.

The results show dramatic promise for the premise that the QED functions of the SCIO can have healing effects on a cancer patient. There was over 2,000 cases of cures reported in this study. More than fifty percent of the patients reported positive results. There was insignificant negative effects reported.

OVER 2000 CASES THAT WERE CLAIMED TO BE SPONTANEOUS REMISSION BUT WERE ACTUALLY JUST QUANTUM BIOFEEDBACK

Introduction:

Over View:

This Large scale research was designed to produce a extensive study of people with a wide variety of diseases to see who gets or feels better while using the SCIO for stress reduction and patient monitoring. The SCIO is a evoked potential Universal Electro-Physiological Medical apparatus that gauges how a individual reacts to
miscellaneous homeopathic substances. The device is registered in Europe, America, Canada, S Africa, Australia, S.
America, Mexico and elsewhere. The traditional software is fully registered. Some additional functions where
determined by the manufacturer to be worthy of evaluation. Thus a study was necessary to determine safety and
efficacy. (As a result of these studies these additional functions are now registered within the EC)

An European ethics committee was officially registered and governmental permission attained to do the
insignificant risk study. Qualified registered and or licensed Biofeedback therapists where enlisted to perform the
study. Therapists were enrolled from all over the world including N. America, Europe, Africa, Australia, Asia, and S.
America. They were trained in the aspects of the study and how to attain informed consent and transmit the
results to the ethics committee or IRB (Institutional Review Board).

2,569 therapists enlisted in the study. There were 98,760 patients. 69% had more than one visit. 43% had
over two visits. There were over 275,000 patient visits recorded. The therapists were trained and supervised by
medical staff. They were to perform the SCIO therapy and analysis. They were to report any medical suspected or
confirmed diagnosis. Therapists personnel are not to diagnose outside of the realm of their scope of practice. Then
the therapist is to inquire on any reported changes during the meeting and on follow-ups any measured variations.
It must be pointed out that the Therapists were free to do any additional therapies they wish such as homeopathy,
nutrition, exercise, etc. Therapists were told to not recommend synthetic drugs. Thus the evaluation was not
reduced to just the device but to the total effect of seeing a SCIO therapist.

Part 1. The emphasis was on substantiating safety followed by efficacy of the SCIO.
Part 2. Proving the efficacy of the SCIO on diseases (emphasis on degenerative disease)
Part 3. Proving the efficacy of the SCIO on the avant garde therapies of Complementary Med
Part 4. QQC standardization

Methods and Materials:

SCIO Device:

The SCIO is an evoked potential Universal Electro-Physiological Medical device that measures how a
person reacts to items. It is designed to measure reactions for allergy, homeopathy, nutrition, sarcoodes, nosodes,
vitamins, minerals, enzymes and many more items. Biofeedback is used for pre-diagnostic work and or therapy.

The QXCI software will allow the unconscious of the patient to guide to repair electrical and vibrational
aberrations in your body. For complete functional details and pictures, see appendix.

Subspace Software:

The QXCI software is designed for electro-physiological connection to the patient to allow reactivity
testing and rectification of subtle abnormalities of the body electric. If a patient is not available a subspace or
distance healing link has been designed for subspace therapeutics. Many reports of the success of the subspace
have been reported and thus the effectiveness and the safety of the subspace link is part of this test. Many
companies have tried to copy the subspace of Prof. Nelson and their counterfeit attempts have ended in failure.
SOC Index:

The SCIO interview opens with a behavioral medicine interview. This is called the SOC Index. Named after the work of Samuel Hahneman the father of homeopathy, he said that the body heals itself with its innate knowledge. But the patient can suppress or obstruct the healing process with some behavior. Hahneman said that the worst way to interfere with the healing natural process was allopathy or synthetic drugs. These upset the natural healing process by unnatural intervention and regulation disturbance. Other ways to Suppress or Obstruct the Cure are smoking, mercury amalgams, stress, lack of water, exercise and many others. This behavioral survey then gives an index of SOC.

The scores relate to the risk of Suppression and Obstruction to the natural Cure. The higher the scores the more the Suppression and or Obstruction. The scores of 100 or lower are ideal. A copy of the SOC index questions appear in the appendix.

Study Technicians:

The study technicians were educated and supervised by medical officers. The study technicians were to execute the SCIO therapy and analysis. All were trained to the standards of the International Medical University of Natural Education. Therapists from all over the world including N. America, Europe, Africa, Australia, Asia, S. America and elsewhere were enlisted to perform the study according to the Helsinki study ethics regulations.

They were to chronicle any medical suspected or confirmed diagnosis. Therapists personnel are not to diagnose outside of the realm of their scope of practice. Then the study technician is to inquire on any disclosed observations during the test and on follow-ups report any measured changes.

Into a small bowl mix ½ cup rich natural flower pollen dark honey with 1 cup crushed black and or blue berries. Add 2 tablespoons of fructose, 2 tablespoons of cumerin, tumeric, 2 tablespoons of crushed agrimony, 2 tablespoons of crushed dried young oranges peel and all (use the oranges when they are about slightly larger than a golf ball, dry thoroughly) try ginger cinnamon and garlic for flavor. Mix and take 1 teaspoon morning and 1 before bed. See the 3D Cancer Book for more
To test the device as subspace against the placebo effect, two of the 2,500+ therapists were given placebo SCIO devices that were totally outwardly the same but were not functional. These two blind therapists were then assigned 35 patients each (only 63 showed). This was to assess the double blind factor of the placebo effect as compared to the device. Thus the studied groups were

A. placebo group, B. subspace group, and C. attached harness group.

Cross placebo group manipulation was used to further evaluate the effect.

**Important Questions**: these are the key questions of the study

1. Define Diseases or Patient Concerns
2. Percentage of Improvement in Symptoms
3. Percentage of Improvement in Feeling Better
4. Percentage of Improvement Measured
5. Percentage of Improvement in Stress Reduction
6. Percentage of Improvement in SOC Behavior
7. What Measured + How (relevant measures to the patient’s health situation)
8. If Patient worsened please describe in detail involving SOC

After the patient visit is complete the data was e-mailed to the Ethics Committee or IRB for storage and then analysis. This maneuver minimized the risk of data loss or tampering. Case studies were reported separately in the disease analysis.

**MEDICAL DETAILS**

**Cancer Categories**

A malignant tumor or neoplasm; a sarcoma or carcinoma.

- Unusual bleeding or discharge from any body site internal or external
- A lump or thickening in any area, but especially the breast
- A sore that does not heal
- A change in bowel or bladder habits
- Hoarseness or persistent cough
- Indigestion or difficulty in swallowing
- Change in size or shape or appearance of a wart or mole
- Unexplained loss of weight
Results:

Before we review the direct disease improvement profiles, we need to review the overall results. The first most basic of question in the results is the basic feedback of the generic patient conditions.

1. Percentage of Improvement in Symptoms
2. Percentage of Improvement in Feeling Better
3. Percentage of Improvement Measured
4. Percentage of Improvement in Stress Reduction
5. Percentage of Improvement in SOC Behavior

The SOC index gives us great insight to this study. Each disease has a different cut off where the ability of the SCIO to help was compromised. As a general index scores of 200 + where much less successful.

This groups significant SOC cut off was 80.

The Large scale study had over 98,000 patients and 275,000 patient visits we have direct evidence of the safety and efficacy. A placebo group was used for the large scale test to help validate the results.

This disease group total number of patients was 7,672

Subspace Treatment 2,109 patients, 5,563 SCIO Harness Patients

OVERALL ASSESSMENT

A. Subspace Treatment 5,601 patient visits

There were 4 cases of patients who reported a negative Improvement.

None of these cases reported any major difficulty.

There were

11 cases reporting no improvement of Symptoms, .002% of Subgroup
15 cases reporting no improvement in feeling better, .002% of Subgroup
11 cases reporting no improvement in stress reduction .002% of Subgroup

27%--- Percentage of Improvement in Symptoms
27%--- Percentage of Improvement in Feeling Better
28%--- Percentage of Improvement Measured
35%--- Percentage of Improvement in Stress Reduction

6 %--- Percentage of Improvement in SOC Behavior
B. SCIO Harness Treatment 16,720 patient visits

There were 5 cases of patients who reported a negative improvement. None of these cases reported any major difficulty.

There were

14 cases reporting no improvement of Symptoms, .001 % of Subgroup
15 cases reporting no improvement in feeling better, .001% of Subgroup
15 cases reporting no improvement in stress reduction .001% of Subgroup

56%--- Percentage of Improvement in Symptoms
57%--- Percentage of Improvement in Feeling Better
63%--- Percentage of Improvement Measured
75%-- Percentage of Improvement in Stress Reduction
20%----Percentage of Improvement in SOC Behavior

World’s Largest
Clinical Biofeedback
Peer Reviewed
Research Study
on the SCIO

Expect a Miracle with the
SCIO/Educator/Eductor
Institute of Noetic Sciences update

The Institute of Noetic Sciences (IONS) was co-founded in 1973 by former astronaut Edgar Mitchell and investor Paul N. Temple to encourage and conduct research on human potentials. Institute programs include “extended human capacities,” “integral health and healing,” and “emerging worldviews.”

This research includes topics such as spontaneous remission, meditation, consciousness, alternative healing practices, consciousness-based healthcare, spirituality, human potential, psychic abilities and survival of consciousness after bodily death.

Headquartered outside Petaluma, California, the organization is situated on a 200 acres (81 ha) campus that includes offices, a research laboratory, and a retreat center (originally the campus of World College West). The institute does not grant educational degrees.

History

Edgar Mitchell, co-founder of the institute

The institute was co-founded in 1973 by Edgar Mitchell, an astronaut who was part of the Apollo 14 mission, investor Paul N. Temple and some others. During the three-day journey back to Earth aboard Apollo 14, Mitchell had an epiphany while looking down on the earth from space. “The presence of divinity became almost palpable, and I knew that life in the universe was not just an accident based on random processes ... The knowledge came to me directly,” Mitchell said of that experience. Following his spaceflight, Mitchell and others founded the Institute of Noetic Sciences. Willis Harman served as its president from 1975 until his death in 1997.

The word noetic is derived from the Greek nous, for which, according to the institute’s website, there is no exact equivalent in English. It refers to “inner knowing,” a kind of intuitive consciousness—direct and immediate access to knowledge beyond what is available to our normal senses and the power of reason.

Research

The institute identifies three principle areas of interest: extended human capacities, integral health and healing, and emerging world views. Projects sponsored by the institute include a bibliography on the physical and psychological effects of meditation, a spontaneous remission bibliography, and studies on the efficacy of compassionate intention on healing in AIDS patients. The institute has also conducted a number of parapsychological studies into extra-sensory perception, lucid dreaming, and presentiment.

Publications

Since 2009, the Institute has published a semi-annual bulletin, The Noetic Post. From 2003 to 2009, it published a quarterly magazine, Shift: At the Frontiers of Consciousness. In February 2007, IONS announced a co-publishing agreement with New Harbinger Publications. Noetic Books and New Harbinger partnered to publish books that incorporate science and focus on global issues, consciousness, spiritual and psychological wellness. Authors include Edmund Bourne, Charles Tart, and Marilyn Schiltz.

Institute research has also been published as papers in peer-reviewed journals, including:

- British Journal of Psychology
Criticism

Stephen Barrett, organizer of the nonprofit organization Quackwatch, whose website describes itself as a "Guide to Quackery, Health Fraud, and Intelligent Decisions," lists the Institute of Noetic Sciences as one of the 729 organizations that he views "with considerable distrust."[10]

See also

- Noetic Psychology
- Noetic theory
- Marilyn Schlitz - President and CEO of the Institute of Noetic Sciences

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2. ^ Paul N. Temple biography at BioGenesis
3. ^ Institute of Noetic Sciences. About: History of the Institute of Noetic Sciences
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6. ^ Mitchell, Edgar, The Way of the Explorer, GP Putnam's Sons, 1996. "I wish to thank those who had faith in an idea that led to the founding of the Institute of Noetic Sciences: Henry Rolfs (deceased) and Zoe Rolfs, Richard Davis, Judith Skutch Whitson, Paul Temple, Phillip Lukin (deceased), and John White. And to those who came a bit later to carry the idea further: Osmond Crosby, Brendan O'Regan (deceased), Diane Brown Temple, and Willis Harman."
7. ^ Institute of Noetic Sciences. "What the Bleep do we Know?!"
8. ^ The new business of business: sharing responsibility for a positive global
9. ^ Willis Harman, 1918-1997
10. ^ Weaving possibilities for a New Era
11. ^ Ions – About: What is “noetic”?
12. ^ Institute of Noetic Sciences. Research & Education Projects at the Institute of Noetic Sciences
13. ^ Institute of Noetic Sciences. Research & Education Projects at the Institute of Noetic Sciences
17. ^ Noetic Books web page

External links

- Institute of Noetic Sciences official website
- Institute of Noetic Sciences Shift in Action community & archive website
- Noetic Books
- Institute of Noetic Sciences entry in the University of Virginia course guide for "New Religious Movements"
- Noetic science conference in Argentina, April 2003 (photos)
- Brendan O'Regan on the Unexplained Mystery of Spontaneous Remission
Kirlian Photography Study of the SCIO Eductor

Researcher: Colonel medic Dr. Radu Stefan. Bucuresti, Romania ; 07 August 2010.

Abstract:
It is apparent that there is energy in the body and this energy flow is highly regulated. When we put the body into a high energy field of the Kirlian device there appears that the life energy follows the high voltage energy. We believe in energetic medicine and as we balance the energy fields of the body we can reduce disease. Some people have called it spontaneous remission when there are unexpected results from such new avant-garde techniques, but we believe these are not spontaneous or haphazard the healings come from stabilizing the life energies. We will measure the Kirlian field before and after using the SCIO device.

Introduction:
A Romanian doctor Radu Stefan in 2010 used a Kirlian photograph unit to do a test of the electrical SCIO systems validity. This Kirlian imagery device immerses the patient in safe electrical plasma that can accentuate the presence of free electrical energy. Thus a type of electrical aura can be seen. Whatever you think of this technique and its somewhat bizarre claims, it is undeniable that it is showing a reflection of the electrical field in certain areas of the body. He took pictures before and after chiropractic, acupuncture, and massage therapies. There was little change. But the pre post pictures of the SCIO system show an undeniable electrical change.
We report these findings and photos as preliminary speculative evidence of the proposed effect of the SCIO on the body electric.
In his pre and post pictures there are very astounding changes in the body electric shown by the Kirlian photography. This proves that the SCIO system is capable of producing and increased electrical field around the human. There was no double blind or use of a standard measure, so a new experiment was needed to be designed. We need to measure more critically the effect.

Method:
Kirlian photography is a collection of photographic techniques used to capture the phenomenon of electrical coronal discharges. It is named after Semyon Kirlian, who, in 1939 accidentally discovered that if an object on a photographic plate is connected to a high-voltage source, an image is produced on the photographic plate.[1] The technique has been variously known as "electrography",[2] "electrophotography",[3] "corona discharge photography" (CDP),[4] "bioelectrography",[2] "gas discharge visualization (GDV)",[5] "eletrophotonic imaging (EPI)",[6] and, in Russian literature, "Kirlianography".

In 1958, the Kirlians reported the results of their experiments for the first time. Their work was virtually unknown until 1970, when two Americans, Lynn Schroeder and Sheila Ostrander
published a book, *Psychic Discoveries Behind the Iron Curtain*. Although little interest was generated among western scientists, Russians held a conference on the subject in 1972, at Kazakh State University.[11]

Kirlian photography was used extensively in the former Eastern Bloc. For example, in the 1970s, Romania had 14,000 state-sponsored scientists working on the technique.[12] The corona discharge glow at the surface of an object subjected to a high voltage electrical field is referred to as a Kirlian aura in Russia and Eastern Europe,[13][14] however this should not to be confused with the paranormal concept of the aura. In 1975 Belarusian scientist Victor Adamenko wrote a dissertation titled *Research of the structure of High-frequency electric discharge (Kirlian effect)* images.[15][16] The scientific study of Kirlian effect in Kazakhstan State University has performed Victor Inyushin.[17][18]

Kirlian photography might depict a conjectural energy field, or aura, thought, by some, to surround living things. Kirlian and his wife were convinced that their images showed a life force or energy field that reflected the physical and emotional states of their living subjects. They thought these images could be used to diagnose illnesses. In 1961, they published their first paper on the subject in the Russian Journal of Scientific and Applied Photography.[33] Kirlian's claims were embraced by energy treatments practitioners.[34]

Scientists such as Beverly Rubik have explored the idea of a human biofield using Kirlian photography research, attempting to explain the Chinese discipline of Qigong. Qigong teaches that there is a vitalistic energy called qi (or chi) that permeates all living things. The existence of qi has been mostly rejected by the scientific community. Rubik's experiments relied on Konstantin Korotkov's GDV device to produce images which were thought to visualize these qi biofields in chronically ill patients. Rubik acknowledges that the small sample size in her experiments "was too small to permit a meaningful statistical analysis."[39] Vitalistic energies, such as qi and prana, if they exist, would exist beyond the natural world. Claims that these energies can be captured by special photographic equipment are criticized by skeptics.[34]

The SCIO device is a biofeedback stimulation device that has been FDA registered since 1989. The SCIO device uses a cybernetic loop to modify an autofocused signal that is designed to stabilize the body electric. We have seen in many studies positive effects of this therapy. Here we will measure 9 patients before and after.
Discussion:

So after this series of experimental tests and evaluation we can conclusively conclude that the SCIO is able to improve and stabilize the Kirlian energy field. As we improve the body electric and the energy increases and stabilizes the energy field will be fuller and more symmetrical. When the medical community sees a device function that they do not understand they call it spontaneous remission. We call it energetic medicine.
The aura is composed of seven fields within and outside the body. Each field called a density represents a specific energy range, corresponding to color, light, and sound. When densities are clear, energy moves freely through the body, unifying the physical body, the subtle body, and the causal body with a person's higher consciousness.

Interpretation of Photo one: Indigo Blue on the outside area indicates an old soul... many past lives... full of wisdom and this is the time to complete one's mission because of the wisdom and experiences of past lives. The colors Rose and Fusia are signs of unconditional love and compassion. White throughout the entire aura is the connection with spirituality and the spirit world. The shaded areas above the head are signs of self doubt. There is much love but a strong need to have confidence in one's own abilities with this power.

Photo 2: After SCIO (Quantum Bio Feedback) the SCIO energetically cleanses and repairs by mending the Aura if it is ripped or torn, and then adjusts frequencies within the corresponding Auric fields that strengthens and provides protection. Aura Cleansing Cactus is used for cleansing and regeneration of the aura and the astral body. White Angelica is used to ward off bombardment of negative energy, increase the Aura, and for strength and protection.... The golden arch over the top is the energy of the Christ Consciousness. An entity appears on both sides of the person. The one on the left is Golden with green... Transformation with the Christ consciousness... The turquoise blue and white entity on the left side is about a message of the need to be in service (blue) and the focus is on the service mixed with spirituality (white). The fact that there are entities on both sides confirms the opportunity to complete one's mission in this life and this person has support from higher beings who have come to help. There is green in the heart chakra and is mixed with purple as well. The transformation of the heart with the purple color is of the highest vibration of spirituality such as seen on Easter when the priests celebrate the Ascension he wears purple.... All colors of the second photo are higher levels of vibration and show a shift from the first photo of love but with self doubt... to the golden, purple and transformational greens.

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"What we Know about Biology Fills a Library. What Nature Knows Fills a World. Maybe a Universe"

Desire' Dubounet
The Main Fact of Life is

You Do NOT Create the World or the Events Around You

But You Do Control Completely Your Interpretation of the World and Events Around You
The world is awakening to WELLNESS. This was not even a word until recently. Now it is a world wide movement, people want to become WELL. Desire has developed and credentialed a new Doctorate in Wellness to awaken people and teach the art of making themselves and others WELL. For more details go to the International University at www.imune.net