Chapter 2: IVC's Sweet Sixteen QOL Enhancing Benefits

In the search for a "Cure-all" why have we neglected a "Care-all"?

Since the 1980s there have been a number of studies to determine the best way to improve the quality of life (QOL) for most cancer patients.

Although this sounds like a positive development, a recent analysis of these BSC (Best Supportive Care) studies found that these analyses were nearly all poorly designed, poorly evaluated and were delivered by physicians who were possibly inadequately skilled or trained for the task [2a] [2b] [2c] [2d]. More disconcerting is that these reports of the dismal state of cancer care research have gone almost entirely unnoticed despite being published in popular and well-respected professional medical journals. Meanwhile, caregiving decisions (ie. decisions made to provide the best care) continue to be made based on these poorly done studies.[2e]

This should concern everyone since the serendipitous similarity between the two words "cure" and "care" underlies a commonality: they are *both* essential to beating cancer. The most effective treatment plan includes *equal* and *simultaneous* curing (removing cancer) and caring (restoring the patient to normal health).

The oncological community has staunchly specified the *cure* for cancer as a rigid series of popular cancer-killing strategies. But "killing cancer" (often euphemistically misnamed "cancer care") is only preparative to the *real care*: restoring the patient to precancerous health which, despite conventional practice, indeed *can* start immediately even simultaneously *with* killing cancer. The simultaneous approach of restoring health (caring) at the same time as killing cancer is something that only the best and most progressive doctors are leveraging, but which is easily available to anyone who will simply follow the recommendations herein.

In fact, true cancer *care* prepares the patient *prior* to conventional cancer treatment, protects patients from harsh side effects and damage *during* the treatment, and *fully* repairs damage from whatever treatment that is employed. Ideally, the practitioner will *simultaneously* repair the damage *in concert* with their cancer killing actions.

Health restoration is the #1 reason *why* patients went to the doctor in the first place. By neglecting this "care-all" approach patients leave the "cancer care center" having received only

50% of the treatment they should receive. In fact, a patient may still be left with undetectable cancer, and thereby they may be worse off given their significantly weakened state after treatment than before.

True Care = QOL. QOL = True Care.

As just mentioned, in most cases “care-plans” are generally euphemisms for getting rid of cancer plus a patchwork of complementary treatments that attempt to address the most common cancer “care” (quality of life) issues. The reality is that “true care” is more than just a euphemism plastered on the side of an oncological center. It’s more than mere smiling faces from upbeat nurses who fluff pillows with encouragement (although that does help with one of the many quality of life issues). “True care” means doing *everything within reason* to impart quality of life (QOL).

These quality of life issues are many … we can probably mention a hundred ranging from great fingernails and hair to feeling spiritually whole. If however we were to boil them all down to some minimalist terms they would fall into categories similar to the following eight:

Energy	Appetite	Infection	Optimism / Morale
Pain	Organ function	Inflammation	Resistance / Immunity

How well do current “care” plans stack up?

A typical modern “care” plan consists of radiation (alleviates pain from tumor-growth), yoga or exercise (helps energy and attitude), counseling and support groups (psychology), and painkillers, and maybe an experimental treatment. IVC by itself is *not* a replacement for this plan, but although this plan is helpful it is severely incomplete and inadequate to address all the quality of life issues on its own in most cancer cases (for some few patients it might be adequate, but even then it can be improved).

Also, some of these treatments, like radiation and some painkillers only improve certain quality of life factors at the expense of other quality of life factors like fatigue, nausea, and slow healing. In fact, many care-specific treatments have a dark side so the play-it-by-ear approach common in “cancer care” is risky, speculative, and potentially harmful ... all symptoms of an old-school purely *reactive-medicine* approach.

Contrast that with a one-kind-fits-all and proactive “*care all”* treatment that is *very* effective improving all the above 8 listed factors, with no negative side-effects or trade offs. Proactively preventing all quality of life problems *upfront* also improves survivability and resistance to residual undetected cancers. So much so that this new approach really should be intrinsic and essential to the cure, rather than being considered merely “adjunctive”, “complementary” or “optional” as is usually believed.

Indeed, a “care-all” would help empower weak and battle-worn patients to beat cancer. Even strong patients deserve such a cancer “care-all”, if such a thing existed.

IVC … the Care-All.

There is no other treatment that has demonstrated consistently as many modalities of efficacy as does IVC in the treatment of patients with diseases (and not just cancer). Note that above we boiled down the QOL factors down to eight …and IVC helps all eight, some on multiple fronts (which is why it’s called sweet 16 below, and not sweet 8).

In fact, there are *far more* than sixteen modalities of efficacy, but in order to be memorable and to not boggle the mind too much let’s focus on just 16 qualities of life.

Now oddly enough, using quality of life as a cancer-fighting strategy in the treatment of cancer is a relatively new thing … and in fact many oncologists as a rule still do not consider the improvement of quality of life as an essential part of a good cancer-fighting strategy. It’s just something they might facilitate (like giving pain-killers) because apparently they’re nice people.

So before we even go into these sweet-16 let’s investigate whether increased QOL also increases cancer survival.

A Disruptive Principle: Pain Relief Extends Survival Time

A recent analysis of roughly 4493 patients over a 4-year period showed an **average survival time extension of 5%-10% for pancreatic cancer patients when treatment was suspended and they only received hospice (palliative) care**, which consisted mostly of eliminating pain and complete cessation of cancer-fighting efforts.[2f] Note that in this study IVC wasn't part of the care. In fact IVC mediated survival statistics can be far more impressive as shown in subsequent chapters. The point being made here is that palliative care (merely improving quality of life) extends life.

This observation that mere hospice care improved survival time was a surprising finding for most doctors who, as admitted in the published study, assumed that (in the words of the authors) *“medications used to alleviate symptoms may hasten death in hospice patients”*. Instead, the study demonstrated to the astonishment of the researchers that *“hospice is associated with longer survival times”.*[2f]

Putting Money Where Your Care Is

This is a very noteworthy finding since end-stage terminal cancer patients often turn to extremely expensive (up to $10,000 / month) oral chemo drugs that are justified by extending survival also to 10% to 15%, which is close to the same survival extent as observed when on palliative care (compared to conventional treatment). It causes one to wonder if those

expensive oral chemo drugs were doing much since those patients are also on the same palliative treatment plan besides receiving the expensive drugs (was part of the extension due to palliative care?). Also, if patients are spending that kind of money (insurance will often not cover it), what else are they affording that the typical cancer patient can't afford? Considering the financial incentives and research costs behind those drugs… how sure can one be that all other things are really equal?

More importantly if similar extended survival is possible through palliative effects of IVC (with myriads of other benefits), for 1/10th of the oral chemo cost, and also escape the nausea / vomiting and bowel complications of oral chemo,[2g] then IVC seems a far more propitious route (or at least as an essential integration). In fact, as described in the next Chapter, the life extension due to *proper* IVC use has been found to be far greater (demonstrated up to a 4X extension in survival time in one study and 5.7X in another)[5ad] [3.3r] than what is experienced with oral chemo which costs 10 times more, and destroys stomachs. So why doesn't IVC get at least comparable support from oncologists? Note this is not intended to be a critique on the oncological community, and it is getting off-topic … but these are important questions.

Again, it is noteworthy from the published study that many oncologists wrongly assumed that palliative care might decrease survivability, which helps explain why some might unwittingly discourage IVC since they know of its palliative effects.

Broad Agreement About IVC's Palliative Effects

Even among the detractors of IVC there is broad agreement that IVC improves an astonishing number of quality of life (QOL) factors such as pain management, appetite, emotional well-being, and energy, as well as the only way to have vitamin C rich blood (cancer patient blood is otherwise always vitamin-C deficient[1c]). In total there are at least 16 or more palliative effects for those who are on IVC (and not just cancer patients):

Palliative Benefits of IVC

"Palliative Benefits of IVC" in the appendix, or http://ivcbook.com/ebooks/PalliativebenefitsofIVC.pdf

- less pain
- less dizziness
- less fatigue*
- better appetite
- physical function
- better sleep
- less nausea
- less vomiting
- less bleeding
- less fever
- less anxiety
- better cognition
- sense of well-being
- improved mood
- easier to breathe
- better bowel function

* note: fatigue is significantly reduced overall during non-IVC days, but temporarily often occurs during the treatment itself.

Since there is broad consensus that IVC improves QOL ... the question must be asked: can those ameliorating effects just mentioned be entirely responsible for its purported efficacy against cancer? It's true that patients fight cancer better when they're happy, energetic, and in prime cancer-fighting condition. So the idea does appear to have some merit.

See the table, below, for a summary of IVC's palliative benefits from 12 different QOL studies done around the world. See the appendix entry "Palliative Benefits of IVC" for a more complete discussion.

Study	Sample Size	Dose		QOL		
		IVC	Oral	Increased	Decreased	Notes
Germany [2j]	53 IVC / 72 Control	7.5g, 1x/week		Appetite, Rest	Nausea, fatigue, depression, dizziness, bleeding, complaints	
Korea [2j]	39 Terminal Patients	2*10g, 3x/week	4g daily	QOL: Physical, Cognitive, Emotional	Fatigue, Nausea/Vomiting, Pain, appetite loss	QLQ-C30 questionnaire
China [2k]	44 IVC / 40 Control	10g/day for 5 days		Recovery (shorter hospital stay)	Fever, Vomiting (disappeared), Complication rate	For pancreatitis, not cancer, but this often leads to pancreatic cancer
Japan [2l]	60 Newly Diagnosed	25g – 100g 2x wkly for 4 wks	2-4g Daily	QOL: Physical & role function; emotional, cognitive & social	Fatigue, nausea, vomiting, pain, dyspnea, insomnia, appetite loss, constipation, diarrhea	Average 38% QOL improvement (QLQ-C30 questionnaire)
Canada [2m]	24 Patients	0.1-1.5g 3x/wk	1g.C+80 0 IU vit E	Only the higher IVC doses "maintained their physical quality of life throughout the trial"		
With Chemo [2n]	27 Ovarian, Stages 3,4	75 to 105 grams, w/ chemo		Energy level, survival time (by 8.75 months)	Chemotherapy toxic effects, improvement in all std QOL issues	Improvement areas: neurological, bone marrow, hepatobiliary/pancreatic, renal/genitourinary, pulmonary, infection, gastrointestinal, and dermatological
Case Studies [2o]	multiple, with chemo	30g-50g, 2/wk		same as Korea, Japan above	same as Korea, Japan above	QLQ-C30, "complete cessation of pain, nausea/vomiting, and insomnia"
Riordan [2p] [2q]	40,000+ treatments	65g, 3x/week	4g daily	"sense of well-being"	Pain	Improved QOL "by a variety of metrics"
Max Dose [1j]	17 Terminal Patients	60-200g, 4X/wk		Improvement in all standard QOL factors except constipation (no change), the greatest improvement occurring in week 4. All doses were well tolerated [including 200g].		
Turkey [2s]	15 IVC-only / 15 chemo / 9 control	2.5 g. 2x/week	12g C daily	Functional improvement observed in ¼ of IVC patients compared to 1/15 for chemo, and 0 for control. 50% less pain for IVC group only, 10 month median survival IVC, 2 month median survival all others.		
W/ Surgery [2t]	97 Patients	50mg/kg w/ surgery		Statistically significant decrease in pain and morphine use compared to standard. Note this is a very low dose, about 3 grams … corresponds with what is possible with megadose oral consumption.		
A Hoffer [2u]	101 IVC / 33 Control	2.5g, 2x/week	12g C & multivit.	"A lot more cheerful … less discomfort, less pain, less anxiety"		
Scotland [2v]	5 IVC / 100+ Control	10g/daily		The first study on IVC, Pain from tumoral growth is diminished enough to discontinue morphine		

(See appendix: Palliative Benefits of IVC, or http://ivcbook.com/ebooks/PalliativebenefitsofIVC.pdf for details.)

The QOL findings noted above are *not* isolated observations among a larger population of similar studies. In fact these are *all* the known studies which investigated palliative effects of IVC. These IVC Quality of Life studies span the globe with an accumulated population of at least 618 closely studied subjects for which detailed QOL measurements were made.

Of course, that number (618 patients) doesn't include Riordan's report in the table where they summarize the observations of over 40,000 IVC treatments given.

Decreased pain is specifically mentioned by name in almost all the studies, as are metrics related to appetite, digestion, and bowel functioning. Same with energy, and psychological factors such as 'sense of wellness', emotional and social functioning, and cheerfulness … these observations are *common* among most of the studies.

Note that increased energy is not always apparent during the administration. In fact the patient should hope to increase their dose to a point where they are stretching their tolerance … often this is with respect to fatigue, which is the most common side effect. The fatigue goes away after administration and overall they feel greater energy during the non-IVC days that they do otherwise.

In some of the studies only some of the QOL factors are mentioned, but there are no opposing observations in any of the 12 studies. **Additionally, no studies have ever been done that have contradicted the QOL findings in these 12 studies**.

Statistical significance is the measuring stick whereby efficacy is determined. That significance increases when the results are reproduced under widely different circumstances, as is the case here.

While under independent evaluation, this correlation between QOL and IVC for any one of these studies might be related to some unaccounted / unrecorded factor, but the disparate testing conditions from each study suggest that no such factor exists.

These two factors: (1) the disparate test conditions of the correlating studies, and (2) the comprehensive inclusion of all such studies ever done, are two invaluable factors that "systematic medical reviews", such as those done by the Cochrane Collaboration, rarely if ever consider. Instead, they (and other medical-study review boards) seem to consider each study independently as if it were the only study done in the world, but were they to take those 2 factors with regards to IVC and QOL, their review would validate and in fact should substantially magnify the confidence in the QOL enriching abilities of IVC.

Simply put, all the data demonstrates there is nothing that comes close to improving so many Quality of Life issues for cancer patients.