# Q&As

# Prostate Health – The Updated Pfeifer Protocol

By Professor Ben L. Pfeifer

### 1. What is the view on removal safely of mercury dental amalgam fillings in terms of heavy metals?

Integrative Cancer Care physicians recommend the safe removal of all amalgam fillings in our cancer prevention programme, as well as for patients with established cancers prior to starting our integrative treatment protocols. We recommend special dentist clinics, who have experience in the safe removal of amalgam fillings.

### 2. I have read somewhere that this therapy is not suitable for people who have had radiotherapy.

In the contrary, we have shown that ProstaSol is sensitising prostate cancer cells towards radiation damage. That is the reason for us to recommend ProstaSol to all patients with prostate cancer who opt for any form of radiation treatment, be it with curative intent, or in the palliative setting. We have seen, however, that prostate cancer patients who enter out protocol after prior heavy radiation treatment (for example "blind" radiation of the prostate bed and pelvic lymph node stations for biochemical recurrence after radical prostatectomy) often have less favourable disease courses compared with those who did not have this type of radiation. We know that those patient's NK cell activity is depressed, and their lymphocyte count often low for many months after the radiation therapy. Our protocols still work, but take longer for cancer control and usually higher dosages of the various medications used.

### 3. I thought Prostasol was withdrawn as it was estrogenic? Is this a different formula?

ProstaSol was never withdrawn. There was a raw material contamination in 2006, when raw material was still sourced from the USA. This was corrected together with the help of the Dutch Health Authorities in 2006. Since then, there was never again any contamination problem. As a matter of fact, ProstaSol has been tested several times during the last decade by us in independent laboratories outside the Netherlands and we never found anything else in the product than stated on the label. Be aware of many fake products with the same name. I even have found ProstaSol here in Indonesia with the same label claims that certainly has never seen Holland or any other European manufacturing site…

## 4. May the product Detox me+ clear the liver from Al nanoparticles?

We have not tested this in vivo, but I refer to my answer to question number 5.

## 5. Can the product remove Al?

Bioavailable free aluminium (Al) cations pose a serious problem for human health and are increasing in our environment due to industrial development. Although, our DETOX me+ contains aluminium and silica in a tetrahedral alumosilicate framework, it does not liberate Al into the patient when taken orally. Al does neither enter the patients' blood stream, nor will it be accumulated in the patient, even after long-term and high-dose treatment. In the contrary, DETOX me+, as other clinoptilolites with a high silica (Si) content, is expected to remove free Al from the patient. We have not specifically proven this property, for DETOX me+, but there is scientific evidence for clinoptilolites to efficiently remove aluminium from aluminium chloride intoxicated rats in vivo. Furthermore, it is known that DETOX me+ releases some silica of its framework, which in its dissolved form is able to bind and remove Al from the human body (Buffoli et al., 2013; Davenward et al., 2013), and this Si and Al relation has been recognized as the main evolutionary mechanism for fighting ecotoxicity of aluminium in living organisms.
DETOX me+ is rather stable in acids, hence it is not significantly changing its physical or chemical properties when passing through the stomach. DETOX me+ has been shown to remove aflatoxins, zearalenone, ochratoxin by adsorption of these harmful substances in the GI-tract. It also removes radio-active isotopes, ammonia, and various organophosphates. DETOX me+ does not affect the homeostasis of micronutrients and trace elements but rather acts selectively on heavy-metals and toxicants.

## 6. Is Detox me+ suitable for breast cancer?

Absolutely. We use this versatile compound for all our cancer patients, independent on cancer type. We also recommend DETOX me+ to family members and friends of our patients who embark on our cancer prevention programmes. It is easy to use, totally non-toxic and very effective in removing various toxins, heavy metals, and pesticides. Our recommendation for cancer patients is a 2-month treatment with 1 sachet per day, followed by 1 months OFF. And then, they repeat the cycle. As a cancer preventive measure, we recommend 1 months of treatment followed by 2 months OFF and repeating the cycle. However, our recommendations are also dependent on the individual levels of heavy metal concentrations measured in blood and urine.

## 7. Is Prostasol suitable for use after medical management of prostate cancer?

Yes, it is. Many men have asked this question. Considering the very high recurrence rate of almost 50% after the so called "GOLD STANDARD" curative treatments such as radical prostatectomy or various forms of radiation treatment, it is wise to start with ProstaSol about 2 to 3 weeks prior to those treatments and then continue with ProstaSol for 6 to 12 months. If there is R1 resection in the pathology report after radical prostatectomy or indications for seminal vessel involvement for prostate capsule infiltration we usually recommend our extended treatment programme for 12 to 18 months post definitive treatment.

## 8. What specific DNA mutations are tested?

For our "Designer Peptide Tumour Vaccination Programme" we look at mutations in the entire tumour cell genome by comparing next generation DNA sequencing data of healthy white blood cells with next generation DNA sequencing data of the tumour cell. If the participant who asked this question, would like to get more detailed information on this vaccination protocol, I will be glad to provide it on a personal basis. Please send me an email: bpf@integrative-cancer-care.com

## 9. What would the protocol be for BPH? Can the prostate be shrunk?

For BPH with lower urinary tract symptoms, we would start with IMUPROS (1 to 2 tablets a day) and ProstaLin-C (3x1 capsule per day). If this does not provide sufficient symptom relief within 2 to 3 months' time, then we would add our high dose phytosterol complex combined with a patented Serenoa repens extract. The new product is presently still made by our compounding pharmacy for an individual patient, but we are in the last stage of testing and I believe that a commercial product will soon be available.

## 10. Would you recommend a similar protocol for bladder cancer or ovarian cancer?

Yes, I would. The general principle of our treatment protocol for urothelial cancers is the same: Life-style choice correction, stress rehabilitation and relaxation, anti-oxidation, anti-inflammation, anti-angiogenesis measures, specific phytotherapy and immune support as well as immune modulation.
The individual protocol components will differ from the treatment protocol outlined for metastatic and castration resistant prostate cancer, but the general goal and targets are the same.

## 11. To what extent is your protocol available on the NHS & if not how can this be made available on an equitable basis?

Our protocols are not available on the NHS level. Patients will have to pay directly for medication and medical services rendered.

## 12. What are the professor's thoughts on HOLEP surgery? I have a patient that is about to have the surgery but would prefer to have something less evasive. There doesn't seem to be much evidence on whether the alternatives work. He has contacted the Prostate Society and they don't seem to know much about the alternatives.

Holmium laser enucleation of the prostate (*HoLEP*) is a treatment for men with benign prostatic hyperplasia (BPH). This treatment method has several advantages over other surgical approaches. It can be used in prostates of any size; it also has a much lower retreatment rate compared with the traditional TURP. The chance for erectile dysfunction post treatment is very low (approaching ZERO). However, no medical procedure is side effect free. The most common side effects of HoLEP are temporary burning and bleeding upon urination as well as urinary incontinence for the first few days and may last for some weeks. Since I do not know the specific situation of your patient, I am unable to make any recommendations. However, I assume that his urologists have been carefully weighing the proposed surgery against other treatment options for him.

## 13. An obvious one, as I am assuming this will be discussed. Can the enlargement be shrunk without surgery?

Yes, there are several medications that can improve lower urinary tract symptoms (LUTS) in men with benign prostatic hypertrophy. Alpha Blocker (Tamsolusin), 5-alpha-reductase-inhibitors (Finasteride), anti-cholinergic drugs (Detrol), beta-3-adrenoceptor agonists (Myrbetriq), phospodiesterase type 5 inhibitors (Viagra, Cialis) – are all useful drugs, however, they also come with a myriad of side effects.
We have seen 80% of men discontinue the treatment with the above-mentioned drugs, due to various side effects. We usually recommend IMURPSO and ProstaLin-C as 'first-line' treatment. If the urinary symptoms are not improving within 2 to 3 months of treatment, then we would add our new compound that combines high dose phytosterols with full extract of serenoa repens (see also answer number 9).

## 14. I wondered if Cimetidine taken alongside Biobran could increase the effectiveness of Biobran as Cimetidine is known to reduce TH2 immunity?

Theoretically, this might happen. However, there also is evidence that treatment with cimetidine in cell cultures in a dose range from 0.3 to 30.0 micrograms/ml will suppress NK cell activity of PBL probably due to reduced IFN production by leukocytes. That is our reason not to combine cimetidine with BioBran routinely. However, we might use cimetidine in patients with high cell count of T-regulatory cells. I have looked also in the presently available literature of BioBran use in vivo and have not found anybody that has recommended parallel treatment with Cimetidine & BioBran.

## 15. What are your thoughts on the emerging thoughts that antioxidants are counterproductive with cancer? Antioxidants and Cancer - Should I take them? - Care Oncology US

This indeed is a question and topic that has kept a heated discussion between conventional oncologist and alternative / complementary oncology practitioners alive for decades. Some studies suggest taking antioxidants supplements during chemotherapy and radiation treatment may be beneficial, others tell us that the antioxidant intake during these treatments is harmful.
It is even suggested that prevention efforts with antioxidant supplements is harmful.
As for the use of antioxidants during chemo/radiation therapy, the basis of controversy is the fact that many chemotherapy drugs and radiation therapy work by generating reactive oxygen species that are indiscriminately damaging DNA in normal and cancerous cells. The argument is that if you're taking antioxidants to reduce oxidative stress, then you may reduce the efficacy of the chemotherapy or radiation treatment to kill cancer cells.
Although, theoretically possible, this cannot be clearly deducted from any of the large studies that have been published to resolve this discourse. In my opinion, there are simply too many other confounding factors in all these studies to conclude that the intake of antioxidant supplements will lower the efficacy of chemotherapy and radiation and increase the patients risk for treatment failure. First, one certainly must differentiate whether antioxidants are taken concurrently with chemotherapy, or after chemotherapy, in a time-delayed fashion and according to the pharmacokinetics of the respective chemotherapy drugs. Secondly, the dose of the respective antioxidants will certainly play a role with respect to counteracting ROS species, but several studies do not take daily intake dosage into considerations, but still conclude that antioxidants are harmful for cancer patients under chemotherapy and radiation treatment.

Thirdly, most studies were not concerned with the fact that every tumour is unique, and the role of reactive oxygen species (ROS) and antioxidants can differ depending on hereditary, epigenetic, and environmental variations. In our experience, antioxidation is one pillar in our treatment protocols for patients with stage IV cancer that we do not want to miss.

https://journals.sagepub.com/doi/10.1177/1534735415610427
https://www.intechopen.com/online-first/the-two-sides-of-dietary-antioxidants-in-cancertherapy
https://pubmed.ncbi.nlm.nih.gov/26503419/
https://www.swog.org/news-events/news/2019/12/19/antioxidant-use-during-chemo-risky

## 16. Do you do any pulsing of your protocol?

I do not know what this question refers to. However, I can tell you that we do "pulsing" with various antigens during the process of cell-culturing for our dendritic cell vaccines. We also use a "pulsed" treatment approach for many of our patients, which means that we have ON-treatment periods that are followed by OFF-treatment periods. This has many reasons, from retaining longer efficacy to reducing possible side effects to providing time for receptor systems to recover and become sensitive again to the treatment intervention.

## 17. Do you consider the inclusion of repurposed drugs with your protocol?

Yes, we have several repurposed drugs in use for selected patients. These are:

- Syrosingopine and metformin as combination
- 2-DG
- Diamox
- Amiloride
- Lansoprazole

## 18. Have you had any cooperation from oncologists with your protocol enabling hormone therapy to be used intermittently?

Yes. We are working together with many oncologists on all continents and can confirm that over the years, collaboration has clearly improved. This improvement is associated with proof of efficacy and avoidance of serious side effects with our protocols.

## 19. Can we have the name of the antihypertensive the professor just mentioned? I'm not familiar with that.

Yes. The name is Syrosingopine. It was registered in Europe and the US for many years. It might still be registered in several European countries, since some of our patients are getting the cost for this compound reimbursed by their insurance. A research group from University of Basel, Switzerland has published some ground-breaking work for the combination use of Syrosingopine and metformin for leukaemia and other cancers. Please check out the following links:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5182053/

https://healthcare-in-europe.com/en/news/treating-cancer-with-drugs-for-diabeteshypertension.html

https://www.sciencedaily.com/releases/2018/12/181211113024.htm

Unfortunately, Syrosingopine is no longer available commercially in Europe. Therefore, we were forced to manufacture it ourselves from rather expensive raw material for our patients.