For the wonderful team at THE FOAM

Part A

If you, a loved one or a friend is diagnosed with cancer, here are all of the relevant questions that you should consider asking your oncologist and general practitioner.

Here's a comprehensive list of questions cancer patients (or anyone concerned about their health) can ask their GP and oncologist to challenge conventional medical thinking and demand a more holistic, informed approach to treatment:

General Questions for Your GP & Oncologist

1. How much training have you received in Nutritional Oncology?
2. What do you know about how diet and micronutrients influence cancer progression and recovery?
3. Are you trained in identifying and correcting nutrient deficiencies in cancer patients?
4. Can you explain how chemotherapy affects my metabolism, mitochondria, and immune system?
5. What is your approach to improving my overall health during and after cancer treatment?
6. What steps can I take to reduce inflammation and improve my body's resilience to treatment?

Toxicity & Side Effects of Chemotherapy

7. Can you explain exactly what these chemotherapy drugs do to my biochemistry and genes?
8. What are the long-term effects of chemotherapy on my immune system, gut microbiome, and mitochondria?
9. How do you monitor and mitigate the risks of secondary cancers caused by chemotherapy?
10. What support do you provide to help patients detoxify from chemotherapy and recover their health?
11. How does chemotherapy impact my risk of developing other diseases, such as cardiovascular or neurodegenerative conditions?

Nutritional Support & Integrative Oncology

12. Do you routinely test cancer patients for vitamin and mineral deficiencies?
13. What role do you believe vitamin D, magnesium, zinc, and selenium play in cancer treatment?
14. What dietary recommendations do you make for cancer patients beyond 'eat a balanced diet'?
15. Have you reviewed research on ketogenic diets, fasting, or other metabolic therapies for cancer?
16. Why aren't anti-cancer nutraceuticals like curcumin, quercetin, and sulforaphane more widely recommended?
17. Would you be open to working with a functional or integrative medicine practitioner to support my treatment?

Addressing the Root Causes of Cancer

18. What tests do you use to determine why my cancer developed in the first place?
19. How do you assess the role of environmental toxins, chronic inflammation, and metabolic dysfunction in cancer?
20. How do you measure and support my mitochondrial health during treatment?
21. Do you evaluate my blood sugar and insulin levels, given the links between cancer and metabolic disorders?
22. What lifestyle changes (besides quitting smoking and exercising) do you recommend to improve my prognosis?

Medical School & Systemic Failures

23. Why do medical schools provide so little training in nutrition and biochemistry for cancer patients?
24. Why aren't medical students taught about integrative or metabolic oncology?
25. Do you think medical education is too influenced by pharmaceutical companies?
26. Are you allowed to recommend treatments outside the standard chemotherapy, radiation, and surgery model?
27. Have you ever challenged conventional oncology practices, and if so, what was the response?
28. What is your view on complementary treatments, and why are some dismissed as 'quackery' despite supporting evidence?

Empowering the Patient: What to Expect from Your Doctor

29. How do you define treatment success—tumour shrinkage or long-term health?
30. What is your plan to help me regain my health and vitality after treatment?
31. If chemotherapy and radiation weaken my immune system, how do you plan to help me rebuild it?
32. How do you ensure that my cancer doesn't return after treatment?
33. Would you be open to helping me create a personalised treatment plan that integrates conventional and natural medicine?

Final Challenge: Holding Your Doctor Accountable

34. If you were diagnosed with cancer, would you follow the exact same treatment protocol you're recommending to me?
35. If there was an effective, non-toxic alternative to chemotherapy, would you tell me about it?
36. Are you comfortable with me getting a second opinion from an integrative oncologist?
37. Why is the 'standard of care' in oncology so resistant to new research and emerging therapies?
38. Do you believe Big Pharma's influence affects cancer treatment guidelines?

This list is designed to encourage doctors to think critically, engage in honest discussions, and take a more holistic approach to cancer treatment. Patients who ask these questions will quickly learn whether their doctor is open-minded and truly invested in their health—or merely following protocols without questioning them.

Part B

Issues Facing Cancer Patients: A Critical Examination of Oncology, Nutrition, and Medical Education

1. Toxicity of Chemotherapy: Do You Know What These Chemicals Are Doing to My Biochemistry and Genes?

Cancer patients are routinely subjected to a barrage of highly toxic chemotherapeutic agents, yet oncologists often lack a deep biochemical understanding of what these drugs are doing beyond their primary tumor-killing effects. Medical training prioritises memorisation of drug mechanisms, dosages, and protocols while neglecting the broader physiological impact of these treatments, especially the myriad of complex interactions.

Many chemotherapy drugs, including alkylating agents and topoisomerase inhibitors, damage DNA, increasing the risk of secondary cancers. Yet, oncologists rarely, if ever, discuss this risk with patients in meaningful detail.

Cancer metabolism is profoundly linked to mitochondrial health, yet medical schools fail to emphasize the effects of chemotherapy-

induced mitochondrial damage. Patients frequently suffer from treatment-induced fatigue, neurodegeneration, and metabolic syndrome—consequences that could be mitigated with proper interventions.

Oncologists prescribe drugs that obliterate immune function and gut microbiota but are almost universally untrained in how to restore these critical systems post-treatment. This neglect increases infection risk, contributes to long-term inflammation, and may even promote cancer recurrence. Neglect equate to negligence.

The result? Oncologists become glorified prescription writers, dispensing toxic regimens with little awareness of their long-term effects on patient biochemistry and health.

2. The Medical System's Total Neglect of Nutritional Oncology

"Have you trained in Nutritional Oncology?" is a question that will stump nearly every oncologist because medical schools utterly fail to teach doctors anything beyond the most rudimentary aspects of nutrition.

Cancer patients are often critically deficient in vitamin D, magnesium, zinc, selenium, and B vitamins, yet oncologists are not trained to test for or correct these deficiencies. Negligence.

The Warburg effect (a hallmark of cancer metabolism) suggests that reducing glucose availability may slow tumour progression. Yet, the medical establishment refuses to explore ketogenic or fasting-based strategies, despite robust evidence supporting their potential benefits. Sugars and refined carbohydrates are rarely stopped. Negligence.

Nutraceuticals are dismissed as ‘quackery’. Despite mountains of research on compounds like curcumin, quercetin, resveratrol, and sulforaphane—each with proven anti-cancer properties—

oncologists are trained to dismiss them outright. Why? Because medical education is steeped in pharmaceutical-driven biases that reject anything that cannot be patented and monetised. Their patients may be in a clinical trial and these other substances may confound the results. Negligence.

The lack of nutrition education in medical school is not just a failure—it is medical negligence. The refusal to integrate nutritional strategies into oncology is condemning patients to worse outcomes. These University medical schools should not receive any government money until they properly reform.

3. The Paradox of Treatment: Are You Actually Going to Make Me Healthier?

Most cancer patients assume that treatment will ultimately restore them to health. Instead, they are frequently left sicker than before.

-"Success" is defined by tumour shrinkage, Not Patient Health. Oncologists measure victory by reductions in tumour size and number , but they rarely track whether the patient's overall health improves. In fact, most cancer survivors are left with severe chronic illnesses.

There is the ongoing failure to address the root causes of cancer. Oncologists are not trained to investigate why cancer developed in the first place. Diet, environmental toxins, chronic inflammation, mitochondrial dysfunction, micronutrient deficiencies and immune dysregulation are major drivers of malignancy, yet they are virtually ignored in clinical practice.

Conventional oncology has no roadmap for rebuilding the body before, during and after chemotherapy, radiation, or surgery. Patients are left to navigate their recovery alone, often receiving no guidance on how to detoxify from toxic treatments, restore gut health, or repair immune function.

How can an oncologist claim to "cure" cancer if the patient is left debilitated, vulnerable to secondary cancers, and with a

dramatically shortened lifespan due to treatment-induced complications? Distrust develops.

4. The Root of the Problem: Medical Schools Are Failing Doctors and Patients

At the heart of this crisis is the utter failure of medical schools to train doctors in critical areas of oncology, biochemistry, and nutrition. The medical education system is hopelessly outdated, pharmaceutical-driven, and shockingly resistant to change. Money making schemes, for example accepting funds and building mRNA factories, are making the system worse.

Medical school curricula are stuck in the 20th Century. Doctors are trained as drug dispensers, not healers. The overwhelming focus on pharmacology ensures that doctors learn to manage symptoms with drugs rather than address the underlying causes of disease. Basic science is taught in isolation, not in clinical context. Students spend years memorising biochemical pathways but are never taught how to apply this knowledge to real-world patient care.

Nutrition is an afterthought—or worse, nonexistent. The average medical student receives less than 20 hours of nutrition education, I received about 4 hours in a 6 year undergraduate course—and even that is often outdated, filled with myths about low-fat diets and calorie counting rather than evidence-based nutritional medicine.

Doctors are brainwashed to reject integrative medicine. Instead of fostering curiosity about promising treatments outside the pharmaceutical paradigm, medical schools actively discourage students from exploring alternative or complementary therapies. Anything outside of the "standard of care" is dismissed as unscientific—even when high-quality research suggests otherwise.

The Medical-Pharmaceutical Complex Controls the Curriculum

Who designs medical education? Big Pharma.

Medical schools are funded by drug companies. Universities in the US receive massive donations from pharmaceutical corporations, ensuring that medical curricula are designed to prioritise drug-based treatments. We in Australia are not so lucky. We have to pay for our education. But you can be certain our medical schools are ‘influenced’.

Continuing medical education (CME) is controlled by industry. Once in practice, doctors rely on CME courses—many of which are funded by drug companies—to stay up to date. The result? A never-ending cycle of pharmaceutical and vaccination indoctrination. Doctors who challenge the system are silenced-not me. Physicians who advocate for nutritional medicine, metabolic therapies, or integrative oncology are ridiculed, ostracised, and even threatened with license suspension.

The Consequences of This Failure Are Catastrophic

Cancer patients are subjected to toxic treatments without a plan for health restoration. The potential of nutrition, lifestyle medicine, and metabolic therapies is ignored. Doctors are left woefully unprepared to address the complexities of cancer beyond chemotherapy and radiation. Patients who seek alternatives are dismissed, ridiculed, or forced to go outside the medical system to find real and sometimes unaffordable solutions.

Conclusion: The Medical Establishment Must Be Held Accountable

The failure of medical schools to properly train doctors is not just an oversight—it is a scandal. The consequences are devastating: cancer patients suffer unnecessarily, doctors remain ignorant of life-saving therapies, and the medical system remains locked in a profit-driven model that prioritises pharmaceuticals over true healing.

It is time for a radical overhaul of how we train doctors. Medical education must evolve to include:

1. Comprehensive training in biochemistry and metabolism – So oncologists understand the full impact of cancer treatments.

2. Rigorous nutrition education – So doctors can harness the power of diet and micronutrients in cancer prevention and treatment.

3. Integration of evidence-based alternative therapies – So patients are not forced to choose between conventional and holistic care.

4. A shift from drug-based thinking to patient-centred healing – Because real medicine is about restoring health, not just fighting disease.

Until this transformation occurs, cancer patients will continue to suffer at the hands of an antiquated, pharmaceutical-dominated medical system and its doctors; a system that refuses to embrace the full spectrum of healing and allows patients to die without giving them 'the right to try'. The time for change is now.

THIS IS NOT INTENDED AS MEDICAL ADVICE. YOU MUST ALWAYS BE UNDER THE CARE OF A TRAINED, QUALIFIED AND EXPERIENCED PRACTITIONER

Part C

The Agents I recommend in Integrative Oncology.

Integrated Nutraceutical-Plus Treatment

Professor Ian Brighthope

Updated January 2025

Professor Ian Brighthope's teachings for general cancer patient care. You must have a doctor treat you with the regime because it requires variations depending upon your individual metabolism and other treatments such as chemotherapy, immunotherapy and radiotherapy.

This regime is modified for particular patients with specific cancers and at different stages of the illness. It is not recommended as medical advice for any individual but a guide for the doctor trained in nutritional and integrative oncology.

1. Vitamin C both orally and intravenously Daily (see below)
   INTRAVENOUS VITAMIN C:

HDIVC should be administered before or during the HBO.

It should be in the form of sodium ascorbate, 15G sodium ascorbate per 50 ml of sterile distilled water.

Using Ascorbic Acid- is not recommended.

The starting dose should be 15-30 gram and increasing to 60 gram over the following 3 days. Need to monitor the response to all therapy and an increase to 120 gram may be warranted.

HDIVC twice weekly until we see signs of clinical improvement and/ or tumour regression and CTC's numbers decrease.

ORAL VITAMIN C:
Oral intake of vitamin C should be maintained at a level or 10-20 gram per day in at least 4 divided doses, especially on non-IVC days.
There are powdered forms of vitamin C containing mixed ascorbates such as sodium, magnesium and the acid form. They are often sweetened with stevia and flavoured.

2. Hyperbaric Oxygen (HBO) Daily for 14-21 days.
The HBO should be taken daily for 14-20 days in conjunction with the HDIVC.

Observe for the shift in the inflammatory mediators (cytokines)

3. a). Glutathione 1,000 -2,000mg IVI biweekly

3 b). Modified Citrus Pectin: MCP 15 grams per day.

4. NAC 500mg bd and Ivermectin

5. Selenium 1,000 mcg daily for 1 month
Monitor serum selenium levels weekly. Maintain upper limit of selenium range.

Reduce to 200 mcg per day thereafter.

6. a) Mixed Tocopherols and Tocotrienols 125mg of each bd. Plus

b) Vitamin A, 50,000iu for 2 weeks then 5,000iu per day. Monitor levels. Watch for signs of toxicity; dry skin and global headaches.

7. Mushroom extracts (Beta Glucans)

Coriolus Fruiting Body extract equivalent 10G bd

Reishi Fruiting body extract equivalent 5G bd

8. High dose vitamin D 50,000-100,000 IU per day

To achieve a plasma level of 250 nmole/L. then reduce to 10,000IU per day.

Test after 2 weeks on the high dose.

For rapid effect, give intramuscular dose or better still, oral Calcifediol, the active form. Its effect occurs within a couple of hours.

9. Magnesium orotate equivalent to 100 mg elemental magnesium per tablet.
Two tablets bd

10. Ubiquinol (Coenzyme Q10) 300mg per day.

11. A trace element combination of Daily zinc, copper, manganese, selenium and boron

At least 5-10mg of boron per day.

12. Lugol's Iodine 6-8 drops per day.

13. Naturally fermented sauerkraut one or two servings per day.

Also, encourage green juicing if possible.

14. Intravenous B17 (Laetrile probably only available in Mexico) dose and frequency based on manufacturer's product information and local use. Only permitted in Australia for terminally ill cancer patients. Must obtain permission from TGA and State poisons authority.

The use of B17 and Artemisinin are extremely important

The oral B17 should be commenced at 500mg laetrile twice daily with meals

15. Cannabis:

Highly recommended now for all cancer patients.

The cannabis should be started with the objective of having an intake of up to 500 mg per day of cannabinoids with a preponderance of THC. I know some patients who take more, up to 1000mg per day of THC.

However, this dose taken immediately will have severe psychoactive effects. The dose must be slowly increased over a period of days to weeks depending on the development of tolerance. Preferably taken in nebulised form in divided doses qid.

16. Hyperthermia may be offered to selected patients with certain cancers. In cases of hyperthermia, isoquercetin is prescribed to decrease the production of heat shock proteins before treatment.

17. Colloidal silver is an optional therapeutic and may be of value in the management of infection.

18. Keto Diet especially for brain tumours. Keto responders can be based on genetic markers.

A full genomic workup to look at COMT, MTHFR etc to utilize best genetic data.

19. IP6 High-dose inositol hexakisphosphate (IP6) is a preferred active ingredient along with HD Vitamin C

IP6 works on all things calcium via the 6 phosphates, ultimately controlling and limiting cancer growth.

Food for thought ~ Here are some foods/herbs that may down-regulate glutamate in research.

Strongly recommended shown in red

1. EGCG (Green tea)
2. Curcumin (Turmeric root)
3. Lycopene (Tomatoes)
4. Ursolic Acid (Holy basil, pistachio nuts)
5. Resveratrol (Red grape skins)
6. Honokiol, magnol (Magnolia Bark Extract)
7. Graviola (Soursop)
8. Sulforaphane (Sprouting seeds)
9. Valerian
10. 10.Withanolide (Ashwagandha)

11. 11.Herbs: Relaxing herbs such as lemon balm, chamomile, and passion can offset the negative effects of glutamate by restoring its balance with gamma-aminobutyric acid (GABA).
12. 12. Indian Flower Remedies are also recommended.
13. 13. Sweetbread (pancreas), liver and /or brains from lamb. Can be cooked Crumbed. Brains can be made into ice cream after cooking by adding fruits and honey and freezing. Not always a favoured food but can become accustomed to it.
14. 14. Chinese wormwood. A very useful herb.Also known as Artemisia.
15. 15. Ivermectin:
    has powerful anticancer effects in some patients and some cancers. Individuality is a crucial factor in re-purposed medicine therapeutics. The dose is 1-2mg/g/day (Guzzo et al 2002). 1mg/kg/day for 180 days has been used safely (de Castro 2002).
16. 16.Mebendazole:
    50mg/kg/day for months has been used. Up to 4000mg per day has been taken safely (Gocmen 1993).
17. 17.Fenbendazole:
    1000mg three time a day has been taken safely for several months.