

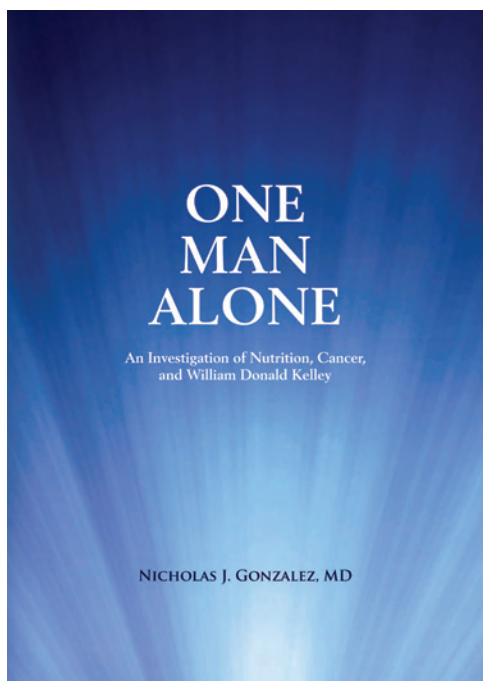


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Excerpt from *One Man Alone: An Investigation of Nutrition, Cancer, and William Donald Kelley* By Nicholas J. Gonzalez, M.D.



In 1971, President Nixon declared a "War on Cancer," and over the subsequent decades the best and the brightest researchers at the National Cancer Institute have spent billions of dollars. The result? According to a recent publication by the American Cancer Society, "Although progress has been made...cancer still accounts for more deaths than heart disease in persons younger than 85 years of age." (CA Cancer J Clin 2009;59:225-249) Direct medical costs of cancer in the US in 2009 were estimated at \$93.2 billion.

While President Nixon was starting his war on cancer, a Texas orthodontist named William Donald Kelley was treating patients with a nutritional program he designed for himself after being diagnosed with terminal cancer. After his unexpected survival, a word-of-mouth network brought him more and more patients until finally, a young medical student, Nicholas Gonzalez, came to investigate his work.

This book describes Dr. Gonzalez's five-year investigation of the nutritional/enzyme cancer treatment developed by Dr. Kelley. The author includes 50 representative case histories of patients diagnosed with a variety of poor prognosis or terminal cancer who did well under Dr. Kelley's care, with copies of the actual relevant medical records to prove the point. Although it was completed in 1986, it was not published until 2010; nonetheless, this monograph generated interest in the alternative and conventional medical world for over two decades.

The following is one of the 50 case histories included in the book. For more information, please visit www.newspringpress.com/oneman.html or see Dr. Gonzalez's website at www.dr-gonzalez.com.

One Man Alone: An Investigation of Nutrition, Cancer, and William Donald Kelley by Nicholas J. Gonzalez, M.D. 8.25 x 11, 520 pages with references and copies of original medical records. ISBN 978-0-9821965-1-9. \$39.95.

Patient #43

Patient #43 is an 81-year-old chiropractor from Arizona, alive 11 years since his diagnosis of metastatic prostatic carcinoma.

In November 1975, Patient #43 first experienced pain in the region of the right shoulder blade that worsened over a several-week period. After consulting his primary doctor, he was referred to an orthopedist. X-ray studies revealed compression fractures in the seventh and eighth thoracic vertebrae, believed to be the result of osteoporosis. At that point, the physician prescribed a number of supportive braces, but informed Patient #43 that nothing more could be done from an orthopedic perspective.

Over the following months, the shoulder pain gradually worsened. Finally, in the spring of 1976, Patient #43 consulted a second physician who discovered, after routine testing, an elevated level of the enzyme alkaline phosphatase—a finding at times associated with bone disease.

Patient #43 was admitted to Nebraska Methodist Hospital on June 2, 1976 for further evaluation. There, laboratory studies revealed an alkaline phosphatase of over 350 (normal less than 180) and an acid phosphatase of 302 (normal 0–10) with a prostatic fraction of 269, results strongly suggesting prostate cancer.

Patient #43 then underwent a needle biopsy of his prostate, which confirmed adenocarcinoma in all specimens. At that point, the bone lesions were thought to be definitely metastatic in origin, and subsequently Patient #43 underwent bilateral orchiectomy (removal of both testes), to reduce his testosterone levels. During the procedure, the surgeon discovered tumor extending into the bladder and subsequent diagnostic studies, including a bone scan, confirmed extensive, stage D-2 metastatic disease, clearly summarized in the records:

Chest x-ray revealed extensive skeletal metastasis . . . Bone scan revealed multiple areas of increased uptake [areas of disease] throughout the skeleton.

While still hospitalized, Patient #43 began oral estrogen therapy and a course of radiation to his spine for pain relief. After his discharge on June 26, 1976, he continued the radiation as an outpatient, but despite the treatment, Patient #43 failed to improve. Then during the second week of July 1976, when his mental status suddenly deteriorated, in a confused, disoriented state, he was readmitted to Nebraska Methodist.

One Man Alone

A thorough evaluation revealed the cancer was growing unchecked, as described in the hospital records:

Chest x-ray revealed wide spread lytic and blastic lesions suggestive of prostatic carcinoma. There has been interval development of bilateral pleural effusions along with some increased markings suggestive of lymphatic metastases since the film of 6-3-76. Films of the thoraco-lumbar spine showed diffuse involvement with metastatic carcinoma with compression of T-7, T-8 [thoracic vertebrae] and slight compression of L-1 [lumbar vertebra] . . . Pathologic rib fractures were described. These were felt related to metastatic disease. X-ray of the pelvis revealed metastatic bony involvement. Films of the sacrum and coccyx again revealed again [sic] metastatic bony involvement . . . Chest x-ray of 7-27 revealed increase in the bilateral pleural fluid. Films of the left hip dated 7-31 revealed no evidence of fracture. Diffuse skeletal metastases were seen. Brain scan was normal. However, an abnormally positive skull or spine lesions [were noted] on the previous bone scan.

Patient #43 completed a second course of “palliative megavoltage external radiation to the lumbar spine.” Eventually, after more than five weeks in the hospital, his pain and mental status improved sufficiently so that he could return home. Nevertheless, when discharged on August 26, 1976 Patient #43’s physicians warned he most probably would not live out the year.

In desperation, Patient #43 decided to investigate unconventional approaches to cancer. In September 1976, he learned of Dr. Kelley, and shortly thereafter began the full nutritional program, at the same time discontinuing hormone medication.

Within several months, all of Patient #43’s symptoms—his bone pain, fatigue, lethargy and malaise—resolved, and he says within two years he felt better than at any time in his life. Today, 11 years after his diagnosis, Patient #43 still follows the Kelley program, reporting excellent health with no sign of his once extensive disease. At age 81, he works part-time as a chiropractor and plays violin in a ragtime band.

Patient #43 is another unusual patient. He was initially diagnosed with widely metastatic prostatic cancer that failed to respond to orchiectomy, radiation, and

a course of estrogen therapy. His condition improved only after he abandoned conventional treatment and began the Kelley program. It seems logical, therefore, to attribute his prolonged survival and current good health to his nutritional protocol.

PATIENT NAME:

Patient #43

ROOM 615



nebraska methodist hospital
8303 dodge street
omaha, nebraska 68114

HOSPITAL NUMBER:

PHYSICIAN:

E. S. [redacted], M.A./R. W. [redacted], M. D.

ADMISSION DATE:

6-3-76

CC: Back pain primarily in the right shoulder.

HPI: Since November of 1975 the patient has complained of right scapular pain, x-rays taken at that time revealed a compression fracture of the T-7 through T-8 vertebrae according to the patient. He denies any incident of trauma. Patient consulted several doctors and had been wearing a number of supportive devices to help with the pain, which would exasperate on movement of the upper extremities. These devices range from a rib belt to a steel brace. However, patient suffered much soreness in the anterior ribs and as intermittently use the braces because of the soreness. Approximately 2 months ago the patient saw and endocrinologist by the name Dr. L. [redacted] in Arizona and the doctor notified the patient that he had an elevated alkaline phosphatase value being approximately 202. Dr. L. [redacted] then told [redacted] the patient, that he should have a urologist see him. Dr. L. [redacted] did do a prostate exam and on examination that the prostate was stony hard however he did not find any gross lesion. He however felt that the patient's symptoms may be secondary to CA of the prostate. At the time of Dr. L. [redacted]'s exam and now the patient has had no GU symptoms. According to the patient, the right scapular pain would at times radiate to the left scapula and sometimes involve the muscles of the upper extremities. He was taking Tandaril 100 mg. for the pain but he denies any relief. In addition yesterday the patient did use Darvon and he claims this has been of no help either.

PMH: Operations:

T & A 1925, appendectomy 1926.

Illnesses:

Patient's childhood illnesses were unremarkable. In adult life he suffered from asthma severely. He did live on a farm, moved to Arizona primarily because of his asthma and there he has had no problems and has taken no meds.

Allergies:

Patient has no known drug or food allergies.

Medications:

Other than the medication Tandaril for pain and the Darvon unremarkable.

RCS: HEENT:

Negative.

Skin:

Negative.

CV:

Negative. He denies any chest pains.

Resp:

Negative.

GI:

Occasional constipation which he relieves with laxative.

GU:

Negative other than that stated in the HPI.

MS:

Unremarkable except for the in the HPI.

Neuro:

Negative.

PH: Patient's father died at the age of 70 of cancer of the pancreas. Patient has a 67 year old sister who is still alive and has diabetes. Patient has never had any children.

SH: This patient is a retired chiropractor presently lives in Arizona. He has never smoked and is a social drinker.

PHYSICAL EXAMINATION:

General:

70 year old white male, 5'4", 141 lbs. Patient was most cooperative, very accurate historian and no acute distress.

HISTORY & PHYSICAL

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PATIENT NAME:

Patient #43

HOSPITAL NUMBER:

PAGE 2

PHYSICIAN:



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Vital signs: Oral temp. 98.2, pulse 62, resp. 16 and regular, BP 164/90 from left arm.

Skin: Patient had numerous senile keratosis of the anterior chest and the posterior chest wall. He also had febrile areas that were slightly raised and erythematous but with scaling. These areas were not tender and seemed to be case of seborrheic dermatitis. Skin turgor was normal.

HEENT: Normal cephalic and without bruits. Eyes clear sclera bilaterally and normal eyegrounds. PERRLA and normal EOMS. Nostrils is unremarkable. Throat revealed slightly hyperemic pharyngeal area, midline uvula, and no gross lesions.

Neck: Not supple. There was some tenderness in the left supraclavicular area, however there were no nodes or masses found. Patient did have somewhat restricted range of movement, and movement would cause exacerbation of his back pain. Thyroid was not palpable. Trachea was midline. Carotids were 2+ on the left side and 1+ on the right side without bruits.

Chest: Patient had rather barrel shaped chest. The lung fields were clear to A and P. There were no wheezes or rales or rhonchi. Axillary nodes were negative and there were no masses found in the chest wall. There was some slight tenderness around the 3rd-5th anterior ribs on the right side.

Heart: Patient had a normal sinus rhythm. PMI was in the 5th intercostal space in the left midclavicular line, there were no murmurs or gallops or rubs.

Abdomen: There is a scar in the lower right quadrant from his appendectomy. The abdomen was rather tender to palpation, he claims he was vomiting several times this morning and that his reason for the abdominal tenderness. There was no organomegaly or masses felt. There was no evidence of distasis of the rectus muscle. Patient did seem to have some left CVA tenderness however.

Genitalia: Normal uncircumcised male.

Rectal: Patient had normal external sphincter tone, with no evidence of external hemorrhoids. Examination of the prostate revealed a rather stony hard prostate without any gross nodules. It could not be perceived if the patient's prostate was enlarged.

Extrem: Radial was 2+ $\frac{1}{4}$ and equal, femoral pulse 1+ $\frac{1}{4}$ and equal, dorsalis pedis not perceived. Patient had normal muscle strength in all extremities. However he seemed to have some limited range of movement in the upper extremities particularly on elevating the hands above the head. There was no evidence of cyanosis, clubbing or edema.

Neuro: Cranial nerves 2 thorough 12 were grossly intact. DTRs were 2+ $\frac{1}{4}$ and equal. Patient had no obvious sensory loss. On the shin to heel test patient had some gross tremor but no pass pointing on the finger to nose test. He had no pathological reflexes such as Babinski or Hoffmann. Gait was rather stiff but steady.

IMPRESSION: Upper right back pain with history of compression fracture of T7 through T-8 possibly secondary to metastatic carcinoma of the prostate.
Stony hard prostate. High BP.

ES/ks 23-89
6-4-76

ERROL S. MA

RONALD W. M. B.

HISTORY & PHYSICAL

HISTORY & PHYSICAL

HISTORY & PHYSICAL

HISTORY & PHYSICAL

JOHN R. S. M.D.
JERALD R. M.D.
MILTON N. M.D.
ROBERT L. M.D.
MARTIN M.D.
THE PATHOLOGY CENTER
OMAHA, NEBRASKA 68114

6-9-76

Patient #43

M 70 615 - 1

Perineal prostatic biopsy. "F"
Right testicle.
Left testicle.

cc: R. W. M.D.

Hal M. M.D.
Omaha, NE

CLINICAL DIAGNOSIS AND HISTORY

Question of carcinoma of prostate.

GROSS DESCRIPTION

The first part, labeled "perineal prostatic needle biopsy", and previously submitted for frozen section with the diagnosis of adenocarcinoma, consists of two firm, gray-tan cylinders of fibrous-appearing tissue, the larger measuring 1.8 x 0.2 cm.

The second part, labeled "left testicle", consists of a soft, smooth, glistening gray-white, 4.5 x 3.2 x 2.8 cm. testicle together with coverings and a 2 cm. segment of spermatic cord with aggregate weight of 38 grams. Sectioning reveals a glistening, homogeneous, soft, tan cut surface from which seminiferous tubules string. Sectioning reveals no obvious lesions.

The third part, labeled "right testicle", consists of an entirely similar-appearing, 4.5 x 3.4 x 2.2 cm. testicle, coverings and section of vas and spermatic cord measuring 1.3 cm. The tunica is smooth and glistening. Sectioning the testis reveals a similar pattern to that noted above. No gross lesions are noted.

MICROSCOPIC DIAGNOSIS

Adenocarcinoma, perineal prostatic needle biopsy.
Oligospermia, mild, right and left testes.

so
ML:p1

John R. S.

PATIENT NAME:

Patient #43

HOSPITAL NUMBER:

PHYSICIAN:

A. F. [REDACTED], M. D.

ADMITTED: 6-2-76

DISCHARGED: 6-26-76

FINAL DIAGNOSIS: Adenocarcinoma of the prostate.

SECONDARY DX: Wide spread bony metastasis.

OPERATION: Prostate needle biopsy and bilateral orchiectomy on 6-8-76.
Biopsy of skin lesions of the back 6-23-76.

History: The patient is a 70 year old white male who has noted back pain since November of 1975. He was treated symptomatically for his complaint. He also developed some pain in his anterior ribs. About 2 months prior to admission the patient was seen by a physician for evaluation of his problems. He was found to have a markedly elevated alkaline phosphatase. The patient is now referred to NMH for evaluation and treatment. On physical examination the lungs were clear to auscultation. There was no evidence of any peripheral adenopathy. No abdominal organomegaly or masses were palpated. On rectal examination the prostate was hard without nodularity. Several reddish, scalling, sharply circumscribed lesions were present on the lower back and right upper chest.

X-ray and lab data: Perineal needle biopsy of the prostate revealed adenocarcinoma. Skin biopsy of back lesions revealed basal cell carcinoma. CBC of 6-4-76 revealed white count of 6,500, hmg. 12.1, hmt. 37. Platelets were normal. BUN 26, glucose 100, TSP 6.3, albumin 3.9, calcium 8.7, phosphorus 3.3, cholesterol 205, uric acid 5.5, creatinine 1.1, total bilirubin 0.6, alkaline phosphatase over 350, SGOT 10. Acid phosphatase 302, normal being 0-10, orotic fraction was 269 normal being 0-4. Chest x-ray revealed extensive skeletal metastasis. IVP revealed prostatic enlargement. Irritability of the calyces consistent with pyelitis was noted. Some nephrolithiasis on the left was seen. An old calcified infarct in the spleen was present. Considerable osteoporosis of the lumbar spine was noted. Right retrograde pyelogram revealed the upper pole calyces of the right kidney to be incompletely filled. The collecting system and ureter showed no intrinsic abnormalities. No calculi are seen along the right ureter. Bone scan revealed multiple areas of increased uptake throughout the skeleton.

Hospital course: During his hospitalization the patient was evaluated regarding the extent of his disease. On 6-8-76 the patient was taken to the operating room where a perineal needle biopsy of the prostate and a bilateral orchiectomy were performed. He was subsequently started on Stilphostrol therapy. Megavoltage external radiation to the dorsal spine for relief of pain was initiated. Circumscribed skin lesions of the back were biopsied and found to be basal cell carcinoma. The diagnosis and treatment of these lesions were under the supervision of Dr. F. [REDACTED]. Patient tolerated his treatment moderately well. He did have some nausea which was treated with antiemetic medication.

Disposition and instructions to patient:

At the time of discharge from the hospital the patient was improved. He will continue to take his



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4138
Pacule/ptd/ptd
R. H. H. H.

26

Patient #43



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PATIENT NAME:

HOSPITAL NUMBER:

A. F. [redacted] M. D.

PHYSICIAN

Admitted: 7-12-76

Discharged: 5-26-76

FINAL DIAGNOSIS: Adenocarcinoma of the prostate with wide spread bony metastases.

SECONDARY DX: None.

OPERATIONS: None.

Patient is a 70 year old white male with a known diagnosis of adenocarcinoma of the prostate with wide spread metastases. Patient is presently undergoing a course of palliative external radiation to the dorsal spine on an outpatient basis. He has been doing well but during the past few days the patient has had trouble speaking especially with articulation of words. He has also had some photophobia along with dizziness. According to his wife the patient may be acting somewhat depressed. He is being admitted to the hospital for further evaluation and treatment. On physical examination patient appeared to be somewhat lethargic and drowsy. There was no evidence of any peripheral adenopathy. Auscultation of the lungs reveals bronchial sounds on expiration. No abdominal organomegaly or masses were palpated. Prostate gland is slightly enlarged and hard.

X-ray and lab data: CBC of 7-12-76 reveals a white count of 4,700, hmg. 10.3, hmt. 31. Platelets were normal. Blood chemistry of 7-12 revealed sodium 136, potassium 4.7, chloride 106, CO2 29, BUN 18, glucose 88, TSP 5.7, albumin 3.3, calcium 7.9, phosphorus 3.9, cholesterol 149, uric acid 4.0, creatinine 0.7, total bilirubin 0.3, alkaline phosphatase over 350, SGOT 15. Protein electrophoresis appeared to be within normal limits. Acid phosphatase was within normal limits. Chest x-ray revealed wide spread lytic and blastic lesions suggestive of prostatic carcinoma. There has been interval development of bilateral pleural effusions along with some increased markings suggestive of lymphatic metastases since the film of 6-3-76. Films of the thoraco-lumbar spine showed diffuse involvement with metastatic carcinoma with compression of T-7, T-8 and slight compression of L1. Degenerative changes at the lumbosacral level were noted. Pathologic rib fractures were described. These were felt related to metastatic disease. X-ray of the pelvis revealed metastatic bony involvement. Films of the sacrum and coccyx again revealed again metastatic bony involvement. Chest x-ray of 7-22 revealed increased infiltrative changes in the left base and increased pleural fluid in the right base. Chest x-ray of 7-27 revealed increase in the bilateral pleural fluid. Films of the left hip dated 7-31 revealed no evidence of fracture. Diffuse skeletal metastases were seen. Brain scan was normal. However an abnormally positive skull or spine lesions on the previous bone scan.

Hospital course: During his hospitalization the patient was treated on palliative megavoltage external radiation to the lumbar spine. The aim of this external radiation was the relief of pain secondary to bony metastases. A work up was undertaken to determine the cause of his dizziness. The brain scan was normal. Surgical curettement of several basal cell carcinomas of his lower back was performed. He was treated with diuretic medication and was noted to have less pitting edema of his legs. The curetted lesions of the lower back healed well. Patient did have some problem with nausea during the course of his treatment but this was symptomatically controlled with antiemetic medication.

Disposition and instruments to patient: At time of dismissal from the hospital the patient appeared to be generally improved. We will continue to follow him on an outpatient basis for

DISCHARGE SUMMARY DISCHARGE SUMMARY DISCHARGE SUMMARY DISCHARGE SUMMARY

PATIENT NAME:

Patient #43

page 2

HOSPITAL NUMBER:

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further evaluation and treatment of his disease.

AF/kw 207-187
11-11-76

Albert F. [redacted] M. D.