EUROMED

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IPT –
Insulin Potentiated Therapy

Low Dose
Targeted Chemotherapy

By
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IPT - Insulin Potentiated Therapy

One of the safest and most innovative approaches to fight cancer aggressively.

IPT uses about 1/10th the amount of drugs used in standard chemotherapy, and no radiation.

IPT targets chemotherapy directly to cancer cells.

It does this by working with the unique physiology of cancer cells.

Cancer cells rely almost entirely on sugar metabolism – they need more sugar than healthy cells.

To supply that sugar, cancer cells have perhaps 16 times more insulin receptors than healthy cells.

Receptors are like *locks* and insulin molecules are the *keys* designed to fit in those locks.

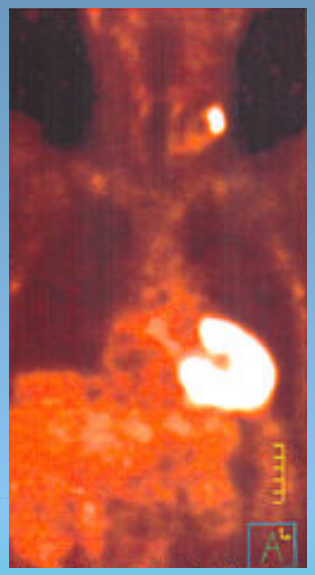
When a “key” fits into a “lock,” a channel opens up through the cell wall.

IPT uses insulin to open the channels in the cell wall to allow sugar to go into the cell.

Along with the sugar, we add a small dose of chemotherapy drugs.

Because the cell walls are wide open, the chemotherapy drugs enter as easily as glucose enters.

- PET scans work on a similar principal to IPT except that a radioactive agent is used instead of chemotherapy.
- To find a cancerous mass, the radioactive agent is mixed with glucose.
- Cancer cells have an increased uptake of radioactive glucose which can be seen on the films.



IPT

The word "potentiate" means that
one substance – insulin –
enhances the effectiveness of another
substance – chemotherapy –
and thus far less drugs are needed.

This method allows us to target chemotherapy directly to the cancer cells.

The drugs poison and eventually kill the cancer cells.

End result: the chemotherapy drugs effectively target just cancer cells, with minimal effect on normal cells.

IPT achieves a higher concentration of chemotherapy agents inside the cancer cells, while reducing the total amount of chemotherapy drugs circulating among healthy cells in the body.

IPT does much less damage to healthy cells so the side effects are greatly minimized.

Standard chemotherapy does not target cancer cells.

Standard chemotherapy does not use insulin to open cellular walls. Patients must be given a big dose of drugs so enough will be absorbed by the cells to do the job. The majority of the drugs are not taken up by the cancer cells; the massive dosage wreaks havoc to healthy cells and blood components.

Good cells die along with the bad. The severe dosage causes side effects such as hair loss, nausea, fever, vomiting.

Over time, standard chemotherapy treatment can lead to poor blood counts, a failing immune system, organ function disruption, cachexia, and death.

Another IPT Advantage:

Cancer cells are rapidly dividing cells.
Cells are more vulnerable when dividing.

However, only some cells are actively growing at any time, which means you can only kill some of the malignant cells at any time with conventional chemotherapy.

The insulin used in **IPT**, on the other hand, *stimulates division* in cancer cells, enabling the drugs to be absorbed by a much higher percentage of cancer cells.

Another IPT Advantage – Insulin is a Detoxifying Agent

- Insulin biologically modifies cell membranes.
- With insulin, things go in – and things go out.
- Insulin enhances transport of nutrients into the tissues and cells of the body.
- Insulin prompts metabolic waste to exit the tissues and cells.

Cancer is a condition for which the treatment is often considered worse than the disease. The rapid growth of alternative medicine in recent years has been driven by people's desires for kinder and gentler treatments for this disease.

IPT is that answer.

Our 4-fold approach with IPT:

1

Use of low dose chemotherapy
to target and kill cancer cells

Our 4-fold approach with IPT:

2

Use of complementary therapies

(Vitamin C, Poly-MVA, etc)

simultaneously to attack cancer cells

Our 4-fold approach with IPT:

3

Use of complementary therapies

(homeopathics, mushroom extracts, nutritional IVs, etc)

to detoxify the body and support your liver

Our 4-fold approach with IPT:

4

Retrain your body to fight cancer on its own so the cancer does not return.

Cancer, simply put, is a breakdown of the immune system and that system must be strengthened.

Greek Test

Each person is unique. We test each patient for their sensitivity to

- The universe of chemotherapy drugs
- The universe of homeopathic and natural substances used in conjunction with IPT

Each patient's treatment is customized – we use what will work best for you.

IPT Used for Cancer

1946 - First patient with breast cancer successfully treated using low dose chemotherapy.

This patient survived disease-free for another 30 years.

IPT is now practiced worldwide and has been used with cancer safely and successfully for more than 60 years.

However, it is not yet taught in America's conventional medical schools.

Medical school curriculum in the U.S. focuses mostly on insulin's role in diabetes. Pharmaceutical companies do not look favorably upon IPT because it uses so little of their product.

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Case Studies

Medical Treatment with Low Dose Targeted Chemotherapy with Insulin as the Biological Response Modifier

Case Study #1

59 year old man with squamous cell colorectal cancer:

- Tumor measuring , 4.3x3x3 cm mass
- Treated with IPT for 8 weeks
- Also treated with
  - Immunotherapy
  - IV homeopathic detoxification
  - IV high dose Vitamin C
- PET scan after 2 months showed dramatic improvement

P.E.T. Scan Arizona

Delivering the Power of Molecular Imaging

Patient Name:	F , J
Date of Birth:	03/11/47
Patient Number:	7327
Referring Doctor(s):	FRANK W. GEORGE, II, D.O.
Date of Service:	11/09/06

WHOLE BODY PET/CT FUSION

Indication: The patient has a recent diagnosis of colorectal cancer and has begun chemotherapy.

Procedure: Whole body imaging was carried out with CT fusion from the skull base through the thighs following the intravenous administration of 15.0 mCi of fluorine-18 FDG with a blood glucose level of 103.

Findings: The sinuses are normal. No cervical adenopathy. No axillary, mediastinal or hilar adenopathy. The heart is enlarged and there are coronary artery and other vascular calcifications. No definite pulmonary parenchymal or pleural changes are evident. Imaging through the abdomen and pelvis reveals diffuse fatty infiltration of the liver. The spleen, gallbladder, pancreas, adrenal glands and kidneys are normal. No free air, abnormal fluid collection, abscess, adenopathy or bowel obstruction is seen. There is a moderate amount of colonic fecal residue. There is marked rectal thickening with a rectal mass demonstrated that is avid for FDG measuring 4.3 cm vertically, 3.0 cm transversely and 3.0 cm in AP diameter with a mean SUV value of 8.1 and a maximum SUV value of 11.6. No regional or distant metastases.

IMPRESSION:

Rectal thickening with a mass measuring 4.3 cm x 3.0 cm x 3.0 cm in size avid for FDG with a mean SUV value of 8.1 and a maximum SUV value of 11.6 without regional or distant metastases.

Note: A CT procedure used for attenuation correction was performed with the PET scan.

Thank you for this referral.

RAL

ROBERT A. LEWIS, M.D.

RAL:glg
DD: 11/09/06/09845
DT: 11/09/06/DS: 11/9/06
Document 110906-glg.Phx.doc

Indication: The patient was recently diagnosed with colorectal cancer and is undergoing chemotherapy. The previous PET/CT examination of 11/09/06 showed rectal thickening with a mass measuring 4.3 cm x 3.0 cm x 3.0 cm in size, avid for FDG with a mean SUV value of 8.1 and a maximum SUV value of 11.6 without regional or distant metastases.

Procedure: Whole body imaging was carried out with CT fusion from the skull base through the thighs following the intravenous administration of 17.0 mCi of fluorine-18 FDG with a blood glucose level of 127, and this study is compared to the prior examination of 11/09/06.

Findings: CT examination shows normal sinuses. Imaging through the neck shows no cervical adenopathy. Chest CT shows no axillary, mediastinal or hilar adenopathy. The heart is enlarged. There are extensive coronary artery calcifications. No pulmonary parenchymal or pleural changes are apparent. Imaging through the abdomen and pelvis shows a normal liver and spleen. The gallbladder, pancreas, adrenal glands and kidneys are unremarkable except for slight irregularity of Gerota's fascia. There are aortoiliac calcifications. No free air, abnormal fluid collection, abscess, adenopathy or bowel obstruction is seen. There are prominent inguinal canals bilaterally. There is extensive colonic fecal residue, particularly in the rectum. There is no longer any significant rectal uptake. Uptake near the anus is likely physiologic. There are degenerative changes in the lumbar spine. This is most notable at L2-3, where there is sclerosis and loss of the intervertebral disk space. Overall, there is normal biodistribution of fluorine-18 FDG with no evidence of metastatic disease. Inhomogeneous uptake of FDG throughout the liver is nonspecific and fairly stable when compared to the previous examination.

IMPRESSION:

1. The rectal mass identified previously is no longer present. Slight increased uptake of FDG is seen in the region of the anus likely physiologic, as there is extensive retained colonic fecal residue most notably in the rectum. This likely represents fecal stasis.
2. Inhomogeneous uptake of FDG throughout the liver. This is fairly stable when compared to the previous examination. Continued three to four month interval follow up is suggested.

Case Study # 2

48 year old female

with inflammatory breast cancer

with extensive metastasis to the bones

- Treated with IPT weekly

Also treated with:

- IV homeopathic detoxification
- IV high dose vitamin C

PET/CT FUSION IMAGING

Clinical Indication: History of left breast cancer with history of lumpectomy in 2000, with recurrent mass.

Technique: Following the intravenous administration of 16.8 mCi of fluorine-18 labeled FDG, total body positron emission images were obtained along with a CT scan and fusion imaging.

Findings: There is an 8 cm greatest diameter lobular mass involving the left breast with areas of metabolic activity with SUV values up to 10.0, consistent with recurrent breast carcinoma. There is some left axillary lymph node involvement as well. There is extensive skeletal involvement beginning in the pelvis with lytic lesion with intense metabolic activity in the right sacroiliac region and to a lesser degree in the left sacroiliac region and in the S2 sacrum. There is involvement of the right side of L4, left aspect of T12, and to a lesser extent L1, right pedicle of T6 and right C1 lateral masses. There is extensive involvement of the right scapula and bilateral glenoid involvement. No mediastinal or hilar lymphadenopathy is seen. No pulmonary nodules are seen and no liver metastases are seen.

CONCLUSION:

1. Large, approximately 8 cm, lobular, metabolically active mass in the left breast consistent with recurrent primary breast carcinoma.
2. Extensive metastases involving the skeletal structures, as above, including right C1, right T6, left T1 and left T12, right L4, and extensive involvement of the right sacroiliac region and lesser involvement of the left sacroiliac region.
3. Extensive involvement of the right scapula, bilateral glenoid regions and left axillary lymph nodes.
4. No pulmonary metastases or liver metastases are seen.


June 2006


August 2008
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WHOLE BODY PET/CT FUSION

Indication: The patient had left breast cancer, for which the patient had a lumpectomy in 2000 followed by chemotherapy. The previous PET/CT examination of 05/26/06 showed an 8.0 cm lobular, metabolically active mass in the left breast consistent with recurrent primary breast carcinoma with extensive skeletal metastases involving C_1, T_6, T_1, T_{12}, L_4 and extensive involvement of the right sacroiliac region, and lesser involvement of the left sacroiliac area. There was also metastatic disease involving the right scapula, bilateral glenoids, and left axillary lymph nodes.

Procedure: Whole body imaging was carried out with CT fusion from the skull base through the thighs following the intravenous administration of 17.6 mCi of fluorine-18 FDG with a blood glucose level of 85, and the examination is compared to the prior study of 05/26/06.

Findings: CT examination reveals normal sinuses. Imaging through the neck shows no cervical adenopathy. Chest CT shows a port in the right anterior chest. There is thickening of the skin over the lateral surface of the left breast. This is only minimally avid for FDG. It is consistent with a dramatic response to therapy. No pulmonary parenchymal or pleural changes are evident. Imaging through the abdomen and pelvis reveals a normal liver and spleen. The gallbladder, pancreas, adrenal glands and kidneys are normal. No free air, abnormal fluid collection, abscess, adenopathy or bowel obstruction is seen. Although there are extensive blastic metastases in the areas previously noted, these areas of metastatic disease are no longer metabolically active. This is consistent with a dramatic positive response to therapy. Overall, the biodistribution of fluorine-18 FDG is essentially within normal limits.

IMPRESSION:

1. Dramatic improvement in the appearance of the PET/CT examination. The large mass in the left breast is no longer apparent, although there is still some thickening along the left lateral chest wall and near the breast with very slight uptake of FDG, below the threshold for malignancy.
2. Excellent response to the abnormal metabolic activity noted throughout the bone marrow when compared to the previous study. There still remain osteoblastic changes on the CT portion of the study, but these areas are no longer metabolically active.

IPT IS OUR SPECIALTY

We are the only medical clinic
in the world with 4 physicians certified
as IPT instructors.

Dr. Frank George, Medical Director,
was the first osteopathic physician in
the United States to be trained in IPT.

The Medical Staff of EUROMED

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Sean Devlin, DO, MD(H)**
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