

**Oncothermia activity and case reports in Clifford Hospital,  
Panyu, Guangzhou, China**

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Clifford hospital is an eminent private medical center in China. It was founded in 2001 by Professor Dr. Clifford Pang. It is the first hospital in China accredited by [Joint Commission International](#) (JCI), and yearly reaccredited as well as it has been awarded China's Level A Tertiary Hospital.

Clifford Hospital covers an area of 90,000 square meters and has the capacity of 600 inpatients, and its enlargement to over 2,000 in-patient capacity is in progress, giving an enormous medical facility for Chinese and foreign patients. Presently it serves 3,000 outpatients per day, and its capacity will be extended remarkable anticipated to increase to 12,000 daily ambulance services. The hospital accepts both Chinese patients and patients from foreign countries, such as the US, Canada, Malaysia, India and the Philippines. It has more than 40 clinical departments, and equipped with the latest medical technology for diagnostics and curative applications. Oncotherm is proud to have more than 10 years working cooperation with Prof. Pang and with his medical complexes.

The Clifford Hospital is eminent not only for their excellent results but due to their research and eager to have the complex integrative approach of personalized medicine with top level of state-of-art knowledge of the international medicine and clinical practice. They amalgamate the high-level traditional medical knowledge with the most modern availabilities, providing the best processes and personalized attention for their patients in all the fields of the medical care.

Their results are frequently reported at conferences and published in scientific journals. The book written by Prof. Pang [1] became one of the reference-books of hyperthermia in oncology. Prof. Pang leads clinical trials like [2], and publishes it in international cooperation, [3]. His other papers [4], [5], [6] clearly show how effectively they cure even complicated and sometimes hopeless cases with the combination of the Traditional Chinese Medicine and modern Western Medical Processes. Prof. Pang does not satisfy with the local control of malignant diseases, but takes emphases on the elongation of the survival time together with the quality of life of the cancer-patients.

The below published case-reports well represent the dynamism and success of the professional staff of Clifford Hospital to cure cancer with oncothermia method. This publication could produce a valuable collection for the medical staff working with oncothermia worldwide. I hope, this shared knowledge will help for physicians and patients reaching the best available result of the curative processes.

## **Allergy asthma**

### **Z1, male, 38 years old.**

The patient had allergy asthma for about 10 years with outbreaks every winter and spring. After 12 sessions of wholebody high temperature hyperthermia (38–40.5°C/2-4 hrs), there was no recurrence for one year, gained weight and obvious improvement of general condition was seen.

## **Benign prostatic hypertrophy (BPH)**

### **F1, male, 87 years old.**

The patient had benign prostatic hypertrophy (BPH) for about 30 years with urination dysfunction. There was no improvement after medication for several years. He could not receive operation due to heart diseases, diabetes and other systemic diseases. Urination only can be made by installation of a catheter. The result is normal urination after one course of local Radiofrequency hyperthermia treatment. The catheter was removed.

### **H1, male, 81 years old.**

The patient had benign prostatic hypertrophy (BPH) for nearly 20 years with difficulty in urination and chronic nephrosis. A bladder fistula was inserted. The symptom of prostatic hypertrophy was obviously improved after 15 local RF-hyperthermia treatments, CT showed that the diameter of prostate cancer diminished by 2 cm, urination returned to normal. The fistula was removed. The patient leads a normal life.

## **Bladder Cancer**

### **K1, male, 62 years old.**

The patient underwent bladder cancer electrocision 2 months ago and was admitted with hematuria for 1 day on July 15, 2013. A bladder mass was found during a health checkup in April 2013. A B-mode ultrasound scan of urinary system in Guangdong General Hospital revealed an iso-echogenic area, measuring 1.5cm×0.6cm in size and further examination suggested; and prostatic hyperplasia. On April 24, 2013, he was admitted to Guang General Hospital and received a series of assistant examinations. On April 28, 2013, transurethral resection of bladder lesion was performed smoothly and postoperative recovery went well. Postoperative pathology result was consistent with bladder cancer (pathology type and staging unknown). On May 2, 2013, the patient started weekly bladder instillation chemotherapy with Pirarubicin. Minor post-chemotherapy hematuria was noted and relieved without special treatment. He didn't experience any discomfort. On June 20, he received a follow-up cystoscopy and a biopsy test, revealing a negative result. Chemotherapy was then discontinued. At about 6 o'clock on the day of admission, he developed sudden fresh red blood in urine with minor blood clot accompanied by frequent, urgent urination and pain in urethral orifice.

He was then transferred to Urology Dept. After the transfer, his urinary catheter was found to be blocked and could not be unblocked by repeated flushing. As preoperative examinations showed no contraindication, he underwent transurethral bladder blood clot extraction. During the procedure, blood clot in large amount was seen and estimated blood loss was 1000 ml. Repeated irrigation and negative pressure suction were used to extract blood clot. Bleeding points were identified at trigone and left posterior wall of bladder. Following the procedure, treatments were administered for bleeding stoppage, fluid replacement, and anti-infection. At 11:30 am, July 18, 2013, the patient developed bladder bleeding and repeated flushing unblocked the urinary catheter. He was not responsive to verbal stimuli and presented with cold and wet extremities and BP 60/30mmHg at 12:55, suggestive of hemorrhagic shock resulting from bladder hemorrhage. Emergency treatment was provided, including rapid blood transfusion and fluid replacement. The BP measured 110/70mmHg at 13:10, indicating a successful emergency care outcome. When being stable, the patient was transferred back to Oncology Dept. on August 15, 2013. On August 24, 2013, urine culture test result was positive. The patient's urodynia subsided following the use of Imipenem and Cilastatin Sodium for Injection. Hyperthermic intravesical chemotherapy with mitomycin was provided on August 21 and 28 and September 4 and 11, 2013 respectively. The chemotherapy went well and he was discharged with an improvement after 60 days of stay as an inpatient.

**Diagnosis:** Status post bladder cancer electrocision.

**Integrative treatment plan:** Cystoscopy revealed no evidence of tumor or neoplasm on October 13, November 12, and December 12, 2013 and January 13 and June 18, 2014 respectively. With contraindication for chemotherapy excluded, the 12<sup>th</sup>, 13<sup>th</sup>, 14<sup>th</sup>, 15<sup>th</sup>, 16<sup>th</sup>, 17<sup>th</sup>, 18<sup>th</sup>, 19<sup>th</sup>, and 20<sup>th</sup> hyperthermic intravesical chemotherapy with mitomycin was successfully performed on Jan.13, Feb. 18, Mar.19, Apr. 15, May 16, Jun. 18, Jul. 16, Aug. 14, and Sept. 17 respectively. In addition, daily systematic biofeedback therapy and medical ozone were administered to boost immunity and healthy Qi and inhibit tumor. Traditional Chinese medicine was also provided based on syndrome differentiation.

**Treatment outcome:** The patient complied with outpatient and inpatient follow-ups. The follow-ups in the last 2 years showed he was in the course of recovery. Male tumor markers (5 items) on March 16, 2015 were unremarkable. Pelvic MR showed status post bladder cancer resection and chemotherapy and similar findings compared with those on September 15, 2014. On March 17, 2015, a transurethral cystoscopy revealed 2 mushroom-shaped masses at the neck and trigone of bladder. The masses protruded from bladder's mucous membrane and shared similar color with adjacent tissue. Bilateral urethral opening was unremarkable. A mushroom-shaped mass was sampled for pathology testing. The result reported minor fibrous connective tissue.

Follow-up examinations in June, 2016 showed no sign of cancer relapse. The patient is completely normal at present.

### **L1, born in 1947, Guangzhou citizen.**

The patient was diagnosed with bladder cancer in December 2008 but presented with no bloody urine. After completing related examinations in our hospital, the patient underwent a transurethral resection of bladder tumor under epidural anesthesia on December 15, 2008. The procedure was successful. Mitomycin of 20mg was administered by intervesical instillation. Postoperative pathological analysis revealed bladder transitional cell carcinoma, stage I-II. The patient was transferred to Oncology Department.

**Conditions on admission:** The patient felt foreign body sensation of throat, with intermittent cough but no phlegm. He has always been sensitive to cold. There were no chills, fever, dizziness, headache, chest tightness, chest pain, nausea, vomiting, frequent urination, urgent urination or bloody urination. The tongue was light red with thin white coating. The pulse was thready.

**Physical examination:** There was tenderness at the lower abdomen, without rebound tenderness. No sign of tenderness over hepatic region. Hepatic dullness was normal. Liver and spleen were not palpable. Murphy sign (-), shifting dullness (-). No tenderness or percussion-elicited pain was noted on renal regions. Bowel sounds were normal, without vascular bruit.

**Assistant examination:** Postoperative pathological analysis revealed bladder transitional cell carcinoma, stage I-II.

**Diagnosis:** Bladder transitional cell carcinoma, stage I-II.

**Integrative treatment plan:** Completing cystoscopy after admission, the patient received fluid supplement intravenously and traditional Chinese medicine and acupuncture. In TCM treatment plan, this senile patient lost vital qi when suffering serious illness. Kidney-yang is the most vital yang essence in the body. Insufficiency of kidney-yang could not strengthen the exterior so that the patient was sensitive to cold. Tongue and pharynx located between kidney Channels of Foot-Shaoyin. Since there is kidney qi insufficiency, discomfort in pharynx and throat is induced. Withal, tongue and pulse expressed insufficiency of the kidney-yang.

With a method of warming and invigorating kidney yang, Jinkui Shenqi Wan was adopted orally. Three doses of the detailed prescription included Radix Rehmanniae Preparata (Shu Di Huang) 18g, Fructus Corni (Shan Zhu Yu) 18g, Rhizoma Dioscoreae (Shan Yao) 18g, Cortex Moutan (Mu Dan Pi) 12g, Poria (Fu Ling) 30g, Herba Cistanche (Rou Cong Rong) 15g, Semen Cuscutae (Tu Si Zi) 18g, Rhizoma Alismatis (Ze Xie) 12g, Cortex Cinnamomi (Rou Gui) 6g, and Radix Aconiti Lateralis Praeparata (Fu Zi) 5g. One dose of the listed herbs was decocted with water for oral administration once daily. Treatment with acupuncture: The acupoints of BL 13, LU

1, LU 5, ST 36, LI 11, ST 40, SP 10, LR 3, SP 3 were selected for acupuncture with mild reinforcing and attenuating method, with the needle remained for 20minutes, once a day, and a 2-day interval after 5 needling sessions. Nutritionist instructed body conditioning with herbal cuisine. Local endogenous hyperthermia was given once weekly in combination with bladder hyperthermic intravesical chemotherapy with Mitomycin (30mg) once weekly. Chemotherapy was changed into once monthly with Pharmorubicin RD (30mg) after 12 times bladder hyperthermic intravesical chemotherapy continuously.

**Treatment outcome:** Cystoscopy and CT scan performed in Clifford Hospital revealed unremarkable findings and no recurrence in March and July 2009, May 2010, and February 2011.

Laboratory findings in inpatient dept. in August 2012:

Interleukin 6: 44.30pg/ml

T lymphocyte subset analysis:

CD3+T cell/lymphocyte	32%
CD3+CD4+T cell/lymphocyte	16%
CD3+CD8+T cell/lymphocyte	13%
NK cell/lymphocyte	64%

Cystoscopy revealed no tumor recurrence in the bladder.

The patient returned for follow-up examinations in October 2013. Laboratory study showed normal results including whole blood count, biochemical test, urine and stool analyses, and no remarkable abnormality in pelvic MRI.

He has survived for 7 years and fully recovered.

## **L2, female, 72 years old.**

The patient was admitted with “a two-day history of frequent, urgent and painful urination” on February 24, 2011. Two weeks before admission, the patient presented with unexplained frequent, urgent and painful urination, especially during daytime. But she denied macroscopic hematuria, difficulty urination, cough, sore throat, fever or lumbar pain. Urine analysis in other hospital revealed “WBC +++, RBC +”. She took some oral medication (name and dosage unknown) but gained no improvement. Therefore, she presented to Clifford Hospital. B-mode ultrasound at Outpatient Department revealed “hypoechoic structures in bilateral kidneys, suspicious of small cysts; multiple space-occupying lesions in the bladder, suspicious of tumor”. Further examination was suggested.

The patient stated a healthy history.

A contrast CT scan of the middle and lower abdomen after admission revealed:

1. Multiple nodules in the bladder, suggestive of possible bladder cancer.
2. Multiple small cysts in bilateral kidneys.
3. Multiple small cysts in the liver.

Cystoscopy report:

The scope was smoothly inserted. Mucosa of the bladder was smooth. Bilateral ureteral orifices were normal, with clear ureteral jet. Cauliflower-like neoplasms with peduncles of various sizes were noted in the dome, right trigone (1.5cm away from the ureteral orifice) of the bladder and left side of internal urethral orifice. Those tumors were about 2×2cm, 2×1cm and 1×1cm, without bleeding, necrosis or erosion on their surfaces. Congestion was seen in the trigone and base of the bladder, with follicular hyperplasia noted. Pathological diagnoses were consistent with transitional cell papilloma and chronic mucosa inflammation.

In a joint consultation on March 1, 2011, oncologists suggested the greatest possibility of bladder cancer and total cystectomy which was rejected by the patient. The alternative plan suggested included a “partial cystoectomy” and bladder instillation chemotherapy, medical ozone therapy, chelation and hyperthermia therapy after surgery. Because the patient refused “total cystectomy”, a “transurethral resection of bladder tumor” under combined spinal and epidural anesthesia was performed on March 3, 2011. Postoperative pathology report was consistent with low-grade invasive urothelial carcinoma.

Dr. Yao Yousheng, head of Urology Department of Sun Yat-sen Memorial Hospital, Sun Yat-sen University, was invited to attend the consultation on March 7, 2011. Dr. Yao suggested close observation of the patient, administration of bladder instillation chemotherapy, and cystoscopy every three months. On day 5 after surgery, the patient was transferred to Oncology Department for further treatment and a joint oncologist consultation was held to decide a treatment plan. The patient successfully received 8 cycles of hyperthermic intravesical chemotherapy with mitomycin respectively on March 10, March 29, April 6, April 13, April 20, April 27, May 4, and May 13, 2011. A follow-up cystoscopy showed no sign of new neoplasm. Hyperthermic intravesical chemotherapy with mitomycin was performed once monthly on June 13, July 13, August 13, and September 14, 2011. A cystoscopy on September 14, 2011 showed no evidence of tumor recurrence or metastasis. A contrast CT scan of the middle and lower abdomen on September 15 also showed no tumor recurrence or metastasis.

Bladder instillation chemotherapy with Mitomycin 20mg was successfully performed on October 13, November 13, December 13 of 2011, and January 13, February 13 of 2012. A cystoscopy on January 12, 2012 showed no tumor recurrence and a color ultrasound scan of urinary system disclosed cysts in bilateral kidneys (possible pyelogenic cyst in the left kidney).

Hyperthermic intravesical chemotherapy was applied on March 26, 2012. A contrast MR scan of the pelvic cavity on April 25, 2012 revealed changes after bladder cancer surgery but no sign of cancer recurrence. Abnormal signal intensity was noted in the cervix. A cystic lesion was noted in sacral nerve root, which was probably a cyst. Cystoscopy showed normal findings. The 19<sup>th</sup> hyperthermic intravesical chemotherapy with Mitomycin 20mg was successfully applied on April 27, 2012. Follow-up gynecological ultrasound showed unremarkable finding and TCT result was also normal. The 20<sup>th</sup> hyperthermic intravesical chemotherapy with MMC 20mg was smoothly applied on May 29. The patient returned to Clifford Hospital for follow-up regularly and no cancer relapse or metastasis was found.

**Diagnosis:** Status post chemotherapy after transurethral resection of bladder tumor (low-grade infiltrating urothelial carcinoma pT<sub>2</sub>N<sub>0</sub>M<sub>0</sub> stage II)

**Integrative treatment plan:** Hyperthermic intraperitoneal chemotherapy was totally applied for 20 times; local deep hyperthermia once the other day, extracorporeal blood oxygenation and ozonation once to twice weekly, 30g chelation therapy once every other day, systemic biofeedback therapy once daily, acupuncture once daily and oral traditional Chinese medicine once daily.

**Treatment outcome:** After the hyperthermic intraperitoneal chemotherapy accomplished, the patient complied with outpatient and inpatient follow-ups every 3-6 months for 5 years. There is no evidence of cancer recurrence or metastasis.

The patient is fully recovered currently.

## Brain Glioma

### L3, female, 30 years old.

In 2006, the patient presented with unexplained intermittent headache, which was intermittently dull, tolerable and more significant on the left side and each episode lasted for 4-5 days and then subsided on its own. The patient visited Hainan People's Hospital and underwent a Brain MRI, which revealed a space-occupying lesion in the right brain (details unknown). As the lesion was small, it was left untreated and observation suggested.

But she experienced strong headache again in November, 2008, accompanied by nausea and vomiting. So she presented to Hainan People's Hospital again and a brain CT revealed masses in the right thalamus and parietal lobe, possible glioma; and abnormal signal intensity in the left parietal lobe, raising the possibility of edema lesion. She underwent a "lumpectomy of the right brain", and postoperative pathology indicated grade 2 oligoastrocytoma. She recovered well after surgery. She later continued her care in Clifford Hospital and received 4 cycles of chemotherapy with oral temozolomide capsules respectively on January 5, 2009, February 3, 2009, March 3,

2009 and March 31, 2009 (the first cycle: temozolomide capsules 150mg, qd, d1-d5; the last three cycles: temozolomide capsules 200mg, qd, d1-d5). Combined with chemotherapy, other therapies were also applied, including medical ozone, chelation and TCM therapies. The patient presented with chemotherapy side effects like leucopenia, nausea and vomiting, but those effects were relieved by symptomatic treatment.

In April 2009, she visited General Hospital of Guangzhou Military Command of PLA for gamma knife therapy (details unknown). Since the second half of 2009, annual brain MRI scan revealed no evidence of tumor recurrence or metastasis. At the end of 2012, she suddenly presented with unexplained headache and limb weakness, but no consciousness disturbance or limb cramp. The episode lasted about 5-8 minutes and subsided without any intervention. She visited Hainan People's Hospital where she was diagnosed with secondary epilepsy and given "sodium valproate sustained-release tablets 0.1g po bid" to fight against epilepsy. But there was no improvement. Since February 2013, she started to experienced paroxysmal dizziness, consciousness disturbance, limb jerking, and foaming at the mouth, but no urinary or fecal incontinence or injury. Each seizure lasted for about 30 minutes and subsided on its own. When she regained her consciousness, she felt week, unable to recall the event. The epilepsy occurred once every month. But the onset frequency changed into every 10 days since July. The patient experienced the same symptoms as before, and was again given "sodium valproate sustained-release tablets 0.1g po bid" to fight against epilepsy. Treatment outcome turned out unsatisfactory and therefore she visited Clifford Hospital for further treatment. A brain MRI with contrast on September 19, 2013 indicated, compared to MR findings on May 4, 2009, lesions in left temporal and parietal lobes significantly increased in size, suggestive of recurrence of astrocytoma in the right parietal lobe. After admission, topiramate tablets 50mg bid and oral sodium valproate 0.5g qd were administered for anti-epilepsy and dehydration. On September 26, 2013, the patient went to 421 Hospital of PLA and underwent brain gamma knife therapy: 50% isodose curve surrounding the gross tumor volume and accumulated dose around the tumor of 1500cGy/3F. In September, 2013, she presented to Clifford Hospital to received non-toxic integrative cancer treatments.

The patient had a healthy history and underwent "cesarean section" in June 2010.

**Assistant examination:** A brain MRI with contrast in Clifford Hospital on September 19, 2013 indicated, compared to MR findings on May 4, 2009, lesions in left temporal and parietal lobes significantly increased in size, suggestive of recurrence of astrocytoma in the right parietal lobe.

**Diagnoses:** 1. Relapse of grade 2 oligoastrocytoma after gamma knife surgery, radiation therapy and chemotherapy. 2. Secondary epilepsy.

**Integrative treatment plan:** Stereotactic gamma-ray radiation therapy was applied to treat the brain tumor relapse, combined with brain hyperthermia once every other day, chelation therapy once every day, and major ozonated autochemotherapy once every other day. According to traditional Chinese medicine (TCM) system, the patient suffered stagnation of blood stasis and therefore Naoliu Decoction + Sanleng Jianwan was prescribed: Rhizoma Sparganii (San Leng)15g, Fructus Polygoni Orientalis (Shui Hong Hua Zi)10g, Rhizoma Curcumae (E Zhu)15g, Radix Paeoniae Rubra (Chi Shao)15g, Poria (Fu Ling)15g, Semen Coicis (Sheng Yi Yi Ren)30g, Scorpio (Quan Xie)5g, Scolopendra (Wu Gong)5g, Herba Hedyotis Diffusae (Bai Hua She Cao)30g, Liuwei Dihuang Pills (bag)12g. The TCM was one dose daily for oral administration and should be decocted with water.

Acupoints for acupuncture therapy: EX-HN5, DU 20, DU 14, GB 20, LI 4, DU 23, ST 36, Triple Points (Sanchongxue) and Outer Three Passes (Waisanguan). Acupuncture adapted a "even reinforcing and reducing" method and the needles remained in the points for 20 minutes. The therapy was administered once daily for 5 days a week, followed by a 2-day rest.

Moxibustion therapy: CV 4, DU 20, ST 36, DU 14 were selected for moxibustion therapy. Method: each session of moxibustion was applied to 2 acupoints for 10 minutes respectively in the frequency of once a day, and there was a 2-day interval after 5 sessions.

Auricular therapy: acupoints selected were as follows: TF 4, AH 6a, AT 4, AH 6a, TF 4, LO 5 6i, AT 1, CO 12, and TG2P. Method: auricular therapy alternated once a week between two ears.

Cowherb Seeds were applied to the auricular points and the patient was instructed to press each acupoint 3 to 5 times per day, with each press lasting for 3 to 5 minutes. In addition, head hyperthermia was also employed once every other day with chelation therapy; Anti-Tumor Mixture one dose daily and major ozonated autochemotherapy once every other day (employed during the interval of chelation therapies).

**Treatment outcome:** The patient remained inpatient for 52 days without seizure. She was good in spirits and normal in limb strength and tone. She continued outpatient follow-up visits for 6 years and there was no evidence of remarkable change. Follow-up brain CT scan in other hospital revealed a stable tumor status.

## Breast cancer

### F2, 52-year-old.

The patient noticed a non-tender, broad bean-sized lump under areola of right lateral breast without nipple discharge or hemorrhage in April, 2011. The lump enlarged before menstruations and shrank after. Since 2012, the lump enlarged progressively that she consulted doctor in our hospital. Color ultrasound scan of the breasts on May 30, 2012 indicated mild hyperplasia of bilateral breasts and a nodule near the right nipple with possibility to be excluded. She was admitted with initial diagnosis of unexplained lump in the right breast and diagnosed with right breast cancer through related examinations in Inpatient. On June 16, 2012, lumpectomy of right breast was performed under local anesthesia and frozen pathological section during operation reported invasive ductal carcinoma of the right breast, at the same time, modified radical mastectomy of right breast cancer was done under general anesthesia successfully. Postoperative pathological analysis revealed breast fibrosdenosis and residual invasive ductal carcinoma in part of tissue. Skin of the nipple and deep fascia were not involved. Lymph nodes were metastasized (5/18, with maximal diameter of 0.5cm at nests). Immunohistochemical test (3 items) showed negative HER2, but positive ER and PR. The patient with a history of lumpectomy of right breast 20 years ago (it was benign without unknown pathological report) was transferred to Oncology Department after operation.

**Physical examination:** 20cm-long surgical scar was in the chest wall. Neck was soft without resistance, and no jugular varicosity or abnormal carotid pulsation. A soft and non-tender nodule of 1cm\*1cm in the left thyroid was palpable, which moved up and down following swallowing movements. The chest without deformity was symmetric. Right breast was resected and left breast lump was impalpable.

**Assistant examination:** Lumpectomy of right breast was performed under local anesthesia on June 16, 2016 and frozen pathological section during operation reported invasive ductal carcinoma. Postoperative pathological analysis revealed breast fibroadenosis and invasive ductal carcinoma residual locally. Skin of the nipple and deep fascia were unremarkable. There were lymph node metastases (5/18, maximal diameter of cancer nests of 0.5cm). Immunohistochemical test (3 items) revealed negative HER2 but positive ER and PR.

**Diagnosis:** status postoperative change of right breast invasive ductal carcinoma, stage III.

**Integrative treatment plan:** This middle-aged woman with reduction of hormone function was in poor emotion. That was caused by dysfunction of liver in regulating and spleen in transport. Retention of water-dampness obstructed channels and collaterals that phlegm and stasis were accumulated. Sen Mai Fu Zheng Zhu She Ye was applied for supplementing qi and strengthening body resistance. In TCM theory, traditional Chinese medicine was used to relieve depressed liver, remove phlegm and boost qi of spleen and stomach. The prescription named "Six Gentlemen Decoction" was administered based on the patient's response. The detailed prescription included Radix Codonopsis (Dang Shen) 15g, Radix Scutellariae (Huang Qin) 15g, Radix Astragal (Huang Qi) 30g, Fructus Crataegi (Shan Zha) 30g, Rhizoma Atractylodis Macrocephalae (Bai Zhu) 30g, Fructus Hordei Germinatus (Mai Ya) 30g, Endothelium Corneum Gigeriae Galli (Ji Nei Jin) 20g,

Fructus Ligustri Lucidi (Nv Zhen Zi) 15g, Herba Ecliptae (Mo Han Lian) 20g, Fructus Corni (Shan Zhu Yu) 20g, Fructus Amomi (Sha Ren) 10g, and Fructus Aurantii (Zhi Ke) 10g. One dose of the above herbs was decocted with water for oral administration twice daily.

Since July 26, 2012, the patient was given systemic chemotherapy following AC-T plan, concurrently with deep hyperthermia on chest every other day, and intravenous medical ozone therapy and electro-magnetic biofeedback therapy once a day respectively. Acupuncture was adopted with principle of neutral supplementation and draining, with the needle retained for 20 minutes, once a day, and 2 days interval after 5 sessions. Moxibustion was applied to 2 acupoints for 10 minutes respectively in the frequency of once per day and a 2-day interval after 5 sessions. Auricular points included breast, AH10, CO4, CO12, CO18, AT4, TG2p, AT2,3,4i, and AH6a. Method: Cowherb Seed was applied to auricular points and the patient was instructed to press it 3 to 5 times per day.

**Treatment outcome:** Decrease of WBC after chemotherapy indicated the appearance of myelosuppression. Treatment to elevate WBC was adopted in combination with chelation therapy and ozone administration intravenously for effect-enhancing and toxicity-reducing. Follow-up complete blood test and liver and kidney function were normal. The patient has followed outpatient and intermittent inpatient treatment. Her illness is in stable conditions in 5 years' follow-ups.

The patient returns for inpatient treatment every 6 months. There is no recurrence or metastasis.

## **H2, female, 49 years old.**

The patient felt a mass in her right breast on April 21, 2013 and she presented to Clifford Hospital for medical care. The mass was of about 1.0×2.0cm, ill-defined, and non-tender, with moderate hard texture, unsmooth surface and limited mobility.

A color ultrasound in Clifford Hospital on April 21, 2013 showed: Bilateral mammary hyperplasia. There was a nodule in the right breast, suspicious of breast tumor and biopsy recommended. A hypoechoic nodule was detected in the right axilla, probable lymphadenopathy.

Mammography revealed heterogeneously dense breasts, with the right breast consistent with BI-RADS Category IV (a MRI with contrast suggested) and the left breast consistent with BI-RADS Category II. The patient was admitted to the Surgery Department and underwent a lumpectomy + modified radical mastectomy under local + general anesthesia on April 28, 2013. Postoperative pathology was consistent with invasive ductal carcinoma of the right breast, with the largest diameter of 2.0cm and metastasis to the lymph nodes (3/13). Immunohistochemical analysis: P53 (4+), Ki67 (4+), EGFR (-), HER2: (1+, negative). ER (-), PR (-). After the surgical incision healed, the patient was transferred to Oncology Department.

**Conditions on admission:** There was mild referred pain along the thoracic incision when the patient moved her right upper limb. There was no restricted limb motion. Appetite was general.

**Physical examination:** A longitudinal and well-healed surgical scar of about 20cm was noted in the right chest. The right breast was absent. The left breast developed well with its nipple free of retraction. Nothing abnormal was palpated in the left breast. No enlarged lymph node palpated under bilateral axillae or above the collarbone.

### **Assistant examination:**

Postoperative examination revealed invasive ductal carcinoma of the right breast, with the largest diameter of 2.0cm and metastasis to the lymph nodes (3/13). Immunohistochemical analysis: P53 (4+), Ki67 (4+), EGFR (-), HER2: (1+, negative). ER (-), PR (-).

**Diagnosis:** Status post lumpectomy + modified radical mastectomy & chemotherapy of right breast invasive ductal carcinoma (pT1N1M0 stage II).

**Integrative treatment plan:** The patient was a middle-aged female with a depressed nature. After she developed the disease, she suffered mental stress, which caused liver Qi disorder and Qi stagnation. Because "Qi transformation promotes blood circulation and Qi stagnation results in

blood stasis and pain”, the patient presented with pain in the right breast. “Liver Wood restrains Spleen Earth, causing spleen dysfunction and transformation failure of essence of water and grain”. The patient’s liver had been long-term depressed and fluid and wetness stagnated inside her body, leading to formation of phlegm and mass in the breast. She also occasionally experienced nausea and loose stool, which indicated she was deficient in spleen.

Traditional Chinese medicine “Xiaoyaosan Decoction” was employed to relieve the depressed liver, regulate Qi and tonify the spleen, including the following herbs: Radix Bupleuri (Chai Hu)15g, Radix Angelicae Sinensis (Dang Gui)15g, Radix Paeoniae Alba (Bai Shao)15g, Radix Glycyrrhizae (Gan Cao)6g, Rhizoma Atractylodis Macrocephalae (Bai Zhu)15g, Poria (Fu Ling)15g, Radix Codonopsis (Dang Shen)15g, Spica Prunellae (Xia Ku Cao)15g, Radix Curcumae (Yu Jin)10g. The TCM was one dose daily and should be drunk warmly after meals.

Chemotherapy with cyclophosphamide + epirubicin was planned. Chest local deep hyperthermia was applied every other day; EBOO therapy once a day and chelation therapy every other day. Such integrative therapies were employed to promote chemotherapy and reduce toxic effects.

**Treatment outcome:** The patient has been keeping outpatient and intermittent inpatient visit. During the 2-year follow-up, chest CT scans and whole body bone scans show no cancer recurrence or metastasis. Currently she is still on follow-up.

### **H3, female, 38 years old.**

The patient was admitted on July 28, 2011 due to "space-occupying lesions in bilateral breasts for half a month".

On July 10, 2011, a color ultrasound scan performed during a health checkup showed:

1. A solid space-occupying lesion with calcification in the right breast, suggestive of a further examination;
2. A cystic-solid nodule in the left breast with possibility of a space-occupying lesion not excluded;
3. Bilateral mammary hyperplasia with multiple nodules;
4. Lymphadenopathy in the right axilla;
5. A lymph node in the left axilla.
6. Hypo-echogenic masses in the right breast, with the largest having well-defined margin measuring 31.0mm\*19.5mm in size at the 10 o'clock position;
7. A cystic and solid echogenic mass with ill-defined margin at the 8 o'clock position of the left breast, approximately 34.0mm\*14.0mm in size.

A subsequent mammography showed:

Bilateral breasts contained more fibrous and glandular tissue. The right breast was consistent with BI-RADS Category IV with solid lymph nodes in the axilla. The left breast was consistent with BI-RADS III suggestive of a periodic follow-up.

For further diagnosis and treatment the patient was admitted to Oncology.

On admission, the patient was conscious and alert and in good spirit. Appetite and sleep were good. Urination and bowel movement were normal. He denied discomfort all over the body.

After admission, she underwent nipple conserving lumpectomy of bilateral breasts and right-sided modified radical mastectomy under general anesthesia in General Surgery Department on August 6, 2011. Post-operative pathology revealed: The right breast: invasive ductal carcinoma (45%), ductal carcinoma in situ (40%) and papillary carcinoma (15%); the tumor was 5.5\*3.5\*2cm in size and 1cm from the nearest surgical margin; no cancer embolus was noted in blood or lymphatic vessels; margins of subcutaneous tissue of nipple, skin above tumor, and deep fascia were free from cancer invasion; and lymph nodes were unremarkable (0+/8). The left breast lesion was fibroadenoma. After removal of most stitches and wound healing, the patient was transferred to Oncology for non-toxic integrative cancer treatments such as wound dressing, hyperthermia

therapy, medical ozone therapy, and TCM (traditional Chinese medicine). After oncologists excluded chemotherapy contraindications, the patient received AC→T chemotherapy with Doxorubicin (90mg) and Cyclophosphamide (0.9) by IV (on 09/14/2011, 09/30/2011, 10/14/2011, 10/29/2011), and then intravenous chemotherapy with Paclitaxel (270mg) (11/13/2011, 11/29/2011, 12/15/2011, 12/31/2011).

**Integrative treatment plan:** Chemotherapy was combined with non-toxic integrative cancer treatments, including chest deep hyperthermia therapy each other day, intravenous medical ozone therapy once per day, magneto-electric biofeedback therapy once per day and acupuncture therapy. Acupuncture was administered in the principle of neutral supplementation and draining, with the needle retained for 20 minutes, once a day, and a 2-day interval after 5 needling sessions.

As to moxibustion therapy, acupoints included BL26, DU14, ST36, SP6, BL18, BL20, BL23. Each session of moxibustion was applied to 2 acupoints for 10 minutes respectively in the frequency of once a day and there is a 2-day interval after 5 sessions.

Cowherb seeds were applied to the auricular points and the patient was instructed to press the auricular points on her own 3-5 times per day. And the auricular points included RUXIAN, AH10, CO4, CO12, CO16, AT4, TG2p, AT2·3·4i, NAODIAN, AH6a.

With principle of clearing away heat and toxic materials, dispersing stasis and removing swelling, traditional medicine named "Wu Wei Xiao Du Decoction" was adopted for accumulation of heat-toxic based on her current conditions and comprehensive analysis by four diagnostic methods. The detailed herbs of the decoction included:

Lonicera Japonica (Jin Yin Hua)30g

Dandelion (Pugongying)15g

Herba Violae (Zihuadiding)15g

Begonia Fimbristipula (Zibeitiankui)15g

Peach seed (Taoren)10g

Flos carthami (Honghua)10g

Nidus Vespae (Lufengfang)6g

Spina gleditsiae (Zaojiaoci)10g

One dose of the herbs were decocted with water and administered once a day.

**Treatment outcome:** The patient has been followed for 5 years and receives periodic examinations and non-toxin integrative cancer treatments. There is no evidence of cancer recurrence or metastasis.

## **K2, aged 59, female, American.**

The patient was admitted on October 18, 2007 due to right breast invasive ductal carcinoma for more than 4 years, progressive lump enlargement with emaciation for 3 months and skin redness and swelling for one week.

With a history of estrogen replacement therapy for over 3 years, the patient found a peanut-sized, painless, hard lump in the right breast in October, 2003. Regional tissue biopsy result revealed breast invasive ductal carcinoma PR (+), ER (+), CerbB2(+++) in Carolina State Hospital, United States. But she preferred natural therapies like Vitamin C, medical ozone therapy, massage and hydrotherapy in local hospital rather than any invasive treatment such as operation, radiotherapy and chemotherapy. Her illness was in stable state; however, 3 months before admission to Clifford Hospital, the lump enlarged progressively and then the right breast appeared hard, red and swollen. She also experienced significant weakness, shortness of breath and palpitation after activities, and recurrent paroxysmal dry cough. She had lost about 10kg in 3 months before admission. She was not so energetic during inpatient stay, and had general appetite. Urination and bowel movement were normal.

**Physical examination:** The patient was conscious but looked ill and emaciated. Body weight was 51kg. Bilateral breasts appeared swollen and red with local ulcerations covered with pus. Retracted nipples looked like fragiform. Multiple lymph nodes could be palpable in armpits and

left supraclavicular fossa, of which the biggest one of 2.0×2.0×1.5cm in size was firm and hardly movable, but was well-defined from the surrounding tissue. One hard lump of 2.0×1.5×1.5cm in size with poor mobility was in the 6<sup>th</sup> intercostal space of the right posterior axillary line and ill-defined to the surrounding tissue.

HR was 112bpm and heart rhythm was normal without murmurs. Percussion dullness was noted from lower lungs to the 5<sup>th</sup> intercostal space and respiratory sounds significantly decreased. She was unable to lie on her right side. Pitting edema was noted in the right forearm and upper arm while mild edema appeared in lower limbs. KPS: 60.

#### **Assistant examinations:**

Pathology reported invasive ductal carcinoma of right breast, PR(+), ER(+), CerbB2(+++) in Carolina State Hospital, United States.

Complete blood count: Hb 93g/L.

Biochemistry: ALT 37U/L, AST 32U/L, TP 58g/L, ALB 27.3g/L, ALP 157U/L, GGT 88U/L, TBIL13.2umol/L, DBIt 5.0umol/L, Cr 35umol/L, Ua 335umol/L, BUN 5.3mmol/L, GLU 5.25mmol/L, TG0.2 mmol/L, GHO3.46mmol/L, K<sup>+</sup>3.95 mmol/L, Na<sup>+</sup> 141mmol/L, Cl<sup>-</sup> 107mmol/L, Ca<sup>2+</sup> 2.01mmol/L, while immunological test (5 items) and micro-element were normal.

CEA 48ng/ml, AFP 7.09ng/ml, CA12-5(OV) 34.99U/ml, CA199 35.94U/ml, CA153(BR) 238U/ml.

Chest and abdomen CT scan indicated cancer metastases to lungs, liver and chest cavity, one tumor of 5×4.5×4cm with pedicle in the left pleural cavity connected to parietal pleura, and bilateral pleural effusion, particularly in the right side.

Whole body bone scan revealed no bone metastasis.

ECG indicated sinus rhythm, HR 115bpm and right bundle branch block.

Diagnosis: Right breast invasive ductal carcinoma in stage IV with metastases to left breast, lungs, liver, chest cavity and skin.

**Integrative treatment plan:** At admission, the patient suffered cancer metastases to liver, lungs, chest cavity, skin and lymph nodes, moderate malnutrition, ulceration and infection on breast surface, and bilateral pleural effusion. Right upper limb edema was probably due to lymphatic obstruction of chest wall, while bilateral lower limbs edema resulted from hypoproteinemia. Debridement and local medical ozone therapy on breasts were provided for three days, which healed superficial ulceration and relieved swelling. After drainage of pleural effusion, Cisplatin 30mg plus Interleukin-II 4×10<sup>6</sup>U were injected once weekly and local hyperthermia of the bilateral chest every other day. Letrozole was administered orally once daily at a dosage of 2.5mg. Pleural effusion almost disappeared after 2 weeks treatment. Since then, general medium-high temperature hyperthermia was given every 10 days and chelation therapy every other day. Local hyperthermia (20 sessions in total) was given during intervals of general hyperthermia (4 sessions in total).

Nutrition support was administered. Extracorporeal Blood Oxygenation and Ozonation (EBOO) was adopted every other day, alternately with chelation therapy. Chinese herbal medicine and acupuncture therapy were given throughout the treatment. Tongue was dark red with yellow and greasy coating. Pulse was thready and uneven. The patient was diagnosed with accumulation of toxic heat in accordance with her symptoms. Chinese herbal medicine named “Wu Wei Xiao Du Yin” was used to clear away heat and toxic materials and disperse blood stasis and swelling.

The prescription was as follows:

Flos Lonocerae (Jin Yin Hua) 30g	Herba Tataxaci (Pu Gong Ying) 15g
Herba Violae (Zi Hua Di Ding) 15g	Begonia Fimbristipula (Zi Bei Tian Kui) 15g
Semen Persicae (Tao Ren) 10g	Flos Carthami (Hong Hua) 10g
Nidus Vespae (Lu Feng Fang) 6g	Spina Gleditsiae (Zao Jiao Ci) 10g

One dose of the above herbs was decocted with water for oral administration once daily.

Acupoints of ST 36, SP 6, RN 12, KI 3, CV4, RN 6, BL 23, BL 20, and San Chong Xue were selected for acupuncture with principle of neutral supplementation and draining. The needles

remained in place for 20 minutes. This procedure was performed once daily, and a 2-day interval after 5 needling sessions.

Moxibustion was applied to the following points: RN 4, DU 14, ST 36, SP 6, BL 14, BL 23, and BL 20. Methods: Each session was applied to 2 points for 10 minutes respectively in the frequency of once a day and there was a 2-day interval after 5 sessions.

Auriculotherapy alternated weekly between two ears. Cowherb Seeds were applied to the auricular points (breast, AH10, CO4, CO12, CO18, AT4, TG2p, AT2,3,4i, and AH6a) and the patient was instructed to press each acupoint 3 to 5 times per day, with each press lasting for 3 to 5 minutes.

Chinese herbal medicine and acupuncture were adjusted based on the patient's response to the treatment. She was discharged after 2-month hospitalization and continued traditional Chinese medicine.

**Treatment outcome:** Ulceration and swelling of breasts disappeared and mega lump at the right breast became soft and smaller (shown as pictures) after 60 days non-toxic integrative cancer treatment. Edema of limbs and weakness subsided. She did not complain of shortness of breath on climbing up and down stairs. Heart rate was 80-90bpm. Lymph nodes in bilateral armpits and left supraclavicular fossa were smaller, of which the biggest one measured 1cm×1.5cm×1.5cm in size and softened. Her weight increased to 62kg with good appetite. She could lie on the supine position and lived a normal life. Follow-up CT scan of chest and abdomen indicated lung and liver lesions became smaller than the prior findings and no new lesion, and the lesion in the left pleural cavity was 3.5cm×4.2cm×3.4cm in size.

Laboratory findings: RBC $4.2\times 10^{12}$ /L, Hb123g/L, ALB36.5g/L, CEA15ng/ml, AFP7.09ng/m, CA12-5(OV)20U/ml, CA19930U/ml, CA153(BR)88U/ml. KPS was 90.

The patient kept in touch via email in the following 3 years after discharge and continued Letrozole 2.5mg once per day. Her condition was stable.

But she lost her life in a flight accident in 2011.

#### **L4, female, 39 years old.**

In 2010, the patient accidentally found a corn-sized lump in the lateral side of right breast. There was no galactorrhea or bleeding in the nipple and no evidence of rapid mass growth. At that time she also suffered periodic swelling and pain in bilateral breasts, which appeared more significantly before menstruation and alleviated after.

Therefore, she presented to the Outpatient Service of Clifford Hospital. Mammography was performed and indicated hyperplastic changes in bilateral breasts, which were consistent with BI—RADS Category II.

In June, 2010, the patient noticed the painless lump in right breast increased in size. She visited General Surgery and received a color ultrasound scan of bilateral breasts. The scan (by Clifford Hospital, 06/04/2010) indicated:

1. Bilateral breast hyperplasia;
2. Multiple nodules in the right breast, with the possibility of breast cancer to be excluded for larger ones. Surgery and biopsy were recommended;
3. Small nodules and fluid sonolucent areas in the left breast, suggestive of possible cystic hyperplasia or local ductal dilation.

On June 5, 2010, she was admitted to General Surgery and underwent a lumpectomy of right breast on June 9. Pathological examination of the intraoperative frozen section revealed right breast invasive ductal carcinoma. Modified radical mastectomy of the right breast was performed immediately afterwards.

Post-operative pathology: Invasive ductal carcinoma was noted in the upper outer quadrant of the right breast with lobules involved. The cancerous nodules were 2.0 cm and 1.8cm in diameter. Cancer emboli were seen in some small blood vessels. The cancer was histologically classified as Grade 3 (score: 8). No cancer involvement was noted in the nipple, areola, deep fascia or incisional

margins. Ductal epithelial and lobular hyperplasia was noted in tissue around the cancer. Lymph nodes in right axilla were unremarkable (+0/4). Immunohistological test revealed ER (+), PR (+) and Cerb2 (-).

History review was significant for congenital heart disease (atrial septal defect). On April 29, 2008, she underwent an atrial septal defect closure in Clifford Hospital. In 2005, she received a caesarean section.

**Physical examination on admission:** A surgical scar about 10cm in length was noted on right chest with good healing. Right breast was absent. The left breast was normal in development without nipple retraction, but was positive for a painful, palpable, rice-sized nodule in the upper outer quadrant.

**Assistant examinations:**

Color ultrasound scan of bilateral breasts: Mild hyperplasia of the left breast; small nodules in the left breast, suggestive of possible hyperplastic nodules.

Color ultrasound scan of axillary lymph nodes: A nodule in the right axilla, suggestive of an enlarged lymph node, with other possibilities to be excluded.

**Diagnoses:**

1. Status post right mastectomy; stage 1 invasive ductal carcinoma (PT1N0M0);
2. Left breast hyperplasia.

**Integrative treatment plan:**

The patient was a middle-aged woman with menstrual dysfunction and emotional depression. Because of this, her liver failed to maintain the normal flow of Qi, resulting in Qi depression in the liver. The overwhelming excessive liver Qi therefore leaked and invaded the neighboring organ-spleen, and impaired the spleen's major function to transport water through the human body and maintain the water balance. Water and dampness were retained within the body and finally led to the stagnation of blood stasis in the arteries and veins, and further caused a vicious circle, the accumulation of phlegm and blood stasis. Since meridians and collaterals of liver and stomach passed through breasts, but now were blocked by the accumulation of phlegm and blood stasis, masses developed in the breasts and finally turned into cancer. Hence the TCM treatment targeted soothing the liver, regulating Qi, dissipating phlegm and resolving masses. "Xiao Yao Powder" was prescribed according to her symptoms and signs. Local hyperthermia of the left breast and intravenous ozone therapy once per day, and chelation every other day were administered. She also received TC chemotherapy (07/08/2010/, 07/29/2010, 08/19/2010, 09/09/2010, 09/30/2010, 10/23/2010) with Docetaxel Injection (120mg d1) + Cyclophosphamide Injection (1g d1). After chemotherapy, she experienced grade II gastrointestinal reaction and grade II myelosuppression, for which she received symptomatic treatment to inhibit gastric acid, protect stomach, stop vomiting, and increase white blood cells. She was discharged from hospital after improvement.

**Treatment outcome:**

The patient has been receiving regular outpatient treatment and intermittent inpatient care. Two years of follow-ups showed an ongoing recovery and no cancer recurrence or metastasis. The follow-up is still going on. Her follow-up chest and abdominal enhanced CT scan showed changes after the modified radical mastectomy of the right breast and no evidence of cancer recurrence or metastasis. Emission Computed Tomography also revealed no abnormal finding of whole body bones.

It has been more than six years with no cancer recurrence since the patient's operation. She now lives and works normally.

**L5, female, 64 years old.**

The patient underwent modified radical mastectomy of the right breast due to a right breast mass on May 16, 2000. Postoperative pathology result was consistent with invasive ductal carcinoma, ER2+, PR+, stage T2N1M0. Chemotherapy with Cyclophosphamide, Methotrexate, and 5-Fluorouracil (CMF) of 6 cycles and hormonal therapy with Tamoxifen of 5 years in duration were

provided. On February 3, 2010, she was admitted to Endocrinology in Clifford Hospital. A chest CT scan revealed breast cancer with metastases to lung and lymph nodes. She was then given hormonal therapy, non-toxic integrative cancer treatment, intermittent oral Capecitabine, deep hyperthermia, medical ozone and acupuncture. Regular examinations showed no sign of tumor progression.

History review was significant for hypertension, type 2 diabetes mellitus, diabetic peripheral neuropathy, diabetic nephropathy, osteoarthritis of knees and hyperthyroidism.

Diagnoses: 1. Status post modified radical mastectomy, with metastases to lung and hilar lymph nodes. 2. Type 2 diabetic nephropathy. 3. Type 2 diabetic peripheral neuropathy. 4. Arthritis of knees. 5. Grade 2 hypertension, extremely high risk group. 6. Coronary atherosclerotic heart disease.

**Integrative treatment plan:** During and after chemotherapy, non-toxic integrative cancer treatments were administered, including chelation (once a day), chest hyperthermia (every other day), EBOO (twice a week), and biofeedback therapy (once a day). Acupuncture was administered in the principle of neutral supplementation and draining, with the needle retained for 20 minutes, once a day, and a 2-day interval after 5 needling sessions. Moxibustion was applied to the following acupoints: CV 4, GV 14, ST 36, SP 6, BL 18, BL 20, and BL 23. Methods: Each session of moxibustion was applied to 2 acupoints for 10 minutes respectively in the frequency of once a day and there was a 2-day interval after 5 sessions. Auricular points included breast, AH 10, CO4, CO12, CO18, AT4, TG2P, AT2, 3 & 4i, and AH6a. Method: Auriculotherapy alternated once a week between two ears. Cowherb Seeds were applied to the auricular points and the patient was instructed to press each acupoint 3 to 5 times per day, with each press lasting for 3 to 5 minutes. Oral Chinese medicine decoction was ordered based on syndrome differentiation.

**Treatment outcome:** The patient complied with regular outpatient and inpatient follow-ups for 5 years. CEA and CA153 were normal, Chest x-ray on May, 2015 revealed status post modified radical mastectomy; similar lesions of right middle and upper lung fields compared with chest x-ray on January 30, 2015.

Currently, she suffers breast cancer with lung metastasis. She has been living with breast cancer for 16 years, with good quality of life at present. She continues weekly outpatient treatment with hyperthermia and Chinese medicine.

### **W1, female, 66 years old.**

The patient presented with a mass in right breast without any cause 3 years ago. The mass measured in a size of a rice grain, without pain or discomfort, and was unattended. In the past 3 years, the patient received a color ultrasound of breasts every half a year and results showed no significant change of the mass, and no treatment was given. Over the last 2 months, the mass in right breast increased in size and number. A sequential ultrasound revealed a mass of right breast with malignant tendency and surgical treatment was recommended. Mammography of bilateral breasts showed: Bilateral mammary glands contained more fibrous and glandular tissue; a nodule was noted in the right lower quadrant; a nodular density was detected in the right upper quadrant with sand-like calcification, and biopsy suggested; the right breast was consistent with BI-RADS Category IV while the left breast consistent with BI-RADS Category II.

History review was positive for hypertension and subtotal gastrectomy due to gastric perforation 30 years ago.

After admission, she underwent lumpectomy of the right breast on June 17, 2011. As the neoplasm was confirmed as malignant during surgery, right-sided radical mastectomy was performed, with a drainage tube placed to right chest wall and axilla respectively. Postoperative treatment was ordered for anti-infection and hemostasis. Postoperative recovery went smoothly. Postoperative pathology results were consistent with invasive ductal carcinoma, intraductal carcinoma and mucinous adenocarcinoma of right upper breast (see pathology report). On July 4, 2011, the axillary drainage tube was removed as there was no discharge. On July 8, 2011, the

patient was transferred back to Oncology Department for integrative cancer treatment. On July 13, 2011, chest wall drainage tube was removed as there was no discharge. A chest CT scan with contrast excluded lung metastasis. Chemotherapy plan was dose-dense AC→T with Epirubicin Hydrochloride for Injection 60mg/m<sup>2</sup> and cyclophosphamide 0.6g/m<sup>2</sup>, IV drips for 1 day (14 days as a cycle, 4 cycles in total). Four cycles of chemotherapy above were followed by sequential paclitaxel of 4 cycles. Epirubicin Hydrochloride for Injection 90 mg and cyclophosphamide 0.9 were administered intravenously. It was also combined with local deep hyperthermia, intravenous medical ozone, acupuncture and chelation. The patient stayed as an inpatient for 44 days and was discharged with an improvement.

Intravenous chemotherapy with Epirubicin Hydrochloride for Injection 90 mg and cyclophosphamide 0.9 was provided on July 15 and 28 and August 11 and 25 respectively in 2011. On September 10, sequential paclitaxel of 270 mg was administered. On September 24 and October 10 and 26, sequential paclitaxel of 210 mg was administered, with treatment for anti-allergy, anti-vomiting and stomach protection. Meanwhile, it was combined with local deep hyperthermia, intravenous medical ozone, acupuncture and chelation. The chemotherapy went successfully. On November 7, 2011, the patient started conformal radiotherapy for right chest wall, right supraclavicular area, and left and right axillae, which went smoothly. Following radiotherapy, she has been on Exemestane Tablets 25 mg daily.

**Diagnosis:** Status post chemotherapy and radiotherapy of right breast cancer; invasive ductal carcinoma, pT2N2aM0, stage IIIa.

**Integrative treatment plan:** During chemotherapy, deep hyperthermia was administered every other day; intravenous medical ozone daily; chelation every other day; acupuncture daily; and traditional Chinese medicine. Following the end of chemotherapy, the patient complied with outpatient and inpatient follow-ups and received integrative treatment once every 3 to 6 months, with each lasting for 15 to 30 days.

**Treatment outcome:** The patient followed up for about 6 years. Contrast CT scan of the chest on June, 2014 revealed status post right-sided mastectomy and chemotherapy without any sign of relapse; radiation pneumonia of right lung; similar findings compared with that on December 23, 2013. A color ultrasound scan of breasts indicated status post right mastectomy and a nodule of left breast (no significant enlargement compared with previous finding.)

It has been 5 years since surgery and the patient has fully recovered.

## **Bruise, sprain in lumbar**

### **Y1, male, 52 years old.**

Japanese businessman, had bruise and sprain in lumbar and back soft tissues caused by a traffic accident, bad sleep caused by pain. He gained obvious improvement from pain and slept well after one treatment of lumbar and back local RF-hyperthermia treatment. He was cured and discharged after 9 treatments.

## **Chronic cholecystitis**

### **L6, male, 45 years old.**

The patient had chronic cholecystitis for about 10 years, no good medication treatment effect and had lots of side effect. No resolution of subcostal pain because she refused surgery. After one course of local hyperthermia no recurrence of pain within one year.

## Chronic salpingitis, pelvic inflammation

### G1, 31 years old.

The patient had had chronic salpingitis and pelvic inflammation for many years. No pregnancy within 5-years even though she had received many kinds of fertility treatments. After undergoing abdomen hyperthermia therapy, she achieved pregnancy after 3 months and gave birth to a healthy baby boy.

## Colon Cancer

### F3, male, 75 years old.

The patient was admitted on January 2, 2014 due to "status post resection of colon cancer for 8 months and hepatic metastasis found for over 1 month".

On April 11, 2013, the patient was hospitalized to Surgery Department of Clifford Hospital because of "intermittent blood in stool for 5 months". Through assistant examinations he was definitively diagnosed with "sigmoid colon cancer" and underwent radical colectomy on April 15, 2013. Post-surgical pathology results: Consistent with Moderately differentiated adenocarcinoma of sigmoid colon, 5.0x3.3cm in size, infiltrating the full thickness of colonic wall. There was necrosis but no evidence of vascular or nervous invasion. Cancer tissue did not involve incisional margins. Lymphatic metastasis was noted (1/10, diameter of cancer nest was 0.2cm).

Immunohistochemistry revealed GAT $\pi$ ++, ToPoI-, ToPoII+,>25%), PgP-, P53(+,>50%), Ki67(+,40-50%), MLH1+, MSH6+, MSH2+, PMS2+, indicative of stable microsatellite and relatively low possibility of HNPCC.

Stitches were removed as expected from the wound which healed well. The patient was therefore discharged after improvement and later he continued follow-ups and treatment in USA.

He later returned to Clifford Hospital for follow-up examination. CEA was 17.18ng/ml and CA19-9 was 295U/ml. And a CT scan on in November, of 2013 demonstrated two quasi-circular, annular enhanced lesion in the liver, suggestive of metastases. Therefore, the diagnosis was liver metastasis of colon cancer. On November 26, 2013, he was discharged after he underwent an interventional therapy in Clifford Hospital.

#### **Past history:**

The patient underwent subtotal gastrectomy because of "gastric antral ulceration" in 1975 and received intraoperative blood transfusion without transfusion reaction. He received left-sided orchiectomy in 2005 because of probable left-sided carcinoma of testicle. He was also given 6-month drug therapy in an American hospital for prolonged PSA elevation of 10 years in duration. He denied a history of hepatitis, tuberculosis, hypertension, diabetes or heart disease. His vaccination history was unknown.

**Conditions on admission:** The patient was conscious and alert with good spirit. There was no sign of spontaneous or night sweating, chills or fever, dizziness or headache, chest tightness or shortness of breath, abdominal pain or bloating, nausea or vomiting. Urination and bowel movement were normal. He had normal appetite and no significant weight gain or loss recently.

**Physical examination:** There were two well-healed longitudinal surgical scars, 5cm in length in upper abdomen and 15cm in length in lower abdomen, without oozing. No enlarged superficial lymph node was noted. Heart and lungs were normal in auscultation. Abdomen was non-distended and non-tender. There was no palpable liver and spleen or edema in limbs.

#### **Assistant examinations:**

A whole abdominal CT scan showed several findings:

1. Status post resection of sigmoid cancer without evidence of local recurrence; two quasi-circular, annular enhanced lesion in the liver, suggestive of metastases.

2. A sub-capsular nodule with abundant blood supply in the lateral region of left hepatic lobe was probably focal nodular hyperplasia, similar to the finding on March 28, 2013.

3. Prostatic hypertrophy.

A color ultrasound scan revealed the liver had increased in size with multiple nodules, suggestive of metastases. Suspicious embolus was noted in main portal vein with its nature undetermined.

Laboratory studies:

Tumor markers showed:

CA19-9	374.7U/ml	CEA	18.64ng/ml
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Complete blood count showed:

WBC	$3.43 \times 10^9/L$	HGB	105g/L
RBC	3.28	MCH	32.0pg
MCV	97.4fL	HCT	31.90%

Liver function I + II: CHE 4606U/L

Electrolyte, liver function and glucose were normal.

CEA 17.34ng/ml CA19-9 319.20U/ml

HBV-DNA  $<1.0 \times 10^3$ copies/ml

Hepatitis B Serologic Test (5 items): HBsAb (+), and others were negative.

CT scan of upper abdomen showed:

1. Right hepatic lobe: Two well-defined, hypodense masses measured about 42.6mm×37.2mm and 32.4mm×25mm in size respectively with CT value of 24Hu. The center of the two lesions saw spots of much lower density, without lipiodol deposit. Lesions were mildly enhanced after injection of lipiodol.

2. There was lipiodol accumulation in the left hepatic lobe, clear-structured porta hepatis and no dilated internal and external bile ducts. Gallbladder was not enlarged with smooth wall and homogeneous enhancement. No radiopaque calculus could be seen in the bladder.

3. Spleen was normal in appearance and size. No abnormal density or contrast enhancement was detected in the splenic parenchyma.

4. And pancreas was also normal in appearance, size and density with non-dilated pancreatic duct and clear peripancreatic space.

5. There was no retroperitoneal lymphadenopathy or peritoneal effusion. Poor lipiodol accumulation showed status post interventional therapy of liver metastasis.

**Diagnoses:** Status post operation of moderately differentiated adenocarcinoma of sigmoid colon; status post interventional therapy of liver metastasis.

**Integrative treatment plan:** In western medicine, treatment was given to protect liver, supply nutrition and boost immunity. Interventional therapy of liver metastases was also planned.

In Chinese medicine, "Shenqi Fuzheng Zhushenye" was given to boost Qi, reinforce the healthy Qi and boost immunity. The patient's symptoms and signs were attributed to spleen-kidney Yang deficiency. So traditional Chinese decoction named "Fu Zi Li Zhong Tang" combined with Chinese patent medicine "Si Shen Wan" were given to warm the kidney and fortify the spleen. Six doses of the above formula were given and included the following herbs:

Radix astragali (Huang Qi) 30g  
Fried atractylodes macrocephala (Chao Bai Shu) 30g  
Roasted ginger (Pao Jiang) 10g  
Platycodon grandiflorum (Jie Geng) 10g  
Roud cardamon seed (Bai Kou Ren) 10g  
Fructus amomi (Sha Ren) 10g  
Cinnamon (Rou Gui) 10g  
Radix aconite lateralis preparata (Fu Zi) 10g  
Fructus psoraleae (Bu Gu Zhi) 20g

Fructus alpiniae oxyphyllae (Yi Zhi Ren) 15g

Radix codonopsis (Dang Shen) 15g

Radix liquiritiae (Zhi Gan Cao) 10g

One dose of the listed herbs was decocted with water for oral administration once daily after meals in warm temperature.

**Treatment outcome:** The patient had been hospitalized for 5 days with significantly improved general conditions. Currently he was conscious and alert with good spirit. He denied spontaneous or night sweating, chills or fever, dizziness or headache, chest tightness or shortness of breath, abdominal pain or distention, nausea or vomiting. Urination and bowel movement were normal. The tongue was light red with thin-white coating and the pulse was thin. Consequently, he was discharged. Since then he complies with outpatient and inpatient follow-ups.

The patient has survived with colon cancer with liver metastasis for 3 years and 6 months by now although he didn't undergo chemotherapy. He has a good quality of life and is still on treatment.

## **Z2, male, 75 years old.**

In 2013, the patient started to experience unexplained repeated blood in his stool, which was bright red or sometimes black in color. The bleeding was minor but present every day. Since he had no diarrhea, fever, abdominal distension or poor appetite, the problem was left unattended and he had never sought diagnosis or treatment. Not until October 2013 when the patient presented with increased amount of the bright-red blood in feces, weakness and weight loss, did he start a long-term treatment in Clifford Hospital.

A colonoscopy showed an annular, protruding mass in the sigmoid colon of about 25-29cm. It covered 1/2 of the colonic cavity and was superficially ulcerated and prone to bleeding. The nature of the sigmoid colon mass remained to be investigated: Colon cancer? Pathology revealed well-differentiated sigmoid colon adenoma. Surgery was indicated whereas the patient declined. So non-toxic integrative treatment like stopping bleeding and hyperthermia therapy were given to improve immunity and control tumor growth.

He stated a past history of coronary heart disease, atrial fibrillation, type II diabetes mellitus, chronic bronchitis, pulmonary emphysema, gastric ulcer, esophagitis, internal hemorrhoids and cerebral atrophy.

### **Conditions on admission:**

The patient suffered abdominal distension and pain. He had 2-3 bowel movements per day with blood in the stool. He had poor appetite and painful shoulder with slightly limited motion, but no nausea, vomiting, fever, chills, chest tightness, shortness of breath, or edema in bilateral lower limbs. His sleep was normal but urination was weak. No significant weight loss was noted for the last one year. Physical examination revealed normal findings.

### **Assistant examination:**

The colonoscopy (February 24, 2014) showed an annular, protruding mass in the sigmoid colon of about 25-29cm. It covered 1/2 of the colonic cavity and was superficially ulcerated and prone to bleeding. The nature of the sigmoid colon mass remained to be investigated: Colon cancer? Pathology reported well-differentiated sigmoid colon adenoma.

A test showed (May 7, 2014) CEA 2.97ng/ml. Stool analysis and occult blood test revealed positive findings. Urine analysis was unremarkable.

ECG: Abnormal heart rhythm and atrial fibrillation were noted, and ventricular rate was 84bpm. Left axis deviation by  $-51^{\circ}$ .

Cervical spine X-ray (PA + LAT + bilateral oblique) showed: Left uncovertebral joint hyperplasia at C5/6, with corresponding narrowed intervertebral foramen. Intervertebral disc disease was noted at C6/7. Cervical vertebrae degeneration was shown.

Holter ECG: Ectopic cardiac rate and atrial fibrillation accompanied by long pause were shown. Occasional multifocal premature ventricular beats in four forms were noted and some occurred in pairs; ST-T was unremarkable.

**Diagnoses:**

1. Sigmoid colon cancer
2. Atrial fibrillation and flutter
3. Class II chronic cardiac insufficiency
4. Type II diabetes mellitus

**Integrative treatment plan:**

Non-toxic integrative cancer treatments were provided such as deep hyperthermia therapy three times per week and magneto-electric biofeedback therapy three times per week to improve immunology, CIK cell therapy and deep hyperthermia therapy once every other day, rod massage therapy and acupuncture to control the growth of the tumor.

**TCM treatment:**

The elderly patient had a history of hypertension, diabetes and colon cancer for many years which made the abdominal and collateral diseases become chronic without improvement. Thus, the pathogen entered the collaterals and led to blood stasis and obstruction. That was the reason he experienced abdominal bloating and pain. After a long period, there came spleen and stomach weakness, spleen Qi deficiency, and spleen failure to transport blood, and then the blood deviated from its normal path and overflowed to the colonic tract. That's why the blood was seen in stool. And also persistent diseases could injure kidney Yang, causing the kidney Yang declination. This also led to the malnutrition of viscera and collaterals. As a result, the patient suffered pain in the left shoulder with slightly limited motion and weak urination. He presented with signs of Qi deficiency including light white tongue, thin and white tongue coating, and knotted pulse. The patient's disease was located at the spleen and colon tract. Therefore, he was treated by "Ba Zhen Tang" was prescribed for boosting Qi and tonifying blood. Acupuncture and Tuina massage were also ordered.

**Treatment outcome:** After being hospitalized for 26 days, the patient was alert and conscious and with good spirit. His abdominal distension and pain were alleviated and the pain in the left shoulder was basically relieved as well. He had bowel movement twice per day with stool well-formed and light brown. He had normal appetite, sleep and urination. He visited our hospital periodically for examinations and non-toxic integrative treatment. On April 17, 2015, his whole abdominal and chest CT scans revealed status post sigmoid colon cancer treatment; posterior wall of sigmoid colon was thickened and clinical correlation was suggested.

In July 2016, the patient's follow-up examination showed significant alleviation of the posterior wall thickening of the sigmoid colon. The patient had never received any surgery for the sigmoid colonic cancer, but TCM and local hyperthermia therapy. The goal of remission was basically achieved.

Currently, the patient returns for a rehabilitation treatment every three months.

**Z3, female, 95 years old.**

The patient was admitted with status post sigmoidectomy due to colon cancer for 10 months on March 11, 2013. With a space-occupying lesion of sigmoid colon with hemorrhage, the patient underwent laparoscopic sigmoidectomy in Guangzhou First People's Hospital on May 17, 2012. Pathology result was consistent with sigmoid colon cancer. She presented to Clifford Hospital for follow-up examinations. She was then admitted to Oncology. History review was significant for hypertension.

Physical examination revealed an oblique surgical scar on left lower abdomen and 3 puncture scars of 1 to 1.5 cm on abdominal wall. Abdomen was non-distended, without visible outline of stomach and intestine or gastrointestinal peristaltic wave. Abdominal walls were free of viscosity. Abdominal respiration was not limited. Abdomen was soft in muscles, without tenderness or

rebound tenderness. Liver region was negative for tenderness. Hepatic dullness borders were normal and liver and spleen were impalpable. It was negative for Murphy sign and shifting dullness. Kidneys were free of tenderness and percussion-induced pain. Bowel sounds were normal. There was no vascular bruit heard.

**Assistant examinations:** Pathology result (Guangzhou First People's Hospital) was consistent with sigmoid colon cancer. Complete blood count: WBC:  $4.81 \times 10^9/L$ , Neu%: 66.5%, RBC:  $3.65 \times 10^{12}/L$ , HGB: 96g/L, PLT:  $227 \times 10^9/L$ . Liver and kidney profiles, electrolytes, fasting blood glucose, blood lipid, urinalysis and stool analysis were unremarkable.

**Diagnosis:** Status post sigmoidectomy

**Integrative treatment plan:** 1. Non-toxic integrative cancer treatment included chelation and hyperthermia, every other day, and intravenous medical ozone and biofeedback therapy, every day. 2. Given the fact of being elderly and physically frail after surgery, therapy focused on boosting Qi and nourishing blood. Prescribed Chinese herbs included Radix Codonopsis (Dang Shen) 30 g, Poria (Fu Ling) 15 g, Rhizoma Atractylodis Macrocephalae (Bai Zhu) 12 g, Radix Glycyrrhizae Preparata (Zhi Gan Cao) 9 g, Radix Rehmanniae Preparata (Shu Di Huang) 15 g, Radix Angelicae Sinensis (Dang Gui) 15 g, Radix Paeoniae Alba (Bai Shao) 15 g, and Rhizoma Chuanxiong (Chuan Xiong) 12 g. Later, the patient was diagnosed with Yang deficiency of spleen and kidney based on TCM syndrome differentiation. Therefore, the TCM prescription aimed to warm Yang and invigorate spleen and included the following herbs: Radix Codonopsis (Dang Shen) 15 g, dried ginger 15 g, Rhizoma Atractylodis Macrocephalae (Bai Zhu) 15 g, Licorice Root (Gan Cao) 10 g, Fructus Psoraleae (Bu Gu Zhi) 30 g, Semen Cuscutae (Tu Si Zi) 30 g, Fructus Lycii (Gou Qi Zi) 30 g, and Herba Epimedii (Yin Yang Huo) 30 g. Shenqifuzheng Injection was provided to boost healthy Qi. Acupuncture and dietary instructions were also combined into the treatment.

**Treatment outcome:** The patient stayed as an inpatient for 12 days and gained a significant improvement in her conditions, and was good in spirit. The patient complied with outpatient and inpatient follow-ups. Follow-ups in the last 2 years revealed an ongoing recovery. Assistant examinations on July 15, 2013, September 9, 2014, and March 6, 2015 revealed status post sigmoidectomy and no other evidence of tumor relapse.

The patient, aged 95 this year, has been living for 5 years since sigmoidectomy, and receives non-toxic integrative cancer treatment every half a year. Her quality of life scores 0 currently.

Follow-up examination in July, 2016 showed no evidence of tumor and good physical conditions.

## Esophageal Cancer

### H4, male, 49 years old.

He was admitted to Clifford Hospital on June 19, 2007 with a status post esophageal cancer resection for 20 months, progressive emaciation with hoarseness for over 2 months, and progressive dysphagia for 20 days.

The patient suffered repeated epigastric pain and vomiting in October, 2005 and underwent a CT scan which disclosed possible cancer of the lower esophagus. A gastroscopy revealed neoplasm in the lower esophagus and pathology reported moderately differentiated squamous carcinoma. Radical resection of esophageal cancer was successfully performed under general anesthesia. Pathology study indicated esophageal squamous cell carcinoma, which infiltrated muscular layer to serosal layer. Upper and lower surgical margins were negative for cancer invasion. There was no lymphatic metastasis. The patient recovered well after surgery and didn't receive any chemotherapy. In April 2007, he presented with emaciation (weight loss about 10kg in 2 months), hoarseness, poor appetite and occasional vomiting. Twenty days before admission, he experienced progressive dysphagia; therefore, he was admitted to the hospital for further treatment.

**Physical examination:** The patient was normal in physical development but was emaciated. He weighed 49kg and looked moderately anemic. There was no enlarged superficial lymph node. Heart and lung auscultation were normal. The abdomen was not distended, without tenderness.

Liver and spleen were impalpable. A surgical scar of 15cm in length was noted in the chest. Ecchymosis was seen in left abdomen and lower back. Karnofsky score was 70.

**Assistant examination:**

Tumor markers test: CEA 3.7ng/ml, AFP 6.6ng/ml, CA-125 12U/ml, CA-153 12U/l, CA19-9 27ml, TSGF 31.7U/ml. Immunology (5 items) and trace elements tests were normal. Ultrasound scan of the abdomen was unremarkable. Gastroscopy showed a red, swollen and erosive anastomosis and pathology study was consistent with canceration of the anastomosis, moderately differentiated squamous cell carcinoma. Esophageal barium swallow test showed postoperative change of the lower esophagus, and barium filling defect in the anastomosis. ECG and chest X-ray were normal. Fecal occult blood test: (++)

**Diagnosis:** Relapse after esophageal cancer surgery.

**Integrative treatment plan:** The patient suffered postoperative recurrence; his general conditions were poor, with a Karnofsky score of 70. He presented with nausea, vomiting, and significant emaciation, which were caused by eating difficulty from esophageal stricture after tumor recurrence and severe malnutrition due to tumor consumption. Therefore, nutritional support was given to the patient immediately after his admission, including total parenteral nutrition (TPN) and herbal cuisine.

For anti-tumor treatment, chest local hyperthermia was provided once every other day, together with chelation therapy. Intravenous medical ozone saline was employed once every other day at intervals of hyperthermia therapies, and systematic biofeedback therapy was also applied once every other day. Traditional Chinese medicine (TCM) and acupuncture therapies were combined during the whole treatment process.

The patient's tongue was dark-red, with white and greasy coating. Pulse was thready and thin. According to TCM syndrome differentiation, it was Phlegm Qi stagnation and TCM treatment was provided to remove the depressed Qi and Phlegm. Therefore Xuanfu Daizhe Decoction + Sinisan was prescribed: Flos Inulae (Xuan Fu Hua)15g, Haematitum (Dai Zhe Shi)15g, Radix Bupleuri (Chai Hu)15g, Fructus Aurantii (Zhi Ke)15g, Radix Curcumae (Yu Jin)15g, Pericarpium Citri Reticulatae (Chen Pi)10g, Rhizoma Pinelliae (Ban Xia)15g, Radix Sophorae Tonkinensis (Shan Dou Gen)10g, Rhizoma Paridis (Cao He Che)15g, Radix Paeoniae Alba (Bai Shao)15g, Gekko Japonicus Dumeril et Bibron (Bi Hu)6g, Nidus Vespae (Lu Feng Fang)10g. The TCM was one dose daily for oral administration and should be decocted with water.

In acupuncture therapy, the following acupoints were selected: BL 13, PC 6, RN 17, ST 36, RN 12, SP 6, KI 3, BL 18, RN 6, and Outer Three Passes (Waisanguan). The acupuncture adapted an "even reinforcing and reducing" method, and needles remained in the points for 20 minutes. This therapy was administered once daily, for 5 days, followed by a 2-day rest.

Moxibustion therapy: RN 12, RN 4, RN 8, and ST 36 were selected for moxibustion therapy. Method: each session of moxibustion was applied to 2 acupoints for 10 minutes respectively in the frequency of once a day, and there was a 2-day interval after 5 sessions.

Auricular therapy: acupoints selected were as following: CO 2, CO 4, CO 3, CO 12, AT 4, AH 6a, CO 13 and CO 1. Method: auricular therapy alternated once a week between two ears. Cowherb Seeds were applied to the auricular points and the patient was instructed to press each acupoint 3 to 5 times per day, with each press lasting for 3 to 5 minutes.

During the treatment, TCM therapy and acupuncture therapy (acupoints selected) were adjusted according to the patient's symptom. One week later, symptoms like nausea and vomiting disappeared. Therefore, chelation therapy increased in dosage, 3 times a week for 6 weeks successively. Ozonated saline and systematic biofeedback therapy were employed continuously for 2 weeks. TCM therapy and acupuncture therapy remained unchanged. Two weeks later, the patient was better in spirits and he gained more weight to 52kg. Intravenous ozonated saline therapy was changed into EBOO (18 sessions in total), while hyperthermia into whole-body moderate-high temperature hyperthermia (every two weeks, 4 sessions in total) + local hyperthermia (every other day, 3 sessions weekly, and 27 sessions in total). Systematic biofeedback was provided every other day, 3 sessions weekly, and 27 sessions in total. Chelation therapy and hyperthermia were applied

at the same time and acupuncture therapy remained the same as before. TCM therapy was adjusted based on the previous formula.

After 3-month treatment, a gastroscopy showed mildly red and swollen anastomosis and a significant shrinkage of the erosive lesion.

After discharge, the patient continued non-toxic integrative cancer treatments, including local hyperthermia, EBOO, chelation, TCM, acupuncture, systematic biofeedback and herbal cuisine. Local hyperthermia, systematic biofeedback, EBOO and chelation therapies were all administered once a week.

**Treatment outcome:** The patient received the integrative non-toxic cancer treatments (mainly hyperthermia therapy) for 3 months, which alleviated nausea, vomiting, poor appetite, emaciation and anemia. He was better in spirits and gained 9kg and returned to normal appetite and good sleep. Anemia was basically reversed. Karnofsky score was 100. In order to strengthen the treatment outcome and avoid cancer relapse and metastasis, he complies with one-week of the non-toxic integrative cancer treatments ever month.

Currently the patient leads a life with good quality and a ECOG PS score of 0.

## Glioma

### L7, 28 years old.

The patient was admitted on December 26, 2008 due to intracranial space-occupying lesion for over two years, headache and dizziness for over one month and aggravation for one day.

The patient found a left intracranial space-occupying lesion in a health checkup in December, 2006. Despite such a finding, she denied the presence of headache, dizziness, nausea, vomiting, blurred vision or hearing loss, and the lesion was left untreated. In early November, 2008, the patient experienced headache and dizziness, accompanied with intermittent nausea and vomiting. A head CT scan done at a local hospital revealed masses in the right-sided thalamus and parietal lobe, raising the possibility of glioma; abnormal signal intensity in the left parietal lobe with a significant edema zone. On November 5, 2008, she underwent resection of intracranial mass. Postoperative pathological analysis indicated oligoastrocytoma (grade 2). The patient recovered well after operation. But one month later, after being fatigued by a long journey, she experienced worsening headache and dizziness accompanied by nausea and vomiting. Therefore, she was admitted through emergency department to Clifford Hospital.

**Conditions on admission:** Headache, dizziness, nausea and vomiting affected walking. No complaint of tinnitus, limb numbness, or restricted motions. Appetite was poor. Sleep was good. Urination and bowel movements were normal. Tongue was light red with thin white coating and cyanotic sublingual veins. Pulse was weak and unsmooth.

**Physical examination:** General conditions were good. Two arc-shaped surgical scars of about 7cm in length were noted at the right parietal region. No enlarged superficial lymph nodes could be palpable. Neck was soft without resistance. Respiratory sounds were clear and free of dry or moist rales. HR was 72bpm. Cardiac rhythm was normal without any murmurs. Abdomen was soft and non-distended. Liver and spleen was impalpable. No tenderness or rebound tenderness was noted at the whole abdomen. Bowel sounds were normal. Limbs moved normally, without limited motions. There were physiological reflexes but no pathological reflex.

**Assistant examinations:** A head CT scan done in Hainan General Hospital on December 8, 2008 revealed status post resection of right parietal lobe glioma. Compared with prior study, there was edema and a small amount of blood at the surgical site. Left parietal lobe lesion remained unchanged. A small amount of fluid was noted in the right frontal, temporal and parietal regions. Subcutaneous blood buildup was noted at right occipital and parietal regions. Sphenoid sinusitis and right mastoiditis were indicated as well.

**Diagnosis:** Status post resection of brain astroglioma.

**Integrative treatment plan:** A joint consultation suggested the patient was in postoperative recovery phase and initial treatments should include intracranial pressure reduction, WBC elevation, nutritional supplement and symptomatic treatment. Oral chemotherapeutic agent (Temozolomide 150mg, qd×5/28d) was administered. Integrative treatments involved traditional Chinese medicine, acupuncture, local hyperthermia, chelation therapy, anti-tumor mixture and medical ozone therapy. As blood stasis and internal obstruction according to TCM syndrome differentiation, “Nao Liu Yin and San Ling Jian Wan” were prescribed to activate blood, remove stasis, and disperse mass. The prescription included the following ingredients: Rhizoma Sparganii (San Ling) 15g, Fructus Polygoni Orientalis (Shui Hong Hua Zi) 10g, Curcuma Zedoary (E Zhu) 15g, Radix Paeoniae Rubra (Chi Shao) 15g, Poria (Fu Ling) 15g, Semen Coicis (Sheng Yi Yi Ren) 30g, Scorpion (Quan Xie) 5g, Scolopendra (Wu Gong) 5g, Herba Hedyotidis Diffusae (Bai Hua She She Cao) 30g, and Liu Wei Di Huang Wan 12g. One dose of the above herbs was decocted with water for oral administration daily.

Acupuncture was applied to the acupoints including EX-HN 5, DU 20, DU 14, ST 8, GB 20, LI 4, DU 23, ST 36. It adopted principle of neutral supplementation and draining, with the needle retained for 20 minutes, once a day, and a 2-day interval after 5 sessions.

Moxibustion was applied to 2 acupoints for 10 minutes respectively in the frequency of once per day and a 2-day interval after 5 sessions.

Auricular points included AH10, CO4, CO12, CO18, AT4, TG2p, AT2,3,4i, and AH6a. Method: Cowherb Seeds were applied to auricular points and the patient was instructed to press them 3 to 5 times per day. Auriculotherapy alternated weekly between two ears. Local hyperthermia of the head was given every other day; chelation therapy every other day; one dose of anti-tumor mixture every day; and medical ozone therapy every other day (alternately with chelation therapy).

The patient was basically symptom free after one week of treatment. Hyperthermia, chelation therapy, EBOO, acupuncture and traditional Chinese medicine continued and her conditions improved to discharge one month later. She continued non-toxic integrative cancer treatments for over 3 months at outpatient department after discharge. The patient received 36 sessions of hyperthermia and 45 sessions of chelation therapy. Her condition was stable without presence of increased intracranial pressure.

**Treatment outcome:** All the symptoms were relieved after integrative treatment. On discharge, the patient’s appetite was normal and her weight increased by 3kg. Limbs moved normally and she could care for herself independently. One week after discharge, she returned for chemotherapy with oral Temozolomide and non-toxic integrative treatment including traditional Chinese medicine, chelation therapy, hyperthermia, medical ozone therapy, anti-tumor mixture and acupuncture. After she continued above therapies for 3 months, a follow-up head MRI revealed status post resection of right parietal lobe astrogloma. The lesion was smaller than the prior MRI finding on December 8, 2008. She was recommended to continue non-toxic integrative treatment. Follow-ups in the past 4 years showed no significant abnormality. Imaging reports showed continuous improvement. The patient has returned to normal life and work. She gave birth vaginally to a boy in 2011. She and her boy are healthy.

## Hypothyroidism

### L8 female, 36 years old.

The patient had hypothyroidism for many years; she had oral administration of thyroxin 75 mg a day, one wholebody low-temperature hyperthermia session a week for 10 weeks. After one wholebody low-temperature hyperthermia, 25 mg thyroxin can meet patient's daily requirement and the symptom caused by hypothyroidism disappeared or obviously improved.

## Liver Cancer

### L9 female, 82 years old, Mongolian.

The patient was admitted on March 9, 2014 with status post liver cancer surgery for 5 years and epigastric discomfort for over 2 years, which became severer in the past 3 weeks.

In April, 2008, she was hospitalized to Clifford Hospital for further investigation into abdominal discomfort. A CT scan of the epigastrium revealed multiple space-occupying lesions in anterior lower and posterior upper segments of right liver lobe, supportive of malignant liver tumor (cancer); and hypodense diffuse lesion in the liver, suggestive of liver damage.

On May 9, 2008, she underwent resection of liver cancer (segment V & VI), cholecystectomy and chemotherapy pump placement for portal vein. The surgery went successfully. Postoperative pathology result was consistent with hepatocellular carcinoma. She was then transferred to Oncology Dept. and received local chemotherapy (Epirubicin 10 mg + Fluorouracil 0.25 mg) and integrative treatments like medical ozone and chelation. The treatment course went smoothly and the patient was free of discomfort or post-chemotherapy side effect. Following the treatment, she stayed on long-term use of oral Chinese medicine, but didn't return for follow-up regularly due to her residency in Mongolia.

In 2013, the patient started to present with unexplained, repeated and intermittent epigastric discomfort, especially in middle and upper abdomen, which was not aggravated or relieved by any factor. She left the discomfort untreated; however, such symptoms were present 3 weeks ago including acid reflux, heartburn, and fatigue, which were more significant after meal and walking.

On February 24, 2014, she presented to outpatient office for medical attention. A color ultrasound scan of the epigastrium revealed a solid space-occupying lesion of the liver, supportive of liver cancer, and clinical correlation was suggested; and minor ascites. On February 25, 2014, a CT scan performed in outpatient department suggested: 1. Status post liver cancer surgery. Compared with CT findings on July 23, 2008, this scan showed multiple liver masses, indicating cancer relapse. 2. Multiple cysts of left kidney.

Outpatient treatment was administered for protecting stomach and liver, which yielded a poor outcome. She was then admitted to Oncology Department for further treatment with a diagnosis of relapse of liver cancer after surgery.

**Conditions on admission:** The patient was alert and energetic and complained of epigastric discomfort, acid reflux, heartburn, occasional pricking pain of left upper limb, weakness, and poor appetite. He denied significant abdominal pain and had normal nocturnal sleep and urination. His bowel movement frequency was about once every 1 to 2 days.

**Physical examination:** Patchy focal proliferation was noted on the skin all over the body, which was itchy and free of discharge. There was no sign of petechia. A well-defined mass with a moderate texture measuring 4\*2 cm in size was palpated behind the neck. A surgical scar was seen along bilateral costal margins. Bilateral respiratory sounds were clear to auscultation, without any dry or moist rales. There was no sign of precordial bulge. Apex beat was noted at the left 5<sup>th</sup> intercostal space, about 2 cm medial to midclavicular line. Cardiac dullness borders were normal; heart rate 80 bpm; and heart sound and rhythm were normal. No murmur was auscultated in valves. Abdomen was non-distended, without visible outline of stomach and intestine or gastrointestinal peristaltic wave. Abdominal walls were free of viscosity. A surgical scar measured 10 cm on the left and 15 cm on the right. Abdominal respiration was not limited. Abdomen was soft in muscles, without tenderness or rebound tenderness. Liver region was negative for tenderness. Hepatic dullness borders were normal and liver and spleen were impalpable. It was negative for Murphy sign and shifting dullness. Kidneys were free of tenderness and percussion-induced pain. Bowel sounds were normal. There was no vascular bruit heard.

#### **Assistant examinations:**

In February, 2014, a color ultrasound scan performed in outpatient department revealed a solid space-occupying lesion of the liver, supportive of liver cancer, and clinical correlation was suggested; and minor ascites.

On February 25, 2014, a CT scan performed in outpatient department suggested: 1. Status post liver cancer surgery. Compared with CT findings on July 23, 2008, this scan showed multiple masses in the liver, cancer relapse considered.

Laboratory study: Complete blood test: WBC  $2.35 \times 10^9/L$ . Biochemistry test: LDL 2.17 mmol/L, HDL 1.00 mmol/L, ALP 225 U/L, ALT 76 U/L, AST 89 U/L, LDH-1 84 U/L, DBIL 9.3  $\mu\text{mol/L}$ , PA 52.0 mg/L, GLB 41.6 g/L, ALB 25.8 g/L, A/G 0.6. DIC profile: activated partial thromboplastin time: 36.1 seconds; thrombin time: 22.2 seconds; D-dimer: 1420.94 ng/ml; and other findings were normal. Hepatitis B test: positive for hepatitis B virus surface antigen, hepatitis B e antigen, and hepatitis B core antibody.

ECG: 1. Sinus bradycardia. 2. Degree I atrioventricular block. 3. ST changes. Whole-body bone scanning: 1. Abnormal hypermetabolism of anterior portion of 7th right rib and follow-up suggested in 3 months. 2. Degenerative changes of right knee. 3. Degeneration of thoracic and lumbar vertebrae. 3. Whole body osteoporosis. These findings were suggestive of liver cancer with bone metastasis. CT scan results: 1. Status post liver cancer surgery. Compared with CT findings on July 23, 2008, this scan showed multiple masses in the liver, cancer relapse considered.

**Diagnoses:** 1. Relapse of hepatocellular carcinoma after surgery, with bone metastasis. 2. Ascites. 3. Prurigo nodularis. 4. Degree I atrioventricular block.

**Integrative treatment plan:** In western medicine, treatments included chemotherapy (arsenious acid 5 mg, 10 sessions) and supportive treatments like liver protection and nutrition support in combination with medical ozone and chelation.

In Chinese medicine, the patient was an elderly female with status post liver cancer surgery and suffered deficiency of Qi and blood of Zangfu. In addition, she was subject to emotional depression, internal injury caused by excess of seven emotions, and impaired dispersion of the liver and gallbladder. As liver and spleen interpromote and interrestrict each other, a depressed liver restricts spleen, resulting in abnormal transportation and transformation. A deficient spleen compromises nutritional absorption and generation of blood and Qi, which results in inadequate energy supply and weakness. The signs of fat tongue body with white coating and fine, stringy pulses were suggestive of stagnation of liver-Qi with deficiency of the spleen.

This was a cancer case and differentiation of syndromes also points to stagnation of liver-Qi with deficiency of the spleen. The treatment focused on reinforcing the spleen to replenish qi, relieving depression of the liver-qi and softening masses. In Chinese medicine, Kangai Injection and other anti-cancer treatment were administered to boost the healthy Qi. The patient suffered itchy proliferative lesions of full body skin, indicating damp toxin accumulation on the exterior. Chinese medicine compress was given to stop itching, remove toxin and expel wind.

During stay in hospital, the patient was provided with oral Chinese medicine, once a day and acupuncture, 5 sessions a week.

**Treatment outcome:** The patient stayed in hospital for 30 days. He was alert and in good spirit, with normal appetite, sleep, urination and defecation. He denied other discomfort. Physical examination: There was a fat tongue body with white coating and fine and stringy pulses. Liver palms of both hands were noted. Patchy and focal proliferation was scattered all over the body, with reduced itch and no oozing. A well-defined mass with a moderate texture measuring 4\*2 cm in size was palpated behind the neck. Abdomen was soft, without tenderness or rebound tenderness. Liver and spleen were impalpable. It was free of shifting dullness and bilateral lower limb edema. The patient's conditions were stable and ascites was reduced, without any significant discomfort. Therefore, the patient was discharged.

The patient has been living with advanced liver cancer for more than 7 years and is still on maintenance treatment with Chinese medicine tablets.

### **L10, male, born in 1947, from Zhejiang Province.**

The patient presented to a hospital in Dongyang city, Zhejiang province due to vague pain in the right upper abdomen with bad appetite in February, 2012, and was diagnosed with "liver cancer".

He received interventional therapy and radiofrequency ablation in the hospital. After such procedures, follow-up examinations like CT scan at Oncology Department in Clifford Hospital showed stable tumor lesion. He had been on long-term traditional Chinese medicine (TCM) (medication) treatment. A complete blood count in November 2013 revealed decreased white blood cell and platelet; and another complete blood count on April 12, 2014 revealed: WBC  $3.25 \times 10^9/L$ , PLA  $53 \times 10^9/L$ , but those problems were left untreated. On March 11, 2015, the patient presented with abdominal bloating and pain, which could be aggravated by food intake, and poor appetite. He was then admitted to Clifford Hospital for treatment. He stated a history of chronic hepatitis B for over 20 years and he had been on Entecavir tablets for a long time, and HBV-DNA was controlled around  $1 \times 10^3$ /copy.

**Conditions on admission:** The patient was listless and could be worsened by activity. The abdomen was distended, with epigastric pain. Facial complexion was dark. He disinclined to talk much. Urination was normal but stool was yellow and loose.

**Physical examination:** There was no jaundice or nevus araneus on whole body skin or mucosae. Bilateral lungs were clear to auscultation, without dry or moist rales. Heart rhythm and sounds were normal. No pathological murmur was heard in cardiac valves. Abdomen was slightly distended, without varicose veins in the abdominal wall. Abdominal muscles were soft, with slight epigastric tenderness but no rebound tenderness. Liver and spleen were impalpable under the ribs. Shifting dullness was positive. Lower limbs were free of edema.

**Assistant examination:**

Blood count: WBC  $3.24 \times 10^9/L$ , PLT  $71 \times 10^9/L$ .

Blood transfusion test (4 items): HBcAb positive, HBsAg positive.

Blood biochemistry: TBIL  $31.3 \mu\text{mol/L}$ , PA  $110.0 \text{mg/L}$ , IBIL  $25.3 \mu\text{mol/L}$ .

**Diagnosis:**

1. Status post interventional treatment for primary liver cancer
2. Chronic Hepatitis B, positive HBsAg, HBeAg, HBcAb
3. Liver cirrhosis caused by hepatitis
4. Ascites

Integrative treatment included TCM, acupuncture, and CIK cells infusion treatment, etc. As the patient was an aged gentleman with a history of chronic hepatitis and excess alcohol consumption, his liver lost control of conveyance and dispersion, causing Qi transformation insufficiency and subsequently presented with Qi stagnation and blood stasis. According to TCM disease differentiation and syndrome differentiation, he had “liver cancer” and “a depressed liver and a deficient spleen”.

In TCM therapy, Xiaoyaosan Decoction was prescribed: Radix Angelicae Sinensis (Dang Gui)15g, Paeonia lactiflora (Shao Yao)30g, Radix Bupleuri (Chai Hu)30g, Poria (Fu Ling)20g, Rhizoma Atractylodis Macrocephalae (Bai Zhu)20g, Radix Glycyrrhizae (Gan Cao)10g, Rhizoma Zingiberis Recens (Sheng Jiang)10g, Herba Menthae Haplocalycis (Bo He)10g (added later), Fructus Aurantii (Zhi Ke)15g, Radix Astragali (Huang Qi)20g. The TCM was given one dose daily for oral administration and should be decocted with water.

Acupoints for acupuncture therapy: BL 18, LU 1, LU 5, ST 36, LI 11, ST 40, SP 10, LR 3, Spirit Bone (Linggu), SP 3 and Outer Three Passes (Waisanguan). Triple Points (Sanchongxue) and Outer Three Passes (Waisanguan). Acupuncture adapted an “even reinforcing and reducing” method and the needles remained in the points for 20 minutes. The therapy was once daily for 5 days a week followed by a 2-day rest. CIK cells infusion treatment was applied twice daily. In addition, intravenous diuretic was provided with albumin supplement and immunity boosting.

**Treatment outcome:** The patient had been hospitalized for 9 days. Abdominal distention and pain were relieved. He denied weakness and stated normal sleep, urination and bowel movement. Tongue was red, with thin white coating. Physical examination showed no jaundice or nevus araneus on whole body skin or mucosae. Bilateral lungs were clear to auscultation, without dry or moist rale. Heart rhythm and sounds were normal. No pathological murmur was heard in cardiac valves. Abdomen was slightly distended, without varicose veins in the abdominal wall. Abdominal muscles were soft, without tenderness or rebound tenderness in the epigastrium. Liver and spleen

were impalpable under the ribs. Shifting dullness was negative. Lower limbs were free of edema or varicosity. Follow-up liver function test was normal.

The patient has been living with advanced liver cancer for 4 and a half years. He only receives TCM and non-toxic integrative cancer treatments. Currently he recovers well with the cancer basically in remission.

The patient keeps periodic follow-ups in Clifford Hospital. Currently he is in stable condition and still on TCM treatment.

### **X1, 62 years old.**

The patient was admitted on April 28, 2007 due to "yellowish discoloration of skin and sclera for 20 days and abdominal bloating with edema in bilateral lower limbs for 3 days".

More than 20 days before admission, the patient noticed yellow discoloration of sclerae and lacked strength. He then sought medical attention in a local clinic and was diagnosed with "hepatitis"; however, the patient paid no attention on doctor's suggestion for further examination. Three days before admission, the patient noted edema in bilateral lower limbs and suffered poor appetite and bloating abdomen. Therefore, he decided to seek medical care at Outpatient Department of Clifford Hospital.

A B-mode ultrasound scan of abdomen indicated multiple nodules in right hepatic lobe, of which the largest one was 4cm×5cm×5.5cm in size.

Later an abdominal CT scan revealed atrophic left hepatic lobe and hypodense lesion in the posterior-upper segment of right hepatic lobe with a sectional area of 5.4cm×6.2cm. A satellite nodule with a diameter of about 6mm was behind the lesion. These were suggestive of primary hepatic carcinoma, hepatic cirrhosis and ascites. He was subsequently hospitalized for further treatment.

At admission, he was in poor spirit and appetite, and felt whole-body weakness and mild abdominal bloating. Sleep was acceptable. Stool was dark-black occasionally.

**Physical examination:** There was medium yellowish discoloration all over the skin and mucosae. Several spider angiomas were noted in neck and upper chest, but no rash or subcutaneous hemorrhage or ecchymosis. The abdomen was soft in muscle and slightly distended, without venous engorgement tenderness or rebound tenderness. Hepatic region was not tender. Liver and spleen were impalpable. Murphy sign was negative, and shifting dullness was positive. Mild edema was noted in lower limbs. Karnofsky Performance Status Scale was 60.

#### **Assistant examinations:**

Complete Blood Count:	RBC	5.5×10 <sup>12</sup> /L	Hb	125g/L
	WBC	5.3×10 <sup>9</sup> /L	PLT	224×10 <sup>9</sup> /L
Biochemistry test:	ALT	775U/L	AST	585U/L
	TBIL	217U/L	DBIL	154.5U/L
	ALB	26.7g/L	ALP	256U/L
	GGT	357U/L	Cr	12umol/L
	Ua	125umol/L	BUN	2.7mmol/L
	GLU	6.21mmol/L	TG	0.54mmol/L
	GHO	3.78mmol/L	K <sup>+</sup>	3.5mmol/L
	Na <sup>+</sup>	137mmol/L	Cl <sup>-</sup>	101mmol/L
	Ca <sup>2+</sup>	1.78mmol/L		
	Tumor markers:	CEA	3.7ng/ml	AFP
CA-125		12U/ml	CA-153	12U/ml
CA19-9		27ml	TSGF	31.7U/ml

Immunology test (5 items) revealed normal findings.

Micro-elements:

Copper 3.55mmol/L

Zinc, lead, mercury, cadmium, nickel were within normal limits.

NH 143umol/L

HBV(5 items): HBsAg (+)

HBsAb (-)

HBeAg (-)

HBeAg (+)

HBeAb (+)

HBV-DNA  $3.37 \times 10^5$ copies/ml

An abdominal CT scan revealed atrophic left hepatic lobe, an abnormal low-density lesion in the inferior-posterior segment of right hepatic lobe with a sectional area of 5.4cm×6.2cm, and a satellite nodule about 6mm in diameter behind the lesion. Therefore, the impression was primary hepatic carcinoma, hepatic sclerosis and ascites.

A gastroscopy showed varicosity of esophagus and gastric fundus.

A chest X-ray showed a small amount of right-sided pleural effusion.

An ECG was normal.

#### **Diagnoses:**

5. Primary liver cancer (T3N0M0);

6. Decompensated cirrhosis secondary to chronic hepatitis B.

#### **Integrative treatment plan:**

The patient suffered obviously abnormal liver function, massive ascites, hypoproteinemia and elevated blood ammonia at admission. Without medical management, it could develop into liver failure or even hepatic coma, hepatorenal syndrome, massive hemorrhage in upper gastrointestinal tract or other major diseases. Therefore, symptomatic treatment was given for detoxification, protecting liver and reducing enzyme, relieving jaundice, lowering blood ammonia, inhibiting gastric acid and reversing hypoproteinemia. And nutritional support included a rational combination of Compound Amino Acid Injection, medium/long-chain fat emulsion and glucose.

In syndrome differentiation of traditional Chinese medicine, the patient's primary symptoms (yellow discoloration of skin and sclerae, ascites, edema in lower limbs, poor appetite, red tongue with yellow-greasy coating, and wiry pulse) were attributed to "liver Qi depression and stagnation" and "water-dampness and retention". Accordingly, the patient should be treated to soothe the liver, regulate Qi, drain dampness and relieve icterus and TCM prescription included the following herbs:

Green tangerine Peel (Qing Pi) 10g

Radix curcumae (Yu Jin) 20g

Cyperus rotundus (Xiang Fu) 20g

Hovenia dulci (Zhi Ke) 10g

Angelica sinensis (Dang Gui) 15g

Radix notoginseng (Tian Qi) 6g

Concha margaritifera (Zhen Zhu Mu) 30g

Light wheat (Fu Xiao Mai) 60g

Prepared liquorice root (Zhi Gan Cao) 10g

Trichosanthes kirilowii maxim (Gua Lou) 30g

Allium macrostemon (Xie Bai) 15g

Acorus calamus (Chang Pu) 15g

Root of red-rooted salvia (Dan Shen) 20g

Root of kudzu vine (Ge Gen) 30g

Mint (Bo He) 6g

Radix curcumae longae (Jiang Huang) 10g

Radix Paeoniae Rubra (Chi Shao) 60g

Capillary worm wood Herb (Yin Chen) 30g

These herbs were decocted with water for oral administration once daily.

A local hyperthermia of abdomen was also given every two days and after 2 weeks of continuous treatment, skin and sclerae discoloration obviously subsided and ascites and edema in lower limbs were reversed. However, the patient developed paroxysmal palpitation and an ECG

indicated paroxysmal supraventricular tachycardia, and subsequently local hyperthermia was stopped.

According to TCM differentiation of symptoms and signs, the patient suffered Qi and Yin deficiency and was given "Si Jun Zi Tang" combined with "Sheng Mai San". Chelation or extracorporeal blood oxygenation and ozonation (EBOO) were administered alternately every other day.

After a week of treatment, the patient got rid of yellowish skin or sclerae, or palpitation, but with poor appetite. In TCM's perspective, symptoms were differentiated as spleen-stomach weakness. Xiangsha Liu Junzi Tang was prescribed to fortify the spleen and improve appetite as well as "Pei Yuan Tang" (1 bag per day).

Symptoms disappeared after the treatment, and the patient continued the local hyperthermia every other day.

Besides, acupuncture therapy was given with a neutral supplementation and draining method and some acupoints (in international codes) selected were as follows:

Ganshu (BL18), Qimen (LA14), Pishu(BL20), Shenshu (BL23), Zusanli (ST36), Taixi (KI3), Sanyinjiao (SP6), Taichong (LR3), Yinlingquan (SP9), and Waisanguan (GB34). Needles remained for 20 minutes and there was a 2-day interval after 5 sessions. Meanwhile, moxibustion was applied to 2 acupoints among Guanyuan (RN4), Zusanli (ST36), Ganshu (BL18), Shenshu (BL21), Pishu (BL20) for 10 minutes respectively in the frequency of once per day and a 2-day interval after 5 sessions. Auriculotherapy alternated weekly between two ears. Cowherb seeds were applied to the auricular points (CO12, CO13, HX1, GAN YAN DIAN, HX6,7i, CO18, TG2p, AT4, AH6a, TF4).

Typical symptoms of decompensated cirrhosis on admission were treated with western medicine for liver protection, gastric acid inhibition, albumin supplement, and reduction of enzymes and blood ammonia. Since he went through the critical days, treatment increased progressively and systematically in intensity.

#### **Treatment outcome:**

After 2 months of inpatient stay, the patient stated well improved spirit and normal appetite. Stool was yellow and soft. He was free of weakness, abdominal distension and edema in bilateral lower limbs. Physical examination revealed no yellowish skin or sclerae. In follow-up examination, space-occupying lesion in liver measured 5.4cm×5.5cm in size, which had shrank comparing with that before treatment. No evidence of ascites or lymphadenopathy.

Liver function test:

ALT	35U/L	AST	47U/L
TBIL	39U/L	DBIL	18.5U/L
ALB	20.5G/L	AFP	173UG/L

KPS was 100. The patient has good spirit, appetite and sleep in periodic follow-ups. He returned for 10 days of non-toxic integrative cancer treatment in inpatient department every 20 days and stayed on Chinese medicine after discharge. The follow-up treatment frequency was adjusted to 1 week per month after 3 months and three days per month after six months. A follow-up CT scan in outpatient department (1.5 year after discharge) showed stable lesions of unchanged size, and no evidence of new lesion. Liver function and AFP were normal.

The patient has a good quality of life currently and is still on non-toxic integrative cancer treatment.

## **Lung Cancer**

### **C1, female, 64 years old.**

The patient was admitted on August 27, 2014 with lung cancer for over 1 year, cough for over 1 month, and left chest pain for 3 days. In December 2012, the patient presented with cough,

shortness of breath, and chest distress, without hemoptysis or night sweat. Then she sought medical attention at Nansha Hospital of Chinese Medicine where she was diagnosed with lung cancer accompanied by pleural effusion. However, she didn't receive assistant examinations like pathology test. As patient family refused surgery, radiotherapy and chemotherapy, she only received Chinese medicine. From February 2013 until now, the patient was admitted to Clifford Hospital multiple times with chest pain, cough, shortness of breath and other discomfort. Chinese medicine and non-toxic cancer treatment helped relive patient's symptoms. One month prior to admission, the patient presented with non-productive cough, which was not treated systematically. Three days ago, the patient developed paroxysmal chest pain, with each episode lasting for about 1 hour, which was relieved by oral analgesic.

**Past history:** History review was positive for rheumatic arthritis for over 10 years and cervical spondylopathy with repeated dizziness for over 5 years. She denied the history of hepatitis, tuberculosis, hypertension, diabetes mellitus, heart disease, surgery or trauma, or blood transfusion. Vaccination history remained unknown.

**Conditions on admission:** The patient was alert and in general spirit. She complained of non-productive cough and left chest pain. She denied chest distress, shortness of breath, chills or fever. Appetite, sleep, urination and bowel movement were normal. There was no recent weight loss. On physical examination, the patient was in an active posture and normal in development, poor in nutritional status, alert in consciousness, normal in gait, correct in response to questions, and cooperative in physical examination. The left lung presented with an inadequate respiratory movement and increased vocal fremitus as well as a flat percussion note. Significantly reduced respiratory sound was noted in the left lower lung. Right lung was clear to auscultation. Both lungs were free of dry or moist rale. There was no sign of precordial bulge. The apex beat was noted at the left 5th intercostal space, about 2 cm medial to midclavicular line. Cardiac dullness borders were normal; heart rate 77 bpm; and heart sound and rhythm were normal. No murmur was auscultated in valves.

**Assistant examination:** Chest CT scan: 1. Nodule has increased in size in lingular and apicoposterior segments of left lung. There were multiple new metastases in both lungs as well as left pleural metastasis. Lymphadenopathy was showed in left pulmonary hilus, mediastinum, and left supraclavicular region. There was an evidence of encapsulated pleural effusion. 2. Right thyroid had a space-occupying lesion, suggestive of adenoma.

Laboratory study: Liver function: DBIL: 7.4  $\mu\text{mol/L}$ ; complete blood count:  $13.98 \times 10^9/\text{L}$ , NEU#:  $9.99 \times 10^9/\text{L}$ , RP: 14.1mg/L.

Tumor markers (5 items): CEA: 86.82ng/ml, CA153:42.66U/ml, CA125:165.60U/ml. Other findings were normal.

**Diagnoses:** 1. Stage IV Lung cancer with metastases to lymph nodes and internal lung. 2. Pleural effusion. 3. Mixed cervical spondylopathy.

**Integrative treatment plan:** 1. Oral Dextromethorphan to stop cough and Esomeprazole Magnesium Enteric-coated Tablets to protect stomach. 2. Coenzyme Complex for Injection by IV for nutritional support. 3. Medical ozone to improve immunity. 4. Kangai Injection by IV to boost healthy Qi and inhibit cancer. 5. Cefoperazone Sodium and Sulbactam Sodium for Injection by IV drips (3 g, Q12 h) for infection. 6. Instruct the patient to stay positive, lead a regular life, keep good indoor ventilation, keep warm, and prevent secondary lung infection from pathogens. The patient was advised to minimize the intake of sticky, greasy, and spicy food and turn to food with anti-cancer properties, like mushroom, coix seed, and sea tangle.

The patient suffered deficiency of Qi and Yin in terms of syndrome differentiation. The Chinese medicine focused on supplementing Qi and nourishing Yin. Shashen Maindong Tang was prescribed, one dose a day orally, and included the following herbs: Radix Adenophorae (Sha Shen) 10 g, Ophiopogon Root (Mai Men Dong) 15 g, Fragrant Solomonseal Rhizome (Yu Zhu) 10 g, Radix Glycyrrhizae (Sheng Gan Cao) 6 g, Folium Mori (Sang Ye) 10 g, Radix Trichosanthis (Tian Hua Fen) 10 g, and Hyacinth Bean (Bian Dou) 10 g. Adenophorae (Sha Shen) and Ophiopogon Root (Mai Men Dong) serve to supplement Qi and nourish Yin. Fragrant Solomonseal rhizome (Yu Zhu) and Radix Trichosanthis (Tian Hua Fen) promote fluid production

to quench thirst. Folium Mori (Sang Ye) clears heat. Hyacinth Bean (Bian Dou) eliminates dampness.

**Treatment outcome:** After admission as an inpatient for 11 days, the patient was alert and energetic. A dragging sensation of left chest was noted, without pain, and discomfort below xiphoid process subsided. She coughed occasionally, but denied chest distress, shortness of breath, productive cough, chills or fever. Sleep, urination and defecation were normal. The tongue was red with a thin coating. The pulse was thready and rapid. Physical examination: There was no palpable enlarged superficial lymph node all over the body. Respiratory sounds of left lower lung weakened while that of right lung remained normal. Both lungs were free of dry or moist rale. The cough and chest pain subsided significantly, and the patient was discharged without obvious discomfort.

Currently, the patient continues treatment with Chinese medicine and local hyperthermia, without use of KTI treatment or chemotherapy. She has been living with lung cancer for more than 4 years with a stable quality of life.

### **D1, male, 64 years old.**

On March 28, 2014, the patient was admitted with lung cancer for over 3 years and productive cough for 10 days. In October, 2010, the patient developed cough productive of excessive sputum with blood streak. A CT scan revealed a space-occupying lesion of left upper lung, suggestive of lung cancer accompanied by obstructive pneumonia. A follow-up CT scan in Clifford Hospital showed: 1. A space-occupying lesion of left upper lung, highly suggestive of lung cancer with metastases to lymph nodes of supraclavicular fossa and mediastinum; and hydropericardium and minor left pleural effusion. 2. Old lacunar infarction in left basal ganglia and thalamus. Sequential fiberoptic bronchoscopic pathology result was consistent with squamous cell carcinoma, stage IIIb, which was inoperable. Therefore, local hyperthermia and nontoxic integrative cancer treatment were administered and the patient improved and was discharged.

The patient presented with cough productive of sputum 10 days ago and was readmitted. On physical examination, the patient was in an active posture, moderate in nutritional status, normal in gait, correct in response to questions, and cooperative in physical examination. The full-body skin was free of yellowish discoloration, cyanosis, mucosal ulcer, or spider nevus. No evidence of superficial lymphadenopathy. The thorax was symmetrical without malformation. Both lungs were normal in respiratory movement. Vocal fremitus was asymmetrical. Auscultation of right lung revealed low-pitched respiratory sound. No respiratory sound was heard in left upper lung. There was no sign of dry or moist rale. There was no evidence of precordial bulge. The apex beat was noted at the left 5th intercostal space, about 2 cm medial to midclavicular line. Cardiac dullness borders were normal; heart rate 73 bpm; and heart sound and rhythm were normal. No pathologic murmur was auscultated in valves.

**Conditions on admission:** The patient looked tired and thin and suffered productive cough, chest distress, exertional dyspnea, and unclear speech. Diet intake, urination and defecation were normal. There was no sign of extremity edema. The tongue was red with thin and white coating. The pulse was stringy and thready.

**Assistant examination:** Complete blood count: WBC  $8.49 \times 10^9/L$ , Neu% 84.7%, HCT 38.7%, Lym% 9.9%. The remaining findings were normal. Liver function: ALT 43U/L, GLU) 18.13mmol/L, PA 134.0mg/L, GLB 35.7g/L, and S/L 0.5. Myocardial enzymes, renal function and electrolytes were unremarkable. HbA1C% 8.80%. FT4 1.80ng/dl. Urine analysis: Glucose 4+. Stool analysis: Weak positive ( $\pm$ ) for occult blood.

Chest CT scan with contrast: Status post treatment of left upper lung cancer. Compared to CT scan findings on November 6, 2012, this CT scan revealed the following findings: lesion increased in size; atelectasis of left upper lobe; mediastinum displaced to the left; possibility of multiple metastases in left lower lobe to be excluded; small nodule in lateral segment of right middle lobe below pleura and regular follow-up suggested; minor left-sided pleural effusion; hydropericardium; and compensating emphysema of right lung.

Diagnoses: 1. Squamous cell carcinoma of the left lung with lymph node metastasis (T3N3M0, stage IIIb). 2. Obstructive pneumonia

**Treatment plan:** Non-toxic integrative cancer treatment was provided, involving Chinese medicine, acupuncture, hyperthermia, and medical ozone.

As a frail elderly, the patient suffered chronic lung disease, which consumed lung Qi and caused lung Qi deficiency. Lung Qi deficiency results in pulmonary dysfunction, impaired Qi activities, blood stasis, and interrupted body fluid circulation. Fluid accumulation forms phlegm while phlegm accumulation leads to Qi stagnation and block collaterals and subcollaterals. As a result, toxin accumulates and results in lung masses as time goes by. Impaired lung function and upward invasion of lung Qi result in cough productive of phlegm. Lung Qi deficiency induces chest tightness and exertional shortness of breath. Tongue and pulse showed signs of deficiency of both Yin and Qi. Therefore, Kangai Injection was administered to boost health Qi. Sha Shen Mai Men Dong Tang, a Chinese medicine formula, was prescribed, one dose per day after meal and heated before use, to nourish Yin and moisturize the lung and eliminate cough and sputum. The formula included Radix Glehniae (Bei Sha Shen) 15 g, Radix Ophiopogonis (Mai Dong) 10 g, Radix Trichosanthis (Tian Hua Fen) 15 g, Stir Fried White Hyaciath Bean (Chao Bai Bian Dou) 15 g, Folium Mori (Sang Ye) 10g, Fragrant Solomonseal Rhizome (Yu Zhu) 12 g, Radix Glycyrrhizae Preparata (Zhi Gan Cao) 6 g, Radix Codonopsis (Dang Shen) 15 g, Poria (Fu Ling) 15 g, Rhizoma Pinelliae (Fa Ban Xia) 12 g. The patient also received treatment to fight against infection and control blood pressure and glucose. Deep hyperthermia of the chest was ordered to inhibit tumor growth. Chinese medicine treatment focused on nourishing Yin and moistening lung while relieving cough and reducing sputum. With treatment given, patient's general conditions were good and productive cough subsided significantly.

During the 1-year follow-up, he presented regularly for outpatient and inpatient care. Assistant examinations after admission on August 2, 2014: liver function: LDL: 1.76mmol/L; HDL: 1.05mmol/L; ALT: 63U/L. Complete blood count, stool and urine analysis, glycosylated hemoglobin, lung cancer associated antigen (2 items), and TPSA were unremarkable. Chest CT scan results showed: Status post treatment of left upper lung cancer. Compared to CT scan findings on March 29, 2014, this CT scan revealed the following findings: mass shrank in size; foci were almost absorbed in left lower lobe; previous left-sided pleural effusion was almost absorbed. Small nodule in lateral segment of right middle lobe below pleura, hydropericardium; and compensating emphysema of right lung remained almost unchanged. The patient continued treatment as directed.

The patient with advanced squamous cell carcinoma of the lung did not receive chemotherapy, radiotherapy or targeted treatment. Treated with Chinese medicine and local hyperthermia, he survived for more than 5 years, with a significant outcome.

In July, 2016, the patient died of cardiovascular disease.

## **G2, male, 73 years old.**

The patient was admitted on January 30, 2015 with status post lung cancer surgery for 4 years and shortness of breath and bilateral lower extremity edema for 1 month.

On December 2, 2010, he underwent right lower lobectomy and lymphadenectomy in Nanfang Hospital. Postoperative pathology result was consistent with moderately differentiated adenosquamous carcinoma of right lower lung (stage Ib), without evidence of lymphatic metastasis. The patient took long-term Chinese medicine after surgery, instead of chemotherapy. A PET-CT scan on December, 2013 revealed no sign of cancer relapse or metastasis. He complied with regular outpatient follow-up in Clifford Hospital. Past history: The patient received right liver resection and cholecystectomy as a result of suspected liver cancer in Zhongshan Hospital, Shanghai in 1991 and postoperative pathology result was consistent with nodular hyperplasia. History review was also significant for hypertension, coronary heart disease, lacunar infarction, diabetes mellitus, and pulmonary tuberculosis.

**Conditions on admission:** The patient stated shortness of breath, chest distress, bilateral lower extremity edema, and restricted motion range. He denied productive cough, hemoptysis, nausea or vomiting. His appetite, urination and defecation were normal, without recent weight loss or gain. The tongue was pink with thin and white coating. The pulse was stringy.

**Physical examination:** Bilateral respiratory sounds were clear to auscultation, without any dry or moist rales. There was no sign of precordial bulge. The apex beat was noted at the left 5th intercostal space, about 2 cm medial to midclavicular line. Cardiac dullness borders were normal; heart rate 84 bpm; and heart sound and rhythm were normal. No murmur or pathologic murmur was auscultated in valves. A 2cm surgical scar was noted on right chest and healed properly. A 20 cm surgical scar was seen on the abdomen and healed well. Moderate edema of bilateral lower extremities was noted.

**Assistant examinations:** Chest and abdomen CT scan revealed the following findings: 1. Status post right lower lobectomy due to lung cancer: minor organization foci in the right lung. A cystic lesion was seen at right heart margin. There was no significant interval change from CT results on June 28, 2014. 2. Fatty liver and small cyst in Segment 2 of liver. 3. Multiple cysts of bilateral kidneys, and bilateral adrenal gland thickening. 4. Multiple thyroid nodules. 5. Absence of gallbladder was noted. The findings remained similar to those on June 28, 2014. Prostatic hyperplasia and calcification were shown. CTA of coronary artery showed: Coronary heart disease; multiple calcifications of three coronary branches; mild to moderate luminal stenosis.

**Laboratory study:** Complete blood count and urinalysis were unremarkable. Biochemistry test: Uric acid 542  $\mu\text{mol/L}$ . Glucose test result is 6.65mmol/L. Triglyceride 2.09mmol/L. Male tumor markers (6 items): Normal.

**Diagnoses:** 1. Lung cancer, status post adenosquamous lung carcinoma surgery. 2. Hypertensive heart disease with heart failure and class 3 heart function. 3. Grade 1 hypertension, extremely high risk group. 4. Type 2 diabetes mellitus. 5. Old cerebral infarction. 6. Benign nodular hyperplasia of the liver and status post right liver resection and cholecystectomy.

**Integrative treatment plan:** 1. In western medicine, deep hyperthermia of the lung was provided every other day to control cancer relapse and metastasis; cardiogenic and diuretic agents to control heart failure; and anti-platelet therapy and coronary artery dilator to prevent coronary event. 2. In Chinese medicine's perspective, the patient suffered deficiency of Qi and Yin and deficiency-excess complex. Sha Shen Mai Dong Tang, a Chinese medicine formula, was ordered to boost healthy Qi and nourish Yin, one dose a day (3 doses in total) and taken in the morning and evening. The formula included the following herbs: Radix Astragali (Huang Qi) 15g, Radix Adenophorae (Sha Shen) 15 g, Radix Ophiopogonis (Mai Dong) 15 g, Bulbus Lili (Bai He) 15 g, Radix Scrophulariae (Xuan Shen) 12 g, Fritillariae Thunbergii Bulbus (Zhe Bei Mu) 12 g, Semen Armeniacae Amarae (Ku Xing Ren) 12 g, Herba Scutellariae Barbatae (Ban Zhi Lian) 15 g, Poria (Fu Ling) 18 g, and Grifola (Zhu Ling) 15 g.

**Treatment outcome:** The patient stayed as an inpatient for 13 days and gained a significant improvement in his conditions. The patient was alert and in good spirit and chest tightness subsided. It was negative for expectoration, fever, nausea or vomiting, abdominal pain or bloating, lower extremity edema or restricted motions. Appetite, urination and defecation were normal. The patient complies with outpatient and inpatient follow-ups and is free of cancer relapse.

He has been living with lung cancer for 6 years, without use of chemotherapy, radiotherapy, targeted therapy or immunotherapy. The patient only received non-toxic integrative cancer treatment and led a completely normal life.

### **H5, female, 65, Hong Kong citizen.**

The patient was admitted on August 29, 2014 with a 2-year history of adenocarcinoma of the left lung accompanied by multiple metastases. On September 14, 2012, she found unexplained enlarged lymph node in the left side of her neck, which was hard in texture, with limited mobility but no pain. She underwent an aspiration biopsy in a local hospital and was verbally informed that

the result revealed pulmonary adenocarcinoma with lymphatic metastases (detailed pathology report unknown). Later, as presence of pleural effusion resulted in shortness of breath, she underwent thoracentesis to remove the pleural effusion (pathology report of the pleural effusion unknown), which led to a minor relief in shortness of breath. Then she was transferred to Clifford Hospital for further treatment.

**Conditions on admission:** The patient was alert but in low spirits. Lymph nodes on left side of the neck were enlarged. There was no fever, cough, hemoptysis, chest tightness, nausea, vomiting, abdominal pain or diarrhea. She was poor in appetite and sleep, but was normal in urination and bowel movement. The tongue was dark red, with thin and white coating. Pulse was deep and thin.

**Physical examination:** The patient was emaciating, in bad nutrition and with dry body skin. Two enlarged lymph nodes of 0.4cm×0.4cm in size were noted on the left side of the neck, hard and hardly movable. Thoracic deformity was noted with significant shrinking of the left thorax. Respiratory sounds in the left lung weakened, but that was normal in the right lung. No dry or moist rale was auscultated in both lungs. A badly-circumscribed mass of 5×5cm was palpated in the left epigastrium, which was firm and unmovable. Other quadrants of the abdomen were flat.

**Assistant examinations:**

PET/CT on February 2014 revealed: 1. A mass was noted in the dorsal segment of the left lower lobe with increased glucose metabolism, consistent with lung cancer. Massive pleural effusion accumulated in the left chest, accompanied by left lung atelectasis. 2. Multiple nodules were detected in both lungs. Multiple nodules and masses were seen in left pleura, chest and abdominal wall, with increased glucose metabolism, suggestive of metastatic tumors. 3. Multiple lymph nodes with increased glucose metabolism were found in level V of the neck, mediastinum and abdominal wall, suggestive of metastatic tumors. 4. Multiple osteogenesis and osteolysis with partly increased glucose metabolism were noted in the whole body, suggestive of metastatic tumors. 5. Spinal degeneration.

Chest X-ray on September 7, 2014 revealed the following results: left lung cancer, pleural effusion in left chest, metastatic tumor in left upper lung and increased infection lesion in right lower lung.

Laboratory study: CRP: 17.8mg/L, WBC:17.12×10<sup>9</sup>/L, HGB:87g/L, PLT:441×10<sup>9</sup>/L. Liver function: ALB: 32.5g/L. Tumor markers for female (5 items): CEA: 9.19ng/ml, CA15-3: 147.80U/ml, CA19-9: 27.72U/ml, AFP and A12-5 (within normal range). 2014-09-09: Blood count: WBC: 14.10×10<sup>9</sup>/L, Neu#: 12.93×10<sup>9</sup>/L, HGB: 93g/L, CRP:69.0mg/L. Liver function and electrolytes: Na: 128.20mmol/L, Cl: 84.20mmol/L, ALB: 32.40g/L, Ca:1.91mmol/L, Mg: 0.60mmol/L.

**Diagnosis:** Adenocarcinoma of the left lung accompanied by lymphatic metastases in the mediastinum, supraclavicular fossa and multiple metastases to both lungs.

**Integrative treatment plan:** Non-toxic integrative cancer treatments were provided, including traditional Chinese medicine (TCM), acupuncture, chelation, hyperthermia and medical ozone therapies.

TCM: The patient was in older age and frail. Due to consumption and waste, lung Qi was deficient and obstructed, inducing chest tightness. Prolonged diseased status injured spleen and stomach and the spleen lost its normal function of transport, causing a bad appetite. Qi transformation was disordered and Qi was unable to transform into blood. Therefore, Qi and blood were too weak to ascend into the lungs, causing lung Yin deficiency. The tongue was red with scanty coating, together with thready and rapid pulse, suggestive of deficiency of both Qi and blood. In conclusion, the patient was diagnosed with lung cancer according to disease differentiation and deficiency in both Qi and blood according to syndrome differentiation.

Treatment focused on tonifying Qi and nourishing Yin. Shashen Maidong Decoction was prescribed and included the following herbs: Radix Ophiopogonis (Mai Dong) 12g, Radix Adenophorae (Sha Shen) 6g, Rhizoma Polygonati Odorati (Yu Zhu) 15g, Radix Glycyrrhizae (Gan Cao) 30g, Folium Mori (Sang Ye) 12g, Radix Trichosanthis (Tian Hua Fen) 15g, Semen Lablab

(Bian Dou) 9g. The prescription should be decocted in water for oral administration, one dose daily

Acupuncture was applied to acupuncture points: BL 13, LU 1, LU 5, ST 36, LI 11, ST 40, SP 10, LR 3, Spirit Bone (Linggu), SP 3, and Outer Three Passes (Waisanguan). The "even reinforcing and reducing" acupuncture method was adapted and the needles were remained in the acupuncture points for 20 minutes. The acupuncture therapy was administered once daily for 5 days a week, followed by a 2-day rest.

Moxibustion was applied to two acupoints selected from BL 13, DU 14, CV 4 and ST 36. The moxibustion therapy lasted 10 minutes each time with the frequency of once daily for 5 days, followed by a 2-day rest.

Auriculotherapy: Acupuncture points for auriculotherapy were as following: CO 14, AH 10, AT 4, TF 4, CO 16, CO 18 and AH 6a. Method: auricular therapy alternated once a week between two ears. Cowherb Seeds were applied to the auricular points and the patient was instructed to press each acupoint 3 to 5 times per day, with each press lasting for 3 to 5 minutes.

Intravenous nutrition and herbal cuisine were combined to strengthen nutrition. Local chest hyperthermia was applied together with chelation therapy 3 times weekly. EBOO was applied twice a week during the interval of hyperthermia therapy. In addition, intravenous medications were provided to fight against infection, protect the heart, promote urination, relieve spasm and supply nutrition (combined with herbal cuisine to regulate the body condition).

**Treatment outcome:** The patient has advanced lung cancer and presents with pleural effusion and dyspnea. By receiving TCM therapy and local hyperthermia, she has survived for more than 3 years with a good quality of life.

### **H6, female, 67 years old.**

The patient developed rib pain secondary to an accidental bump of her right front chest during housework on August 24, 2013. On the following day, she sought medical care at Orthopedics in Clifford Hospital and underwent a chest X-ray. The X-ray demonstrated an abnormal nodule in the superior lobe of right lung, for which, further examination with contrasted CT scan was recommended. Anterior rib fracture (right 6th) was also suspected. The enhanced chest CT scan showed a well-defined lobular and spiculated soft tissue mass in the superior lobe anterior segment of right lung, measuring approximately 20.4mm\*25.4mm, suggestive of a space-occupying lesion in the anterior segment of superior lobe of right lung. There was a high possibility of peripheral lung cancer. For a definitive diagnosis and treatment, she was admitted with outpatient diagnosis of "lung mass".

After admission, preoperative examinations showed no operative contraindications and patient's general conditions were acceptable. Following a multidisciplinary consultation, on September 3, 2013, a thoroscopic resection of right superior pulmonary mass was performed under tracheal intubation and general anesthesia.

The post-operative pathology revealed papillary adenocarcinoma in the right superior lung. No cancerous tissue was noted in pleura or bronchial stump. A lymphatic metastasis (1/3) was noted in right inferior lung and other lymph nodes remained unremarkable. There were congestion and bleeding in lung tissue spaces near the tumor. Immunohistochemistry result showed CEA (+), EGFR (+), Ki-67 (index of about 10%), P53 (+<5%), CK5/6 (-), TOPOII (10%+), GSTπ (80%) and PgP (-).

The patient was transferred to Oncology on September 16, 2013 after stitches were removed.

Her past medical history was significant for "cholecystectomy", "hepatic cyst resection", "left distal forearm fractures", "hyperlipemia", and "bile reflux gastritis".

**Physical examination:** A transverse, well-healed surgical scar about 5 cm in length was noted in the right front chest. No swollen superficial lymph node was noted. Bilateral respiratory movement was normal. There were symmetrical vocal fremitus, clear percussion sounds, and

normal respiratory sounds without dry or moist rales in auscultation. HR was 72 bpm, heart rhythm normal, heart sounds normal and there was no heart murmur in valve auscultation.

**Assistant examination:** The post-operative pathology revealed papillary adenocarcinoma in the right superior lung. No cancerous tissue was noted in pleura or bronchial stump. A lymphatic metastasis (1/3) was noted in right inferior lung and other lymph nodes were unremarkable. There were congestion and bleeding in lung tissue space near the tumor. Immunohistology result showed CEA (+) EGFR (+), Ki-67(index of about 10%), P53 (+<5%), CK5/6(-) TOPOII (10%+), GST $\pi$  (80%), and PgP (-).

**Integrative treatment plan:**

The patient's symptoms and signs were attributed to Qi deficiency of lung and spleen. "Yangyin Qingfei Tang" was ordered to boost Qi and tonify Yin. The detailed herbal formula and their respective remedial effects were shown as follows:

To tonify Yin:

Radix rehmanniae recen (Sheng Di Huang)12g

Radix Rehmanniae Praeparata (Shu Di Huang)12g

Asparagus fern (Tian Dong)12g

Radix ophiopogonis(Mai Dong)12g

Radix scrophulariae (Xuan Shen)12g

Radix codonopsis(Dang Shen)12g

To clear heat and detoxify the body:

Houttuynia cordata (Yu Xing Cao)30g

Rhizoma cimicifugae(Sheng Ma)30g

To detoxify the body and dispel dampness:

Smilax glabra(Tu Fu Ling)30g

To tonify Qi and secure the exterior:

Radix astragali(Huang Qi)15g

To purge fire and detoxify the body:

Radix scutellariae(Huang Qin)10g

Gardenia(Zhi zi)10g

The decoction should be orally administrated when still warm, 1 dose per day in 2 separate times after meals.

In acupuncture, therapists used moxibustion and arranged needles on scalp.

The patient was also given ozonated autohemotherapy twice per week and deep hyperthermia therapy once every other day. In addition, standard chemotherapy was administered.

**Treatment outcome:**

The patient has been receiving outpatient treatment and intermittent inpatient care. Three years of follow-ups showed an ongoing recovery. She returned for follow-up every three months, which revealed no cancer recurrence and metastasis.

**T1, 44-year-old, Malaysian.**

The patient was admitted with "lung cancer for 1 month through Outpatient Department " on October 31, 2012.

In October, 2012, the patient underwent a CT scan in a local hospital in Malaysia secondary to the presence of low-grade fever and cough, which revealed a right bronchial nodule. Biopsy indicated poorly differentiated adenocarcinoma. Oral medication (details unknown) was given, but yielded a poor outcome. He sought further medical attention in Clifford Hospital in that month. A sequential CT scan showed space-occupying lesions in anterior mediastinum and right pulmonary hilum, suggestive of mediastinal lung cancer with metastasis to mediastinal lymph nodes. The right trachea and superior vena cava were compressed and narrowed. After patient's conditions became stable with treatment, he started radiotherapy 5 sessions weekly (35 sessions in total, 70Gy) on December 10, 2012 as well as chemotherapy with Paclitaxel Injection 90mg + Cisplatin

Injection 30mg once per week (9 sessions in total). Meanwhile, non-toxic integrative cancer treatments were also provided, such as pulmonary hyperthermia therapy, Chinese medicine, medical ozone therapy to reduce side effects of radiotherapy and chemotherapy. He was discharged after improvement. Since then he returned to Clifford Hospital for follow-ups and treatments. No cancer recurrence and metastasis were noted.

**Conditions on admission:** The patient was conscious and in good spirits. He stated thoracic dragging sensation and shortness of breath but denied chest pain, cough, expectoration, hemoptysis, chills or fever. There was normal sleep, urination and bowel movement. No significant weight loss was noted. Physical examination showed no yellow discoloration of skin and membrane, cyanosis, mucosal ulcer, spider angioma, or enlargement of superficial lymph nodes. Jugular vein was not distended and hepatojugular reflux sign was negative. The respiratory sounds were clear to auscultation without dry or moist rales. Heart rate was 85bpm with occasional premature beats; cardiac sounds normal; and no pathological murmurs auscultated at cardiac valves. The abdomen was non-distended without visible outline of stomach or intestines or gastrointestinal peristaltic waves. Abdominal wall was free of venous engorgement and abdominal breathing was not restricted. Right lower abdomen was positive for tenderness but was negative for palpable mass. There were free of hepatic tenderness, normal hepatic dullness, and impalpable spleen and liver. Murphy's sign and shifting dullness were negative. No tenderness or percussion pain in bilateral renal regions. Bowel sounds were normal without vascular murmurs. No edema was noted in bilateral lower limbs.

**Assistant examinations:**

A CT scan performed in Malaysia in November, 2012 showed a large nodule in right bronchus and a biopsy confirmed poorly differentiated adenocarcinoma. On November 28, 2012, the patient presented to our hospital and a CT scan indicated lung cancer.

Laboratory studies revealed no significantly abnormal findings in tumor markers (5 items), hepatic or renal functions, electrolyte, urine or stool analyses.

**Diagnoses:** 1. Stage IV pulmonary adenocarcinoma with metastasis to lymph nodes 2. Superior vena cava syndrome

**Integrative treatment plan:** Integrative treatment included chelation, vitamin B17 and deep hyperthermia therapy to enhance immunity and control cancer recurrence and metastasis. In TCM theory, lung cancer pathology is as follows: Lung cancer is phlegm-damp and stagnant blood coagulation as a consequence of yin-qi deficiency from long-term deficiency of lung yin and residue of smoke toxin remained in the body (particular in lungs and nose) blocking trachea due to chronic smoking. This deficiency origins from lack of vital qi and disorder of yin and yang. As a consequence, differentiation of disease was lung cancer, of which its syndrome was deficiency of lung-Yin. The disease was located in lung and was closely related to liver, spleen and kidneys. It was deficiency pattern in nature with good prognosis. Clinically, nourishing Yin and tonifying lung should be taken as the fundermental method.

The patient was given oral Chinese medicine one dose per day and acupuncture therapy, once daily and successively 5 times per week.

**Treatment outcome:**

The patient had been hospitalized for 7 days and he was conscious and oriented and in good spirit. His symptom of thoracic dragging sensation had been subsided and there was no chest pain, cough, expectoration, hemoptysis, chills or fever. Urination and bowel movements were normal. The general conditions were acceptable so he was discharged.

By August 2016, the patient has lived with cancer controlled for 4 years and returned to work. He had never received inhibitor treatment like TKI or ERGF. The next follow-up will be scheduled in this September.

## **Y2, born in 1938, from Jiangxi Province.**

A chest X-ray done in Clifford Hospital (October 2011) indicated a space-occupying lesion in the lung.

A CT scan revealed soft tissue mass of 5.1cm×4.3cm×3.8cm in the right upper lobe. The mass's margin with long and short spicules was lobulated. Pleural indentation and upward oblique fissure indentation could be noted with significantly uneven enhancement after contrast medium injection. The lesion invaded right mediastinum. Enlargement of multiple lymph nodes were noted in the mediastinum, right hilum and bilateral supraclavicular fossae, and right superior diaphragmatic lymph nodes enlargement noted as well. A few patches of hyperattenuation were noted in the right middle lobe, without any solid lesions in the rest of lung. She was diagnosed with lung cancer with metastasis to lymph nodes.

The patient received aspiration biopsy guided by CT scan in New Zealand which revealed adenocarcinoma of lung. After then, she underwent 6 cycles of chemotherapy (details unknown) in New Zealand, but developed chest tightness, limb numbness and mobility limitation after chemotherapy. Even though the symptoms were relieved after related treatment, the patient still felt chest tightness and limb numbness. Therefore, she turned to Clifford Hospital for treatment.

**Conditions on admission:** The patient was in poor spirit. She complained of chest tightness, limbs numbness and restricted motions, but denied cough, shortness of breath, difficult breath, or hemoptysis. Appetite and sleep were poor. Urination and bowel movement were normal. Physical examination: No superficial lymphadenopathy. Normal respiratory motions. Respiratory sounds were clear to auscultation, without dry or moist rales. Heart and abdomen were unremarkable.

**Assistant examination:** Whole blood count and biochemistry test were normal. Tumor markers showed CEA 17.64ng/ml, and CA19-9 115.40U/ml. Urine analysis showed RBC 16/ul and WBC 10/ul. Stool test was unremarkable. Chest and head CT scan with contrast on November 23, 2013 indicated the lesion larger than the prior study on December 22, 2012, with metastasis to right hilar lymph nodes, and cystic lesion in the left frontal lobe with possibility of metastatic tumor. Head MRI with contrast on December 5, 2013 indicated likely metastatic tumor in the left frontal lobe and no remarkable change compared with prior CT finding (11/24/2013); and multiple small ischemic lesions in bilateral frontal lobes.

**Diagnosis:** Status post chemotherapy for lung adenocarcinoma with metastases to lymph nodes and brain.

**Integrative treatment plan:** Non-toxic integrative cancer treatment included traditional Chinese medicine, magnetic therapy, hyperthermia and medical ozone therapy. As the patient suffered chronic illness and weakness and Yin deficiency dominates in senile person, symptoms and signs were differentiated as Yin deficiency of lung and kidney and treatment focused on nourishing lung and kidney. Qingzao Jiufei Tang was administered once a day. The prescription included Radix Codonopsis (Dang Shen) 15g, Radix Scrophulariae (Xuan Shen) 10g, Radix Rehmanniae (Sheng Di) 10g, Radix Rehmanniae Preparata (Shu Di) 15g, Radix asparagi (Tian Dong) 15g, Radix Ophiopogonis (Mai Dong) 15g, Glabrous Greenbrier Rhizome (Tu Fu Ling) 30g, Rhizoma Cimicifugae (Sheng Ma) 30g, Herba Houttuyniae (Yu Xing Cao) 30g, Folium Mori (Sang Ye) 30g, Flos Chrysanthemi (Ju Hua) 10g, and Cortex Lycii (Di Gu Pi) 15g. The herbs were decocted with water for oral administration. Magnetic therapy 4 times a week and deep hyperthermia 3 times a week were provided alternately, and medical ozone therapy once daily. Intravenous nutrition supplement combined with herbal cuisine for body conditioning.

**Treatment outcome:** The patient stayed as an inpatient for 41 days. The patient was in improved spirit and her chest tightness and limb numbness subsided. No complaint of dizziness, headache, cough or shortness of breath. Appetite and sleep were good. Urination and bowel movement were normal. Physical examination revealed unremarkable findings. The patient returns for periodic outpatient follow-ups and her illness is under control.

The patient has been living with lung cancer for 5 years. Currently, the patient has a stable quality of life and has almost recovered.

## Mouth Cancer

### L11, male, 65 years old.

He was admitted with “pain of left-sided tongue for 3 months” on August 29, 2009.

The patient presented with unexplained pain on left side of the tongue in the last third of May, 2009. He took some medications by himself (detail unknown) but gained no improvement. Later, as the pain intensified, he went to a hospital and underwent a biopsy for tongue neoplasm, which disclosed well-differentiated squamous cell carcinoma (on dorsum of the tongue). Consultants suggested surgical resection of half of the tongue and part of the mandible and stated that speech and swallowing would be badly affected after surgery. Therefore, he turned to Clifford Hospital for medical attention.

**Physical examination:** There was an about 3cm×1.5cm neoplasm at the margin of left root of tongue, about 0.3 cm protruding from the surface, with surface ulceration and tenderness.

**Assistant examination:** Blood count, liver and renal function tests were basically normal. A CT scan of the neck and nasopharynx revealed pathological change of left tongue root, which suggested tongue cancer, together with the pathology report. Lingual tonsils enlarged. Multiple small lymph nodes were noted in level II, III of bilateral neck. Abnormal calcification was detected under the skin of the lateral part of the right parotid gland.

**Diagnosis:** Well-differentiated squamous cell carcinoma of the tongue.

**Integrative treatment plan:** The oncologist team reviewed the case and developed an integrative treatment plan including cryoablation surgery, radiotherapy, chemotherapy, local hyperthermia, chelation, medical ozone and TCM therapy. The patient underwent a cryoablation for tongue cancer under general anesthesia with tracheal intubation on September 4, 2009. TP (Paclitaxel, cisplatin) whole body chemotherapy started in October, 2009, in addition to local hyperthermia, chelation, major ozonated autohemotherapy, TCM and acupuncture therapy.

The patient’s tongue was dark in color with white coating. His pulse was wiry and rapid. According to the traditional Chinese medicine (TCM) syndrome differentiation, it was Qi deficiency and blood stasis. Therefore, TCM treatment was mainly to tonify the spleen and Qi, promote blood circulation and remove stasis. Prescription were as follows: Rhizoma Atractylodis Macrocephalae (Bai Zhu) 30g, Poria (Fu Ling) 30g, Radix Glycyrrhizae Preparata (Zhi Gan Cao) 6g, Rhizoma Alismatis (Ze Xie) 30g, Ramulus Cinnamomi (Gui Zhi)6g, Fructus Perillae (Zi Su Zi)15g, Spica Prunellae (Xia Ku Cao)15g, Semen Vaccariae (Wan Bu Liu Xing)30g, Herba Hedyotis Diffusae (Bai Hua She She Cao)30g, Herba Scutellariae Barbatae (Ban Zhi Lian)15g, Herba Agrimoniae (Xian He Cao)30g, Herba Lophatheri (Dan Zhu Ye)10g, Medulla Junci (Deng Xin Cao)10 sheaves, Radix Rehmanniae (Sheng Di Huang)15g, Herba Menthae Haplocalycis (Bo He)6g. The TMC was one dose daily for oral administration and should be decocted with water.

In acupuncture therapy, the following acupuncture points were selected: LI 11, LI 4, P 6, ST 36, SP 9, SP 6, KD 3, LR 3, KD 6 and Outer Three Passes (Waisanguan). Method: An “evenly reinforcing and reducing” method was adapted, with the needles remaining in the acupuncture points for 20 minutes. The therapy was applied once daily and 5 days weekly, followed by a 2-day rest.

Moxibustion therapy: Acupuncture points for moxibustion: CV 4, RN 6, RN 8, ST 36. Two of the above mentioned points were selected for moxa roll moxibustion and the therapy in each point lasted for 10 minutes. The moxibustion was employed once daily and for 5 days a week, followed by a 2-day rest.

Auricular therapy: Acupuncture points selected were as following: CO 13, CO 1, CO 10, CO 12, CO 18, AT 4, AH 6a, HX 6 7i, and TG2P. Method: auricular therapy alternated once a week between two ears. Cowherb Seeds were applied to the auricular points and the patient was instructed to press each acupoint 3 to 5 times per day, with each press lasting for 3 to 5 minutes. After 2 cycles of chemotherapy, the tumor shrank significantly.

Radiotherapy started on December 12, 2009, with a total dose of 50 Gy. Local hyperthermia and chelation therapy were included once every other day. TCM and acupuncture therapy remained unchanged.

After the radiotherapy, chemotherapy continued to the fourth cycle, followed by the whole-body moderate & low temperature hyperthermia and chelation therapy in the next day, as well as EBOO once the other day. During the chemotherapy, TCM and acupuncture still continued.

According to traditional Chinese medicine, blood and toxins stagnated in the patient's body. Thus TCM treatment was based on promoting blood circulation, removing stasis and toxins: Fructus Perillae (Zi Su Zi)15g, Concha Ostreae (Mu Li)30g, Spica Prunellae (Xia Ku Cao)30g, Semen Vaccariae (Wan Bu Liu Xing)30g, Herba Hedyotis Diffusae (Bai Hua She She Cao)30g, Herba Scutellariae Barbatae (Ban Zhi Lian)15g, Herba Houttuyniae (Yu Xing Cao)30g, Cortex Lycii (Di Gu Pi)30g, Rhizoma Belamcandae (Shen Gan)10g, Rhizoma Paridis (Chong Lou)10g. The TCM was one dose daily for oral administration and should be decocted with water. Acupuncture therapy continued as before.

After the treatment, the tumor disappeared. After discharge, the patient still kept treatment at Outpatient Department, including local hyperthermia, chelation, medical ozone, TCM and acupuncture therapies.

Since admission, the patient had received psychotherapy to boost the confidence against cancer. He also learned medical Qigong and exercises to improve self-healing.

**Treatment outcome:** The patient was admitted intermittently. He underwent chemotherapy at Inpatient Department and radiotherapy at Outpatient Department. In total, he received 4 whole body moderate & low temperature hyperthermia, 60 local hyperthermia, 55 chelation therapy and 20 EBOO. By these treatments, tumor of the tongue disappeared and the tongue returned to normal activity and clear speech. Tongue and oral ulcer once occurred, but was relieved after symptomatic treatment. Since then, the patient kept integrative treatment once a month at Outpatient Department and underwent follow-up examination every 3 months.

The patient has survived for 7 years and currently has a good quality of life.

## Nasopharyngeal Cancer

### L12, aged 39.

The patient was admitted on February 4, 2007, due to status post radiotherapy and chemotherapy of nasopharyngeal cancer for over 2 years. A lump was found below the left jaw in October, 2004 accompanied by enlargement of cervical lymph nodes and he was diagnosed with poorly differentiated nasopharyngeal squamous carcinoma with bone metastasis, stage IV. He had received radical radiotherapy and 6 cycles of chemotherapy.

**Conditions on admission:** He presented with headache, thirst, dry throat, swollen and painful gums, swollen and aching cheeks, hearing loss, tiredness and poor appetite.

**Physical examination:** Weight was 46kg. General conditions were bad and he looked emaciated. Superficial lymph nodes were not enlarged. Heart, lungs, liver and spleen were unremarkable. Cervical skin was stiff due to radiation injury. Left-sided hearing loss was noted. Tongue was red with thin coating. Pulse was weak and rapid. KPS was 70.

Assistant examinations: An ECT revealed nasopharyngeal cancer with metastasis to skull.

**Diagnosis:** Relapse of nasopharyngeal cancer with metastasis to bone after radiotherapy and chemotherapy

**Integrative treatment plan:** After admission, the patient was given intravenous nutritional supplement, acupuncture and traditional Chinese medicine in the frequency of once per day; medical ozone therapy and local hyperthermia every other day. Symptoms such as headache, poor spirit and appetite were relieved after one week treatment. Two courses of TP chemotherapy plan were administered. In each course of chemotherapy, one systemic moderate-low temperature hyperthermia was given and local hyperthermia every other day but stopped 3 days before and

after systemic one. Following 2 courses of chemotherapy, there were totally 35 sessions of radiotherapy and 21 sessions of local hyperthermia (every other day), and then TP chemotherapy plan + systemic hyperthermia + local hyperthermia were adopted again for 4 courses.

Chinese medicine and acupuncture therapy were given along with chemotherapy. Red tongue with thin coating and weak and rapid pulse acted as symptom of deficiency of qi and yin, Sheng Mai San was adopted for tonifying qi and yin, and detoxifying and dispersing mass.

The prescription as follows:

radix psuedostellariae (Tai Zi Shen) 15g	Lilyturf root (Mai Dong) 15g
Schisandra fruit (Wu Wei Zi) 12g	Prepared pinellia ( Fa Ban Xia) 12g
Arisaema cum bile (Dan Nan Xing) 12g	Rhizoma pleionis (Shan Ci Gu) 15g
Agrimonia pilosa (Xian He Cao) 30g	Cortex Moutan (Dan Pi) 10g
Herba Selaginellae Doederleinii (Shi Shang Bai) 12g	
Fructus gardeniae (Zhi Zi) 10g	Fructus Xanthii (Cang Er Zi) 15g
Flos magnoliae (Xin Yi Hua) 10g	

One dose of the above herbs was decocted with water for oral administration once daily.

With principle of detoxifying and dispersing mass, acupuncture was applied to the acupoints (LI 4, LI 11, ST 36, DU4, DU 20, LI 20, GB 2, KI 3, BL 13, and Wai San Guan) with neutral supplementation and draining. The needle retained for 20 minutes, and 2-day interval after 5 sessions. Moxibustion was applied to 2 acupoints among ST 36, RN4, DU4, BL20, RN8, BL23 for 10 minutes respectively in the frequency of once per day and a 2-day interval after 5 session. Auriculotherapy alternated weekly between two ears. Auricular points included TG4, TG1,2i, TG3, AH6a, AT1.AT2, TG2p and CO14. Method: Cowherb Seeds were applied to auricular points and the patient was instructed to press them 3 to 5 times per day.

**Treatment outcome:** The patient received intermittent inpatient treatment for 6 months. At admission, general conditions were poor accompanied with poor appetite, headache and tired looking, therefore, treatment were mainly to improve symptoms and malnutrition. Medical ozone therapy and chelation therapy started at a low dose or basic dose and increased gradually until symptoms like headache and weakness were relieved. Radiotherapy and chemotherapy were given in combination with traditional Chinese medicine, chelation therapy, medical ozone therapy, systemic hyperthermia and local hyperthermia. Such a combination helped achieve anti-tumor efficacy and reduce side-effects of radiotherapy and chemotherapy. Two months of treatment led to disappearance of dry mouth and swollen gum, hearing improvement, 3kg of weight gain. KPS was 90.

He stayed on oral traditional Chinese medicine after discharge. He returned for 3 days of non-toxic integrative cancer treatments every 2 weeks, with the frequency changed to every month from the 3<sup>rd</sup> month of discharge. A follow-up CT scan 7 months after discharge revealed the lesion disappeared basically, while ECT indicated bone metastasis remained similar to the prior finding and no new lesion. The patient complied with periodic follow-ups, with stable conditions. There is no sign of recurrence or new metastasis in follow-up examinations.

The patient has lived for more than 10 years since diagnosis with cancer, and he has recovered.

## Nasopharynx Cancer

### Y3, male, 54 years old.

The patient noticed a firm, painless mass in left neck in May, 2013, without redness, swelling or fever. At that time he underwent a CT scan in Clifford Hospital, which was suggestive of "left-sided nasopharynx cancer with metastases to lymph nodes and bone". Subsequently he was transferred to Guangdong No.2 Provincial People's Hospital where he was given 35 sessions of radiotherapy (70 GY in total and 2 GY per session) and 6 cycles of chemotherapy with "Paclitaxel" and " Cisplatin" (specific dosages unknown). After the radiotherapy and

chemotherapy, the patient experienced dry mouth, foreign body sensation of the mouth, and suppuration in left auditory canal. He paid a few visits to our hospital for such symptoms and was diagnosed with radioactive otitis externa and radioactive otitis. He was provided with non-toxic integrative treatment and was discharged after improvement. He had a history of smoking and alcohol consumption.

**Conditions on admission:** The patient was alert and conscious, but looked tired. He experienced slight weakness and dry mouth, but denied dizziness, headache, fever, or chills. There was no chest tightness, shortness of breath, nausea or vomiting. Appetite, sleep, urination and bowel movement were normal. No significant weight loss was noted recently. Physical examination revealed normal findings.

**Assistant examination:** Head, chest and abdomen CT scan and bone ECT scan (May, 2013) were suggestive of "left nasopharynx cancer with metastases to lymph nodes and bone".

**Diagnosis:** Status post radiotherapy and chemotherapy for nasopharynx cancer

**Integrative treatment plan:**

Non-toxic integrative treatments: Chelation every other day; hyperthermia therapy every other day; Medical ozone treatment once per day; magneto-electric biofeedback therapy once per day.

TCM treatment: As the patient was a middle-aged man, his healthy Qi gradually declined due to aging, making the body vulnerable to external pathogens and toxins. Given the patient had been a chronic smoker, the external toxin and pathogen invaded his channels and collaterals, leading to lung collateral obstruction and further lung Qi blockage. Since the Qi passage was blocked, the external pathologic fire would reach the nose through Taiyin meridian. It could retain in nose and pharynx and finally form a tumor.

As pointed out in *Yi Xue Zhun Sheng Liu Yao* (医学准绳六要), " Like drinkers or those from wealthy family, they always prefer overly spicy, irritable, or roasted food, which makes the pathologic fire flame upward to and stuff in the nasal orifice. Consequently, turbid discharge pours out like the flowing spring water and gradually turns into a nosebleed. That is caused by long-term heat accumulation in Shang Jiao (including lungs and heart)." The patient's disease is located in nasopharynx, the breathing passage, which is closely related to the lungs. The lungs govern Qi, manage breathing and open at nose.

Because of long-term smoking, drinking and chemotherapy as well, the patient's pathologic heat retained in lung (i.e. lung Yin was deficient), causing the diffusion failure of lung Qi and steaming of fire and heat. It led to the scorching of fluid-humor and that's the reason he presented with dry mouth, red tongue, white-thin tongue coating, and thready and rapid pulse. Therefore, he was treated by nourishing Yin and clearing lung heat and fire, and reinforcing the earth to generate metal (the theory of Yin and Yang and five elements). TCM medicine was given by a famous TCM physician according to syndrome differentiation and dietary instruction by Dietetics.

**Treatment outcome:**

CT scan of nasopharynx and chest performed on August 30, 2014 showed post-chemotherapy (for nasopharynx cancer) changes:

1. Damage to clivus of occipital bone;
2. Thickened membranes of bilateral maxillary, ethmoidal, and sphenoid sinuses;
3. Fluid buildup in left mastoid cells.

The result was basically the same as that of June 1, 2014.

Bone ECT: Compared with the scan on September 2, 2014, no significant change was noted in previous locations of metastases. The follow-ups in the past 3 years showed no cancer recurrence and metastasis.

His follow-up check on July of 2016 revealed that he completely recovered from the cancer.

Now the patient's quality of life is scored 0, and he lives a normal life.

## Paget's Disease of Penis

### G3, aged 70.

The patient was admitted on February 23, 2014 due to status post operation of Paget's disease of penis for two and a half years. Penis base skin was rash without oozing or itch. Pathological analysis in Clifford Hospital reported Paget's disease of penis and then the patient received wide local resection of Paget's disease of penis and scrotal skin graft. The wound healed well. Postoperative pathological analysis reported Paget's disease of penis. But he did not undergo radiotherapy or chemotherapy after then. The patient returned for follow-ups in Clifford Hospital. History review was positive for cerebral infraction and left lower leg fracture.

**Conditions on admission:** The patient was alert and energetic. Appetite, urination and bowel movement were normal. He denied cough and shortness of breath. Skin of penis base was normal without rash, exudation or itch.

**Physical examination:** Well-healed surgical incision at the perineal region and graft site. Others were negative.

**Assistant examinations:** Pathology report revealed extramammary Paget's disease of penis base. Laboratory studies including complete blood count, urine test, stool test, liver function, kidney function, blood lipid, blood glucose and electrolyte were normal. Male tumor markers (6 items): CEA 5.58ng/ml, others were negative.

A color ultrasound scan of liver, gallbladder, pancreas and spleen was unremarkable.

A chest X-ray indicated increased lung markings and aortic arteriosclerosis, similar to the prior findings on March 26, 2013.

Pelvic MRI with contrast revealed postoperative changes related to wide local resection of lesion in Paget's disease of penis and scrotal skin graft without recurrence or metastasis, similar to the findings on March 26, 2013. Prostate hyperplasia was considered.

**Diagnosis:** Status post operation of Paget's disease of penis

**Integrative treatment plan:** Chelation (30g) for improving metabolism was given on every Tuesday, Thursday and Saturday; hyperthermia for improving circulation and immunity on every Tuesday, Thursday and Saturday; and intravenous medical ozone every day to improve immunity.

On TCM theory, the disease is named as Shenyan (pennis carcinoma). Yin deficiency of liver and kidney results in disturbance of ministerial fire, kidney's failure to nourish liver, and blood dryness at the liver channels. As liver channels surround external genitals and are impaired over time, Yin essence diminishes. Collaterals turn void and defenseless and cause damp toxins of liver downward, stagnation of pathogenic fire, and burning fluid into phlegm. Therefore, all these pathological factors build up in penis, resulting in carcinoma of penis.

According to differential diagnosis of TCM, it was everted flower-like Shenyan (carcinoma of penis), and the syndrome was downward of damp-heat. San Miao Wan was administered with therapeutic principle of clearing away heat and promoting dampness based on symptoms.

**Treatment outcome:** The patient continues non-toxic integrative cancer treatment in inpatient dept. since operation performed in 2011. No tumor recurrence or metastasis could be found in the follow-up examinations. The patient currently lives a normal life.

## Pancreatic Cancer

### L13, 83 years old.

The patient was admitted on September 4, 2007 due to status post operation of pancreatic cancer for one year and abdominal pain accompanied with poor appetite and emaciation for over 2 months. A CT scan revealed a mass of 5.7cm×3.6cm×4cm in the tail of pancreas in Toronto Hospital, Canada in September, 2006. He underwent partial pancreatectomy in a hospital in

Canada, during which multiple enlarged lymph nodes in the abdominal cavity could be found and gastric wall was involved. But he did not receive any treatment after surgery. A follow-up CT scan 6 months ago revealed abnormal growths around left renal artery and multiple intrahepatic metastases. The patient presented with recurrent dull abdominal pain accompanied with significant poor appetite and emaciation, and weight loss of 8kg since July, 2007. Therefore, he came to Clifford Hospital for treatment from Canada.

**Physical examination:** Body weight was 48kg. Surgical scar was at the upper abdomen. A protruding hard and ill-defined bulge in local upper abdomen was tender. Respiratory sounds bilaterally were clear, without dry or moist rales. Cardiac dullness was normal. HR was 60bpm. Heart rhythm was normal, without pathological murmurs at valves. KPS was 50.

**Assistant examination:**

Complete blood count: RBC $3.1 \times 10^{12}/L$ , Hb103g/L, WBC $4.7 \times 10^9/L$ , PLT $235 \times 10^9/L$ ;

Biochemistry: ALT 125U/L, AST 87U/L, TBIL 32U/L, DBIL 15.5U/L, ALB 16.8g/L; ALP 312U/L, GGT 127U/L, Cr 8umol/L, Ua 313umol/L, BUN 3.6mmol/L, GLU 6.62mmol/L, TG 0.17mmol/L, GHO 1.65mmol/L, K<sup>+</sup> 3.64mmol/L, Na<sup>+</sup> 139mmol/L, Cl<sup>-</sup> 99mmol/L, Ca<sup>2+</sup> 2.21mmol/L;

Serum ammonia: 21umol/L;

Tumor markers: CEA 127.6ng/ml, AFP 9.09ng/ml, CA12-5(OV) 13.72U/ml, CA-199 47.14U/ml, PSA 3.1U/ml;

Immunological test (5 items) and micro-elements of Cu, Zn, Pb, Cd and Ni were normal.

Abdominal CT scan revealed a mass of 3cm×2cm in the tail of pancreas accompanied with abdominal wall, intrahepatic, abdominal and retroperitoneal lymph nodes enlargement. ECG and chest X-ray were negative.

**Diagnosis:** Status post operation of pancreatic cancer with recurrence and metastases to lymph nodes and liver.

**Integrative treatment plan:** The patient's admission symptoms mainly presented as poor appetite and emaciation. He also had pain but was in good spirits. For this, the symptoms were treated with supplement of pancreatin and herbal cuisine supplement of lipase and amino acid to improve nutrition. Meanwhile, anti-tumor treatment included general moderate hyperthermia and chelation therapy alternately with EBOO. Traditional Chinese medicine was used to soothe liver, regulate vital energy, resolve dampness and disperse stasis. The prescription included Radix Bupleuri (Chai Hu) 10g, Radix Paeoniae Alba (Bai Shao) 20g, Fructus Aurantii (Zhi Ke) 15g, Herba Pogostemonis (Guang Huo Xiang) 10g, Mangnolia officinalis (Hou Pu) 10g, Rhizoma Pinelliae Praeparata (Fa Ban Xia) 10g, Fructus Amomi Rotundus (Bai Dou Kou) 10g, Caulis Bambusae in Taeniam (Zhu Ru) 10g, Herba Eupatorii (Pei Lan) 10g, Radix Platycodi (Jie Geng) 6g, Semen Arecae (Bing Lang) 6g, Haematitum (Dai Zhe Shi) 20g, Dens Draconis (Long Chi) 30g, Rhizoma Corydalis (Yuan Hu) 10g, and Radix Glycyrrhizae Preparata (Zhi Gan Cao) 6g. One dose of the above herbs was decocted with water for oral administration once daily.

During treatment, the patient complained of stomach and abdominal pain, dry mouth, hiccups, weakness and constipation. Tongue was red with less fluid, and pulse was thready and weak. Herbal medicine was changed for liver-dredging and stasis-dispersing. The prescription included Radix Glehniae (Bei Sha Shen) 15g, Radix Ophiopogonis (Mai Dong) 15g, Radix Trichosanthis (Tian Hua Fen) 12g, Fructus Toosendan (Chuan Lian Zi) 10g, Rhizoma Anemarrhenae (Zhi Mu) 10g, Cortex Lycii (Di Gu Pi) 12g, Carapax Trionycis (Bie Jia) 12g, Colla Corii Asini (E Jiao) 12g, Fructus Polygoni Orientalis (Shui Hong Hua Zi) 12g, Semen Persicae (Tao Ren) 12g, Curcuma Zedoary (E Zhu) 10g, Radix Paeoniae Rubra (Chi Shao) 10g, Herba Hedyotidis Diffusae (Bai Hua She She Cao) 30g, Radix et Rhizoma Rhei Preparata (Zhi Da Huang) 6g, and Radix Glycyrrhizae (Gan Cao) 3g. One dose of the above herbs was decocted with water for oral administration twice daily.

And treatment plan of chelation therapy was changed to every other day with increased dosage. Traditional Chinese medicine named "Pei Yuan Decoction" was administered one dose orally every day. Proper exercise was recommended, preferably no sweating.

Treatment with acupuncture: Acupoints including ST 36, ST 37, SP 6, RN 12, ST 25, BL 20, BL 23, RN 4 were selected for acupuncture with equal tonifying and purging needling method, with the needle remained for 20minutes, once a day, and a 2-day interval after 5 needling sessions. Moxibustion was applied to the following points: RN 4, ST 36, BL 23 and BL 20. Methods: Each session was applied to 2 points for 10 minutes respectively in the frequency of once a day and a 2-day interval after 5 sessions. Auriculotherapy alternated once a week between two ears, applied to CO12, CO13, diaphragm, CO11, HX6,7, TG2p, AT4, AH6a.

**Treatment outcome:** After 45 days of non-toxic integrative cancer treatment. the patient had better spirits, relieved pain and normal appetite. His weight increased to 56kg. His quality of life improved to the extent that allowed him to do recreational activities, with a KPS of 90. At the second month of hospital stay, a follow-up CT scan of abdomen revealed: no recurrent lesion in the residual pancreatic head; intrahepatic hypo-attenuation lesions increased in number but decreased in size comparing to the prior study at admission. The patient continued outpatient treatments including chelation therapy twice weekly, ozone therapy and local hyperthermia on a weekly basis. A CT scan of the abdomen 5 months later revealed status postoperative change of pancreatic cancer with liver metastasis, and a decrease in the number and size of intrahepatic lesions. Complete blood count was normal. Liver function showed ALP of 135U/L, r-GT of 99U/L. Tumor markers showed CEA of 37.5ng/ml, CA-199 of 21.03U/ml. Other test results were negative. The patient lived normal life without discomfort and continued outpatient treatment per week.

The patient died of pancreatic cancer in September, 2009.

## Prostate Cancer

### T2, 78-year-old

A health checkup indicated elevated PSA level in April, 2009. A prostate biopsy done in a hospital of New Zealand revealed prostate cancer without metastasis, stage T1. He did not receive any treatment. In July, 2017, a PSA test in outpatient dept. of the Second Affiliated Hospital of Sun Yat-sen University showed T-PSA 9.210ug/L and F-PSA 1.490ug/L. Bilateral orchiectomy was performed and endocrine therapy was adopted after operation. Follow-ups showed a gradual increase in PSA level. History review was positive for hypertension and diabetes. The patient was admitted to Clifford Hospital on July 14, 2016 due to frequent urination for over one month.

**Conditions on admission:** He was alert and in good spirit. He stated frequent urination, but denied urgent urination, dysuria, and hematuria, fever, abdominal pain. Appetite and sleep were good, and urination and bowel movement were normal. The tongue was light dark with greasy coating. The pulse was deep and thin. Others were unremarkable.

#### **Assistant examinations:**

A pelvic MRI with contrast in May, 2013 revealed hyperplasia of prostate and multiple nodules at peripheral zones of prostate, suggestive of prostate cancer. Seminal vesicles were probably involved and the right side had mild effusion. Small lymph nodes were noted at the right mesorectum.

A CT scan of the abdomen and pelvis in July 2014 indicated post-operative change of prostate cancer, abnormal oval signal intensity in the right seminal vesicle with possibility of protein-containing cyst and hematocele.

Bone imaging showed possibly degenerative disease of lumbar spine.

Gastroendoscopy indicated chronic erosive gastritis, chronic enteritis and internal hemorrhoid.

#### **Diagnoses:**

1. Status post operation of prostate cancer;
2. Chronic gastritis;
3. Type 2 diabetes mellitus;

#### 4. Grade 1 hypertension

**Integrative treatment plan:** Integrative treatment included deep hyperthermia of abdomen once every other day, EBOO and electro-magnetic biofeedback therapy once daily respectively.

On TCM theory, the senile and physically weak patient presented with hypofunction of spleen and stomach resulting in dampness accumulation and phlegm production. Meanwhile, obstruction of phlegm and stasis to bladder due to enduring illness induced bladder dysfunction, which was the cause of frequent urination. Tongue and pulse formed this evidence. At admission, the mainly symptom differentiation was obstruction of phlegm and stasis and treatment focused on activating blood, dispersing stasis, strengthening spleen and removing phlegm.

From July 14, 2014 to July 16, 2014, with a treatment principle of activating blood, dispersing stasis, strengthening spleen and removing phlegm, 3 doses of “Tao Hong Si Wu Tang” were administered. The detailed prescription included Semen Persicae (Tao Ren) 10g, Flos Carthami (Hong Hua) 10g, Radix Rehmanniae Preparata (Shu Di Huang) 15g, Radix Paeoniae Alba (Shao Yao) 10g, Radix Angelicae Sinensis (Dang Gui) 10g, Rhizoma Chuanxiong (Chuang Xiong) 10g, Rhizoma Pinelliae (Ban Xia) 10g, Mangnolia officinalis (Hou Pu) 10g, and Atractylodes Macrocephala (Bai Zhu) 10g. One dose of the listed herbs was decocted with water for oral administration once daily before meals.

Six doses of “Bu Zhong Yi Qi Tang” were administered in a principle of invigorating stomach-spleen and replenishing qi. The prescription included Radix Astragali (Huang Qi) 30g, Rhizoma Atractylodis Macrocephalae (Bai Zhu) 30g, Pericarpium Citri Reticulatae (Chen Pi) 10g, Rhizoma Cimicifugae (Sheng Ma) 6g, Radix Bupleuri (Chai Hu) 6g, Radix Codonopsis (Dang Shen) 15g, Radix Glycyrrhizae Preparata (Zhi Gan Cao) 6g, Radix Angelicae Sinensis (Dang Gui) 6g, Radix Ophiopogonis (Mai Dong) 10g, Fructus Schisandrae (Wu Wei Zi) 10g, Agrimonia pilosa (Xian He Cao) 30g, and Fructus Corni (Shan Yu Rou) 30g. One dose of the listed herbs was decocted with water for oral administration in warm temperature once daily after meals.

**Treatment outcome:** General conditions had improved significantly after 18 days inpatient treatment. Follow-up tumor markers test demonstrated CEA 4.11 ng/ml , AFP 3.34 ng/ml , CA15-3 12.00 U/ml , CA19-9 0.84U/ml , T-PSA 0.04ng/ml , F-PSA 0.01ug/ml , and F-PSA/T-PSA 0.25. No significant elevation of tumor markers could be found in follow-up tests done in outpatient dept.

The patient has been living for over 7 years since diagnosis with cancer, and he has recovered.

#### **Y4, male, 80 years old.**

The patient was admitted with status post prostate cancer surgery for over 6 years, status post repeated chemotherapy, lymphatic metastasis for 1.5 years, and bone metastasis found for 1 week on December 21, 2012. The patient received a checkup in New Zealand 1 week prior to admission, which revealed bone metastasis with significant pain. He did not respond well to analgesic therapy provided. He then presented to Clifford Hospital for continuous care. History review was positive for hypertension and surgery of right lower extremity varicosity.

**Conditions on admission:** The patient was alert and oriented and experienced swelling pain (score 5) of the waist which intensified and disturbed sleep during the night. His appetite and defecation were normal, but he suffered frequent urination. He denied painful or bloody urine, or recent weight loss. The tongue was light red without coating. The pulse was thready and uneven. Physical examination revealed unremarkable findings.

#### **Assistant examinations:**

1. Tumor markers: TPSA: 107.20ng/ml and Free-PSA: 35.33ng/ml. Remaining tumor markers were normal.

2. Color ultrasound of the heart: Left ventricular size in high normal range; luminal diameter of ascending aorta widened; slightly thickened interventricular septum; decreased diastolic function of left ventricle; these findings were supportive of hypertensive heart change. There was

evidence of mild regurgitation of aortic and mitral valves. It was free of abnormal segmental ventricular wall motion at rest. Normal systolic function in the left ventricle was noted.

3. Whole body bone imaging: Whole-body skeletons were clearly imaged. Significant radiotracer uptake was noted in bilateral kidneys, especially the right one. Bladder was not displayed. Posterior image revealed increased uptake in vertebrae L 3, 4 and 5 and sacrococcygeal vertebrae. There was slightly increased radionuclide uptake in upper end of right femur. There was no other radionuclide distribution anomaly. Increased bone metabolism was noted at locations mentioned above. It was suggestive of multiple bone metastases (suspected upper end of right femur).

4. Coronary CT angiography: There were evidences of multiple calcifications of left main coronary artery, left anterior descending artery, left circumflex artery and diagonal branch. There was a sign of soft plaque formation of upper segment of left anterior descending with moderate luminal stenosis. Myocardial bridge of middle segment of left anterior descending was noted. Aortosclerosis and multiple hepatic cysts were seen.

5. Lumbar MRI: Lumbar degeneration. L4/5 disc herniation. By correlating to past history, it was supportive of prostate cancer with multiple metastases to L3, 4 and 5 vertebrae. There was a significant dilation of right renal pelvis and ureter with fluid buildup. Thickening of bladder wall was noted.

6. Transrectal color ultrasound of the prostate: Status post prostatectomy: a nodule in residual prostate with rich blood flow and PSA test suggested. Bladder wall was coarse.

7. Gastroscopy: Multiple gastric polyps (already resected), erosive duodenitis and erosive gastritis.

**Diagnoses:** 1. Status post chemotherapy after prostate cancer surgery, with lymphatic and bone metastases. 2. Grade 1 hypertension (medium risk group). 3. Status post right lower extremity varicosity surgery. 4. Formation of bilateral lower limb thrombosis. 5. Multiple gastric polyps. 6. Erosive duodenitis. 7. Erosive gastritis. 8. Chronic colitis. 9. Intestinal polyp. 10. Internal hemorrhoid.

**Integrative treatment plan:** D3 and Zoledronic acid were administered for relieving pain and Sr89 was suspended. Besides such therapies, non-toxic integrative cancer treatments were provided, including Chinese medicine, acupuncture, chelation, hyperthermia, and medical ozone. TCM treatment: As the patient suffered deficiency of both blood and Qi and blood stasis, TCM treatment focused on boosting healthy Qi and tonifying kidney, and promoting blood and qi circulation for analgesia. Prescribed Chinese herbs included Rhizoma Sparganii (San Leng) 20 g, Curcuma Zedoary (E Zhu) 20 g, Fructus Aurantii Immaturus (Zhi Shi) 20 g, Rhizoma Atractylodis Macrocephalae (Bai Zhu) 20 g, Mangnolia officinalis (Hou Po) 20 g, Parched Hawthorn Fruit (Jiao Shan Zha) 20 g, Scorched Germonater Barley (Jiao Mai Ya) 20 g, stir-baked Massa Fermentata Medici-Nalis (Jiao Shen Qu) 20 g, Rhizoma Alpiniae Officinarum (Gao Liang Jiang) 20 g, Semen Raphani (Lai Fu Zi) 20 g, Fructus Tsaoko (Cao Guo) 20 g, Radix Aucklandiae (Mu Xiang) 20 g, Fructus Amomi (Sha Ren) 20 g, Ramulus Cinnamomi (Gui Zhi) 10 g, Poria (Fu Ling) 30 g, Grifola (Zhu Ling) 30 g, and Rhizoma Alismatis (Ze Xie) 30g. Chinese medicine foot bath was ordered for promoting blood circulation to remove meridian obstruction and stopping pain and promoting diuresis. Prescribed herbs included Radix Angelicae Sinensis (Dang Gui) 50 g, Radix Rehmanniae Preparata (Shu Di Huang) 50 g, Radix Paeoniae Alba (Bai Shao) 50 g, Rhizoma Chuanxiong (Chuan Xiong) 50 g, Poria (Fu Ling) 50 g, Rhizoma Atractylodis Macrocephalae (Bai Zhu) 50 g, Grifola (Zhu Ling) 50 g, and Radix Achyranthis Bidentatae(Niu Xi ) 50 g. Acupuncture was administered in the principle of neutral supplementation and draining, with the needle retained for 20 minutes, once a day, and 2-day interval after 5 needling sessions. Each session of moxibustion was applied to 2 acupoints for 10 minutes respectively in the frequency of once a day and a 2-day interval after 5 sessions. Auricular acupoints for auriculotherapy included CO14, AH10, AT4, TF4, CO16, CO18, and AH6a. Method: Auriculotherapy alternated weekly between two ears. Cowherb Seeds were applied to auricular points and the patient was instructed to each acupoint 3 to 5 times per day, with each press lasting for 3 to 5 minutes. Shenqi Yiqi Injection and parenteral nutrition were administered in combination. Lumbar hyperthermia twice a week together

with chelation was given. Medical ozone therapy was used as well. The patient stayed as an inpatient for 1 month and was discharged with an improvement in his conditions. He returned for inpatient care in one week after discharge.

**Treatment outcome:** During hospital stay for 2 months, his lumbar pain, gastric bloating, and bilateral lower extremity edema subsided. He received one course of treatment before discharge. The patient complied with outpatient and inpatient follow-ups. Based on the 3-year follow-up, his quality of life was good.

In January 2016, the patient died of acute myocardial infarction in New Zealand.

## **Pulmonary fibrosis**

### **C2, male, 53 years old.**

Hong Kong resident, who had pulmonary fibrosis for about 5 years. He was predicted by a Hong Kong hospital with only 5 years of life left. When he came to our Hospital, it was his fifth year. After about 70 sessions of wholebody mild-high infrared hyperthermia in 2 years, his pulmonary function obviously improved. He could swim only 50 meters before, but now 1,000 meters, bicycle riding was only half an hour before, but now 3 hours. He had bad sleep before due to irritable cough, but now sleeping well. Now, patient is in good condition and leads a normal life and work.

## **Skin Cancer**

### **L14, male, 45 years old.**

He had received chemotherapy for 5 months after surgery due to left-sided scrotum skin cancer and was admitted to Clifford Hospital with “paroxysmal abdominal pain for 20 days” on December 22, 2007.

The patient experienced external scrotum itching in July, 2007. He scratched and accidentally broke the skin, causing repeated, unhealed ulcer. He went to Queen Mary Hospital and underwent an excision of local skin. Pathology analysis result was consistent with “eccrine carcinoma of the skin, Ki-67 (+)”. An abdominal MRI revealed metastasis to multiple lymph nodes in the abdominal cavity. The patient received chemotherapy with paclitaxel, cisplatin, methotrexate, and gemcitabine hydrochloride, etc (detailed regimen unknown) as well as tamoxifen.

An abdominal MRI in October, 2007 revealed multiple enlarged lymph nodes in bilateral groins, retroperitoneum and abdominal cavity. The patient experienced paroxysmal abdominal pain, accompanied by shortness of breath, weakness, sweating and mild edema in the right lower limb. Therefore he was admitted to Clifford Hospital for further treatment.

**Physical examination:** Multiple enlarged lymph nodes of about 2cm×3cm were palpated in bilateral groins. Part of them adhered with each other, with hard texture, limited mobility and mild tenderness. Mild edema was noted in the right lower limb. Karnofsky score was 80.

#### **Assistant examination:**

Abdominal CT after admission: Multiple enlarged lymph nodes were noted in bilateral groins, retroperitoneum and abdominal cavity, suggestive of skin cancer with lymphatic metastasis.

Biochemistry study: ALT 38U/L, AST 25U/L, TBIL 26U/L, DBIL 14.5U/L, ALB 38g/L; ALP 53U/L, GGT 321U/L, Cr 56umol/L, Ua 235umol/L, BUN 6.2mmol/L, GLU 4.31mmol/L.

Electrolytes and blood lipid tests were normal.

Tumor markers: CEA 6.1ng/ml, AFP 5.6ng/ml, CA-12 54U/ml, CA-15 33.8U/ml, CA19-9 13ml/L, TSGF 11.2U/ml.

Immunology (5 items): IgM (immune globulin) 0.7g/L, and others were normal.

Trace elements test was normal.

**Diagnosis:** Eccrine carcinoma of the scrotal skin, status post surgery and chemotherapy, stage III (metastasis to lymph nodes in the groins, retroperitoneum and abdominal cavity).

**Integrative treatment plan:** The patient was diagnosed with eccrine carcinoma of the scrotal skin, which is a rare case without established treatment plan. Metastasis to abdominal lymph nodes had been noted when the patient first visited Queen Mary Hospital. The primary lesion was removed, followed by treatment with multiple chemotherapy agents. As it was eccrine carcinoma, tamoxifen has also been provided for endocrinotherapy. Despite such therapies, the patient's condition remained uncontrollable. Because the patient was weak after many courses of chemotherapy, traditional Chinese medicine (TCM) and acupuncture were provided in Clifford Hospital.

The patient presented with weakness, shortness of breath, sweating, slight edema of the right lower limb, loose stool, light-red tongue, thin and white coating and slow-deep pulse, indicating deficiency of both Qi and blood. Tradition Chinese medicine was mainly to tonify Qi and blood, eliminate toxins and promote healing. Thus Shiquan Dabu Decoction was prescribed: Radix Ginseng (Ren Shen) 10g, Radix Rehmanniae Preparata (Shu Di) 12g, Rhizoma Atractylodis Macrocephalae (Bai Zhu) 15g, Poria (Fu Ling) 15g, Radix Angelicae Sinensis (Dang Gui) 10g, Radix Paeoniae Alba (Bai Shao) 15g, Rhizoma Ligustici Wallichii (Chuan Xiong) 10g, Radix Astragali (Huang Qi) 30g, Cortex Cinnamomi (Rou Gui) 5g, Radix Glycyrrhizae Preparata (Zhi Gan Cao) 10g, Rhizoma Zingiberis Recens (Sheng Jiang) 3 slices, and 8 Fructus Jujube (Da Zao). The TCM was administered one dose daily for oral administration and should be decocted with water.

Acupuncture therapy: The following acupoints were selected for the therapy: BL 13, LU 1, LU 9, ST 36, BL 20, BL 17, SP 9, ST 40, SP 10, BL 40, Spirit Bone (Linggu) and SP 3. The acupuncture adapted an "even reinforcing and reducing" method and the needles remained in the points for 20 minutes. The therapy was once daily for 5 days a week followed by a 2-day rest.

Moxibustion therapy: BL 20, BL 17, BL 13, CV 4 and ST 36 were selected for moxibustion therapy. Method: each session of moxibustion was applied to 2 acupoints for 10 minutes respectively in the frequency of once a day, and there was a 2-day interval after 5 sessions.

Auricular therapy: acupoints selected were as follows: AT 4, CO 15, HX 6 7i, AH 6a, CO 12, TF 4, SF1 Zi, TG2P and points that related to lesion region. The therapy was twice weekly and two ears were alternatively selected.

In addition, chelation therapy and intravenous medical ozone therapy were alternately applied, as well as right-sided groin local hyperthermia. One-week treatment alleviated pain in the patient's abdomen, shortness of breath and right lower limb edema. Whole-body moderate-high temperature hyperthermia therapy + intraperitoneal perfusion chemotherapy (with cisplatin and mitomycin) were applied totally 4 sessions. Before and after the treatment, routine pretreatment and symptomatic treatment were provided to prevent adverse reaction. During the interval of whole-body hyperthermia, local abdominal hyperthermia was also employed. In total, the patient had been hospitalized in Clifford Hospital for 50 days.

**Treatment outcome:** By the 50-day active therapy in Clifford Hospital, the patient's symptoms like abdominal pain, weakness, and sweating disappeared. Three lymph nodes of 1cm×2cm in size were palpated in bilateral groins, with medium texture and mobility but no tenderness. Karnofsky score was 90. Compared with previous findings, lymph nodes in the groins, retroperitoneum and abdominal cavity shrank significantly. Currently the patient complies a 5-day integrative treatment plan at Outpatient Department every 15 days. He is normal in appetite and sleep and has returned to his work in Hong Kong.

## Stomach Cancer

### D2, female, aged 56.

She was admitted to Clifford Hospital because of “one-year history of epigastric pain and melena, with one-week aggravation” on December 29, 2006.

In December 2005, the patient experienced unexplained epigastric pain and bloating pain, which were not radiating but intensified after eating or at night. She also complained of acid reflux, belching, heartburn and repeated melena but denied fever, nausea, vomiting or diarrhea. She took some Chinese medicine (unknown) but gained no improvement. One week before admission, the symptoms above were aggravated and then she presented to the Outpatient Department of Clifford Hospital for treatment. A gastroscopy and an abdominal CT scan revealed “stomach cancer, with multiple metastases to the right lobe of liver, pancreas, retroperitoneal lymph nodes and cancer thrombus of the main portal vein, left and right splenic veins, and superior mesenteric vein. Pathology result was consistent with “moderately differentiated gastric adenocarcinoma”. As the cancer was inoperable, she was admitted to Oncology Department in Clifford Hospital. The patient was general in spirits on admission, with poor appetite, poor sleep, normal urination, loose and tarry stools. She lost more than 10kg in the past 8 months.

**Physical examination:** The patient was emaciating, with a body weight of 37kg. She appeared moderately anemic and pale in whole body skin and mucus. Abdomen under xiphoid process was distended. An ill-defined mass of about 5cm×6cm×7cm was palpated. The mass was firm and hardly movable, with significant tenderness but no rebound tenderness. Slash sound was heard in the gastric cavity. Bowels sounds were active. Karnofsky score was 30.

**Assistant examinations:** An abdominal CT scan revealed soft tissue masses in the stomach body and antrum, accompanied by multiple metastases to the right lobe of liver, pancreas, and retroperitoneal lymph nodes, and cancer thrombus of the portal vein, left and right splenic veins, and superior mesenteric vein. Cavernous transformation of the portal vein and mild fluid buildup in the rectouterine pouch were noted. Pathology reported moderately differentiated gastric adenocarcinoma. Tumor markers (5 items): CEA: 1183.6ng/ml, AFP: 143.22ng/ml, CA199: 194.32U/ml.

Complete blood count: WBC $19.03 \times 10^9/L$ , NEUT73.6%, RBC $3.19 \times 10^{12}/L$ , HGB76g/L, HCT0.246.

Biochemistry study: ALT69U/L, AST78U/L, TP 65g/L, ALB31.3g/L, ALP157U/L, GGT231U/L, TBIL21.5umol/L, DBIt6.5umol/L, Cr 24umol/L, Ua144umol/L, BUN3.7mmol/L, GLU5.21mmol/L, TG1.11mmol/L, GHO3.42mmol/L, K<sup>+</sup>4.1mmol/L, Na<sup>+</sup>137mmol/L, Cl<sup>-</sup>97mmol/L, Ca<sup>2+</sup>1.78mmol/L.

Immunology test (5 items) and trace elements were basically normal.

Diagnosis: Stomach cancer (moderately differentiated adenocarcinoma, stage IV), accompanied by multiple lymphatic metastasis to the right lobe of liver, pancreas, and retroperitoneal lymph nodes, and cancer thrombus of the portal vein, left and right splenic veins, and superior mesenteric vein.

**Integrative treatment plan:** The patient was emaciating on admission. She was moderately anemic and physically weak. Therefore, blood transfusion was provided to reverse anemia; PTN to strengthen nutrition; acid inhibition and gastric mucosa protection to prevent bleeding. Traditional Chinese treatment: Huangqi Jianzhong Decoction + Lizhong Decoction was ordered and included the following herbs: Radix Astragali (Huang Qi) 20g, Rhizoma Zingiberis (Gan Jiang)10g, Poria (Fu Ling)12g, Radix Paeoniae Alba (Bai Shao)12g, Rhizoma Atractylodis Macrocephalae (Bai Zhu)12g, Rhizoma Pinelliae (Ban Xia)12g, Pericarpium Citri Reticulatae (Chen Pi)10g, Fructus Evodiae (Wu Zhu Yu)6g, Pericarpium Citri Reticulatae (Ju Pi)6g, Semen Coicis (Yi Yi Ren)30g, Radix Glycyrrhizae (Gan Cao)6g, Radix Notoginseng (Tian Qi)12g, Rhizoma Imperatae (Bai Mao Gen)12g, Fructus Oryzae Germinatus (Chao Gu Ya)12g & Fructus Hordei Germinatus (Chao Mai Ya)12g, Semen Cuscutae (Tu Si Zi)10g. The traditional Chinese medicine was taken one dose

daily and should be decocted with water for oral use. After 4-day treatment, a complete blood count showed HGB 93g/l and WBC  $8.25 \times 10^9/l$ . The patient denied significant abdominal pain and the digestive tract bleeding stopped. Stool was yellow and loose. She started the whole body moderate temperature hyperthermia combined with peritoneal perfusion with cisplatin + 5-FU. Granisetron was administered to prevent nausea before and after the treatment. Following the hyperthermia, chelation therapy was applied to reduce toxic side effects of chemotherapeutics and to promote chemotherapeutic sensitivity. As whole body hyperthermia tended to massive fluid loss, traditional Chinese medicine was mainly to tonify spleen, nourish Yin and supplement blood. Therefore Guipi Decoction and Danggui Buxue Decoction were prescribed: Poria (Fu Ling) 25g, Paricarpium Citri Reticulatae (Chen Pi) 15g, Radix Angelicae Sinensis (Dang Gui)10g, Radix Glycyrrhizae (Gan Cao)10g, Radix Glycyrrhizae Preparata (Zhi Gan Cao)10g, Radix Paeoniae Alba (Bai Shao)15g, Radix Ophiopogonis (Mai Dong)10g, Radix Codonopsis (Dang Shen)25g, Radix Salviae Miltiorrhizae (Dan Shen)10g, Rhizoma Atractylodis Macrocephalae (Bai Zhu)12g, Radix Rehmanniae (Sheng Di)25g, Rhizoma Dioscoreae (Shan Yao)25g, Radix Bupleuri (Chai Hu)10g, Radix Scutellariae (Huang Qin)10g. The herbs were prepared into water-bindered pills and the patient was instructed to take 10g each time and 3 times daily.

The patient presented with mild nausea after hyperthermia but there was no white blood cell decrease, diarrhea or abdominal pain. In acupuncture therapy, the following acupuncture points were selected: RN12, PC6, BL 21, LR 13, BL 20, SP 6, ST 36, BL 26, KD 3 and Outer Three Passes (Waisanguan). The acupuncture adapted a reinforcing method, and needles were inserted into the points and remained there for 20 minutes. This therapy was once daily, for 5 days a week, followed by a 2-day rest.

Moxibustion therapy: CV 4, RN 8, ST 36, RN 12, DU 14, BL 20 and BL 23 were selected for moxibustion therapy. Method: Two to three acupuncture points were selected each time for moxa roll moxibustion and the moxibustion for each point lasted for 10 minutes. The moxibustion therapy was applied once daily or once every other day.

Auricular therapy: Acupuncture points selected were as following: CO 4, CO 13, CO 12, AT 4, AH 6a, TF 4, AT 2 3 4i, CO 5, CO 18, TG2P and special tumor area. Method: auricular therapy alternated once a week between two ears. Cowherb Seeds were applied to the auricular points and the patient was instructed to press each acupoint 3 to 5 times per day, with each press lasting for 3 to 5 minutes. In addition, traditional Chinese medicine was offered during the whole treatment process.

The treatment plan was applied for 5 weeks, including whole body hyperthermia + peritoneal perfusion (3 sessions respectively), nutrition, chelation, medical ozone, acupuncture, and tradition Chinese medicine therapies. The patient's condition improved, with hemoglobin level controlled at about 95g/L and weight gain by 0.6kg weekly. There was no melena. Stomach function and appetite returned to normal. At that time, peritoneal perfusion drugs were adjusted as cisplatin+mitomycin. As such change resulted in a decreased white blood cell count (to  $1.2 \times 10^9/l$ ), GM-CSF was administered as well as traditional Chinese medicine: Radix Astragali Preparata (Zhi Huang Qi)30g, Radix Angelicae Sinensis (Dang Gui)15g, Cortex Eucommiae (Du Zhong)15g, Cervus nippon Temminck (Lu Jiao Shuang)15g, Semen Persicae (Tao Ren)10g, Flos Carthami (Hong Hua)10g, Rhizoma Atractylodis Macrocephalae (Chao Bai Zhu)15g, Fructus Corni (Shan Yu Rou)15g, Colla Corii Asini (E Jiao) 15g, Plastrum Testudinis (Gui Ban) (decocted first)15g, Carapax Trionycis (Bie Jian) (decocted first)15g, Radix Codonopsis (Dang Shen)10g. At the same time, 3 slices of Rhizoma Zingiberis Recens (Sheng Jiang) and 5 Fructus Jujube (Da Zao) were introduced as the guiding medicine. The traditional Chinese medicine was taken one dose daily and should be decocted with water.

Chelation therapy and medical ozone therapy continued as before. Astragalus injection was added to inject into ST 36 during acupuncture. The patient presented with white blood cell decrease but that became stable 3 days after. She followed the treatment plan for more than one month. Whole body hyperthermia was applied once every 10 days and medical Qigong was also combined as part of the treatment.

**Treatment outcome:** The patient had been hospitalized for 81 days. After the integrative therapy, she improved significantly, with better spirits, normal appetite, sleep, urination and bowel movement. She was free of nausea, vomiting and abdominal pain. She gained 12kg and controlled the body weight around 56kg. Chinese medicine therapy continued and other therapies stopped. Contrast CT scan of the whole abdomen indicated significant shrinkage of the primary lesion, lymphatic metastatic lesion in the hepatic hilar area and thrombus of the portal vein, splenic veins and superior mesenteric vein. Tumor markers test (5 items) after treatment: CEA329.8ng/ml, AFP7.09ng/ml, CA12-5(OV) 34.99U/ml, CA19935.94U/ml, CA153 (BR) 56.45U/ml. (significant decrease compared to that on admission). Complete blood count: WBC $3.70 \times 10^9/l$ , NEUT58.9%, RBC $1.61 \times 10^{12}/L$ , HGB89g/l, HCT0.26. Blood count returned normal and anemia improved. Karnofsky score was 90.

The patient died of intestinal obstruction caused by stomach cancer relapse on June 2009. The patient lived with advanced stomach cancer for three and a half years.

## Thyroid Cancer

### Z4, 26 years old.

She was admitted on June 24, 2007 because of "status post total thyroidectomy secondary to medullary thyroid cancer for 18 months, multiple metastases to bilateral lungs for 9 months, and chest pain, cough and bloody sputum for 7 months".

In early 2006, the patient presented with a mass in left neck with hoarseness. Physical examination revealed a hard and fixed mass of 3cm×4cm in the left lobe of thyroid gland with multiple enlarged lymph nodes in left neck. She was diagnosed with stage III medullary thyroid cancer. After that she underwent a total thyroidectomy and lymph node dissection and received oral thyroxine tablets. In September, an examination for recurrent non-productive cough indicated multiple metastases to bilateral lungs, and she experienced significant emaciation, chest distress, shortness of breath, irritability, pain of head, neck and chest, cough productive of yellow and bloody sputum, hoarseness, breathing and swallowing discomfort, constipation and yellow urine since November. As above symptoms persisted and did not subside, the patient was then admitted for further treatment.

**Physical examination on admission:** Her general conditions were not good. She was emaciated and weighed 49kg and looked anemic. Superficial lymph nodes were impalpable and surgical incision healed. Heart rhythm was normal. Respiratory sounds were diminished. Liver and spleen were unremarkable. KPS was 40.

#### **Assistant examinations:**

Complete blood count: Hb 90g/L;

A chest CT scan showed multiple soft tissue masses in lungs with the largest one of 3.2cm×4.0cm, suggestive of pulmonary metastases. And a cervical CT scan showed status post thyroidectomy and multiple enlarged lymph nodes.

**Diagnosis:** Medullary thyroid cancer with metastasis to lungs.

#### **Integrative treatment plan:**

As the medullary thyroid cancer was in advanced stage and highly malignant with pulmonary metastases, there would be an extremely poor prognosis. After admission, the patient was immediately given western medicine treatments like intravenous nutrition, stoppage of cough and bleeding, phlegm elimination and anti-infection. Other integrative therapies included local hyperthermia, chelation therapy, major ozonated autohemotherapy, TCM (traditional Chinese medicine) and acupuncture. Symptoms like chest tightness, cough, expectoration and headache were gradually alleviated after 7 days of treatment. The patient gradually started therapies like EBOO, systemic medium-high hyperthermia, chelation therapy. TCM and acupuncture were adjusted based on syndrome differentiation.

According to TCM's theory, the patient's signs and symptoms at admission were attributed to pathogenic fire resulting from stagnation of liver Qi and treated in the principle of purging liver fire and detoxifying and dissipating binds.

Therefore, TCM decoction was prescribed and the detailed herbs included:

Radix bupleuri (Chai Hu) 10g  
Dioscorea bulbifera (Huang Yao Zi) 10g  
Radix paeoniae Alba (Bai Shao) 15g  
Radix trichosanthis (Tian Hua Fen) 10g  
Ligusticum wallichii (Chuan Xiong) 15g  
Pericarpium trichosanthis (Gua Lou Pi) 10g  
Fritillaria thunbergii miq (Zhe Bei Mu) 10g  
Pericarpium citri reticulatae viride (Qing Pi) 15g  
Arisaema cum bile (Dan Nan Xing) 15g  
Pangolin scale (Chuan Shan Jia) 10g  
Sargassum (Hai Zao) 15g  
Salvia miltiorrhizae (Dan Shen) 15g  
Prunella vulgaris (Xia Ku Cao) 15g  
Solanum nigrum (Long Kui) 20g

The patient was given one dose daily for more than 1 week. And after treatment her symptoms were improved. Tongue was light red and pulse was weak and slow. The treatment subsequently was adjusted to fortify the spleen, replenish Qi, eliminate toxins, and dissipate masses.

The detailed herbs included:

Radices codonopsis (Dang Shen) 15g  
Atractylodes macrocephala Koidz (Bai Zhu) 20g  
Tangerine peel (Chen Pi) 10g  
Poria cocos (Fu Lin) 10g  
Hyacinth bean (Bian Dou) 15g  
Fritillaria thunbergii miq (Zhe Bei Mu) 10g  
Sargassum (Hai Zao) 15g  
Dioscorea bulbifera (Huang Yao Zi) 10g  
Solanum nigrum (Long Kui) 20g  
Arisaema cum bile (Dan Nan Xing) 15g  
Agrimoniae pilosa ledeb (Xian He Cao) 30g  
Lily (Bai He) 15g

The decoction was taken once daily based on her signs and symptoms until she was discharged. Since then she continued traditional Chinese medicine for over 3 months.

Acupuncture therapy:

With neutral supplementation and draining method, each session of acupuncture was applied for 20 minutes in the frequency of once a day and there was a 2-day interval after 5 sessions.

Acupuncture points included:

Zusanli(ST36)  
Yinlingquan (SP9)  
Quchi (LI11)  
Taiyuan (LU9)  
Taichong (LR3)  
Feishu (BL13)  
Dazhui (DU14)

Fenglong (ST40)

Linggu

Dabai

Moxibustion therapy:

Each session of moxibustion was applied to 2 to 3 acupoints with moxa stick for 10 minutes respectively in the frequency of once every day or every other day.

Moxibustion points included:

Zusanli(ST36)

Guanyuan(RN4)

Dazhui(DU14)

Pishu(BL20)

Feishu(BL13)

Auricular therapy:

Auriculotherapy alternated once a week between two ears. Cowherb seeds were applied to the auricular points and the patient was instructed to press each acupoint 3 to 5 times per day, with each press lasting for 3 to 5 minutes.

The auricular points included:

Neibi(TG<sub>4</sub>)

Waibi(TG<sub>1,2i</sub>)

Yanhou(TG<sub>3</sub>)

Jiaogan(AH6<sub>a</sub>)

E(AT<sub>1</sub>)

Nie(AT<sub>2</sub>)

Shenshangxian(CO<sub>10</sub>)

Fei(CO<sub>14</sub>)

Tumor specific region

Psychotherapy was provided to boost her confidence in fighting cancer. Afterwards, she started practicing medical Qi Gong and exercise to increase spontaneous healing powder.

#### **Treatment outcome:**

The patient had been hospitalized for 60 days, during which she was given totally 3 sessions of systemic medium-high hyperthermia, 20 sessions of local hyperthermia, 25 sessions of chelation therapy, and 16 sessions of EBOO. After non-toxic integrative cancer treatment, general conditions improved and she gained weight to 56kg and could take care of herself independently. Chest tightness or pain, cough or hemoptysis disappeared, even though there was occasional hoarseness. Besides, a follow-up CT scan revealed pulmonary metastatic lesions (maximal size of 1.2cm \*1.2cm) became smaller than the finding in previous study. No new metastasis was noted.

Since then the patient has continued non-toxic integrative cancer treatment in Outpatient Department once per month and follow-up every three months. Currently, the patient has been living with thyroid cancer for more than 9 years with a completely normal quality of life.

### **Other cases**

The statistics of 22 patients with benign prostatic hypertrophy (BPH) treated with local hyperthermia. They were treated between 10 and 20 times (average 13 times). The size of prostate diminished between 1 and 2.5cm (average 1.5cm). The symptom was obviously improved in 20 patients (20/22). The quantity of residue urine was reduced in 19 patients.

32 patients with primary dysmenorrheal were treated with infrared wholebody mild temperature hyperthermia with average treatments ranging from 3 to 6 times. Everyone has got a good effect.

16 female acne patients, ages from 18 to 25, after 3 sessions of wholebody mild - high temperature hyperthermia for every patient, 13 patients'acne disappeared, the other 3 patients'symptom obviously improved.

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