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Dear Friends,

This is to inform you about three decades of my research in the field of oncological diseases which is published under the title

MUDr. Kamil Jurkovič

**“ONCOLOGICAL DISEASES: TREATMENT BY BLOCKING TUMOUR  
METABOLISM TREATMENT OF MASTOPATHIA FIBROSA”**

**Treatment**

I am not claiming to have discovered a miraculous medicine against cancer. What I have found, however, is the manner in which a malignant tumour gains metabolic dominance in the human body, which is responsible for its uncontrollable growth. Based on this finding I have developed a medical treatment, which is able to block the metabolic processes in tumour of the “mother“ organ as well as in the surrounding and more distant organs. This can be achieved through blocking the hormones of the thyroid gland, and enzymotherapy, while simultaneously supporting the immune system. The stages of the self- realisation of the oncogenic process are described in my publication.

The treatment is aimed at patients who refuse the traditional treatment of tumours, for patients to whom the traditional treatment (radiotherapy and chemotherapy) has not brought the expected results and for those to whom the traditional treatment cannot be administered. With the partial reduction of medicaments this treatment can be also applied as a supportive treatment to radio- and chemotherapy. It can also alleviate the effects of the traditional treatment of tumours (fibrosis degeneration of organs) and other secondary effects of radio- and chemotherapy.

As the author I bear no responsibility for the non-professional administration of this medical treatment.

The administration of my medical treatment helps resolve the problem of difficult to treat tumours of the gullet, the gall bladder, sarcomas and other gastroenterological, lung, urological and gyneacological organs as well as breast tumours up to 20 millimetres diameter after mammography or ultrasound examination. The duration of the treatment of breast cancer requires 3 - 5 months.

Good results have been documented in the treatment of sarcomas (retro peritoneal and osteosarcomas) and melanosarcomas immediately after surgery.

**Medicaments**

The individual stages of the self realisation of the oncogenic process are being paralysed by the medicaments that are normally administered at the hyper functional syndromes of the thyroid gland, immune-deficiency syndromes, osteoporosis and anaemic syndrome, and, through the administration of enzymotherapy. These medicaments are available in any quantities on the domestic market in the Czech and Slovak Republics.

These medicaments include:

*Carbimazol* 5 mg tablets (thyreostaticum, 5 carmentoxy 3 metyl-2 thiolidazolium)

*Biomín H* pulv. Div (3 gof powder contains Ca 1110 mg, Mg 15 mg, Ph 1,8 mg plus microelements Cu, Zn, Li, Mg)

*NORGA* (Imunoglobulin sol. humanum normal) 1,9 ml in 1 amp.

*Trypsin retard* 5 mg amp. (Suspension of Trypsin in olive oil)

The pre-clinical study of these medicaments has been made and approved by the State Institute for the Control of Pharmaceuticals of both the Czech and Slovak Republics. Their toxicity is practically zero.

Through the administration of these medicaments at the blocking of the tumours metabolism the indication scale has not been extended.

## **Copyright**

My publication must not be used for commercial purposes and is designed for both doctors and patients. All rights for this publication are reserved in compliance with the copyright laws in particular countries.

The book can be published only after my authorisation.

## **Foundation**

I have financed my research and the publication of the book from my own resources without any assistance of the state or the insurance companies. I have also helped financially many of my patients for whom the disease would have meant financial and social disaster. This is why some of my patients have established

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With my publication I am not following any commercial benefits. I would only like to ask my patients who have successfully been treated or those whose suffering has been alleviated, as well as other people, who are willing to support my efforts, to contribute to the Foundation. Due to the economic situation of Slovakia and other post-communist countries most of my patients have to face financial problems and my working conditions are also fairly modest.

The costs of medicaments per year do not exceed 500-700 USD.

I am ready to treat any number of patients under the supervision of specialists in individual countries. I am also willing to send any of my patients with their medical records for control examination in any research institute or hospital under the condition that their travel will be paid.

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# **“ONCOLOGICAL DISEASES: TREATMENT BY BLOCKING TUMOUR METABOLISM TREATMENT OF MASTOPATHIA FIBROSA“**

*MUDr. Kamil JURKOVIČ*  
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## **Foreword**

Dear Friends.

The present is a shortened version of my study dealing with the problems of the treatment of oncological diseases. The aim of my work is to inform the reader about the essence of a treatment based on blocking the metabolism of the oncological process while simultaneously supporting the immune system.

I have omitted detailed description since this study is intended in the first place for my fellow physicians. It is addressed mainly to those whose endeavour it is to save life even if the patient is in the final stage of the disease and released from hospital for home treatment. Even if the patient's diagnosis is hopeless, there is still a possibility to alleviate suffering through the above mentioned treatment,

I assume that for many colleagues it will be difficult to accept my views. Many of them will ask how it is possible that thousands of researchers have not made any progress and now someone who is a practitioner dares to speak about blocking the progress of the disease. How does he dare challenge this issue?

I would like to assure you that I undertook this task with the sole aim of helping patients in the final stage of the oncological disease, for which I as a doctor was obliged to do something. That is why I applied within the vital indication the above mentioned treatment that consisted of the drugs authorized by the state.

I am convinced there must be hundreds of specialists working on similar alternative treatment of oncological diseases. But they will find it difficult to prevail over the routine methods of treatment by extra corporal factors (radiotherapy, chemotherapy).

Thus I was delighted to hear the news about the overall support that is provided to a team of American research workers who, under the leadership of Dr. Folkman, started treatment through a similar, indirect way of tumour liquidation. Their aim is to block tumour metabolism through the restriction of the coronary system that is supplying the oncological process.

This fact and above all the results of my work have confirmed the direction in which I set out in 1967 as a correct one.

I would like to appeal to the reader to critically view this work but at the same time to take into account my very limited research possibilities.

Archived records containing detailed chronological data regarding the patient's health condition before and after treatment back this work.

Upon request, I am willing to show all the documentation, or to refer patients to a follow up examination at any clinical or research establishment.

In the second part of my work I describe the treatment of fibrous mastopathy.

The advantage of the treatment in these cases is that in 3 - 4 months we can cure the patient completely just through medicamentous treatment, without any surgical intervention, and thus prevent possible development of the breast cancer.

Due to the fact that I work in restricted conditions for continued research, I appeal to doctors and researchers to co-operate on the improvement and scientific verification of this treatment method, which would facilitate its global application.

Herewith I would like to thank my wife and my children for their understanding. My admiration goes to the support they have provided for me for all those long years.

At the same time would also like to express my gratitude to my assistant, Mr. Berith for his help.

To conclude. I would like to express my thanks to nearly 250 fellow practitioners, who closely co-operated with me in the practical verification of my treatment method from 1992 to 1997. Without their help this publication could not have seen the light of day.

Furthermore, I would like to thank the Austrian General Consul to Slovakia, Mr. Otto Roch who, in 1983, kindly mediated the contacts with the Austrian Minister of Health. The Minister of the Republic of Austria asked the experts to pass judgement on my work entitled The Endogenous Blocking of the Metabolic Processes of Malignant Proliferation. I can claim with pleasure that the assessment by the Austrian Ministry of Health was in favour of my work.

My thanks also go to the team of surgeons and hospital staff of the Gynaecological Clinic of Prof. Gitsch in Vienna who, after a 6 years application of B.T.M. treatment to my patient V. A., born 1928, successfully removed a tumour of 12 kgs from her abdominal cavity. In 1981, at the exploratory laparotomy performed by the surgeons in Rychnov nad Knežnou the tumor had been classified as an inoperable malignant tumor. The tumor had the size of two men's heads, rose from the left ovary and two thirds of it were adhered to the dorsal and ventral abdominal wall with an infiltrated peritoneum and the presence of ascites. After 6 years of my treatment, this malignant tumor was degraded to a benign one, which was confirmed by the Austrian surgeons (fibromyom in regression). The medical treatment of this patient is described in the introduction to the Practical part of my work.

My thanks go to the Minister of Health of the Republic of Austria who was in office in 1983. as well as to Professor Sauerman, who mediated the admission of my patient to the Gynecological Clinic of Prof. Gitsch in Vienna. I cannot thank enough the Mayor of Vienna, who financed the hospital stay, as well as the surgery of my patient.

I would like to advise any patients reading this to continue further reading only after having read the explanations for the lay public, which in shortened form also contain the principles of the treatment.

The Author

## **Theoretical part.**

### ***Metabolism***

In spite of the efforts of healthcare education and mass cancer prevention programs, a relatively high proportion of patients still seek medical treatment only when a newly diagnosed oncogenic process (OP) can be classified as Inoperable. Radiotherapy (RT) or chemotherapy (CHT) cannot be indicated for some percentage of patients because of their advanced age or the advanced stage of their oncogenic disease. Many patients treated with radiotherapy or chemotherapy must have their treatment discontinued because it causes secondary damage to the bone marrow, as well as to the internal organs. Some patients even refuse to undergo treatment with radiotherapy and chemotherapy.

Because the medical treatment does not have any other alternative treatment at its disposal, these patients depend on the application of a symptomatic therapy. The number of the above-mentioned patients is significant and it is very important to seek new methods of treatment for them.

In older literature, surgeons describe unique patients who had survived many months - even years - without any treatment, despite the dangerous location of the oncogenic process. These extraordinary cases of survival could be ascribed to the organism's ability to suppress growth of the oncogenic process under certain conditions by its own mechanisms.

The purpose of my work is to discover these abilities of the organism and imitate them by means of therapy. This is a very obscure and controversial topic.

My main objective in developing this treatment method was to use medication to stop the progression of the OP, while simultaneously supporting the organism's immune system.

Blocking the metabolism of malignant tumors (B.T.M.) is the catalyst for the natural healing processes, which will degrade the dominant tissue system of the OP and will subject H to the organism's control. At the same time they lead to a change in the organism's immune system such that RT stops responding to pathological neurohumoral Impulses from the OP.

In 1967, I divided the course of oncogenic disease as follows:

- I. a) Stage of dominance of the oncogenic process and its metabolism in the organism
- b) Stage of decreased immunity of the organism
- c) Stage of weight deficit of the organism
  
- II. a) Anemic syndrome with incipient cachexia
- b) Algesic syndrome and final stage of the disease

I. a) *Stage of dominance of the OP and its metabolism in the organism.*

The explosion of the metabolic processes in the oncogenic tissue is beyond the logic of a purposeful reaction of the organism. We can describe OP as the youngest tissue system, which gradually makes its own metabolic processes so dominant that they reach the same level as the metabolic processes of the vitally important organs. However, its metabolic processes are several times more powerful than the surrounding organs or the mother tissue. Which organs of the organism are able to secure the dominance of the OP's metabolism to the detriment of the macro organism?

In which way does the oncogenic process develop its metabolic dominance?

It is a mechanism, which uses hidden processes that are difficult to identify. At the time when I was developing my treatment method, I had only assumed the existence of certain substances produced by a tumor that facilitate these hidden processes. Thanks to the efforts of scientists, at present, some of these substances have been identified and described.

In the middle of the 80's, endocrinologists described substances of an immunoglobulin character (named by the acronym LATS) produced by the OP, which stimulate the thyroid gland. Later, parathormone-like substances were described, which were produced by the OP, which produced mainly lung cancer and urinary bladder cancer.

There are also other substances produced in OP (which have not been exactly identified so far), which suppress the activity of the hematopoietic organs. This results in the anemization of the organism without a proven metastatic damage of the bone marrow.

The substances have not yet been identified which may affect the endocardium and the coronary blood flow even before the manifestation of the oncogenic disease's clinical symptoms. (Clinical workers and practitioners may have observed that many younger people above the age of 35, who are treated for the oncogenic disease of colorectal carcinoma or lung cancer, have suffered from ischemic heart disease, or myocardial infarction, only 2 - 5 years before).

The oncogenic process is also able to paralyse the organism's immune system through a mechanism that has not been exactly identified so far. This occurs even before the appearance of the clinical symptoms of the disease.

These self-realisation processes of the metabolism of the OP are so imperative as to lead to the production of thyroid gland hormones in a similar way as in oligo-symptomatic thyreotoxicosis.

In the pre-clinical stage of the self-realisation of the OP metabolism the nutriments and the oxygen of the mother's tissue will suffice. In the further stage the demands of the OP for oxygen and nutriments grow many times so that it is then forced to ensure the dominance of its metabolism in the organism through its own mechanism's .

The ability of the oncogenic process to cause an oligosymptomatic thyreotoxicosis-like process can be considered as one of the instruments through which the metabolic dominance in the organism, concealed in the mimicry of its own self-realisation, is ensured.

In this stage of the self-realisation of the OP metabolism muscle hypotrophy and atrophy follows and thus the thyroid gland, which is stimulated by the OP metabolism, does not respond by changing the production of hormones. On

examination, the thyroid gland is found eufunctional at palpation and the laboratory results of T3, T4 and TSH are normal the normal palpation and laboratory results justify the application of a thyreostatic drug and thus provoke the blocking of the OP metabolism in the organism. After being blocked through the thyreostatic drug the OP metabolism gradually comes under the control of the organism. The supply to the muscles of the organism is renewed and the thyroid gland again does not respond either on palpation or in laboratory exams. Impairing the balance through the blocking (characteristic[al] by its mild enlargement) will only follow when the thyroid gland is not burdened by the OP metabolism.

In the attempt to restrict the several times more powerful metabolic processes in the OP. and at the same time to limit the production of LATS. As well as the parathormone-like substances, and other internal secretions through which the oncogenic process affects the bone marrow, coronary blood flow, and the organism's immunity, i administered a thyreostatic drug - *Carbimazole* (5 carbentoxo-3-methyl 2 tialidosolium) 5 mg tablets in a dosage of 3 times 10 mg daily.

**In this way I succeeded to indirectly affect the most sensitive point in the metabolism of the oncogenic process. By the restriction of the OP metabolism we degrade its domination and thus, the OP comes under the organism's control without hurting the macro organism itself.**

During 24 years of administering the thyreostatic drug (Carbimazole) to patients with an oncogenic process. I have not found symptoms of thyroiditis, shock, or myxoedema in the beginning of treatment.

Also, after administering it for 1 year or longer, no symptoms such as hypothyroidism or thyroiditis were noted. I administered this preparation to 530 patients. Depending on the magnitude of the tumorous process, the treatment can last from 5 months to 1 year. I had a female patient, who in 1981 underwent exploratory laparotomy. The finding was a huge tumour rising from the right ovary, which had infiltrated the peritoneum. The tumour was attached to the anterior and posterior abdominal wall and ascites were present. Her diagnosis was Ovarian adenocarcinoma. I treated this patient for 6 years. No damage to the thyroid gland was observed.

I do not discontinue the treatment with this medicament before the completion of the first year of treatment, even though the patient's condition has obviously improved and the findings of the X-ray. CT scan, ultrasound, or laboratory examinations are negative.

I discontinue the treatment only after an incipient reaction of the thyroid gland (its diffusive enlargement) and the first symptoms of myxoedema. Which occur only when the thyroid gland is not overstressed by the OP metabolism any more.

### **I discontinue the treatment as follows:**

#### **Accelerated:**

1st day: 4 times daily  
2nd day: 3 times daily  
3rd day: 2 times daily  
4th day: 1 time daily  
5th day: discontinuation

#### **Gradually:**

1 tablet 1st week: 4 times 1 tablet  
1 tablet 2nd week: 3 times 1 tablet  
1 tablet 3rd week: 2 times 1 tablet  
1 tablet 4th week: 1 time daily 1 tablet  
5th week: discontinuation



After the completion of the first year of treatment, provided that the results of all CT, USG and laboratory examinations are absolutely negative and the patient is feeling well, I don't wait until the reaction of the thyroid gland, but rather I discontinue the treatment gradually.

During the treatment, we monitor TSH, T3 and T4 levels. It is interesting that TSH, T3 and T4 levels are practically normal before the end of the first year of treatment.

I must warn that a diffused enlargement of the thyroid gland and incipient myxoedema can develop in patients who subjectively feel very well and have normal laboratory findings, but whose ultrasound and CT scan examinations still indicate a presence of a tumor. But this represents a stabilized tumorous process. No progression in the growth of the tumor was observed during the examinations. If the tumor does not obstruct the intestinal lumen, bile, or pancreatic ducts, and if its location is risky for surgery, it may be left alone and studied with all available tests. If the circumstances permit, it should be surgically removed. My records include a 32-year-old male patient with carcinoma of the pancreas and liver metastases. After 10 months of treatment the process became stabilized, the tumour did not progress, and after 1 year of treatment he has now returned to work and is living a normal life.

Such degradation of a malignant tumour to a non-malignant tumour, or to a "clinically silent" tumour, has not been described until now.

This process can be irreversible, but we should not be calmed' by the sudden change of the tumour's malignity. The patient must be monitored and we must immediately respond to symptoms of recurrent malignity.

If we observe sudden diffusive changes in the thyroid gland and incipient myxoedema, treatment with Carbimazole must be stopped and we must monitor the patient's condition with all available tests. Treatment with the other drugs of the therapy should not be discontinued. The size of the thyroid gland will decrease to normal. In the case of a relapse of the malignant process, we will renew the administration of a full therapeutic dose of Carbimazole.

If a mistake is made in the histological diagnosis, the response of the thyroid gland to the therapy during the first three months of treatment will be the first sign of the mistaken tumour classification.

The total cholesterol level in the serum is another good indicator of the efficacy of the treatment. In the advanced stages of the disease, the total cholesterol level in the serum is very low (2.2. - 2.5 nmol/l). An Increased level of the total cholesterol in the serum during the treatment signals a halt in the oncogenic process metabolism. The increased levels of cholesterol during the treatment should not be considered as alarming. A sudden decreases in the total cholesterol in the serum signals the possibility that the patient may have discontinued the treatment of his own volition, other complications, or a progression in the disease. In the treatment of elderly patients with oncogenic disease who have normal or decreased total cholesterol level, we administer the full therapeutic dose of Carbimazol and monitor the cholesterol level. When we discover that the cholesterol level of the elderly patient has risen far above normal, we discontinue the treatment with Carbimazole according to the above described methods of discontinuation.

I would like to point out that we should be very careful with patients for whom the RT and CHT do not bring the expected results and who depend on palliative and symptomatic therapy. In the case that we administer the BTM therapy with these

patients we have to take into account that the previous RT and CHT may have caused secondary hypothyroidism. Examinations of T3, T4 and TSH must be performed as "conditio sine qua non". (See The Discussion).

With patients weakened by the RT and CHT or with cachectic patients half doses of Carbimazol must be administered (3 times 1 tablet) and the dosage gradually increased.

### ***I. b) Stage of decreased immunity of the organism***

Decreased immunity is significant as soon as the first clinical symptoms of the oncogenic disease occur.

The common neurohumoral factors also play an important role in the oncogenic process. By their influence on the myocardium, bone marrow, and parenchymatous organs they weaken the organism and gradually paralyze its immune systems.

In 1967, when I began to develop the concept of the treatment of oncogenic disease, there was little literature discussing this topic. Since I had observed that OP caused an immunity deficiency condition in patients, I decided to treat the condition by administering immunoglobulinum humanum normale (NORGA) 1.9 ml in 1 ampoule;

I determined the dose as follows: The first, the second and the third month of treatment we administer the saturation dose of NORGA.

If the location of the OP is in the lungs, larynx, urinary bladder, sarcomas or ovary, the saturation dose of NORGA is as follows:

- 1st month: NORGA 3 ampoules im, once a week (12 ampoules)
- 2nd month: NORGA 2 ampoules im, once a week (8 ampoules)
- 3rd month: NORGA 1 ampoule im, once a week (4 ampoules)
- 4th month: NORGA 1 ampoule im, once every two weeks (2 ampoules).

### **In other locations the administered saturation dose is as follows:**

- 1st month: NORGA 2 ampoules im, once a week (8 ampoules)
- 2nd month: NORGA 1 ampoule im, once a week (4 ampoules)
- 3rd month: NORGA 1 ampoule im, once every two weeks

### **Maintenance dose:**

NORGA 1 ampoule im, once a month until the treatment is finished. In case of Influenza occurring during the treatment, which happens occasionally, we administer an increased dose of 3 ampoules of NORGA.

### ***I. c) Stage of weight deficit of the organism***

Sometimes excessive weight loss creates a suspicion of the presence of OP in the organism. But weight deficit in the pre-clinical stage of the oncogenic disease cannot be considered as a constant symptom of the disease.

### ***II. a) Anaemic syndrome with incipient cachexia***

In some locations (for example in the case of gastric cancer), the anaemic syndrome is a significant symptom of the oncogenic process. In the advanced and the final stage it is a constant symptom of the disease. As I have already described, anaemia, which accompanies OP, develops through an unknown process in the

oncogenic tissue, which suppresses the activity of the bone marrow with no evidence of metastatic damage to it.

In the therapeutic attempt to activate the bone marrow to normal hematopoiesis. I administered

1. 1000 gamma units of Cyanocobalamin (B12) in 1 ampoule intramuscularly.
2. 100 mg of Thiamin in 1 ampoule im.
3. Based on the results of the laboratory examination. I administered medicaments containing iron.

It should be stressed that due to the contraindications of some locations an experienced therapist should perform the administration of Cyanocobalamin.

***Contraindications for the treatment with Cyanocobalamin:***

On principle I leave Cyanocobalamin [B12] out of the all locations that have affinity to lymphatic tissue (breast cancer, lymphomas cancer. lung cancer, liver cancer, and all locations with metastases in the liver). In the treatment of breast cancer and sarcomas I also leave out Thiamin from the therapeutic scheme.

In my therapeutic regimen Cyanocobalamin has an irreplaceable role in the treatment of OP in the other locations. In the treatment of gastric carcinoma without liver metastasis we administer this preparation 1 - 2 months. In the treatment of a female patient with ovarian carcinoma (tumour of the size of 2 men's head) I administered 150 ampoules of Cyanocobalamin and 150 ampoules of Thiamin.

**I administered Cyanocobalamin (1000 gamma units) and Thiamin (100 mg) as follows:**

In the treatment of gastric carcinoma:

1st month: 2 times a week 1 ampoule im.

2nd month: 1 ampoule once a week im, then discontinuation of Cyanocobalamin, followed by 1 ampoule of Thiamin once a week.

Next months: Thiamin 1 ampoule once a week.

***II. b) Algesic syndrome and the final stage of disease***

In addition to the well known factors of the algesic stage of oncogenic diseases (the pressure on the adjacent nerve plexuses, narrowing of the vessel lumen, obstruction of the bronchi and the gastrointestinal tract), the more intensive pain can be ascribed to the ischemic changes in the oncogenic tissue itself.

The algesic syndrome is therefore the summary of pressure, as well as the obstructive and ischemic syndromes caused by the oncogenic tissue in this stage of the disease. Through the imperative impulses of the destructive OP the stoppage crisis of the organism is intensified and the dominant tissue system of the OP is gradually put under its control. Pathological stoppage impulses are those that the organism is trying to comply with up to the final exhaustion of its possibilities. The organism is gradually flooded with products of the OP destruction, which substantially speed up the lethal stage of the disease.

**The ascites (exudates)** in the body cavities also belong among the object of treatment of the algesic stage of the disease. The instrumental removal of the

ascites from the body cavities is a symptomatic procedure which produces known risks and does not provide a final solution.

Any therapeutic procedure, which does not prevent ascite formation, or does not support its resorption by medicaments, is incomplete and its application is limited.

In March 1979, in *The General Practitioner* journal. Dr. Cernak recommended administering **Trypsin Retard** intramuscularly in the treatment of ascites and hydrothorax in the treatment of oncogenic diseases. It is a suspension of lyophilized Trypsin in olive oil (5 mg of Trypsin in 1 ampoule).

By adding this Trypsin Retard to my therapeutic scheme, it also became an efficient treatment in the final stage of oncogenic disease. In addition to the mentioned therapeutic scheme I also administered this medicament to prevent the formation of ascites in body cavities.

I must stress that allergy tests must be performed before administering this medicament (0,3 ml intramuscularly into the distal third of thigh) because some patients can be allergic to trypsin or its vehicle (olive oil).

Because the allergic reaction can come after repeated administration of Trypsin Retard, I preventively administer Dithiaden (antiallergicum) intramuscularly 1 ampoule (even if the test result is negative).

If Dithiaden is applied, the possible allergic reaction is limited to the injection area.

In the event of an anallergic reaction, Trypsin Retard can be administered orally in doses according to the therapy scheme.

**The oral administration of Trypsin Retard is equally efficient as the Intramuscular application because Trypsin dissolved in olive oil is not inactivated in the stomach and, after its resorption in the gastrointestinal tract, it triggers the enzymatic process favourable to the treatment of the oncogenic process.**

**We administer the preparation Trypsin retard intramuscularly as follows;**

1st month: 2 times a week. 2 ampoules im

2nd month: 2 times a week. 2 ampoules im

3rd month: 2 ampoules once a week im; as a maintenance dose also in the next months.

**In case of gastric, breast and pancreas carcinoma, retroperitoneal sarcoma, adnexis and Hodkin disease the administration is as follows:**

1st month: 3 times a week 2 ampoules im.

2nd month: 2 times a week 2 amp. im.

3rd month: 1 times a week 2 amp. im. And as a maintenance dose also in the following months.

We do not administer this preparation intramuscularly but orally to a patient with chronic asthmatic bronchitis because it can cause prolonged spasm of the bronchial muscles, and it cannot be excluded that it may also increase sputum viscosity.

In patients with lung cancer who expectorate, we administer together with Trypsin retard also Oxyphylline intramuscularly.

In patients with gastrointestinal carcinoma, we administer Calcium effervescent C, which alleviates peristalsis and partially relieves constipation.

If metastases occur in the bones, we administer the medicament Biomin H 3 gr (Ca - 1100 mg. Mg - 15 mg, P - 1.8 mg). In patients with breast cancer and

prostatic carcinoma, as well as in the treatment of sarcomas, we administer this medicament as a preventative measure.

We do not overlook the administration of X-ray therapy (analgesic doses) in the treatment of bone metastases.

We treat the **algescic syndrome** of the disease symptomatically. I have used opiates only occasionally.

### ***Some more comments on the practical administration of the Therapeutic scheme:***

When administering some of these preparations intramuscularly alone, the patient is unnecessarily traumatized.

Therefore we administer Trypsin retard, Cyanocobalamine, Thiamin, Dithiaden and when appropriate, also Oxyphylline, as a mixture in a 10 cc syringe.

The mixture can be administered intramuscularly using a yellow needle. The puncture sites vary.

We administer NORGA (Immunoglobulin) alone in the above mentioned doses intramuscularly (with a green needle).

In patients with hemorrhage we administer Kanavit or other preparations intramuscularly or orally also as a preventative measure.

## **Practical Part**

In this section of my work I will present 107 patients whom i treated from 1973 to 1997. For the sake of a clear presentation. I have divided the patients into two groups:

### **Group 1**

#### ***Patients treated only by blocking the tumor metabolism (B.T.M.).***

My therapeutic scheme was formulated for patients who refused or could not undergo chemotherapy or radiotherapy for whatever reason. Of these patients, the number who was treated only with my treatment is 77. The results of treatment of these patients are more than encouraging because these patients were not left without help with their main disease, but were given a chance to survive and live a number of years. With some patients the treatment was successfully applied two or three times after the relapse of the disease. For this reason I completely describe the course of treatment of all patients of this group (77) who were treated between 1993 - 1997 solely by my method. To these patients' radiotherapy or chemotherapy was not administered because of the intolerance of the organism, high-risk location of the oncological process or due to the refusal of the patient.

Patients treated only by B.T.M., who were successfully cured, and still live a normal life for their age,

Patients treated only by B.T.M., who were successfully cured, but died due to **other disease or advanced age**,

Patients treated only by B.T.M., who died due to the extent of the malignant process or recurrence of the main disease,

Patients treated only by B.T.M.,  
with whom the administration of **treatment**  
either **confirmed or excluded the oncological disease**,

Patients treated only by B.T.M., about whose current health condition I do not  
have any information.

## **Group 2**

### ***Patients treated by B.T.M. after the failure of radiotherapy or chemotherapy.***

Less successful were the results in patients whom I treated after the previous failure of radiotherapy and chemotherapy. The number of these patients whom I treated with my treatment is 460. Most of these patients were mostly in a terminal condition, and their vitality important internal organs and bone marrow were primarily damaged. The point of treatment was alleviation of suffering. From this group of patients, I don't describe all of them because this work would grow into hundreds of pages. I will only describe a representative sample of 30 patients, which includes 20 patients who currently are living and also 10 who died due to various reasons.

Patients treated by B.T.M. after the failure of RT or CHT who were success  
fully cured and still live a normal life for their age.

Patients treated by B.T.M. after the failure of RT or CHT who died due to  
additional disease, advanced age. The extent of the oncological process or  
recurrence of the main disease.

### **Notice:**

For complet list of patients MUDR. Jurkovic, please, visit his web page:  
[http://www.jurkovic.sk/staryweb/en/index\\_en.htm](http://www.jurkovic.sk/staryweb/en/index_en.htm)

## **PRACTICAL PART**

### **Patient No. 1: K. M., born in 1953**

7.7. - 18.7.1994: Hospitalization: Prešov Hospital (NsP), POKO. Radiotherapy - TcT CO 60, the total dose: 60 Gy

04.07.1994: The patient with two-month history of swallowing difficulties and sensation of a foreign body in the oral base.

Diagnosis: Carcinoma of the oral base. Status after radiotherapy.

Histology: Differentiated, squamocellular cornified carcinoma.

In the oral base on the right, there was an ulcerated tumour which spread towards the lower right 7th tooth. On the left, it is adhered to the tongue, which causes its fixation. Under the mandible bilaterally, there are enlarged lymph nodes, 2 cm in diameter.

25.10.1994: Repeated examination in the hospital:

He lost 12 kg during the last year. The patient reports dry mouth, loss of appetite, fetor ex ore.

The patient was admitted to the hospital because chemotherapy was suggested. Due to the adverse renal parameters (the solitary kidney due to posttraumatic nephrectomy in 1972) and uncertain prognosis, neither chemotherapy, nor surgery were indicated.

*Dr. Kašćáková, Head of the Department of Radiotherapy, personal signature*

**27.08.1994: Diagnosis: Carcinoma of the oral base with metastases into the submandibular lymph nodes, the size of 3 x 3 cm, status after radiotherapy.**

**Foetor ex ore, ulcerative gingivitis with necrotic changes. The tongue is hardly mobile, spontaneous bleeding from the gum, or after touching the gum occurs. A symptomatic treatment was recommended. The patient has swallowing difficulties, he lost weight, algesic syndrome developed.**

**27.08.1994: From both, the vital indication and also at the patient's request, I administered the following therapeutic scheme:**

- 1. Oral rinses: mixture of Mesokain 1% and Celaskon, equal parts**
- 2. Carbimazole tbl., Flavobion drag., Calcium efferv. C tab., Ascorutin**
- 3. Trypsín retard amp., Dithiaden amp. i.m. in the saturation and maintenance doses**
- 4. NORGA amp. I.M. in the saturation and maintenance doses.**

**During the treatment, the patient's health condition improved, the enlargement of the parotid glands spontaneously relieved (mostly on the right), foetor ex ore disappeared.**

**His appetite improved, the submandibular nodes gradually diminished.**

**01.06.1995: I gradually discontinued Carbimazole.**

**He is regularly followed up by a urologist. ESR: 23/56.**

**07.08.1995: I quote the ORL finding:**

**“Presently, no evidence of tumorous changes in the ORL region and in the tongue.”**

*Dr. Novák, personal signature*

**27.08.1995: The treatment finished.**

**03.10.1997: ORL examination:**

**No signs of tumour presence, RLN in the neck: not palpable, the oral cavity: normal.**

**Chest x-ray: negative findings. Tumour markers (7.8.1997): CEA 3.26, within the normal limits**

*Dr. Novák, personal signature*

**11.10.1997: Follow up examination**

**The patient feels well, he does not report disturbances on swallowing or salivation disorders, he has no pain, RLN are not palpable, the thyroid is not enlarged. The oral cavity: mildly hyperemic mucosa, restored dentition. The heart and the lungs: accentuated second heart sound over the aorta, vesicular breath sounds.**

**The patient has been living a normal life for his age for 3 years.**

## **Patient No. 2: J. A., born in 1934**

**May 1991: Carcinoma of the larynx was diagnosed and histologically confirmed (the invasive type).**

In spite of the recommendations of experts, the patient refused surgery, as well as RAT and chemotherapy.

02.06.1991: At the patient's request, I administered the following therapeutic scheme:

1. Carbimazole tab., , Flavobion tab.
2. Trypsin retard amp., Dithiaden amp. I.M., in the saturation and maintenance doses
3. NORGA amp. I.M. in the saturation and maintenance doses.

During the treatment aphonia disappeared. Laboratory results were normal. ORL examination: no evidence of progression of the main disease was present.

After 1 year, I discontinued the treatment.

Six months later: hoarseness and incipient aphonia developed.

I recommended to administer radiotherapy concomitantly with the therapeutic procedure as described above.

After 6 months, I discontinued the treatment.

The patient is feeling well; he is regularly followed up by an otorhinolaryngologist.

21.05.1997: Oncological examination

No signs of progression of the main disease are present.

*Dr. Kohúteková, personal signature*

21.05.1997: Liver ultrasound: Diffuse hepatopathy.

*Dr. Ayazy, personal signature*

10.09.1997: Follow up examination

The patient is feeling well, he has normal voice, without pain, RLN are not palpable, the thyroid gland is not enlarged, the sclerae are unicteric. The heart and the lungs: regular rhythm, no murmurs, no added breath sounds are heard. The abdomen: soft, palpable, painless, the liver is within the costal margin, the inguinal regions are without masses, the extremities are without oedema. BP: 120/80.

Laboratory studies:

Blood count: normal, ESR: 10/22, ALT: 0.96 ukat/l, ALP: 2.57 ukat/l, total cholesterol: 5.98 nmol/l, s-TG: 1.97 nmol/l. Other laboratory values were normal, TSH: 1.04 mU/l, s-T3: 2.00 nmol/l, s-T4: 114 nmol/l.

The patient has been living a normal life for his age for 6 years without changes to his voice characteristics.

### **Patient No.3: B. F.,born in 1936**

Diagnosis: Carcinoma of the tongue root with metastases into the larynx and RLN.

Status after partial resection of the tongue and the larynx. Tracheostomy.

A symptomatic treatment was recommended. The clinical picture: dyspnoea, dry cough and a decreased verbal contact.

03.10.1992: At the patient's request, I administered the following therapeutic procedure:

1. Carbimazole tab., Flavobion drag., expectorants, bronchodilators.
2. Trypsin retard amp, Dithiaden amp., Oxyphyllin amp. i.m. In the saturation and maintenance doses



3. NORGA amp., I.M., once a week, in the saturation and maintenance doses.

During the treatment the patient's health condition stabilized, dry cough disappeared, now he coughs only in the mornings. After 1 year, I discontinued the treatment.

12.05.1993: Laboratory studies: normal. T3: 1.40 nmol/l, T4: 40.21 nmol/l.

The patient is regularly followed up by an otorhinolaryngologist. he is able to perform light household activities.

18.09.1997: Follow up examination

The patient was feeling well, sporadic coughs, the stools and urine were normal, he could perform household activities, the RLN: in the proximal part of throat there was a fibrous LN, the nasopharynx was hyperemic, no maceration near the tracheostomy opening was noted, the thyroid gland was not enlarged. The heart and the lungs: regular rhythm, no murmurs, breathing was decreased, without added breath sounds. Abdomen: soft, the liver was within the costal margin, the groins and the axillae were without resistance, the extremities: without oedema. BP: 120/80,

Laboratory studies: Total cholesterol: 6.62 nmol/l, AST: 0.64 ukat/l, glucose, creatinine, uric acid, proteins, bilirubin, GMT, ALI, ALP, TG, Na, K, Ca - all within the normal limits. Blood count: normal, TSH: 11.9 uTU/ml, T4: 65.30 nmol/l.

After 5 years, the patient is living without recurrence of the main disease.

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### **Patient (female) No. 4: K. T. born in 1938**

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December, 1985: Hospitalization in Vyšné Hágy Hospital, Department of Lung Diseases. Monitored at the Department of clinical oncology of the polyclinic (POKO) in Topolčany.

December 1985: The patient was released from hospital in Vyšné Hágy, from the Department of Chest Surgery, with the diagnosis: Inoperable cancer of the lungs (right: 10 x 12 cm, left: 4 x 3 cm), with metastases into the liver.

Histology: Small cell carcinoma of the lung.

05.01.1986: Due to the fact that the patient refused radiotherapy and chemotherapy, and also at the patient's request, I administered the following therapeutic scheme:

1. Carbimazole tab., Flavobion drag., expectorants, cardiotonics.

2. Trypsín retard amp., Dithiaden amp., Thiamin amp., Oxyphyllin amp., Kanavit amp. i.m. in the saturation and maintenance doses. (after 1 month, I discontinued Kanavit)

3. NORGA amp., I.M., in the saturation and maintenance doses.

The patient's health condition gradually improved. Hydrothorax on the right side resorbed, secondary bronchitis disappeared. The patient gained in weight, the laboratory studies revealed normal results.

After 1 year, I discontinued the treatment. Immediately after the treatment had been finished, the patient was referred to the Department of Radiology, Podunajské Biskupice Hospital, in Bratislava. During seven days of hospitalization she was examined and then released to be treated at home.

Conclusion: No evidence of malignant disease in the lungs and in other internal organs, including the liver.

Up to 1997 all follow-up examinations in norm.

The patient has been living a normal life for her age for the last 12 years.

### **Patient No. 5: P. K. born in 1934**

In the beginning of 1989: left lobectomy due to carcinoma of the lung was performed.

**Histology: small cell carcinoma of the lung.**

**In May 1989: recurrence of the disease was observed.**

**The patient refused the treatment by radiotherapy and chemotherapy, as well as any surgery in the future. He reported severe cough, chest pain, dyspnoea and hemoptysis.**

**At the patient's request, I administered the following therapeutic scheme:**

- 1. Carbimazole tab., Flavobion drag., expectorants**
- 2. Trypsín ret. amp., Thiamin amp., Oxyphyllin amp., Kanavit amp. i.m. in the saturation and meintenance doses**
- 3. NORGA amp., I.M., in the saturation and maintenance doses.**

**The patient's health condition gradually improved. Laboratory results returned to normal. After 1 year, I discontinued the treatment.**

**Subsequent examinations at the Department of Chest Surgery in Vyšné Hágy did not reveal recurrence of the main disease.**

**11.09.1997: Follow up examination**

**The patient is feeling well, he has no pain, he does not cough, his appetite is good, the stools and urine are normal, RLN are not palpable, the thyroid gland is not enlarged, the sclerae are unicteric. The heart and the lungs: vesicular breath sounds on the right, breathing on the left is decreased, no added breath sounds are heard. The scar is well healed. The abdomen: soft, palpable, painless, the inguinal regions are without masses, the extremities are without oedema.**

**Laboratory studies: Glucose: 4.21 mmol/l, creatinine: 89.5 umol/l, total cholesterol 4.65 mmol/l, TSH: 1.07 mU/l, T3: 1.58 nmol/l, T4: 97.68 nmol/l.**

**Chest x-ray: No evidence of recurrence of the main disease.**

**The patient has been living a normal life for his age for the last 8 years.**

## **Patient No.6: H. J.born in 1929**

**07.09.1989: The patient was released from the Department of Lung Diseases of Trenčín Hospital with the diagnosis: Carcinoma of the right lung.**

**Histology: Spinocellular carcinoma.**

**Chest x-ray: In the right lung field there is a moderately dense, striated opacity, the contours of the diaphragms and angles are clear. Tomography (11 cm): Homogenous shadows in the middle lobe.**

**Clinical picture: Dyspnoea, hemoptysis, cough and incipient cachexia.**

**05.01.1990: Due to the fact that the patient refused surgery, as well as radiotherapy and chemotherapy, and also at the patient's request, I administered the following therapeutic scheme:**

- 1. Carbimazole tab., Flavobion drag., expectorants.**
- 2. Trypsín retard amp., Dithiaden amp., Thiamin amp., Oxyphyllin amp. Kanavit amp. I.M. in the saturation and maintenance doses (after 1 month, I discontinued Kanavit)**
- 3. NORGA amp., I.M., in the saturation and maintenance doses.**

**During the treatment the patient's health condition gradually improved. He gained weight. Dyspnoea and cough disappeared. Laboratory results returned to normal. After 1 year, I discontinued the treatment.**

#### **08.09.1997: Follow up pulmonary examination**

**Chest x-ray:** Near the heart there is an area of shadowing, most likely there is a thickened interlobar space. Exertional dyspnoea.

**Conclusion:** Carcinoma of the right lung - remission of the main disease. I recommend a symptomatic treatment. The patient refused bronchoscopy.

*Dr. Bevilaguová, personal signature*

#### **10.09.1997: Follow up examination**

The patient is feeling well, he has no pain, he has cough in the mornings, dyspnoea on exertion, the stools and urine are normal, RLN are not palpable, the thyroid gland is not enlarged, the sclerae are unicteric. The heart and the lungs: regular rhythm, no murmurs are heard, breathing is decreased, and no added breath sounds are heard. The abdomen: soft, palpable, the inguinal regions are without masses, the liver is within the costal margin.

**Laboratory results:** Bilirubin: 19.8 umol/l, total cholesterol: 7.96 nmol/l, TG: 2.18, (glucose, urea, creatinine, uric acid, proteins, AMT, ALP, GMT, AMS, mucoproteins, Na, K, Ca - all within the normal limits. Blood count: normal. ESR: 15/40. s-TSH: 1.43 mIU/l (reference range: 0.49-4.67), s-T3: 1.70 nmol/l (0.69-2.10), s-T4: 92 nmol/l (57.9-154).

The patient smokes 10-15 cigarettes daily and often consumes alcoholic beverages.

He has been living a normal life for his age for the last 8 years.

### **Patient No.7: J. O.born in 1912**

**20.08.1973:** The patient was referred to the Department of Internal Diseases, Trenčín Hospital (NsP) with suspected malignancy in the lungs.

**ESR: 126/136.** In the clinical picture dominated: loss of weight, malaise, loss of appetite, arrhythmia.

**15.10.1973:** The patient was released from the hospital after the failure of antibiotic treatment. The large scale of antibiotics was used. The patient was regarded as being moribund and a symptomatic treatment was recommended.

**Diagnoses:** Carcinoma of the lung, lymphadenopathy in the hilum and of paraaortic lymph nodes, steatosis of the liver. Cachexia, dyspnoea.

**ESR: 134/140, BP: 95/70** Recommended treatment: Ferronat C 2 x 1 coat. tab.

*Dr. Kratinová R., personal signature*

He was the first patient, to whom I decided to administer the therapeutic treatment of blocking the tumour metabolism from the vital indication. I must emphasise that I was checking his health condition several times daily, as well as during the night. I am happy that I may conclude, that during the treatment, I did not reveal any signs of thyroiditis, myxoedema, shock or other complications, which usually occur after the incorrect indication of treatment with goitrogenic drugs.

Immediately, after his release from the hospital, I administered the following therapeutic scheme from the vital indication:

1. Carbimazole tab., Ferronat, antibiotics, cardiotonics, expectorants
2. Vitamin B12 amp., Thiamin amp., Oxyphyllin amp. I.M. in the saturation and maintenance doses
3. NORGA amp., I.M., in the saturation and maintenance doses.

During the treatment the patient's health condition gradually improved, his appetite returned to normal and the patient gained weight.

After 1 year: ESR: 2/6.

Chest x-ray: No evidence of oncogenic disease.

The patient started to work. He began to perform heavy works as a member of the local agricultural cooperative.

04.05.1986: The patient died of myocardial infarction.

The patient lived a normal lifestyle for his age for 13 years without evidence of recurrence of the main disease.

### **Patient No. 8: D. Š. born in 1902**

11.06.1975: Dyspnoea, loss of weight, malaise and cough.

17.06.1975: After the failure of treatment as an out-patient, he was referred to the Department of Lung Diseases, Trenčín Hospital (NsP).

Chest x-ray: opacity of 8 x 11 cm near the right hilum of the lung. In the center, there is the area of decreased shadowing and the sign of horizontal fluid level. The margins of this opacity have striated character. In the anterior, middle field there is an interlobar band. The diaphragms are normal, the angles are without effusions. Therapy: PNC, STM - 20.0, Chloramphenicol, Sulfamethoxidine.

Conclusion: A 73 year-old patient was admitted to the hospital with the aim of differential diagnosis. After the antibiotic treatment, the abscess cavity closed. The right hilum remained enlarged, reaching into the periphery. I suspect bronchopneumonia associated with the tumour of the lung. With regard to the patient's age and the objective finding, other lung diseases are not suspected. I recommend a symptomatic treatment.

*Dr. Glos, Head of the department, personal signature.*

20.07.1975: The patient was released from the hospital with the diagnoses: carcinoma of the right lung (8 x 11 cm), secondary bronchopneumonia. A symptomatic treatment was recommended.

20.07.1975: From both, the vital indication and also at the patient's request, I administered the following therapeutic scheme:

1. Carbimazole, antibiotics, cardiotonics, expectorants, bronchodilators
2. Thiamin amp., Oxyphyllin amp., Vitamin B12, Kanavit amp. I.M. in the saturation and maintenance doses (after 1 month Kanavit discontinued)
3. NORGA amp. I.M. in the saturation and maintenance doses.

17.09.1975: Follow up chest x-ray: Since the last examination, substantial regression of the process. (the layer: 6-9 cm). The tomography of the hilum: several dense, striated opacities, no signs of destruction.

*Dr. Glos, Head of Dept., personal signature*

The subsequent chest -x-ray examinations after 6 months did not reveal any signs of recurrence of the main disease. The patient's health condition gradually returned too normal.

After 1 year of treatment, the laboratory results were normal, the thyroid was not enlarged, and the chest x-ray was negative.

20.07.1976: I discontinued the treatment.

In 1983, the patient died due to heart failure.

The patient lived a normal life for his age for 8 years without any signs of the recurrence of the main disease.

## **Patient (female) No. 9: K. V. born in 1938**

**Diagnosis:** Status after excision of the tumour from the right breast due to carcinoma of the breast (June 1992).  
**Histology:** adenocarcinoma.

**04.07.1992:** Due to the fact that the patient refused mastectomy, as well as radiotherapy and chemotherapy, and also at the patient's request, I administered the following therapeutic scheme:

1. Carbimazole tab., Flavobion tab., Calcium efferv. C tab., Biomin H powder
2. Trypsin retard amp., Dithiaden amp., I.M., in the saturation and maintenance doses
3. NORGA amp. I.M., in the saturation and maintenance doses.

**15.12.1992:** The patient's health condition gradually returned to normal. The thyroid gland was diffusely enlarged, therefore I gradually discontinued Carbimazole. Other treatments continued according to the plan.

After 1 year, I discontinued the treatment.

The breasts are soft, palpable, the axillae are without resistance.

Laboratory studies and objective findings are normal.

**26.10.1994:** Breast ultrasound: No evidence of pathological structures bilaterally.

*Dr. Kašuba, personal signature*

**1995, 1996:** Ultrasound examinations of the breast were normal.

After 5 years, the patient is living a normal life for her age (without mastectomy).

## **Patient No. 10: H. E. born in 1936**

In March, 1980, mastectomy due to cancer of the right breast was performed .

**Histology:** Invading carcinoma with metastases into the axillary lymph nodes.

The patients reported pain in the wound and in the right upper limb.

After the patient was released from hospital I administered the following therapeutic scheme at the patient's request:

1. Carbimazole tab., Lipovitan coated tab.
2. Trypsin retard amp., Dithiaden amp., I.M., in the saturation and maintenance doses
3. NORGA amp., I.M., in the saturation and maintenance doses.

**Control examination**

The patient's health condition gradually returned to normal. The patient is feeling well, she has no pain, the scar is well healed, the axillae are without resistance, and the upper and lower extremities are without signs of lymphostasis. The heart and the lungs: regular rhythms, no murmurs, vesicular breathe sounds. The abdomen: soft, palpable, the liver is within the costal margin; the inguinal regions are without masses. BP: 140/90.

After 1 year, I discontinued the treatment. Further follow up examinations has been recommended at the Department of clinical oncology of the polyclinic (POKO).

April 1994: The patient had dry cough for six months, more often in the mornings, and breathing difficulties. Hospitalization was recommended. Bronchoscopy did not reveal metastases in the bronchi. Fourteen days after the release from hospital, signs of lymphostasis in the upper limb, predominantly in the brachial region.

10.08.1994: At the patient's request, I administered the following therapeutic scheme:

1. Carbimazole tab., Flavobion coated tab., Biomin H , Oxyphyllin, Mucosolvan unit
2. Trypsín retard amp., Dithiaden amp., Oxyphyllin amp., in the saturation and maintenance doses
3. NORGA amp., I.M., in the saturation and maintenance doses.

The patient's health condition gradually improved, she has no pain, she does not cough. After 1 year, I discontinued the treatment.

25.11.1996: Follow up examination

Subjectively: without substantial difficulties, the stools and urine are normal. The neck: no evidence of lymphadenopathy. Mild lymphoedema of the right upper limb. The clinical condition is presently stabilized, no evidence of recurrence of the main disease.

*Dr. Lepeiová, personal signature.*

28.05.1997: Follow up examination

The patient is feeling well, she has no pain. After exertion, her right upper limb gets swollen.

Liver ultrasound: the picture of a diffuse, parenchymal lesion of the liver, suspected steatosis, the marginal liver size. Laboratory results: GMT: 1.14, other laboratory values - normal limits. T3, T4, TSH: Normal.

The patient has been living a normal life for her age for the last 17 years.

## **Patient (female) No. 11: J. M. born in 1929**

08.03.1990: Left mastectomy due to carcinoma of the breast was performed. Trenčín Hospital (NsP).

Histology: Adenocarcinoma.

Due to the fact that the patient refused radiotherapy and chemotherapy, and also at the patient's request, I administered the following therapeutic scheme:

1. Carbimazole tab., Flavobion tab., Biomin H, Calcium efferv. Tab.
2. Trypsín retard amp., Dithiaden amp., I.M.
3. NORGA amp., I.M., in the saturation and maintenance doses.

The patient's health condition improved. Laboratory results were normal. Chest x-ray: normal. After 12 months, I gradually discontinued Carbimazole. After 1 year, I discontinued the treatment.

Objective findings: RLN are not palpable, the thyroid gland is not enlarged, the sclerae are unicteric, the axillae are without resistance. The upper extremities: no evidence of lymphostasis. The heart and the lungs: regular rhythm, no murmurs, decreased breathing; no added breath sounds are heard. The abdomen: soft, palpable, the liver is within the costal margin, the inguinal regions are without masses, the extremities are without oedema.

10.08.1997: Follow up examination

The patient suffered from bronchitis, after antibiotics, the condition returned to normal. ESR: 27/80. Blood count: hypochromic anemia. Laboratory results: T3, T4, TSH: normal.

**Chest x-ray: Increased bronchial vasculature, the heart is not dilated. No evidence of metastases.**

**The patient has been living a normal life for her age for the last 7 years.**

## **Patient (female) No.12 : G. G. born in 1921.**

**29.3.1993** - St.p. explorative laparotomy, suspected origin - large bowel or ovary.

**Diagnosis: Tumour - leiomyosarcoma of the intraperitoneal region of abdomen.** The tumour fills the small pelvis, the approxim. size of 15x12x10 cm, topically related to the large bowel.

**14.07.1993** - the patient complained of appetite loss, weakness. Objective finding - severe anemia. Stool and urine were normal, the tumorous mass at the site of incision, tender on palpation, the approxim. size of two men's fists. The liver is within the costal margin - it is not palpable, the inguinal regions are without masses, BP: 120/80. At the patient's request I administered the following therapeutic scheme:

**1. Carbimazole, Flavobion**

**2. Biomin H, Calcium effervescens, analgesics**

**3. Trypsin retard amp., Dithiaden amp., Oxyphyllin - im. in the saturation and maintenance doses.**

**4. NORGA amp. im, in the saturation and maintenance doses.**

The patient's condition gradually improved - her appetite was good, she gained weight, the laboratory parameters returned to normal. **24.05.1994:** T3 - 1.57 nmol/l T4 - 41.00 nmol/l **15.07.1994:** T3 - 1.52 nmol/l, T4 - 40.00 nmol/l

### **1.08.1994: Ultrasonography of the upper abdomen:**

HSG: the liver is of marginal size, the proportional increase in echogenicity, without focal changes. VP and hepatic veins are not dilated, the common bile duct (ductus choledochus) is 6.8 mm wide, its walls are smooth, thin and the lumen is without filling defects. Conclusion: A proportional increase in echogenicity, accent. d. choledochus, post-cholecystectomy.

PSG: Pancreas is of normal size, smooth surface, the parenchyma shows a proportional increase in echogenicity, without focal changes. The excretory system is not dilated. **Conclusion:** Proportionally increased echogenicity.

RSG: Both kidneys are of normal size, shape and location. Their surface is mildly rough, the parenchyma is reduced, the papillae are difficult to assess, the pelvic system is accent., on the right, near the hilum - a cyst, 27 mm in diameter, dorsally, on the right kidney, a cyst, 23 mm in diameter - both the 1st category. **Conclusion:** Pyelonephritic changes bilaterally, renal cysts in the right, the 1st cat. LSG: the size of spleen: 129 x 53 cm, the surface is smooth, the parenchyma is mildly proportionally accentuated, without focal changes. Hilum is without pathological changes.

**Conclusion:** The spleen is of marginal size. The urinary bladder is empty.

*Dr. Fitmanová, personal signature*

**01.08.1994 ECG:** Nonspecific changes of repolarization

**02.08.1994: The chest X-ray:** Calcifications in the right hilum, accent. right hilum, accent. bronchial shadowing in both lung fields, diaphragm is of normal shape, angles are clear, the heart is not dilated.

*Dr. Kretik Vladimír, personal signature*

**10.09.1994:** The patient gained 14 kg, she was feeling well, without pain. The finding on palpation in hypogastrium: The tumorous resistance has a smooth surface, it is not painful on palpation, is mobile and fills one third of hypogastrium. Carbimazole was discontinued. Other treatments according to the therapeutic plan. Consider surgery. At present the tumour is clinically „silent“. Compare with the description of treatment of the female-patient No.1. Further check-ups according to the plan.

When the treatment was finished, the exploratory laparotomy was performed. Metastases in the liver were removed and partial resection of the stomach was performed because of metastases. The tumour in the small pelvis was inoperable. The patient was administered chemotherapy postoperatively. After administering the third cycle of chemotherapy, the patient suffered from diarrhea, loss of appetite, weakness and anemia. Therefore she refused further treatment with chemotherapy.

**13.05.1995:** At the patient's request I administered therapeutic scheme:

**1.) Carbimazole, Flavobion, Calcium effer., Importal, Algifen, Biomin H**

**2.) Trypsin retard amp., Dithiaden amp., Oxyphyllin im.**

**3.) NORGA amp., in the saturation and maintenance doses.**

The patient's health status was gradually improving. She had no pain, stools and urine were normal. Appetite was good. 17.02.1996: Carbimazol gradually discontinued.

**16.04.1996 - Control examination in the hospital: Ultrasound:**

PSG: Conclusion: increased echogenicity of pancreas

HSG: Conclusion: finding in accordance with the age

HSG: Conclusion: Postcholecystectomy, the bed is without pathological changes, d. choledochus is normal

RSG: Conclusion: Renal cyst on the right (Ist cat.)

*Dr. Fritzmanová, personal signature*

**19.04.1996:** Gastrofibroscopy: Conclusion: Leiomyoma ventriculi

*Dr. Papso, personal signature*

**Laboratory results:** ESR: 47/72, urine-negat., other lab. results were normal. Barium study (X-ray): I do not find peptic ulcer, nor wall infiltration. The stomach is of sickle shape.

*Dr. Toman, personal signature*

**24.04.1996 - Diagnosis:** The intraabdominal oval resistance has no relation with intraabdominal organs.

Status post resection of the liver and stomach because of leiomyosarcoma.

*Dr. Ďureje, the head of dept., personal signature*

**04.05.1996:** The patient was feeling well, no pain, good appetite, stools and urine were normal. She had occasional swellings of the lower legs. Heart and lungs - normal findings, BP: 140/90, the abdomen is palpable, the liver is within the costal margin, the size of the tumorous mass in hypogastrium was unchanged, the inguinal regions were without masses.

**22.06.1996:** The sclera were unicteric, the thyroid gland was not enlarged, regional lymph nodes were not palpable. The heart - regular rhythm, P:70/1 min, the lungs - reduced breath sounds, without added sounds. BP: 140/90. The abdomen: palpable, the liver is within the costal margin, it is not painful on palpation. The resistance in hypogastrium is of smooth surface. The inguinal regions are without masses, the extremities - no swellings.

**24.08.1996:** The patient's condition was stabilized, the objective findings did not change, she gained weight, her appetite was good, stools and urine were normal. The abdomen was palpable, without pain, the tumorous resistance in hypogastrium was without any changes, ESR: 45/1 hour. The treatment was finished.

**13.09.1997 - Control examination:**

The patient complains of the loss of appetite, she has no pain, stools and urine are normal. RLN (regional lymph nodes) are not palpable, the thyroid gland is not enlarged, heart: regular rhythm, S1 and S2 are within normal limits, lungs: breathing is decreased, alveolar, without pathological breath sounds. Abdomen: postoperative scars are well healed, the liver is not felt, in



the hypogastrium there is a smooth resistance felt by palpation which is not painful, it extends beyond the scars, the inguinal regions are without any resistance, the extremities are without any swellings. X-ray examination of the heart and lungs is normal.

### **23.06.1997 - Ultrasound examination:**

PSG: The finding is in keeping with the patient's age. HSG: the liver is of normal shape and size, in the upper part of the right lobe there is an hypoechogenic structure, the size of 31 mm - the hepatic cyst. RSG: Chronic pyelonephritic changes bilaterally. Cystes renis l.dx

*Dr. Purgátová, personal signature*

Blood count: Substantial decrease in the red blood cells was substituted by administering blood transfusions (erythrocytes).

**Laboratory values:** ESR: 20/50, Blood group: B, Rh positive, glycaemia, creatinine, proteins, AST, ALT, GMT, total cholesterol, Na, K, Ca - within normal limits, uric acid in the serum: 475 umol/l (142-390).

TG: 3.88 mmol/l TSH: 5.48 mU/l (0.55-2.30), T3: 1.9 nmol/l (1.3-2.7), T4: 23.4 nmol/l (10.3-24.5).

At the present the patient is living a lifestyle in keeping with her age.

## **Patient No. 13: F. J. born in 1933 Surgical Department, Trenčín Hospital (NsP).**

11.06.1990: Based on the previous, preoperative, histological examination (adenocarcinoma of the stomach), GEA was performed due to carcinoma of the small curvature and of the oral part of the stomach at the Surgical Department, in Trenčín District Hospital (OUNZ).

At surgery, metastases into the surrounding tissue and adjacent lymph nodes were noted.

The first cycle of cytostatic treatment was administered at the Surgical Department in Trenčín Hospital. Due to bad tolerance, the patient refused further administration of chemotherapy. I recommended the symptomatic treatment.

*Dr. Stríženec, Head of the department, personal signature.*

20.06.1990: At the patient's request, I administered the following therapeutic scheme:

1. Carbimazole, Flavobion, Ferronat, analgesics.
2. Trypsín retard amp., Dithiaden amp., Thiamín amp., Vitamin B 12 i.m. in the saturation and maintenance dose (after 1 month Vitamin B 12 discontinued)
3. NORGA amp. I.M., in the saturation and maintenance doses.

After 3 months of treatment, the patient was without pain, her appetite was good, gained in weight, laboratory values stabilized to normal. The abdomen: soft, palpable, without masses, painless, the liver was within the costal margin.

26.09.1990 : Follow up examination by an oncological surgeon

The abdomen was soft, without resistance, the liver was within the costal margin, the lymph nodes in the neck were not palpable.

*Dr. Stríženec, Dr. Chlapík, personal signatures*

06.02.1991: Follow up examination by an oncological surgeon

The patient gained 6 kilograms. ALT: 0.85, creatinine: 136-normal. Nutrition was appropriate, the lymph nodes in the neck were not palpable. The patient was administered the treatment by Dr. Jurkovič. I recommended the ultrasound examination of the abdomen and endoscopic examination of the stomach.

*Dr. Chlapík, personal signature.*

**11.02.1991: Fibroscopy:**

**Conclusion: Stomatitis superficialis. Status after high resection of the stomach.**

*Dr. Hlista, personal signature.*

**11.02.1991: Ultrasound**

**Conclusion: the liver and other abdominal organs are normal.**

*Dr. Kráčalová, personal signature.*

**In March 1991: due to the enlargement of the thyroid gland I discontinue Carbimazole. Other treatment according to the scheme. Laboratory values in norm. After 3 months thyroid gland in norm. After 1 year the treatment discontinued.**

**09.09.1992: Follow up examination by an oncological surgeon**

**Since the last examination the patient gained 4 kg. The abdomen was soft, without resistance. I recommended a follow up examination on 13.01.1993: Follow up gastrofibroscopy and ultrasound. (Ca grew into mucosis propria).**

*Dr. Chlapík, personal signature.*

**22.01.1993: Fibroscopy:**

**Status after high GEA due to adenocarcinoma in 1990. Stomatitis chronica polypoides - ad histological examination.**

**21.01.1993: Histological examination**

**Conclusion: Chronic post-resection gastritis. Neoplastic changes were not observed.**

*Dr. Gregora, personal signature.*

**15.12.1997: Follow up examination**

**The patient is feeling well, he is without pain, he has good appetite, the stools and urine are normal. RLN are not palpable, the thyroid gland is not enlarged, the sclerae are unicteric The heart and the lungs: regular rhythm, no murmurs, decreased breathing, without added sounds. The abdomen: soft, the scar is healed, the liver is within the costal margin, and the inguinal regions are without masses, extremities without oedema. Laboratory results: Glucose: 3.72 mmol/l, creatinine: 77.1 umol/l, proteins: 76.1 g/l, total bilirubin: 18.3 umol/l, ALT: 0.56 ukat/l, GMT: 7.22 ukat/l, ALP: 1.66 ukat/l, total cholesterol: 7.35 mmol/l, TG: 1,15 mmol/l, S-AMS: 2.04 ukat/l, Na: 142, K: 4.70, Ca: 104 ukat/l.**

**TSH: 0.84 mU/l, T3: 1.38 nmol/l, T4: 114 nmol/l.**

**An oncological surgeon follows up the patient once a year. He is without the recurrence of the main disease.**

**The patient has been living a normal life for his age for the last 7 years.**

## **Patient (female) No. 14: H. M., born in 1947**

**09.09.1995:** The patient was hospitalized at the Surgical Department in Trenčín Hospital where they performed total gastrectomy and oesophagojejunostomy end to side due to carcinoma of the corpus and cardia of the stomach. After the operation the patient transferred to the anaesthesiology-resuscitation department and started the total parental nutrition. ESR: 100/1 hour, anemia. **Histology: Differentiated type of adenocarcinoma.**

Oncological examination:

**Due to persisting febrile status, vomiting and pain in the epigastrium and in the distal third of the thorax, as well as due to the radical character of the surgery, chemotherapy was not indicated.**

*Dr. Cimmerman, Head of the department, personal signature.*

After the patient was released from the hospital, the febrile states, pain in the epigastrium and in the whole abdomen persisted.

In the clinical picture dominated hiccup, febrile states, difficulty in swallowing (inability to swallow even liquid food). Later, **the severe algescic syndrome developed.**

The RLN were not palpable, the sclerae were unicteric. The heart and the lungs: regular rhythm, no murmurs heard on auscultation, breathing was decreased. On palpation, marked tenderness in the epigastric and umbilical regions.

After controlling the algescic state and hiccup, on **12.10.1995** at the patient's request, I administered my therapeutic scheme:

- 1. Carbimazole tab., Flavobion coated tablets, Ca efferv. Tab.**
- 2. Importal powder sachet., Indomethacin supp. at bedtime., analgesics, Torecan, as needed.**
- 3. Trypsín retard amp., Dithiaden amp. Thiamín 100 mg amp. i.m.,**
- 4. NORGA amp. i.m., in the saturation and maintenance doses.**

**The first month** of treatment: febrile states and pain relieved, substantial relief of swallowing difficulties.

The subsequent months: **without difficulty in swallowing, afebrile, without pain. A burning sensation persists from time to time. The patient gained weight. Before the end of treatment, fibroscopic examination was normal. Ultrasound and CT of the abdominal cavity were normal.**

**The targeted examination in the National Oncology Institute in Bratislava:**

Conclusion: Without any signs of recurrence of the main disease.

*Prof. Dr. Koza, PhD., personal signature*

**After 1 year, the treatment was finished.**

**14.03.1997: Follow up examination**

Gastrofibroscopy: Mucosal fragments, vessels, dif. epithelium, without a basal layer.

*Dr. Gogota, personal signature*

**09.05.1997: Oncological examination**

**4x gastrofibroscopy and histology negative. The results were negative. ESR: 14/34, blood count: normal, tumour markers: normal. Without any signs of the recurrence of the main disease.**

*Dr. Kohútková, personal signature*

**06.09.1997: Follow up examination**

**The patient is feeling well, she is without pain, sometimes she reports excessive secretion of saliva and pyrosis. The RLN are not palpable, the thyroid is not enlarged, the heart and lungs: regular rhythm, no murmurs, vesicular breath sounds.. The abdomen: soft, palpable, the scar is well healed, the liver is within the costal margin, the extremities are without swellings. BP: 130/80.**

**Laboratory results:**

ALT: 1.01, ALP: 2.22, cholesterol: 5.72, TSH: 1.65 nU/l, T3:1:38 nmol/l, T4: 115 nmol/l.

The patient comes to the regular check-ups at the oncological department. All available results did not confirm the relapse of the main disease.

**The patient has been living a normal life for her age for the last 2 years.**

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## **Patient (female) No.15 : P.born in 1927**

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17.07. - 10.08.1992 the patient hospitalised at the Surgical Department of the National Oncological Institute.

28.07.1992: Hoffmeister-Finsterer 's procedure (4/5 resection of the stomach) due to **cancer of the stomach** – the prepyloric part, was performed after the preoperative assessment. Cholecystectomy due to cholecystolithiasis was also performed. Before surgery, the patient suffered from pain in the epigastrium.

*Dr. Alexander Huda, personal signature NOU Bratislava*

Postoperatively, the patient experienced pain in the epigastrium, which became worse after meals. Loss of appetite, meteorism and anemic syndrome developed.

From both, the vital indication and at the patient's request, on 15.08.1992, I administered the following therapeutic scheme:

- 1. Carbimazole, Flavobion, carminatives, laxatives, analgesics, Feronat**
- 2. Trypsín retard amp., Dithiaden amp., Thiamin 1000 mg amp., B 12 amp. i.m. in the saturation and maintenance dose (after 1 month B 12 discontinued)**
- 3. NORGA amp. i.m. in the saturation and maintenance doses.**

During the treatment, the patient's condition stabilized. After taking more amount of food, she reports the pressure sensation in her epigastrium. The abdomen palpable, without any pain, liver within a costal margin. The thyroid gland not enlarged. FW 17/1 h.

In the 8 month of treatment I discontinued the treatment. Further check ups at POKO.

**Laboratory results up to 1997: normal.**

**The patient has been living a normal life for her age for the last 5 years.**

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## **Patient (female) No. 16: K. H. born in 1927**

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**23.11.1976:** Dixon's procedure due to carcinoma of the rectum was performed at the Surgical Department in Trenčín Hospital (OÚNZ).

**Histology revealed: Obturating adenocarcinoma.**

**Three months after** surgery, the relapse of the main disease, the size of 10 x 12 cm was noted. The patient was incapacitated, the algesic syndrome had gradually developed.

07.02.1977: **At the patient's request, I administered the following therapeutic scheme:**

- 1. Carbimazole, Lipovitan, analgesics, laxatives, Ferronat**
- 2. Vitamin B12 amp, Thiamín 100 mg i.m., in the saturation and maintenance doses**
- 3. NORGA amp. i.m.in the saturation and maintenance doses.**

During the therapy the pains relieved, the patient's health condition stabilised.

**13.6.1977: Control examination**

The tumour was not palpable; the patient was feeling well, without pain. Laboratory examinations revealed normal results. After 1 year, the treatment was discontinued. She gained 14 kg.

**In 1980** she had cholecystectomy due to cholelithiasis. Postoperative revision of the abdominal cavity did not reveal any abnormal finding.

#### **03.12.1997: Follow up examination**

The patient was feeling well, she was without pain, the stools and urine were normal, the RLN were not palpable, the thyroid gland was not enlarged, the sclerae were unicteric. The heart and the lungs: regular rhythm, no murmurs, breathing was decreased, without added breath sounds. The abdomen: soft, scars were well healed, the liver was within the costal margin, the groins were without resistance, the extremities: without oedema. BP: 130/85, weight: 78 kg.

**Since 1976**, she has not been seriously ill (with the exception of sporadic biliary colics and flu).

#### **Laboratory examinations:**

ESR 22/48, (glucose: 6.00 mmol/l, urea, creatinine, uric acid, bilirubin, ALT, TG, mucoproteins, Na, K, Ca) - all within normal limits. ALP: 2.41 ukat/l, total cholesterol: 5.87 mmol/l, s-AMS: 1.53 ukat/l, s-TSH: 7.35 mU/l, (reference range: 0.49-4.67), T3: 2.24 nmol/l(0.69-2.10) T4: 115nmol/l (57.9-154), blood count: normal.

**After 21 years, she is still living a normal life for her age**

## **Patient (female) No. 17: Ž. H. born in 1936**

**29.05.1981- 22.06.1981:** Nitra hospital.

In March 1981 at the Surgical Department of the Policlinic Nitra, Dixon's procedure due to carcinoma of the rectum was performed. **Histology: Adenocarcinoma.**

*Dr. Čerba, personal signature*

**Because the patient refused to undergo the treatment by radiotherapy and chemotherapy, after she was released from the hospital, and also at the patient's request, I administered the following therapeutic scheme:**

- 1. Carbimazole 3x2, Flavobion 2x1, analgesics, laxatives, Ferronat.**
- 2. Trypsín retard amp., Vitamin B12 amp., Thiamin amp. i.m. in the saturation and maintenance doses (after 3 months B 12 discontinued)**
- 3. NORGA amp. i.m. In the saturation and maintenance doses.**

**After 1 year, I discontinued the treatment. The patient gained 15 kg, she was feeling well and was without pain. The objective finding was within normal limits, laboratory results were normal. In the course of three subsequent years the patient was examined rectoscopically with the negative result.**

**21.10.1997: The mucous carcinoma of the skin in the parieto-occipital region was excised. The wound is well healed.**

#### **08.11.1997: Follow up examination**

The patient was feeling well, the stools and urine were normal, the RLN were not palpable, the sclerae were unicteric, the thyroid gland was not enlarged. The heart and the lungs: regular rhythm, no murmurs, breathing was decreased, without added breath sounds. Abdomen: soft, the scars were well healed, the liver was within the costal margin, the groins were without resistance, the extremities: without oedema. Weight 86 kgs, BP 120/80.

#### **Follow-up examination**

The chest X-ray: without recent structural changes, mild left ventricular enlargement.

Abdominal ultrasound: The liver of the average size, uniform, mild echogenity, without structural lesions, intra- and extrahepatic ducts are not dilated. The gallblader is of the average size, the content is unechogenic, no evidence of stones. The pancreas: well visualized, without structural changes. The kidneys: appropriate size, shape, without stasis or expansion. The spleen: appropriate size, without structural changes.

*Dr. Žákovič, personal signature*

#### **Laboratory results:**

ESR 35/68, blood count: normal, glycemia: 5.50, urea, creatinine, uric acid, proteins, total bilirubin, conjug. bilirubin, AST, ALT, TG, AMS, Na, K, Ca - all within normal limits, total cholesterol: 5.23 nmol/l, tumour markers: Negative.

TSH-ultra s.: 3.22 uTU/ml, T3: 1.72 nmol/l, F-T4: 18.20 pmol/l

**After 16 years, the patient is still living a normal lifestyle for her age.**

### **Patient No. 18: Ing. H. M. born in 1957**

In September 1986, during his military service, laparotomy was performed at the Surgical Department, Military Hospital (VN), Bratislava. Procedure: Excision of the carcinoma in the ileocecal region, the size of 10 x 13 cm.

**Histology: Adenocarcinoma with metastases to the lymph nodes in the surrounding tissue.**

**Due to the fact that only a symptomatic treatment was recommended to the patient, on 01.10.1986, and at the patient's request, I administered the following therapeutic procedure:**

- 1. Carbimazole, Flavobion, analgesics, Ferronat**
- 2. Trypsín retard amp., Vitamin B12 amp., Thiamin amp. i.m., a week in the saturation and maintenance doses (after 3 months B 12 discontinued)**
- 3. NORGA amp. i.m., in the saturation and maintenance doses.**

The patient's condition improved so much that in **January 1987**, he started working as an electrical engineer. **After 1 year**, the patient underwent follow up examinations, which were negative. In the beginning of 1988, he became a father of the second, healthy child. Presently, he has two children.

#### **15.12.1997: Follow up examination**

**The patient feels well, he works as a businessman, he is without pain or other difficulties.**

**After 11 years, he is still living a normal life for his age.**

### **Patient No. 19: K. A. born in 1938**

Hospitalization: 22.06.1992-09.07.1992 Košice Hospital (NsP), Surgical Department

In 1987, he had myocardial infarction. In 1990, he suffered from constipation and the passage of blood in the stools. A colonoscopic examination confirmed the tumorous process in the region of right colic flexure. The patient refused surgery. In 1992, he suffered from loose stools. He lost 8 kg.

Internal examination: Status post transmural myocardial infarction with sporadic supraventricular extrasystoles, hemodynamically compensated.

**Histology: Grade II differentiated tumour, partially the picture of a mucinoid carcinoma.**

**The tumour penetrates into the subserosal tissue.**

Ultrasound: The finding is typical of the tumour in the right colic flexure. No evidence of metastases in liver. IVP: normal, chest x-ray: negative.

**29.06.1992:** Right hemicolectomy due to carcinoma of the caecum and ascending colon was performed. Status after myocardial infarction.

**Surgical report:** Obstructing tumour of the caecum and ascending colon, the size of 8 x 8 cm.

Signs of chronic intestinal obstruction. The liver is without evidence of metastases.

**21.07.1992:** Due to the fact that the patient refused radiotherapy and chemotherapy, and also at the patient's request, I administered the following therapeutic scheme:

**1. Carbimazole, Flavobion , analgesics,**

**2. Trypsin retard amp., Dithiaden amp., Vitamin B12, Thiamin amp. i.m. in the saturation and maintenance dose**

**3. NORGA amp. i.m. In the saturation and maintenance doses.**

After treatment, the patient's condition returned to normal, no evidence of recurrence of the main disease were noted.

**22.10.1992 - The ultrasound examination:** Revealed the liver of normal size and shape, the vascular structure was normal; the intrahepatic bile ducts were not dilated. The gall bladder was well seen and of homogenous content. The pancreas was well visualized, without pathological changes. The paraaortic nodes were not seen.

**Conclusion: Ultrasound examination normal.**

Chest x-ray: The lung fields appear translucent, without structural changes, the diaphragms have clear contours, the angles are without shadowing.

*Dr. Macejko, personal signature*

**10.01.1993: The patient was examined at the Ambulance for colonic and proctal diseases:** In June 1992 the hemicolectomy due to carcinoma of the caenum and ascending colon performed at our department.

**Presently, the patient feels well, since surgery, he gained 13 kg. The stools are normal, without pathological changes, without disturbances of urination. The abdomen is within the level of the thorax, soft, without palpable masses, painless on palpation, the hypogastrium is without resistance, the liver is within the costal margin, the scar is well healed, DRE is normal. I recommend the ultrasound of liver and paraaortic lymph nodes, chest x-ray and barium enema examination.**

*Dr. Vrzgula, personal signature*

**19.01.1993: Follow-up examination**

The liver ultrasound and sonographical examination of paraaortic lymph nodes and pancreas were performed. The results were negative.

Chest x-ray: negat. *Head of the radiological department.*

03.02.1993: Hospitalization follow-up examination

**Barium enema studies: The enema proceeds through the descending colon into the left colic flexure and then into the transverse colon. In the distal third of the large bowel, the colon is resected and end to end anastomosis with the distal loop of ileum is seen. The anastomosis is not obstructed. The ultrasound examination of the liver and paraaortic lymph nodes revealed normal scan. Paraaortal structures were not seen.**

*Dr. Wolfová, personal signature*

**ESR: 5/hour, other laboratory results were normal, total cholesterol was 7.5mmol/l.**

*Dr. Puchír P., personal signature*

**16.03.1993: Laboratory values**

T3: 1.9 nmol/l, T4: 45.1 nmol/l

14.06.1993 - 18.06.1993: Before the treatment was finished, the patient was admitted to hospital (Surgical Clinic in Košice) for the follow-up examination.

**14.06.1994 : Follow -up examination**

The patient underwent surgery at our Clinic due to Ca coeci it col. ascendensis.

The patient feels well, stools and urine are normal. He did not undergo radiotherapy or chemotherapy.

Laboratory examinations: ESR 6/15, BWR is negative, other results are also normal.

Barium enema examination: Status after right hemicolectomy with anastomosis, without obstruction.

Presently, no signs of recurrence of the main disease. Chest x-ray is normal.

Internal examination: Conclusion: Grade 1 obesity, ischemic heart disease, status after myocardial infarction. Recom.: Nitro-Mac ret. 2xl, Dipyridamol 3xl.

Ultrasound examination of the gallbladder, liver, pancreas, kidneys and paraaortic lymph nodes: the liver has slightly increased echogenicity, other findings are normal.

**Conclusion:**

**The patient was admitted for the follow-up examination after right hemicolectomy due to carcinoma of the caecum and ascending colon.**

**The above mentioned examinations did not reveal recurrence of the main disease.**

During hospitalization the patient had no difficulty and was released from the hospital in a good health condition. I recommend a follow-up examination after six months, at the Ambulance for colonic and proctal diseases of our Clinic. Postoperatively, he did not undergo radiotherapy or chemotherapy.

*Assoc. Prof. Dr. Bober; PhD., personal signature - Head of the Clinic*

*Dr. Blažej I., personal signature*

*Dr. Vržguľa, Head of the department, personal signature*

**After 1 year, I discontinued the treatment. Further follo-up examinations according to the recommendation of the Surgical Department of Košice Hospital. During the treatment the patient gained 18 kg.**

**23.06.1997-26.6.1997: Follow-up hospital examination**

ESR: 2/5, blood count: normal. BUN, glucose, creatinine, proteins, and bilirubin: normal. Ultrasound of the abdominal cavity: the liver, bile ducts, pancreas, paraaortic lymph nodes and kidneys are normal.

Colonoscopic examination (110 cm): No signs of recurrence in the anastomosis and in the large bowel.

**Status after right hemicolectomy due to carcinoma of the caecum and ascending colon. Status after myocardial infarction.**

Conclusion: The above mentioned examinations did not reveal recurrence of the main disease

*Assoc. Prof. Bober J., Head of the First Surgical Clinic in Košice*

**18.10.1997: Follow-up examination**

The patient is feeling well, he has no pain, good appetite, stools and urine are normal, and she does not report any pain or difficulty. RLN are not palpable, the thyroid gland is not enlarged, the sclerae are unicteric; heart and lungs: regular rhythm, no



murmurs, breathing without added breathe sounds. The abdomen painless on palpation, the liver is within the costal margin, the inguinal regions are without masses, extremities without oedema. BP: 130/80.

**The patient has been living a normal life for his age for the last 5 years.**

## **Patient No. 20: H. V. born in 1924**

**Trenčín Hospital (NsP), Surgical Department, hospitalized from 31.12.1973.**

**07.05.1973:** The disease of the mitral valve (mitral insufficiency) was diagnosed.

**31.12.1973:** Urgent laparotomy due to ileus was performed. During surgery, obstructing carcinoma of the ileum was diagnosed and later, histologically confirmed. During surgery, pulmonary embolism and myocardial infarction developed. Therefore, only caecostomy was performed.

**14.03.1974:** The patient was released from the hospital in a serious health condition. A symptomatic treatment was recommended.

*Assoc. Prof. Dr. Omanik, personal signature*

16.03.1974: **I administered the following therapeutic scheme:**

- 1. Carbimazole, Lipovitan, cardiotonics, Ferronat, diuretics**
- 2. Thiamin amp., Vitamin B 12 amp. i.m. in the saturation and maintenance doses**
- 3. NORGA amp. I.M. in the saturation and maintenance doses.**

**After two months** of treatment, the oedema in the lower extremities and dyspnoea disappeared, pain diminished to minimum. Two months later: ESR: 2/hour. Laboratory studies: negative. Chest x-ray: normal.

**In the sixth month of treatment, the patient's condition improved so much that he insisted on abolishing caecostomy.** In the same month, caecostomy was closed at the Surgical Department of Trenčín Hospital (OÚNZ). Since then, the stools were discharged per vias naturales.

During 1 year of treatment, he gained 12 kg.

**He was living a normal lifestyle for his age. On 4.05.1991 he suddenly died due to myocardial infarction.**

**After the administration of the treatment, he lived 17 years without evidence of recurrence of the main disease.**

## **Patient No. 21: Ing. L. M., born in 1968**

The patient was hospitalized at the Department of Radioisotopes, the I. Internal Clinic, Faculty Hospital, in Bratislava from 7.1.1992 to 7.2.1992.

A 32-year old patient, electrical engineer. The present complaint was a periodic pain in epigastrium. Since 1985, he also had experienced pain in the right hypochondriac region. In December of 1991, he had a colic pain which radiated below the right costal margin.

**Ultrasound** revealed hepatomegaly with a nonhomogenous, map-like structure and a great number of hypoechogenic foci. The erythrocyte sedimentation rate (ESR), blood count, and biochemical values were within normal limits. The prostatic fraction of the acid phosphatase was raised. The result of prostatic biopsy was negative.

Laparoscopy: Multiple focal damage of the liver, probably metastases.

CT scan: Multiple foci of hypodensity, most probably metastases.

**Conclusion: Hepatic lesion, most probably metastatic, multiple metastases**

*Professor Dr. Ďuriš, personal signature*

**24.02.1992**, the patient was admitted to the Department of Urology, Faculty Hospital at Kramáre. Bratislava.

Diagnosis: Carcinoma of the head of pancreas with metastases in the liver.

After the patient was dismissed from the hospital, I examined him on 27.02.1992. Because of the finding at palpation, (at palpation, the liver reaches 3 fingerbreadths below the costal margin, there is marked tenderness in the umbilical region, the abdomen is above the level of the thorax, and there is diffuse gaseous distension) I suggested that exploratory laparotomy be performed, in order to confirm the diagnosis or to possibly extirpate the tumour of the head of pancreas.

**18.03.1992**, exploratory laparotomy was performed at the Department of Surgery, Faculty Hospital, in Bratislava. The finding was: Tumour of the pancreas with multiple metastases in the liver. Several biopsies of the pancreas and excisions from the liver were performed. Preliminary result: Malignant tumour

*Signature: Assoc. Prof. Dr. Matis, CSc, the head of the department.*

**Histological examination: Neuroendocrine tumour of the pancreas (nesidioblastoma with metastases in the liver).**

*The head of the department: Dr. Hlavčák, personal signature*

**9.03.1992**, a bone scintigram of the whole body with mTc-MDP was performed in the National Institute of Oncology (NOÚ) in Bratislava.

The scintigram showed pathological restructuring in the region of medial-caudal margin of the left acetabulum. Otherwise, the finding on the bones was within normal limits.

*Assoc.Prof. I. Makaiová, CSc, personal signature*

25.03.1992: At the patient's request, I administered the following therapeutic scheme:

- 1. Carbimazole, Flavobion, Pancreolan forte.**
- 2. Trypsín retard amp., Dithiaden amp., Thiamin 100 mg amp by intramuscular injection in a saturation and maintenance dose.**
- 3. NORGA amp once a week by intramuscular injection in a saturation and maintenance dose.**
- 4. Analgesics as required q.s.**

During the course of the treatment, the patient's condition improved, his appetite was good. ESR: 85/h. Other laboratory parameters were within normal limits.

**3.09.1992**: The patient gained 7 kg in weight.. The abdomen was palpable, without pain and resistance, and the liver was behind the costal margin. Inguinal regions were without resistance, stool and urine was normal. No pain was experienced.

**23.01.1993**: The thyroid gland was enlarged, therefore Carbimazole was gradually discontinued.

15.10.1993: The examination performed by an oncointernist

The patient has had a tumour of the pancreas with metastases in the liver for two years. The tumour is histologically verified. The patient is doing very well, he has not undertaken chemotherapy, nor radiotherapy. His weight is stable, he has not been icteric, he is able to eat without substantial restrictions, he does not drink alcohol, and has no swellings.

**Objective finding:** Pulse 60/1 min, regular. The nutritional status is good, he is orientated, anicteric, well built, without peripheral lymphadenopathy. Breathing (chest) is clear, heart rhythm is regular, heart sounds are normal, no murmurs. The abdomen: palpable, without pain or resistance, the liver is behind the costal margin, the spleen is not enlarged, and tapotement is negative. Auxilliary investigations: All investigations were normal, only the activity of the acid phosphatase and prostatic isoenzyme were raised

**Conclusion: Nesidioblastoma of the head of pancreas with metastases in the liver, the tumour is stationary, without any surgical treatment, chemotherapy or radiotherapy.** The patient is very well built and he can live without any restrictions. From our standpoint he can start working again (since September 1992, he has worked as a programmer in a bank

*Dr. Kristína Križanová, personal signature*

After 1 year of treatment the therapy was discontinued.

#### **7.02. 1994: Follow up examination**

Ultrasound of the abdomen: In comparison with the previous examination on 11.10.1993, the finding is without any substantial changes. The liver is enlarged to 16 cm. There is a hypoechogenic focus 5.4 x 4 cm in the left lobe, which is more enlarged than the right. Otherwise, the structure of the liver is in general homogenous, the pancreas is enlarged, mostly its head, and hyperechogenic. The hepatic duct is wider, but it is not as wide as it was at the previous examination. At present it is approximately 7 mm.

*Dr. Vrabec, personal signature*

#### **18.06.1994 : Control examination**

The patient feels well, he has mild, intermittent pain in the epigastrium, he is mildly meteoristic, stool and urine are normal. Regional lymph nodes are not palpable; the thyroid gland is not enlarged. Heart and lungs - nothing abnormal was detected. Abdomen: palpable, without pain and resistance, liver and spleen are within the costal margins - they are not palpable, tapotement is negative, lower extremities are without swellings, inguinal regions and axillae are without resistance. The patient is anicteric, BP: 120/80, laboratory parameters are normal. The thyroid gland is not enlarged now.

12.12.1997 - Control examination

Abdominal ultrasonography (control): When compared with previous findings of 07.02.1992, without substantial changes or progression of the main disease.

*Dr. Vrabec, personal signature*

#### **Laboratory values:**

ESR: 15/34, blood count - normal, glucose: 6.3 mmol/l, creatinine 118 umol/l, uric acid 403 umol/l, total bilirubin: 6.7 umol/l, ALT 0.55 ukat/l, prostatic isoenzyme activity: 3.82 ukat/l, NH: 0-0.250, total activity: 4.55 ukat/l.

The patient is feeling well, he is not on a diet, regional lymph nodes are not palpable, the thyroid gland is not enlarged, sclerae are anicteric, heart: regular rhythm, lungs: breathing is alveolar, the abdomen is palpable, without tenderness, the liver is not felt, the inguinal region is without resistance, the extremities are normal, without swellings, BP: 115/70.

The regular ultrasound examinations and CT scans did not show any evidence of a progression in the pathological process. **The tumour is clinically „silent“** and the patient is living a normal life without any health problems. He works as an electrical engineer.

**By presenting this patient, I wanted to point out that it is possible that there may be a stage in the disease when tumours behave as if „clinically silent“ and no treatment is required. It is possible to observe the tumour for a long period of time, and in case of recurrence, we can repeatedly administer the above-stated therapeutic scheme. When the possibility for surgical extirpation of the tumour occurs, as it was described in the case of the patient V.P. born in 1928, it can be successfully performed.**

**The patient has been living a normal life for his age for the last 5 years**

### **Patient No. 22: Ing. L. M. born in 1968**

The patient was hospitalized at the Department of Radioisotopes, the I. Internal Clinic, Faculty Hospital, in Bratislava from 7.1. 1992 to 7.2.1992.

A 32-year old patient, electrical engineer. The present complaint was a periodic pain in epigastrium. Since 1985, he also had experienced pain in the right hypochondriac region. In December of 1991, he had a colic pain, which radiated below the right costal margin.

**Ultrasound** revealed hepatomegaly with a nonhomogenous, map-like structure and a great number of hypoechogenic foci. The erythrocyte sedimentation rate (ESR), blood count, and biochemical values were within normal limits. The prostatic fraction of the acid phosphatase was raised. The result of prostatic biopsy was negative.

Laparoscopy: Multiple focal damage of the liver, probably metastases.

CT scan: Multiple foci of hypodensity, most probably metastases.

**Conclusion: Hepatic lesion, most probably metastatic, multiple metastases**

*Professor Dr. Ďuriš, personal signature*

**24.02.1992**, the patient was admitted to the Department of Urology, Faculty Hospital at Kramáre. Bratislava.

Diagnosis: Carcinoma of the head of pancreas with metastases in the liver.

After the patient was dismissed from the hospital, I examined him on 27.02.1992. Because of the finding at palpation, (at palpation, the liver reaches 3 fingerbreadths below the costal margin, there is marked tenderness in the umbilical region, the abdomen is above the level of the thorax, and there is diffuse gaseous distension) I suggested that exploratory laparotomy be performed, in order to confirm the diagnosis or to possibly extirpate the tumour of the head of pancreas.

**18.03.1992**, exploratory laparotomy was performed at the Department of Surgery, Faculty Hospital, Bratislava. The finding was: Tumour of the pancreas with multiple metastases in the liver. Several biopsies of the pancreas and excisions from the liver were performed. Preliminary result: Malignant tumour

*Signature: Assoc. Prof. Dr. Matis, CSc, the head of the department.*

Histological examination: Neuroendocrine tumour of the pancreas (nesidioblastoma with metastases in the liver).

*The head of the department: Dr. Hlavčák, personal signature*

**9.03.1992**, a bone scintigram of the whole body with mTc-MDP was performed in the National Institute of Oncology (NOÚ) in Bratislava.

The scintigram showed pathological restructuring in the region of medial-caudal margin of the left acetabulum. Otherwise, the finding on the bones was within normal limits.

*Assoc.Prof. I. Makaiová, CSc, personal signature*

25.03.1992: At the patient's request, I administered the following therapeutic scheme:

**1. Carbimazole, Flavobion, Pancreolan forte.**

**2. Trypsin retard amp., Dithiaden amp., Thiamin 100 mg amp - by intramuscular injection in a saturation and maintenance dose.**

**3. NORGA amp by intramuscular injection in a saturation and maintenance dose.**

**4. Analgesics as required q.s.**

During the course of the treatment, the patient's condition improved, his appetite was good. ESR: 85/h. Other laboratory parameters were within normal limits.

**3.09.1992**: The patient gained 7 kg in weight.. The abdomen was palpable, without pain and resistance, and the liver was behind the costal margin. Inguinal regions were without resistance, stool and urine was normal. No pain was experienced.

**23.01.1993**: The thyroid gland was enlarged, therefore Carbimazole was gradually discontinued.

15.10.1993: The examination performed by an oncointernist

The patient has had a tumour of the pancreas with metastases in the liver for two years. The tumour is histologically verified. The patient is doing very well; he has not undertaken chemotherapy, nor radiotherapy. His weight is stable, he has not been icteric, he is able to eat without substantial restrictions, he does not drink alcohol, and has no swellings.

**Objective finding:** Pulse 60/1 min, regular. The nutritional status is good, he is orientated, anicteric, well-built, without peripheral lymphadenopathy. Breathing (chest) is clear, heart rhythm is regular, heart sounds are normal, no murmurs. The abdomen: palpable, without pain or resistance, the liver is behind the costal margin, the spleen is not enlarged, and tapotement is negative. Auxilliary investigations: All investigations were normal, only the activity of the acid phosphatase and prostatic isoenzyme were raised.

**Conclusion: Nesidioblastoma of the head of pancreas with metastases in the liver, the tumour is stationary, without any surgical treatment, chemotherapy or radiotherapy.** The patient is very well built and he can live without any restrictions. From our standpoint he can start working again (since September 1992, he has worked as a programmer in a bank).

*Dr. Kristína Křižanová, personal signature*

After 1 year of treatment the therapy was discontinued.

#### **7.02. 1994: Follow up examination**

Ultrasound of the abdomen: In comparison with the previous examination on 11.10.1993, the finding is without any substantial changes. The liver is enlarged to 16 cm. There is a hypoechogenic focus 5.4 x 4 cm in the left lobe, which is more enlarged than the right. Otherwise, the structure of the liver is in general homogenous, the pancreas is enlarged, mostly its head, and hyperechogenic. The hepatic duct is wider, but it is not as wide as it was at the previous examination. At present it is approximately 7 mm.

*Dr. Vrabec, personal signature*

#### **18.06.1994 : Control examination**

The patient feels well, he has mild, intermittent pain in the epigastrium, he is mildly meteoristic, and stool and urine are normal. Regional lymph nodes are not palpable; the thyroid gland is not enlarged. Heart and lungs - nothing abnormal was detected. Abdomen: palpable, without pain and resistance, liver and spleen are within the costal margins - they are not palpable, tapotement is negative, lower extremities are without swellings, inguinal regions and axillae are without resistance. The patient is anicteric, BP: 120/80, laboratory parameters are normal. The thyroid gland is not enlarged now.

12.12.1997 - Control examination

Abdominal ultrasonography (control): When compared with previous findings of 07.02.1992, without substantial changes or progression of the main disease

*Dr. Vrabec, personal signature*

#### **Laboratory values:**

ESR: 15/34, blood count - normal, glucose: 6.3 mmol/l, creatinine 118 umol/l, uric acid 403 umol/l, total bilirubin: 6.7 umol/l, ALT 0.55 ukat/l, prostatic isoenzyme activity: 3.82 ukat/l, NH: 0-0.250, total activity: 4.55 ukat/l.

The patient is feeling well, he is not on a diet, regional lymph nodes are not palpable, the thyroid gland is not enlarged, sclerae are anicteric, heart: regular rhythm, lungs: breathing is alveolar, the abdomen is palpable, without tenderness, the liver is not felt, the inguinal region is without resistance, the extremities are normal, without swellings, BP: 115/70.

The regular ultrasound examinations and CT scans did not show any evidence of a progression in the pathological process. **The tumour is clinically „silent“** and the patient is living a normal life without any health problems. He works as an electrical engineer.

**By presenting this patient, I wanted to point out that it is possible that there may be a stage in the disease when tumours behave as if „clinically silent“ and no treatment is required. It is possible to observe the tumour for a long period of time, and in case of recurrence, we can repeatedly administer the above-stated therapeutic scheme. When the possibility for surgical extirpation of the tumour occurs, as it was described in the case of the patient V.P. born in 1928, it can be successfully performed.**

**The patient has been living a normal life for his age for the last 5 years**

## **Patient (female) No. 23: J. L., born in 1914**

**In March, 1975**, the patient was released from the Department of Surgery, Trenčín Hospital (OÚNZ), with the **diagnosis: The tumour of the pancreas, advanced cachexia and algesic syndrome.**

Due to a bad patient's condition, exploratory laparotomy was contraindicated.

Objective findings: There was a tumorous resistance on palpation in the umbilical region, the size of a man's fist. ESR: 90/130.

**Immediately after the patient was released from the hospital, from both, the vital indication and also at the patient's request, I administered the following therapeutic scheme:**

- 1. Carbimazole, Lipovitan, analgesics, opiates, Ferronat**
- 2. Vitamin B12 amp., Thiamin amp. I.M. in the saturation and maintenance doses**
- 3. NORGA amp. I.M. in the saturation and maintenance doses.**

During the treatment, the patient's condition gradually improved. After 6 weeks, I discontinued opiates. The patient gained weight.

**Six months later**, the tumour was not palpable, the abdomen was soft, without resistance, the liver was within the costal margin. ESR:6/12.

**The laboratory results were normal.** After 1 year, I discontinued the treatment.

The patient worked as a cook - assistant in a charity house.

Further check-ups up to 1992 did not reveal the recurrence of the main disease.

**She died in 1992 due to heart failure.**

**She had lived a normal life for her age for 17 years.**

## **Patient (female) No. 24: V. A. (sister Pavla, name as a nun), born in 1928**

**10.07.1981**- discharged from the Surgical Department, Rychnov nad Kněžnou Hospital (OÚNZ).

I quote the surgical record: Exploratory laparotomy. The entire abdominal cavity is filled with a large tumour, round in shape, and the size of two men's heads. The tumour rises from the left ovary. It fills the small pelvis and two thirds of it is adhered to the dorsal and ventral abdominal wall. Diffuse infiltration of the peritoneum. Ascites, which was present was evacuated. **Dg. Ca ovarii inop. I.sin.**

The patient was discharged to be treated at home with a recommendation of symptomatic treatment.

At the patient's request, I administered the following therapeutic scheme after her dismissal from the hospital:

- 1. Carbimazole (administered for 6 years). After 3 years of treatment I reduced the dose of Carbimazole. Lipovitan.**
- 2. Because of the anemic syndrome, I administered vitamin B12 1000 gamma units and Thiamin 100 mg intramuscularly in a saturation and maintenance dose for 6 years.**
- 3. Trypsin retard ampules intramuscularly and later on orally in a saturation and maintenance dose.**
- 4. NORGA 1.9 ml by intramuscular injection in a saturation and maintenance dose.**

After a month of treatment the patient was able to walk around the room with an aid. She had severe constipation and she urinated frequently. The pain in the abdomen and the LS spine was controlled with analgesics. The

erythrocyte sedimentation rate (ESR) decreased to 20/h (previously, in 3 digits). The total cholesterol began to rise from 2.2 nmol/l to 3.5 nmol/l. Blood count showed anemia, bilirubin, AST, ALT were within normal limits. The tumour was rough, „it could be seen through the anterior abdominal wall“, it was not mobile against the base, and when palpated, it was more painful in the lower abdomen.

After 6 months of treatment, the tumour started to separate from the anterior abdominal wall and a partial smoothing of the tumour surface was observed. The proximal part of the tumour reached 5 cm above the umbilicus. In the 18th month of treatment a topical and general reaction to Trypsin retard administration was observed. Therefore Trypsin retard was discontinued. A week later the signs of ascites and oedema of the lower limbs developed and progressed further. I administered Trypsin retard orally (2 ampules 3 times weekly). After 14 days the oedema gradually relieved and ascites started to resorb.

The patient's laboratory values were checked every month. The erythrocyte sedimentation rate (ESR) was normal. The total cholesterol rose up to 8.5 nmol/l. Objective examination: heart and lungs - normal findings. Blood pressure: 115/70, the thyroid gland was not enlarged, regional lymph nodes were not palpable. The tumour was of the same size, but smooth and mobile. The patient was able to perform everyday work in the house and to work in the garden.

15.04.1982: The finding of the regional medical review commission (OLPK) in Rychnov nad Kněžnou :

The patient was hospitalized at the Surgical Department in Rychnov nad Kněžnou from 24.06.1981 to 10.07.1981. On 30.06.1981 exploratory laparotomy was performed. The finding was a large tumour rising from the left ovary, which practically filled the entire abdominal cavity, small pelvis and two thirds of it were adhered to the dorsal and ventral abdominal wall. After confirming the diagnosis of the inoperable ovarian carcinoma the patient was referred to the gynecological department for further follow up. According to the latest finding on 23.04.1982 the general condition of the patient was good, no signs of pronounced cachexia were present. At present the abdomen was markedly protuberant above the level of thorax and was filled with a hard, ball-shaped resistance, which extended from the symphysis to the xiphoid process.

#### **Diagnosis: Inoperable ovarian carcinoma**

Conclusion: Prognosis is terminal, we recommend that the evaluation for disability be initiated.

*OLPK RNK (regional medical review commission): illegible signature*

2.12.1985: Surgical examination

The patient came for an examination of the abdomen at request of Dr. Jurkovič, who is now treating the patient. The patient was hospitalized at our department from 24.06.1981 with a diagnosis of inoperable left ovarian carcinoma. Subjectively, the patient feels well, her appetite is good, she has stool twice a week, and she urinates without problems. Objectively, the general condition is good. Nutrition is appropriate, she is not anemic. The abdomen is above the level of the thorax, the ball-shaped tumour, which is the size of two men's heads and has a smooth surface deformed its. In the hypogastrium on the right side, there is a separate, oval, smooth resistance in the size of a man's fist. **Conclusion: Left ovarian carcinoma, inoperable.** Further check-ups by a gynecologist is recommended.

*Dr. Motýčka, personal signature*

I continued in the treatment according to the scheme.

In the theoretical part of my work I have already mentioned the cases when the thyroid gland began to respond by its enlargement. This occurred at the time when the tumorous process, or processes, did not progress and this treatment changed them to nonmalignant. They gradually became separated from the surrounding tissues. At this time, the surgical intervention is fully indicated when the tumour is accessible. Therefore, during the sixth year of treatment, after consulting Assoc.Prof. Sauerman, I referred the patient to the Gynecology Clinic of Prof. Gitsch in Vienna. On 29.06.1987, the tumour was removed from the abdominal cavity. The postoperative course was without complications.

Histological verification of the tumour type: Ut. myomat. substerose Riosenleiomyofibroma in regression (1522/87). **T3,T4 and TSH were within normal limits.**

**18.09.1997: Control examination**

The patient is feeling well, the urine and stools are normal.

Gynecological finding: Without any signs of recurrence of the main disease.

**Laboratory values:** glycaemia, urea, creatinine, uric acid, bilirubin, ALT, TG, AMS, Na, K, Cl - within normal limits. ALP: 2.27 ukat/l (0.74-2.10) Total cholesterol: 5.68 mmol/l (3.38-5.2), mucoproteins: 1.84 g/l (0.60-1.40), TSH: 11.4 mU/L (0.49-4.47), T3: 1.24 nmol/l (0.69-2.10), T4: 60.0 nmol/l (57.9-154).

During 6 years of treatment, the patient took:

86 packages of **Carbimazole (8600 - 5 mg tablets)**,

**150 ampules** of Cyanocobalamin (1000 gamma ) administered intramuscularly,

**150 ampules** of **Thiamine** (100 mg) intramuscularly,

**90 ampules** of **Imunoglobulin (NORGA, 1.9 ml)** administered by intramuscular injection,

**470 ampules** of **Trypsin retard** (5 mg) **intramuscularly**, and **570 ampules** administered **orally**.

The patient has been living a normal life for the last 16 years.

## **Patient (female) No. 25: M. H., born in 1934**

Prešov Hospital (NsP), Department of Gynecology

**17.03.1992:** Hysterectomy and salpingo-oophorectomy were carried out due to cancer of the uterus.

**Histology: Adenocarcinoma.**

**09.04.1992:** Due to the fact that the patient refused radiotherapy and chemotherapy, and also at the patient's request, I administered the following therapeutic scheme:

1. Carbimazole, Flavobion , Ferronat.

**2. Trypsin retard amp., Dithiaden amp., Thiamin amp., Vitamin B12 amp. I.M. in the saturation and maintenance doses. After 1 month of treatment, I discontinued Vitamin B12.**

**3. NORGA amp., I.M., in the saturation and maintenance doses.**

During the treatment, the patient's health condition returned to normal, she gained weight, the results of laboratory studies were normal.

**Ultrasound and gynecological examinations were normal.** After 1 year, I discontinued the treatment. The gynecologist has been regularly followed up the patient.

**05.09.1997: Follow-up examination**

Chest x-ray: The lungs are without pathological changes.

Abdominal ultrasonography: The liver is not enlarged, it is hyperechogenic, status post cholecystectomy, the common bile duct is 7 mm wide, homogenous, the intrahepatic bile ducts are not dilated. The pancreas is not enlarged. The kidneys have normal structure; no signs of dilatation are present.

**Conclusion: Signs of hepatopathy and pancreatopathy are present.**

*Dr. Košíková, personal signature*

**Gynecological examination:**

Vaginal cystoectocele, the uterus and the adnexa were removed, without palpable mass in the small pelvis.

*Dr. Bandár, personal signature*

**Endocrinological examination:** objective findings in norm.

**Ultrasonography of the thyroid gland:** In the left lobe a node of 1.45 cm in diameter.



### **5.09.1997: Laboratory studies**

ESR: 8/21, urine: negative, blood count: normal, serum SGMT: 0.58 ukat/l, s-ALP: 2.32 ukat/l, total cholesterol: 6.81 mmol/l, TG: 2.46 mmol/l, bilirubin, AST, ALT, proteins, creatinine, uric acid, blood glucose - all these results were within the normal limits.

T4: 96 nmol/l (65-160), TSH-IRMA: 3.50 mIU/l (0.4-4.5).

*Dr. Martenová, personal signature*

### **09.10.1997: Follow up examination**

The patient is feeling well, she has no pain, the stools and urine are normal, RLN are not palpable, the thyroid gland is not enlarged, the sclerae is unicteric. The heart and the lungs: regular rhythm, no murmurs, and vesicular breaths sounds. The abdomen: soft, palpable, painless, the inguinal regions are without masses, the extremities are without oedema.

**After 5 years, the patient is still living a normal life for her age.**

### **Patient (female) No. 26 : B. L., born in 1956**

**Nitra Hospital (NsP), Department of Gynecology:** 11.03.1992-24.03.1992.

**13.03.1992:** Hysterectomy and salpingo-oophorectomy were carried out due to cancer of the uterus.

**Histology: Adenocarcinoma, grade 2, with deep infiltration of the myometrium.**

**28.04.1992:** Due to the fact that the patient refused radiotherapy and chemotherapy, and also at the patient's request, I administered the following therapeutic scheme:

**1. Carbimazole tab., Flavobion tab., Ferronat,**

**2. Trypsín retard amp., Dithiaden amp., Thiamin amp., Vitamin B12 amp., Kanavit amp. I.M. in the saturation and maintenance dose (after 1 month of treatment, I discontinued Vitamin B12 and Kanavit)**

**3. NORGA amp., I.M., in the saturation and maintenance doses.**

The patient's health condition gradually returned to normal. The results of the laboratory studies were normal.

### **24.08.1992: Ultrasound examination**

Presently, no evidence of recurrence of the main disease **Colposcopy:** Negative.

*Dr. Kováč Ján, personal signature*

Up to 1997, a gynecologist regularly followed up the patient. No evidence of the recurrence of the main disease was present.

**After 5 years, she is still living a normal life for her age.**

### **Patient (female) No. 27: Š. J., born in 1919**

**Department of Gynecology, NsP Hospital Bratislava, Assoc. Prof. Dr. Kliment.**

**Histology (No. 74654): Adenocarcinoma of the uterus.**

**September 1979:** Hysterectomy and adnexectomy due to carcinoma of the uterus body were performed.

Due to the fact that the patient refused radiotherapy and chemotherapy, and also at the patient's request, immediately after her release from the hospital, I administered the following therapeutic scheme:

**1. Carbimazole, Lipovitan, Ferronat C**

**2. Trypsín retard amp., Dithiaden amp., Thiamin amp., Vitamin B12, Kanavit amp. I.M., in the saturation and maintenance doses (after 1 month Vitamin B 12 and Kanavit discontinued)**

**3. NORGA amp. I.M.in the saturation and maintenance doses.**

During the treatment, the patient gained weight, she was feeling well, the laboratory results were normal. After 1 year, I discontinued the treatment. She was regularly checked-up by a gynecologist.

**Conclusion: No signs of recurrence of the main disease.**

**1.12.1996: The patient suddenly died due to myocardial infarction.**

**The patient lived a normal life for her age for 17 years.**

## **Patient (female) No. 28: M. A., born in 1921**

Department of Gynecology, Trenčín Hospital (NsP).

**15.01.1975:** Hysterectomy and adnexectomy due to carcinoma of the uterus body were performed.

**Histology: Adenocarcinoma.**

Postoperatively, palliative radiotherapy (3000 r) was administered. After she was released from the hospital, at the patient's request, I administered the following therapeutic scheme:

**1. Carbimazole tab., Lipovitan, Ferronat**

**2. Vitamin B12 amp., Thiamin amp., Kanavit amp. I.M. in the saturation and maintenance doses**

**3. NORGA amp. I.M.in the saturation and maintenance doses.**

The patient's condition gradually improved, she was not bleeding, and she had no pain and was feeling well. The results of laboratory examinations were normal. After 1 year, I discontinued the treatment. The patient started to work hard at the local agricultural cooperative and practically, up to 1993, she lived a normal life for her age.

**In Spring, 1993,** recurrence of the disease was noted. After the failure of chemotherapy, I administered the B.T.M. treatment. Bleeding from the genitalia decreased. Presently, she experiences only mild, intermittent bleeding. After 1 year, I discontinued the treatment. a gynecologist regularly followed her,

**09.1997: Follow up examination**

Pain in the L-S region. It radiates into the lower extremities, mostly into the right. The patient is mobile. The colonoscopic opening was without signs of maceration. She was regularly followed up at the Department of clinical oncology of the polyclinic (POKO).

During 18 years, the complete, therapeutic scheme (including Carbimazole) was administered twice.

The thyroid was not enlarged, painless on palpation. ESR: 28/hour.

The results of laboratory examinations were normal.

TSH: 0.93 mU/l, T3: 1.44 nmol/l, T4: 118 nmol/l.

**The patient has been living for 22 years since the administration of the treatment.**

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## **Patient (female) No. 29: M. B., born in 1946**

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**January 1986:** Hospitalization at the Department of Gynecology, Uherské Hradiště Hospital.

**Beginning of 1986:** Hysterectomy and adnexectomy due to carcinoma of the uterus body were performed. Postoperatively, chemotherapy was administered.

**March, 1986:** chemotherapy was discontinued due to severe anemia, malaise and incipient cachexia. A symptomatic treatment was recommended.

20.03.1986: **From both, the vital indication and also at the patient's request, I administered the therapeutic scheme:**

1. Carbimazole, Lipovitan, Ferronat.

**2. Trypsin retard amp, Thiamin amp., Vitamin B12 amp., Kanavit amp. I.M. in the saturation and maintenance doses (after 1 month B 12 discontinued)**

**3. NORGA amp. I.M. in the saturation and maintenance doses.**

Blood count gradually returned to normal. The results of laboratory examinations also returned to normal. After 2 months of treatment the bleeding stopped. After 1 year, she gained 10 kg.

Gynecological finding: Without recurrence of the main disease. A gynecologist regularly follows her up.

**19.09.1997: Follow up examination**

The patient reports sporadic, mild pain in the left hypogastrium, the stools and the urine are normal.

Objective findings: RLN were not palpable, the thyroid gland was not enlarged, the sclerae was unicteric. The abdomen: soft, palpable, the liver was not enlarged, the inguinal regions were without masses, and there was mild tenderness on palpation in the hypogastrium. ESR: 40/68 (following influenza). She works full time as a nurse.

#### **Laboratory results**

TSH: 2.11 mU/l, T3: 1.64 nmol/l, T4: 92.3 nmol/l.

ALP: 2.32 ukat/l, total cholesterol: 8.46 nmol/l, TG: 2.29 nmol/l, other laboratory results were normal.

**Up to 1997, the follow up and laboratory examinations did not reveal recurrence of the oncological disease.**

**Since the administration of the treatment, the patient has been living a normal lifestyle for her age for the last 11 years.**

## **Patient (female) No. 30: Z. A. born in 1932**

Hospitalization at the Institute of Clinical Oncology, in Bratislava.

**12.06.1988:** The patient was released from the hospital.

**Diagnosis: Inoperable carcinoma of the uterus.**

Status after administering radiotherapy. A symptomatic treatment was recommended.

*Assoc. Prof. Dr. Maňka, CSc, personal signature.*

After the patient was released from the hospital, severe metrorrhagia associated with algetic syndrome developed. Dysuria, incipient cachexia and algetic syndrome were noted.

**Immediately after she was released from the hospital, at her request, I administered the following therapeutic scheme:**

**1. Carbimazole , Flavobion, Ferronat, analgesics as needed**

**2. Trypsín retard amp., Dithiaden amp., Thiamin amp., Kanavit amp. I.M. in the saturation and maintenance doses (After 1 month, I discontinued Kanavit)**

**3. NORGA amp. I.M. in the saturation and maintenance doses.**

**The patient's condition gradually improved, the laboratory results were normal, she gained weight. After 1 year, I discontinued the treatment.**

Up to 1997, the subsequent gynecological examinations and the follow up examinations at the Department of clinical oncology of the polyclinic (POKO) did not reveal the evidence of recurrence of the main disease.

**The patient has been living a normal life for her age for the last 9 years.**

## **Patient (female) No. 31: M. M., born in 1957**

Hospitalization: Považská Bystrica Hospital.

**In February 1991**, hysterectomy and adnexectomy due to **carcinoma of the uterine** body were performed. Postoperatively, radiotherapy was administered. After administering radiotherapy, malaise, metrorrhagia, fatigue and loss of appetite developed. Because of these symptoms, the patient refused chemotherapy.

10.03.1991: **From both, the vital indication and also at the patient's request, I administered the following therapeutic scheme:**

**1. Carbimazole, Flavobion, Ferronat**

**2. Trypsín retard, Dithiaden amp., Vitamin B12 amp., Thiamin amp., Kanavit amp. I.M. in the saturation and maintenance doses (after 1 month, I discontinued Kanavit and B 12)**

**3. NORGA amp. I.M. in the saturation and maintenance doses.**

The patient's condition gradually returned to normal. The ultrasound and gynecological examinations were normal. After 1 year, I discontinued the treatment. Further check-ups were recommended at the Department of clinical oncology of the polyclinic (POKO).

Up to 1997, the regular follow up examinations did not reveal recurrence of the main disease.

**Since the administration of the treatment, the patient has been living a normal lifestyle for her age for the last 6 years.**

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## **Patient (female) No. 6: Š. E. born in 1924**

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**In January, 1984**, the patient was released from the Department of Gynecology, Trenčín Hospital (OÚNZ).

**Diagnosis: Inoperable carcinoma of the uterus.**

Status after administering palliative RT. A symptomatic treatment was recommended.

*Dr. Rafaj, personal signature*

After she was released from the hospital, she complained of frequent and painful urination and gross hematuria. Bleeding from the genitalia and severe pain in the hypogastrium were noted.

01.02.1984: **From both, the vital indication and also at the patient's request, I administered the following therapeutic scheme:**

**1. Carbimazole, Flavobion, Ferronat, analgesics as needed**

**2. Trypsín retard amp., Dithiaden amp., vitamin B12 amp., Thiamin amp., Kanavit amp. I.M. in the saturation and maintenance doses (After 1 month, I discontinued B 12 and Kanavit)**

### **3. NORGA amp. I.M. in the saturation and maintenance doses.**

Blood count and the laboratory results gradually returned to normal. The patient feels well, she has no pain, she gained weight. After 1 year, I discontinued the treatment. A gynecologist regularly followed her up. The subsequent gynecological examinations were normal.

**12.11.1997:** The patient was feeling well, she was without pain, the stools and urine were normal, RLN were not palpable, the thyroid gland was not enlarged, the sclerae were unicteric. The heart and lungs: regular rhythm, no murmurs, vesicular breath sounds. The abdomen: soft, palpable, the liver was not enlarged, the inguinal regions were without masses, the extremities were without oedema. BP:150/85.

#### **Laboratory results**

ESR: 12/28, the urine: negative, blood count + dif.: Neu 0.51% (0.58-0.67), Eos: 0.06: 0.06% (0.01-0.03), other values were normal. Glucose, uric acid, bilirubin, ALP, Na, K, Cl - within the normal limits, cholesterol: 7.60 mmol/l, TG: 2.18 mmol/l.

s-TSH: 1.98 mU/l, s-T3: 1.61 nmol/l, s-T4: 132 nmol/l.

Until 1997, the follow up and laboratory examinations did not reveal recurrence of the main disease.

**The patient has been living a normal lifestyle for her age for the last 9 years.**

## **Patient No.32: H. F. born in 1930**

Nové Zámky Hospital (OÚNZ), Urological Department

08.12.1975: **Partial cystectomy due to cancer of the bladder was performed.**

**Histology ( no. 122901): Adenocarcinoma**

**24.12.1975:** Due to the fact that the patient refused radiotherapy and chemotherapy

**2. Thiamin amp., Kanavit amp., Vitamin B12 amp. i.m. Week, in the saturation and maintenance doses. (After 3 months, I discontinued Kanavit)**

**3. NORGA amp., I.M., in the saturation and maintenance doses.**

**After three months,** hematuria and pain relieved. Therefore, I discontinued analgesics and Kanavit. During the treatment he has been regularly checked by a urologist.

The repeated cystoscopic examinations were negative.

**After 1 year,** I discontinued the treatment. The patient gained 15 kg.

**Three years after the treatment,** regularly in December and in March, the patient was administered 3 ampules of NORGA, I.M.

The subsequent cystoscopic examinations in 1976 and 1977 were negative.

## **Patient No. 33: T. J. born in 1939**

Trenčín Hospital (NsP), Department of Urology.

**Diagnosis: Cancer of the bladder.**

The patient has been recommended a symptomatic treatment. 22.12.1988 he suffered from severe pain, even not during urination. Incipient cachexia was observed.

**22.12.1988:** At the patient's request, I administered the following therapeutic scheme:

**1. Carbimazole, Flavobion, antibiotics, analgesics.**

**2. Trypsin retard amp., Dithiaden amp., Thiamin amp., Kanavit amp., Vitamin B12 amp., I.M., in the saturation and maintenance doses (after 2 months of treatment, I discontinued Vitamin B12 and Kanavit )**

**3. NORGA amp., I.M., in the saturation and maintenance doses.**

The patient's health condition returned to normal. The results of the laboratory studies were negative.

After 1 year of treatment, he gained 12 kg. I discontinued the treatment. The patient has been regularly checked by a urologist.

#### **17.10.1997: Control examination**

**The patient is feeling well, he has no pain, the stools and urine are normal, RLN are not palpable, the thyroid gland is not enlarged, the sclerae are unicteric. The heart and the lungs: regular rhythm, no murmurs, vesicular breath sounds. The abdomen: soft, palpable, the liver is within the costal margin, the inguinal regions are without masses, the extremities are without swellings.**

#### **12.06.1997: Control examination**

Urine culture: quantitative bacteriuria: negative.

Cystoscopy: CH 18, free passage of the cystoscope, the bladder capacity is slightly decreased, the bladder wall is roundish, the mucosa is slightly hyperemic, no signs of recurrence of the main disease are present.

Renal ultrasound: without echogenic changes.

*Dr. Michalik, urologist, personal signature.*

#### **Laboratory results:**

ESR: 12/28, glucose, urea, creatinine, proteins, bilirubin, cholesterol, AST, ALT, ALP, Na, K, Ca - all within the normal limits.

TSH: 1.78 mU/l (0.49-4.67), T3: 1.50 nmol/l (0.69-2.10), T4: 153 nmol/l (57.9-154).

**The patient has been living a normal life for his age for the last 9 years.**

#### **18.10.1997: Follow up examinations**

**Urological examination:** The patient feels well, he is without pain, reports more frequent urination in the night (two times at night), he does not report hematuria.

**Orientalional findings:** The head, the heart and the lungs: normal, the kidneys: normal on palpation. External genitalia: normal findings. The prostate: slightly, diffusely enlarged, half-firm consistency, smooth, with detectable margins. The lower extremities are without oedema and venous varicosities.

**Ultrasound examination of kidneys:** The kidneys without dilatation bilaterally, without structural changes.

The liver: without structural changes. The gallbladder: no evidence of stones. The bladder: minimal content, the prostate: 34 x 32 x 30 mm.

**Conclusion: Status post partial cystectomy due to adenocarcinoma, in 1975.**

**Benign prostatic hyperplasia, St. post dil. colli ves. urin., status post Steinach's vasoligature, bilat.**

*Dr. Imrich Olah, urologist, personal signature.*

**Laboratory results:** ESR: 5/12, glucose: 6.1 mmol/l, urea: 5.7, creatinine: 80.0 umol/l, bilirubin: 5.4 umol/l, AST: 0.43, ALT: 0.58 ukat/l, ALP, TG, total cholesterol: 5.8 mmol/l, Na: 145, K: 5.90 mmol/l, Ca: 2.47 mmol/l. Urine: pH:7, other results + urinalysis: within the normal limits. Weight: 86 kg. TSH: 5.759 mU/ml, T3: 0.84 mg/ml, T4: 7.51 mg/dl.

The patient has been living a normal life for his age for twenty-two years .

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**Patient (female) No. 34: T. J., born in 1935**

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**8.7.1992:** Urological Department, Dérer Hospital (NsP) Bratislava

**17. 03. 1992:** The transmural resection of urinary bladder tumour was performed.

**Histology: Infiltrating carcinoma (infiltration into the muscles).**

Postoperatively, chemotherapy was administered.

**16. 07. 1992:** The CT scan of the urinary bladder and the pelvic region was performed: It is likely that the regression of the thickened bladder wall occurred on the left, dorsally and caudally. Ventrally, the thickened bladder wall persisted. **Metastases into the pelvic lymph nodes on the left.**

*Dr. Belan, personal signature*

**1. 08.1992: From both the vital indication and also at the patient's request, I administered the following therapeutic scheme:**

1. Carbimazole 3x2, Flavobion 2x1, antibiotics, analgesics

2. Trypsin retard amp., Dithiaden amp, Thiamin amp., Kanavit amp. I.M. in the saturation and maintenance doses (after 1 month Kanavit discontinued)

3. NORGA amp. I.M. in the saturation and maintenance doses.

During the treatment, the patient's health condition gradually improved, he did not report any pain. Stools and urine normal.

**22.10.1992: The CT scan of the minor pelvis focused on the urinary bladder:**

Presently, without clear evidence of the bladder wall thickening on CT.

Metastases into lymph nodes were also not clearly confirmed.

*Dr. Borský, personal signature*

**The laboratory results: normal. The patient is feeling well. After one year, I discontinued the treatment.**

Up to 1997, subsequent urological examinations did not reveal recurrence of the main disease.

**The patient has been living a normal life for her age for the last 5 years.**

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**Patient No. 35: R. O. born in 1940**

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In September, 1979, left nephrectomy due to carcinoma of the left kidney (Grawitz) was performed. Postoperatively, radiotherapy was administered.

**The patient complained of severe pain in the region where radiotherapy was administered. Pain was poorly controlled with analgesics.**

**15.01.1980:** From both, the vital indication and also at the patient's request, I administered the following therapeutic scheme:

1. Carbimazole, Flavobion, analgesics

**2. Trypsin retard amp., Dithiaden amp., Thiamin amp., Vitamin B12, Kanavit amp. I.M. in the saturation and maintenance doses (after 1 month I discontinued Kanavit and b 12)**

**3. NORGA amp. I.M. in the saturation and maintenance doses.**

After 4 months of treatment, pain gradually relieved, his appetite was good, the laboratory results returned to normal. After 1 year, I discontinued the treatment.

**09.10.1997: Urological examination:**

In 1979, surgery due to the tumour of the right kidney (Grawitz) was performed. Presently, without substantial difficulties. Tapotment: negative, the scar after laparotomy is firm, the abdomen is without pathological resistance. The genitalia: without pathological findings. The prostate - benign, moderately enlarged, tender. Urinalysis: negative. Ultrasound: the liver, the retroperitoneum on the right: negative, the left kidney: a cyst, 2.5 cm in diameter, the bladder: normal.

Conclusion: Status after nephrectomy due to tumour of the right kidney (Grawitz) in 1979. Chest x-ray: negative. The following examination after 1 year.

*Dr. Pažický, L., personal signature*

**10.10.1997: Follow up examinations**

The patient feels well, he is without pain, the stools and the urine are normal.

Orientational findings: The head, the lungs and the heart: normal. The kidneys on palpation: without pathological findings.

**Laboratory results:**

ESR: 5/12, creatinine: 125.5 umol/l, urea: 8.15, bilirubin: 32.2 umol/l, AST, ALT, GMT, ALP, total cholesterol, glycemia, urea, Na, K, Ca, LDL, TG, Mg - **all within the normal limits.**

TSH: 2.31 mIU/l, T3: 4.30 nmol/l, T4: 14.6 nmol/l.

**The patient has been living a normal life for his age for the last 17 years without recurrence of the main disease**

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## **Patient No. 36: D. J., born in 1947**

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23.04.1991: Prešov Hospital (NsP), Department of Urology: Right transperitoneal nephrectomy of the right kidney due to renal carcinoma (Grawitz's tumour) was performed. Renal cyst on the left. The patient refused radiotherapy and chemotherapy.

**25.11.1991:** At the patient's request, I administered the following therapeutic scheme:

**1. Carbimazole, Flavobion**

**2. Trypsin retard amp., Dithiaden amp., Thiamin amp., Vitamin B12 amp., I.M. (After 1 month, I discontinued Vitamin B12)**

**3. NORGA amp., I.M., in the saturation and maintenance doses.**

The patient's health condition gradually returned to normal. The results of the laboratory studies were negative. After 1 year of treatment I discontinued the therapy. The patient gained 20 kg.

Abdominal ultrasound revealed a renal cyst in the left kidney. Chest x-ray was normal.

The abdominal ultrasound before the end of treatment: The enlarged head of the pancreas was noted, no signs of hyperechogenity were present, the liver was of normal size and without echogenity.



Up to 1997, **the subsequent follow up urological examinations were negative.**  
The patient has been living a normal life for his age for the last six years.

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**Patient No. 37: M. S., born in 1961**

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**15.10.1992:** Diagnosis: Status after right orchidectomy due to seminoma of the testis.

**17.11.1992:** Due to the fact that the patient refused radiotherapy and chemotherapy, and also at the patient's request, I administered the following therapeutic scheme:

1. Carbimazole, Flavobion.
- 2. Trypsín retard amp., Dithiaden amp., Thiamin amp., I.M., in the saturation and maintenance doses.**
- 3. NORGA amp., I.M., in the saturation and maintenance doses.**

During the treatment the patient's health condition returned to normal.

The results of the laboratory studies were normal. After 1 year, I discontinued the treatment.

**Up to 1997,** the subsequent urological examinations and ultrasound examinations of the abdominal cavity were normal.

**The patient has been living a normal life for his age for the last 5 years.**

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**Patient No. 38: T. S., born in 1973**

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Liptovský Mikuláš Hospital (NsP), Department of Urology:

**30.04.1992:** Right orchidectomy was performed due to the cancer of the testis (T1N0M0).

**Histology: Embryonal carcinoma plus teratoma with the dominance of embryonal carcinoma.**

*Dr. Ondruš, Head of the department, personal signature.*

**05.06.1992:** Due to the fact that the patient refused radiotherapy and chemotherapy, and also at the patient's request, I administered the following therapeutic scheme:

- 1. Carbimazole, Flavobion**
- 2. Trypsín retard amp., Dithiaden amp., Thiamin amp., I.M., in the saturation and maintenance doses**
- 3. NORGA amp., I.M., in the saturation and maintenance doses.**

**24.09.1992: The patient was examined in the Institute of Endocrinology in Ľubochňa:** Laboratory results: T3: 3.2 nmol/l, T4: 83.78 nmol/l. Other laboratory results and objective findings were also normal. TSH: 5.54 mU/l - slightly increased, TM: 1.447 - negative, LH: 9.28 U/l (normal), FSH: 4.06 U/l (normal), testosterone: 21.4 nmol/l (normal), prolactin: 240.36 nU/l (normal). The semen analysis: Oligospermia (grade 2).

*Dr. Popovič, personal signature*

**At the beginning of the 6th month** of treatment, the thyroid became diffusely enlarged. Therefore, I gradually discontinued Carbimazole.

**After 1 year of treatment,** the patient gained 12 kg. The thyroid gradually diminished to normal.

The subsequent T3, T4 and TSH examinations were normal.

The abdominal ultrasound and chest x-ray examinations were normal. Urological findings normal. After 1 year, I discontinued the treatment.

#### **31.10.1997: Abdominal ultrasound**

The liver is of normal size and structure, without structural changes. The bile ducts and the gallbladder are normal. The pancreas: difficult to visualize, without substantial changes, the paraaortic nodes are normal, without collection of fluid in the abdominal cavity.

*Dr. I. Trizma, personal signature*

#### **05.11.1997: The thyroid ultrasound**

Parenchyma is normoechogenic; the texture is soft, normal, without nodal changes, the lobe contours are not thickened.

**Conclusion: The thyroid is not enlarged, without substantial echostructural changes.** Left lobe: 14.0 x 53.0 mm, right lobe: 15.0 x 17.0 x 55 mm. The volume: left lobe: 5.33 ml, right lobe: 6.71, total: 12.04 ml.

*Dr. P. Vaňuga, personal signature*

#### **06.11.1997: Follow up examination**

**Since 1992, the patient did not suffer from any serious illness, except for uncomplicated, mild colds. The patient is feeling well, he has no pain, the stools and urine are normal, RLN are not palpable, the thyroid gland is not enlarged, the sclerae are unicteric. The heart and the lungs: regular rhythm, no murmurs, vesicular breath sounds. The abdomen: soft, palpable, painless, the liver is within the costal margin, the inguinal regions are without masses, the left testicle: painless on palpation, of normal size, the extremities are without oedema.**

Laboratory results: ESR: 5/12, blood count: normal, glucose, urea, creatinine, proteins, bilirubin, AST, ALT, ALP, TG, total cholesterol, Na, K, Ca - all within the normal limits. TSH: 0.44 mIU/l, T3: 2.2 nmol/l, T4: 137 nmol/l.

The patient has been regularly followed up by a urologist.

**After 5 years, the patient is still living a normal life for his age.**

### **Patient No. 39: B. J., born in 1964**

**In March, 1984,** chemotherapy was discontinued because of the failure of treatment. The patient was released from the hospital in the terminal condition.

**Diagnosis: Seminoma of the testis with multiple metastases into the abdomen and the lungs.** A symptomatic treatment was recommended.

**Cachexia, weight: 41 kg. The patient is immobile.**

After the patient was released from the hospital, from both the vital indication and also at the patient's request, I administered the following therapeutic scheme:

**1. Carbimazole, Flavobion.**

**2. Trypsin retard amp., Dithiaden amp., Thiamin amp., Kanavit amp., I.M. in the saturation and maintenance doses**

**3. NORGA amp. I.M. once a week, in the saturation and maintenance doses.**

**During the treatment, the patient's health condition gradually improved, his appetite was good, pain disappeared, the stools and the urine were normal.**

3 months later, the patient started seeing me in my office.

During the treatment, the patient was regularly checked up in the Oncological Institute in Bratislava. The results of laboratory examinations were normal.

**Abdominal ultrasound: Normal.**

**Chest x-ray: No evidence of oncological process, metastases were resorbed.**

The patient gained **20 kg**. After 1 year, I discontinued the treatment.

**Three years** after the treatment by B.T.M., in December and March, 3 amp. of NORGA were administered.

**Four years after the administration** of the treatment, the patient got married. So far, he has got three healthy children. He works as an entrepreneur.

#### **20.12.1997: Follow up examination**

The patient feels well, he has no pain, so far he has not been seriously ill. RLN not palpable, the thyroid gland not enlarged. sclerae unicteric. Heart and lungs: regular rhythm, vesicular breathes sounds. The abdomen soft, palpable, liver within costal margin. The groins are without resistance, the extremities are without oedema. Weight 98 kg. The right testis: no resistance on palpation. BP: 135/70.

Laboratory results: normal. ESR: 10/22, T3, T4, TSH, blood count - all within the normal limits. **Up to 1997**, the patient underwent repeated, targeted examinations: without recurrence of the main disease.

**The patient has been living a normal life for his age for the last 13 years.**

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### **Patient No. 40: B. M., born in 1944**

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**Urological Department, Banská Bystrica Hospital (NsP).**

**In June 1986** the patient was released from the Department of Radiology, Banská Bystrica Hospital. Diagnosis: Status after right orchidectomy due to seminoma of the testis. Status after radiotherapy. The patient refused chemotherapy.

Immediately after his release from the hospital, I administered the following therapeutic scheme at the patient's request:

**1. Carbimazole, Flavobion, Ferronat**

**2. Trypsin retard amp. Dithiaden amp. Vitamin B12 amp., Thiamin amp., Kanavit amp. I.M., in the saturation and maintenance doses (after 1 month, I discontinued Kanavit and B12)**

**3. NORGA amp. I.M., in the saturation and maintenance doses.**

The patient is regularly followed up at the Urological Department, Banská Bystrica Hospital (NsP). During the treatment, the patient feels well, he has no pain, and the stools and the urine are normal. Postradiation erythema of the skin and genitalia improved.

The repeated ultrasound examinations of the abdomen were normal. Chest x-ray: negative.

The laboratory results gradually returned to normal. He gained 14 kg. After 1 year, I discontinued the treatment. The patient is regularly followed up in Bystrica Hospital (NsP).

#### **09.07.1997: Abdominal ultrasound**

The liver has normal echogenicity, no signs of structural changes, no metastases. No signs of adenopathy. The kidneys and the bladder are normal.

*Dr. Salaga, personal signature*

10.07.1997: Oncological examination

The liver ultrasound: no structural changes, no signs of adenopathy. Tumour markers are normal. Status after tumour of the right testis. Remission lasts. Next check up: July 1998.

*Dr. Fritzová, personal signature*

#### **11.10.1997: Follow up examination**

The patient feels well, he has no pain, his appetite is good, the stools and the urine are normal. RLN are not palpable, the thyroid gland is not enlarged, the sclerae are unicteric, The heart and the lungs: regular rhythm, no murmurs are heard, vesicular breath sounds. The abdomen: soft, palpable, the liver is within the costal margin, the groins are without resistance, the extremities are without oedema. BP: 130/70.

#### **Laboratory results**

ESR: 5/14, blood count: normal, glycemia, urea, creatinine, uric acid, proteins, bilirubin, AST, ALT, GMT, total cholesterol, TG - all within the normal limits.

TSH: 0.79 mIU/l, T3: 1.44 nmol/l, T4: 86.23 nmol/l.

**Since the administration of the treatment, he has continued to live a normal lifestyle for his age for 13 years, without recurrence of the main disease.**

### **Patient (female) No. 41: B. M., born in 1932**

Trenčín Hospital (NsP), Department of Radiotherapy, Surgical Department, Department of Internal Diseases, the last hospitalization was on 08.03.1996.

**1976:** stroke with subsequent hemiplegia on the right. Post-traumatic mitral valve disease (stenosis) and atrial fibrillation.

**1984:** Angiosarcoma of the left foot with metastases into the left inguinal region, femur and acetabulum. Radiotherapy was administered to the left sole with subsequent necrosis of the left sole and pronounced algesic syndrome.

**14.09.1984:** At the patient's request, I administered the following therapeutic scheme:

**1. Carbimazole, Flavobion, analgesics, Biomin H**

**2. Trypsin retard amp., Dithiaden amp. i.m. in the saturation and maintenance doses**

**3. NORGA amp. i.m., in the saturation and maintenance doses.**

After 8 months of treatment there were no palpable metastases in the inguinal region. The patient was feeling better; algesic syndrome of the left sole persisted. Due to the advanced necrosis of the sole, I recommended amputation of the foot.

**May 1985:** Amputation in the distal third of the thigh on the left. After surgery I continued with the treatment, algesic syndrome relieved, the patient has prosthesis to help her walk. The therapy is discontinued.

At the beginning of 1988, the lymph node, the size of 5 x 5 cm, was noted in both inguinal regions.

Again, I administered the therapeutic scheme in the saturation and maintenance doses.

Six months later, the lymph nodes were not palpable and I discontinued the treatment.

In September 1991, I diagnosed the tumour of the right breast, the size of 3.5 x 5 cm. Due to a heart disease, after mastectomy, a symptomatic treatment was recommended.

After she was released from the hospital stay, I again administered the therapeutic scheme.

I added also Biomin H. After 6 months, I discontinued the treatment. The patient was regularly controlled by an internist and repeatedly hospitalized in the Trenčín Hospital due to cardiac decompensation. The last hospitalization was in September 1997.

### **23.09.1997: Follow up examination**

The patient complained of breathlessness on exertion and frequent bronchitis. The stools and the urine were normal. Regional lymph nodes were not palpable, the thyroid gland was not enlarged, and sclerae was unicteric. The chest: scar after surgery was completely healed, the axillae were without resistance. The upper limb: no evidence of lymphostasis. The heart and the lungs: arrhythmia, P: 67/1 min., BP: 130/80. Breathing was decreased, without abnormal breath sounds, the abdomen was soft, the liver: + 6cm, smooth, tender on palpation. Status after above-knee amputation of the lower limb, the right upper limb was spastic (an old finding), the inguinal regions were without any mass.

#### **Laboratory results:**

ESR: 14/40, hypochromic anemia, glucose: 6.70 mmol/l, urea: 5.9 mmol/l, creatinine: 104.4 umol/l, uric acid: 604.0 umol/l, proteins: 69.10 g/l, bilirubin: 10.80 umol/l, ALT: 0.26 ukat/l, GMT: 0.89 ukat/l, ALP: 2.51 ukat/l, cholesterol: 2.93 mmol/l, TG: 1.00 mmol/l, Na: 142.0 mmol/l, K: 5.20 mmol/l, Cl: 98 mmol/l, TSH: 1.66 mU/l (reference range: 0.49 - 4.67), T3: 1.50 nmol/l (0.69 - 2.10) T4: 131 nmol/l (57.9 - 154).

Based on the above mentioned data, we can see that the patient was administered the treatment of blocking the tumour metabolism for three times, without affecting the function of the thyroid gland.

There was no progression of the bone metastases. The patient can almost live a life for her age; she can walk with the assistance of the prosthesis and perform light works in the household.

We can conclude that administering the treatment of blocking the tumour metabolism not only prolonged the patient's life and relieved her suffering. It is also obvious that co-ordinating the treatment with surgeons may be beneficial to the patient.

**The patient has been living for 13 years since the first administration of the treatment of blocking the tumour metabolism.**

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## **Patient (female) No. 42: M. H., born in 1934**

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04.10.1995: Exploratory laparotomy was performed at the 3rd Clinic of Gynecology and Obstetrics, LFUK Bratislava.

#### **Diagnosis: Status after right salpingo-oophorectomy due to neurofibroma?**

The tumour of the left ovary. Metastases into the small bowel and parietal peritoneum, Ascites.

**Type of the procedure:** Left salpingo-oophorectomy. Extirpation of the tumour from the small bowel. Partial resection of the small bowel.

#### **Histological examination: Conclusion:**

**I. Parietal peritoneum - metastases of leiomyosarcoma.**

**II. Abdominal cavity - reactive changes.**

**III. Ovary - complete infiltration with leiomyosarcoma.**

**IV. Abdominal cavity - metastasis of leiomyosarcoma.**

V. small bowel - metastases of leiomyosarcoma.

*Assoc. Prof. Dr. J. Chabada, PhD, personal signature.*

*Head of the 3rd Clinic of Gynecology and Obstetrics.*

Because the patient refused treatment by radiotherapy and chemotherapy, she was released from the hospital and a symptomatic treatment was recommended.

### **19.12.1995: Control examination**

The patient complained of pain in the whole abdomen. RLN were not palpable. The thyroid gland was not enlarged, the sclerae were unicteric, breathing was decreased, without abnormal breath sounds, rhythm was regular. The abdomen: gas distension with marked palpable pain in the hypogastrum. I did not perform deep palpation. The inguinal regions were without resistance, the extremities were without swellings. BP: 135/80. At the patient's request, I administered the following therapeutic scheme:

**1. Carbimazole tab. , Flavobion tab., Important pulw., Biomín H pulv., analgetics**

2. Trypsin retard amp., Dithiaden amp. i.m.

3. NORGA amp. i.m. In the saturation and maintenance doses.

During the treatment, the patient's health condition was improving, pain was relieved, and the stools and urine were normal. The abdomen was soft, without pain, the liver was not enlarged, the inguinal regions were without resistance, ascites was not present.

**In the fifth month** of treatment, the thyroid gland was mildly, proportionally enlarged. Therefore I gradually discontinued Carbimazole. The patient was feeling well, she had no pain.

Ultrasound was normal. The CT scan was normal. Surgical examination: within normal limits. Laboratory results, including TSH, T3, T4, were all within normal limits.

**After 1 year, I discontinued the treatment.**

**22.01.1997: The follow up CT scan (plain + contrast, small pelvis)**

The uterus was small, 51 x 27 x 40 mm, in AVF; the contours of the organ were without rough irregularities. The left ovary was not easily distinguishable. The bladder wall was smooth, it was appropriately thick. Its content was clear. The tumorous masses in the small pelvis or enlarged lymph nodes in the pelvis were not observed. Ascites was not present. In the right inguinal region, the mildly enlarged lymph node, the marginal size of 12 mm was found. In the left inguinal region, the LN, the size up to 8 mm. The vagina was visualized in its upper half; the rectum was also without pathological changes. The skeleton and muscles of the pelvic floor were without pathological changes..

Conclusion: Marginally enlarged inguinal lymph nodes. Bilaterally. Presently, without obvious tumorous changes in the small pelvis.

*Dr. Drobáň, Komárno Hospital (NsP), personal signature*

**20.11.1997 Control examination**

The patient was feeling well, she was without pain, and the stools and urine were normal. The RLN were not palpable, the sclerae were unicteric, the thyroid gland was not enlarged. The heart: regular rhythm, no murmurs, without pathological phenomena. The abdomen was soft, palpable, without pain and palpable resistance. In both inguinal regions there were LN, the size of 1 cm. The extremities were without swellings. BP: 120/80.

**The patient has been living a normal life for her age for the last 2 years.**

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**Patient (female) No. 43: Š. J., born in 1958**

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**25.05.1992:** Excision of malignant melanoma in the region of the left scapula.

Radiotherapy and chemotherapy were not administered.

**Diagnosis: Malignant melanoma**

Severe pains in the scar region.

**16.06.1992:** At the patient's request, I administered the therapeutic scheme:

**1. Carbimazole tab., Flavobion tab., Biomin H, Calcium efferv. C tab.**

**2. Trypsín retard amp., Dithiaden amp., i.m. in the saturation and maintenance doses**

**3. NORGA amp., I.M., in the saturation and maintenance doses.**

The wound: first intention healing, mildly sensitive on palpation. During the treatment pain in the wound disappeared.

**February, 1993:** Abdominal ultrasound: Normal.

**X-ray of the spine: Negative.**

**March 1993:** Mild, diffuse enlargement of the thyroid, therefore I gradually discontinued Carbimazole.

Laboratory studies were normal. ESR: 5/12, T3: 1.20 nmol/l, T4: 60.5 nmol/l.

The patient is also followed up in the National Institute of Oncology (NOU) in Bratislava.

After 1 year, I discontinued the treatment.

In December and March of the following year I administered Norga 3 amp. i.m.

**10.09.1997: Follow up examination**

The patient is also followed up in the National Institute of Oncology (NOU) in Bratislava. They did not reveal recurrence of the main disease. The patient is feeling well, she has no pain, the stools and urine are normal, RLN are not palpable, the thyroid gland is not enlarged, the sclerae are unicteric. The heart and the lungs: regular rhythm, no murmurs, vesicular breathing, The abdomen: soft, palpable, painless, the liver is within the costal margin, the inguinal regions are without masses, the extremities are without oedema. In the region of the left scapula there is a wound after excision of the malignant melanoma, painless on palpation, without the reaction of the surrounding tissue.

**Laboratory studies:**

BP: 115/70, cholesterol: 5.96 mmol/l, glucose, urea, creatinine, proteins, bilirubin, AST, ALT, ALP, TG, total cholesterol, Na, K, Ca - all within the normal limits. ESR: 16/37, blood count: normal, s-TSH: 2.21 mU/l, T3: 1.51 nmol/l, T4: 93.9 nmol/l.

**The patient has been living a normal life for her age for the last 5 years.**

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## **Patient No. 44: K. V. born in 1956**

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**Žiar nad Hronom Hospital (NsP), Surgical Department.**

**10.02.1994:** Extended excision of the malignant melanoma in this region was performed.

**Diagnosis: Malignant melanoma** in the thoracic region near the sternum, on the right.

**Objective finding:** RLN are not palpable, the thyroid gland is not enlarged, the sclerae are unicteric, the axillae are without resistance. The heart and the lungs: regular rhythm, no murmurs, vesicular breath sounds. The abdomen: soft, palpable, the liver is within the costal margin. In the proximal part of the thorax on the right, near the sternum, there is a scar after radical excision of the malignant melanoma. The scar: first intention healing, without any reaction in the surrounding tissue.

A symptomatic treatment was recommended to the patient.

**18.03.1994:** At the patient's request, I administered the following therapeutic scheme:

**1. Carbimazole tab., Flavobion tab., Biomin H**

**2. Trypsín retard amp., Dithiaden amp. i.m. in the saturation and maintenance doses**

**3. NORGA amp. I.M., in the saturation and maintenance doses.**

During the treatment, the patient did not report any difficulty. The patient's health condition returned to normal, as well as the results of the laboratory studies. T3, T4, TSH: normal.

**After 12 months**, I gradually discontinued Carbimazole. ESR: 10/18, blood count: normal. I discontinued the treatment after one year.

An oncologist regularly follows up the patient.

Up to 1997, no evidence of recurrence of the main disease was revealed.

**The patient has been living a normal life for his age for the last 3 years.**

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## **Patient (female) No. 45 : Z. M., born in 1951**

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Zlín Hospital (NsP), Surgical Department:

**12.12.1994:** Radical excision of the malignant melanoma in the right lumbar region was performed.

**Histology: Malignant melanoma (Breslow 1.0 mm, Clark III)**

*Assoc. Prof. Páčovský, PhD.*

**07.01.1995: Follow-up examination**

The patient reported a feeling of tension in the wound.

RLN are not palpable, the thyroid gland is not enlarged, the sclerae are unicteric, the heart and the lungs: regular rhythm, no murmurs, vesicular breathe sounds. The abdomen: soft, palpable, the liver is within the costal margin, the axillae and the groins are without resistance, and the extremities are without oedema.

Because radiotherapy and chemotherapy was not recommended to the patient, on **07.01.1995**, at the patient's request, I administered the therapeutic scheme:

- 1. Carbimazole tab., Flavobion coated tab., Biomin H , Calcium efferv. C tab.**
- 2. Trypsín retard amp. Dithiaden amp., i.m. in the saturation and maintenance doses**
- 3. NORGA amp. I.M., in the saturation and maintenance doses.**

During the treatment the feeling of tension in the wound disappeared, the wound was well healed, without any reaction in the surrounding tissue. ESR: 10/27

22.05.1995      abdominal ultrasound: Normal.

*Dr. Hinčica, personal signature*

Chest x-ray: Normal.

*Dr. Povolná, personal signature*

**23. 05.1995: Laboratory results:** Blood count: Normal

ESR: 32/71, glucose, urea, creatinine, proteins, bilirubin, AST, ALT, GMT, ALP, TG, total cholesterol, Na, K, Ca - all within the normal limits. TSH: 1.66 mU/l, T3: 1.50 nmol/l, T4: 131 nmol/l.

**10.01.1996: The treatment was finished.**

**In 1997: Follow up examinations: No evidence of recurrence of the main disease.**



RLN are not palpable, the thyroid gland is not enlarged, the sclerae are unicteric, the wound is healed, the axillae are without resistance. The heart and the lungs: irregular rhythm, P: 67/min., decreased breathing, no added breath sounds are heard. The abdomen: soft, palpable, the liver is within the costal margin, the groins are without resistance. BP: 110/70.

**The patient has been living a normal life for her age for the last 2 years.**

## Treatment of mastopathia fibrosa

This disease is characterized by the formation of small cysts (mastopathia cystica) or lumps (mastopathia fibrosa). The mixed form (mastopathia fibrocystica) is also observed. It occurs either unilaterally, or bilaterally in the parenchyma of mammary glands. The mastopathy can occur solo or in several formations. The overproduction of estrogens is regarded as an etiological factor. It occurs in women over the age of 15. Rarely, this disease can also be observed in men. The female patients report pain in breasts during menstrual and premenstrual periods. One of the most frequent complaints is the fear of possible oncogenic disease. This fear can be intensified by the failure of standard treatment and enhanced by the possible failure of surgical intervention. The overproduction of estrogens and their impact on the mammary gland parenchyma leads to the development of fibrous changes in the parenchyma of the mammary gland in manner as described previously. Hand in hand with these changes, an inflammatory process in the adnexa may develop. Based on these facts, in 1980, I formulated the following therapeutic scheme for the treatment of fibrous mastopathy:

1. In order to control the possible adnexitis, I administered broad-spectrum antibiotics
2. Trypsin Retard 5 mg, which with its fibrinolytic effects cause resorption of the mastopathy nodes ad integrum.
3. In an attempt to support the immune system for the benefit of treatment, I administered the preparation Immunoglobulinum humanum normale (NORGA) 1.9 ml in 1 ampoule.

**The therapeutic scheme:**

### 1. Antibiotics (ATB)

**Trypsin retard amp** (a suspension of lyophilized Trypsin in olive oil, 5 mg Trypsin in 1 ampoule). **I must stress that allergy tests must be performed before administering this medicament** (0.3 ml intramuscularly into the distal third of thigh) because some patients can be allergic to trypsin or its vehicle (olive oil).

1st month:

2nd month:

3rd month:

In the following months in the saturation and maintenance doses as in the 3<sup>rd</sup> months.

(Add 3 ml of 1% Mesokain into the syringe to decrease pain of the injection provided it is not contraindicated).

### 2. NORGA (Immunoglobulinum humanum normale, 1.9 ml in 1 ampoule).

Immunoglobulinum humanum normale	273,6 mg
Proteinum	304 mg
Acidum aminoaceticum	42,8 mg
Natrii chloridum	13,3 mg
Tiomersalum	0,19 mg

3 ampoules of NORGA intramuscularly (im), once a fortnight, up to the total dose of 6-9 ampoules.

When the resorption occurs, which must be confirmed by the breast ultrasonography, we can discontinue the treatment. Usually, the treatment lasts 3 - 5 months.

Since 1980 I have treated 150 women and 4 men with the diagnosis of fibrous mastopathy. They refused a surgery although they were scheduled for it after they had failed to respond to the standard therapy or right after the confirmation of their fibrous mastopathy diagnosis.

I have treated another four female patients who had suffered from a recurrence of their disease after the surgery. Three of them had complications in the wound within 3 - 5 months after the surgery. The fourth one had recurrence of the disease in the contralateral breast 1 year after the surgery. The age of these patients ranged between 14 and 50 years.

In 1981 I treated two men. One had unilateral fibrous mastopathy; the second one had bilateral mastopathy. I treated two additional men in 1987 and in 1989. They all were completely cured.

**One female patient who had undergone my therapeutic procedure had a recurrence of the disease 3 years later in the contralateral breast. After a repeated application of my treatment, her condition returned to normal. Only six of my female patients had to undergo a surgery due to a failure of my therapeutic procedure. Most of these patients had cystic forms of mastopathy.**

I describe the treatment of only 20 patients because every physician can observe its beneficial effects on this disease in a very short time. The changes in mastopathy can be observed on palpation already in the 3<sup>rd</sup> week of the treatment due to the incipient resorption in the breast.

## PATIENT WITH MASTOPATHIA FIBROSA

*On this page I present only a few treated patient. Providing, that interested at information about treatment process big quantity patient, you can order my book [The treatment oncologic diseases the blockades metabolism tumours](#) in form electronic or in book edition on E-mail [mudr.kamil@jurkovic.sk](mailto:mudr.kamil@jurkovic.sk)*

### Patient (female) No. 1: S. M., born in 1946

1982 she was hospitalized at the Surgical Department, Šaľa Hospital (NsP Šaľa) with the following diagnosis: mastopathia fibrosa l. utr. (Bilaterally)

The breasts were hard, painful and there was tumorous resistance in both breasts.

Because the patient refused surgical treatment, she was released from the hospital to be treated at home.

Immediately after her release, at the patient's request, I administered the therapeutic scheme.

After three weeks of treatment: the breasts were soft, palpable, without pain, the tumorous resistance was mobile. After three months of treatment: patient's condition returned to normal, the breasts were without pathological resistance, the treatment was finished.

Control examination in 1997: The condition was within the normal limits, without any signs of recurrence of the main disease.

### Patient (female) No. 2: Ing. P. J., born in 1946

Diagnosis (Dg): Mastopathia fibrosa l. sin

10.03.1984: in the left breast there was a palpable resistance of the size 3 x 2.5 cm. The axillae were without resistance. At the patient's request, I administered the therapeutic scheme. 20.06.1984: The condition returned to normal, the breasts were soft, without pain, no mass was felt.

10.08.1987: The recurrence of the mastopathy structure in the right breast, there was a palpable resistance near the nipple, the size of 1.5 x 1.5 cm. The nipple and the axillae were without any mass.

10.08.1987: I administered the therapeutic scheme.

08.11.1987: The condition returned to normal, the breasts were soft, without pain. The treatment was finished. The results of subsequent examinations were normal.

### **Patient (female) No. 3: B. E., born in 1955**

Dg: Mastopathia fibrosa l. sin

In the right breast, at 9 o'clock there was a palpable mass, the size of 1.5 x 1.5 cm. Movement against the base is painful. The mamilla and the axillae were without resistance.

10.05.1985: I administered the therapeutic scheme.

14.09.1985: The condition returned to normal, the breast was soft, palpable, without any resistance. The treatment was finished. USG: Normal

### **Patient (female) No. 4: M. B., born in 1942**

Dg: Mastopathia fibrosa l. dx

10.06.1985: In the upper quadrant of the left breast there was a resistance, the size of 2.5 x 2.5 cm. The left breast and the axillae were without a mass.

At the patient's request I administered the therapeutic scheme.

After three weeks of treatment: the resorption of the mastopathy structure occurred.

20.09.1985: The condition returned to normal, the breast was soft, painless, the mamilla and the axillae were without resistance. The treatment was finished. USG: Normal

### **Patient (female) No. 5: K. J., born in 1955**

Dg: Mastopathia fibrosa l. dx

Near the nipple, in the proximal part, 3 cm from the mamilla, there is a mass, the size of 1.5 x 1.5 cm. The mamilla is without a mass; the axillae and the contralateral breast are normal.

15.02.1987: I administered the therapeutic scheme.

20.05.1987: The condition returned to normal, the breast is soft, palpable, and painless. The mamilla and the axillae are without resistance. The treatment is finished; the results of subsequent examinations were normal.

### **Patient (female) No. 6: V. M., born in 1956**

10.08.1992: diagnosis: mastopathia fibrosa l. sin, the size of 2 x 2 cm, proximally to the nipple. I administered the therapeutic scheme.

22.10.1992: Breast ultrasonography was normal, the breasts were soft, palpable, the axillae were without resistance..

### **Patient (female) No. 7: P. M., born in 1945**

14.01.1991: The surgeon verified TU mammae l. sin, at 12 o'clock, the size of 1 x 1 c. The patient was scheduled for surgery but then she refused.

Prior the treatment, the patient was referred to the gynecological examination. Conclusion: Uterus myomatosus, the average size of 5 cm.

At the patient's request, I administered the therapeutic scheme.

27.03.1991: Breast ultrasonography was normal. Surgical examination: The finding in both breasts was within the normal limits.

*Dr. Haninec, personal signature*

**15.03.1991: I quote the finding of the gynecologist: "the uterus is in AVF, the adnexa are without resistance, the finding does not require surgical intervention".**

*Dr. Kovac, personal signature*

### **Patient (female) No. 8: L.L., born in 1946**

Diagnosis: mastopathia fibrosa l. dx, the size of 1.5 x 1.5 cm

03.01.1992: I administered the therapeutic scheme. 14 days later, the topical reaction after the puncture was observed. Therefore I administered Trypsin Retard, orally.

28.04.1992: mammography: A small structure in the right breast. I continued with treatment. 1.09.1992: The condition returned to normal, the breasts were soft, painless, without a mass, the axillae were without resistance.

7.02.1993: Follow up mammography: Negative finding.

*Dr. Torok, personal signature*

### **Patient (female) No. 9: B. A., born in 1953**

Diagnosis: mastopathia fibrosa l. sin., the size of 1.5 x 1.5 cm.

12.6.1992: I administered the therapeutic scheme.

15.10.1992: The condition returned to normal, the breast was soft, the mamilla was without a mass.

### **Patient No. 10: B. M., born in 1976**

Diagnosis: mastopathia fibrosa l. sin, with the positive reaction in the left axilla where there is a palpable lymphatic node, the size of 1 x 1 cm.

17.06.1992: At the patient's request I administered the therapeutic scheme.

1.10.1992: The condition returned to normal, the breast was painless, without a mass, the axilla was without any resistance.

## **Discussion regarding the treatment of fibrous mastopathy**

In 1980, when I started with formulating a therapeutic scheme for the treatment of fibrous mastopathy, as well as presently, the most effective therapy of this disease was surgical intervention. To treat this disease is very difficult because, first of all, we have to exclude the neoplastic process in the breast.

Diagnostic biopsies and excisions are frequent diagnostic methods used in making the diagnosis of fibrous mastopathy.

During my 17 years of practice I have come to the conclusion that mastopathy, which was diagnosed by the above mentioned methods, had to be treated by my therapeutic scheme much longer, and the treatment was not always 100 percent successful.

The reason is that the mastopathy structure had been altered by the biopsy or excision and the subsequent healing process may form a scar, which with difficulty responds to treatment by resorption. This process may also trigger the malignant explosion of a not yet malignant mastopathy structure.

Biopsies, which were performed at one or two-year intervals, can even worsen the prognosis and the treatment of the disease. When the situation requires, I also advocate extirpation of the mastopathy structure and a subsequent histological examination and further treatment. The negative attitude of female patients towards diagnostic methods is not so rare, with the exception of ultrasonography and mammography of the breast.

In female patients who refuse any instrumental diagnostic procedure into the breast, I administer my therapeutic procedure as a diagnostic procedure at the same time.

Based on my experience, I would like to suggest that it might be beneficial to cooperate with the team of experts in pediatrics and try to treat

### ***The fibrous degeneration of the lungs in children.***

The effects of Trypsin retard could reverse or substantially alleviate the course of this disease.

## **Conclusion**

The above-mentioned therapeutic scheme can be fully used as both the diagnostic and therapeutic procedures in female patients who refuse to undergo instrumental diagnostic procedures.

As early as in the second or third week of treatment we can by palpation observe the positive effects of treatment of the mastopathy structure: softening of breast and initial resorption of mastopathy structure.

We can conclude that the above-mentioned therapeutic scheme for the treatment of fibrous mastopathy does not interfere with the hormonal system of the organism and is capable of curing the mastopathy structure in females and in men ad integrum.

In case of recurrence after years in the contralateral or unilateral breast, we can administer this therapeutic scheme again.

### **Evaluation of the treatment of fibrous mastopathy**

Women.....	150
Men.....	4
Successfully cured.....	148

## **Patient (female) No. 21: G. J., born in 1947**

**Diagnosis:** Pulmonary fibrosis, suspected tumour of the liver, status post biopsy of the lungs - Klassan's procedure). The patient was hospitalized at the Department of Pulmonary Diseases in Podunajske Biskupice from 10.08.1992 to 02.09.1992.

She had fever 39°C for ten days. When leaning forward, pain from the right side of the chest radiated to the left side. She was dyspnoeic due to minimum work. Increased mucus accumulation, she could not expectorate, aponia. Headaches, vertigo, arthralgia, pain in the muscles and swellings in the thigh muscles. The patient's condition became worse in the evening. Eight days ago, she suffered from sharp pain in the epigastrium and in the right hypochondriac region. Anorexia. ESR: 60/83. Leu: 15.6, ASLO, LATEX: negat., ultrasound of the liver: The liver was behind the costal margin, the left lobe was enlarged, its echogenicity was changed in terms of hypo and hyperdensity. Therefore I recommended CT scan of the abdominal organs.

### **13.08.1992: CT scan of the abdomen**

In the caudal part of the left lobe of the liver we could observe an unhomogenous structure of the low density and unclear contours. It did not become better differentiated even after intravenous administering of the contrast medium.

**Chest X-ray:** Increased bronchovascular pattern, there was a confluent, spotted picture, especially paracardially, in the right, low lung field, the diaphragm was difficult to evaluate on the right. Small shadows in the lung parenchyma peripherally. Recommended medication: Prednisone, Cefamezine, and analgesics.

*Dr. Havelka, Head of the department, personal signature.*

**28.09.1992:** The patient was feeling weak, dyspnoeic after minimum work, exhaustive cough, severe pain in the right part of the thorax and in the epigastrium. Objective finding: vesicular breath sounds were decreased, wheezes were present bilaterally, decreased bilaterally near the hilum, on the right and near the base, a short percussion sound. By palpation, there was marked tenderness near the wound after surgery on the base of the lungs on the right side and in the costal region XI-XII, a mass in the epigastrium was expanding to the right hypochondrium, there was tenderness of the extremity muscles and LS region. Body temperature was from 38-39°C. With regard to unclear etiology of the liver tumour and a mass in the epigastrium on palpation, at the patient's request, I administered the following therapeutic scheme:

- 1. Carbimazole, Flavobion, Calcium efferv. C, Biomín H, Indomethacin (Prednison gradually discontinued), analgesics, cardiotonics, expectorants,**
- 2. Trypsin Retard amp., Dithiaden amp., Thiamin amp., Oxyphyllin amp. i.m. in the saturation and maintenance doses,**
- 3. NORGA amp. in the saturation and maintenance dose.**

**During the first two months of treatment the patient's health condition was gradually improving.**

**16.01.1993:** There was a diffuse enlargement of the thyroid gland, therefore Carbimazole was discontinued. The rest of treatment continued according to the therapeutic plan. The patient's health condition was improving, pain diminished to minimum, her appetite was good, by palpation no mass was felt in the epigastrium, the liver was behind the costal margin.

**03.06.1996: Chest x-ray:** The lungs were without pathological changes; there was mildly increased bronchovascular pattern on the right, paracardially. The right diaphragm's position was higher - in the middle part the upper margin it reached the sixth rib. In the lateral part it could not be differentiated because of the confluent shadow in the external angle.

*Dr. Kadráš, personal signature*

**20.09.1993: The conclusion regarding the findings of the Department of functional diagnostics of IVZ:** Without ventilation disorder, decreased vital capacity of the lungs, the specific resistance of the respiratory airways was within normal limits, pulmonary hyperinflation was not present. Dif. capacity for CO was reduced to 19, i.e. to 72.6% of the refraction value, without the decrease related to the alveolar volume. Normoxaemia and normocapnia. When compared with the previous examination of 7.07.1992, the vital capacity (VC) further decreased by 300ml, however, the diffuse capacity for CO improved by 12%.

*Dr. Hajkova, Dr. Urban, personal signatures*

The patient's health condition returned to normal. The laboratory findings were normal.

The patient has been living a normal life for her age for 5 years.

## INFORMATION ABOUT THE BOOK

# THE TREATMENT ONCOLOGIC DISEASES THE BLOCKADES METABOLISM TUMOURS

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**Kamil Jurkovič was born on 11th February 1937 in Chorvátsky Grob near Bratislava. He finished the secondary grammar school in Bratislava in 1955. In 1961 he graduated from the Medical Faculty, Comenius University in Bratislava. First he worked as a medical corps doctor and since 1967 he has been working as a general practitioner in the district of Trenčín. In 1973, using the medicines approved by state authorities, he developed the medical treatment by which he has been successfully treating oncological diseases for almost three decades.**

### *Dr Jurkovič`s Patients*

#### **Group 3.1.1. – Living (state at the end of 1999)**

Patient no.	Type of malignant tumour	Histology	Metastases	Preceding surgical treatment	Man/woman marked 1/10	Age beg.	Living (years)	ET treatment (years)
1	Ovary cystadenoCa							
2	Pancreatic nesidioblastoma	1	0	0	0	53	16	6
3	Pancreatic adenoCa							
4	Leiomyosarcoma colon	1	1	0	1	24	5	1
5	Angiosarcoma pedis							
6	Leiomyosarcoma ovaria	1	1	0	0	73	2	1
7	Stomach adenoCa							
8	Stomach adenoCa	0	1	0	0	72	4	4
9	Stomach cancer							
10	Ca caeci	0	1	0	0	52	13	1
11	Ca rectum							



12	AdenoCa rectum	1	1	1	0	61	2	1
13	AdenoCa ileocaeca							
14	AdenoCa rectum	1	1	1	1	57	7	1
15	AdenoCa colon							
16	AdenoCa rectum	1	0	1	0	48	2	1
17	AdenoCa colon	0	0	1	0	65	5	1
18	AdenoCa colon	1	0	1	1	54	5	1
19	AdenoCa colon	1	0	0	0	69	5	1
20	Ca colon	1	0	0	0	49	21	1
21	Ca sigmae							
22	AdenoCa uterus	1	1	1	1	29	11	1
23	AdenoCa uterus	1	0	0	0	45	16	1
24	Adeno uterus	1	0	1	1	75	6	1
25	Papillary Ca vesicae ur.	1	1	0	1	56	13	
26	Seminoma testis	1	0	1	1	52	3	1
27	Embryonal Ca testis	1	1	1	1	48	2	2
28	Neopl. Renis (Grawitz)	0	0	1	0	39	3	1
29	AdenoCa vesicae ur.	1	0	1	0	68	1	1
30	Ca vesicae ur.	0	1	1	1	75	1	1
31	Ca vesicae ur.	1	0	1	0	36	5	
32	Ca vesicae ur.	1	0	1	0	58	5	1
33	Grawitz	1	0	0	0	45	5	1
34	Ca larynx							
35	Ca linguae	1	0	1	0	57	2	
36	Adeno Ca mammae	0	0	1	1	31	5	1
37	Ca mammae							
38	Ca mammae	1	0	1	1	19	5	1
39	AdenoCa mammae							
40	Ca mammae	0	0	1	1	44	6	1
41	Melanosarcoma							

42	Melanoma	1	0	1	1	45	22	1
43	Melanoma	0	0	0	1	49	9	1
44	Small-cellular lung Ca	1	0	0	1	53	4	1
45	Small-cellular lung Ca	0	0	0	0	72	5	1
46	Spinocellular lung Ca	0	1	1	0	51	1	1
47	Gigantocel. lung Ca	1	0	0	1	57	6	1
		0	1	1	1	56	5	1
		1	0	1	0	54	5	1
		1	1	1	0	44	17	1
		0	0	1	0	51	5	1
		1	0	1	0	61	7	1
		0	0	1	0	33	4	1
		0	0	1	0	34	5	1
		0	0	1	1	38	3	1
		1	0	1	0	43	2	1
		1	1	0	0	47	12	1
		1	0	0	1	55	8	1
		1	0	0	1	60	8	1
		1	0	0	1	65	1	
<b>Sum</b>		<b>32</b>	<b>14</b>	<b>29</b>	<b>21</b>			
<b>Mean</b>						<b>51.5</b>	<b>6.5</b>	<b>1.2</b>
<b>SEM</b>						<b>1.9</b>	<b>0.8</b>	<b>0.1</b>

**Group 3.1.2. – Died from secondary diseases or old age – state at the end of 1999.**

Patient no.	Type of malignant tumour	Histology	Metastases	Preceding surgical treatment	Man/woman marked 1/10	Age beg.	Lived (years)	ET treatment (years)
1	Lung Ca	0	0	0	1	61	13	
2	Ilea Ca	1	0	0	1	49	17	1
3	Stomach Ca	0	0	1	0	70	6	1
4	Lung Ca	0	0	0	1	73	8	1
5	Lung Ca	0	0	1	1	43	1	1
6	AdenoCa uteri	1		1	2	60	17	1
7	Ca vesicae ur.	1	0	1	1	60	4	1
8	Stomach Ca	0	0	0	0	79	6	1
9	Recti Ca	0	1	0	1	58	5	1
10	AdenoCa recti	1	0	0	1	53	8	1
11	Ovary adenoCa	1	0	1	0	76	3	1
12	Ca mammae	0	0	0	0	82	3	1
<b>Sum</b>		<b>5</b>	<b>1</b>	<b>5</b>	<b>9</b>			
<b>Mean</b>						<b>63.7</b>	<b>7.6</b>	<b>1</b>
<b>SEM</b>						<b>3.6</b>	<b>1.5</b>	<b>0</b>

**Group 3.1.3. – Died from the extensiveness or recurrence of the basic disease – state at the end of 1999.**

Patient no.	Type of malignant tumour	Histology	Metastases	Preceding surgical treatment	Man/woman marked 1/10	Age beg.	Lived (years)	ET treatment (years)
1	Mesotelioma	1	1	1	0	41		1
2	Stomach adenoCa							
3	AdenoCa recti	1	1	1	0	64	2	1
4	Colon Ca	1	0	0	0	42	6	1
5	Grawitz	1	1	1	1	48	4	1
6	Pancreatic tu	1	0	1	1	55	2	1
7	Liver Ca	0	1	0	1	59	1	1
8	Stomach Ca	1	0	0	1	39		1
9	Stomach adeno Ca	0	0	0	1	49	1.5	1.5
10	AdenoCa recti							

		1	0	1	1	37	1	1
		1	0	0	1	63	3	1
<b>Sum</b>		<b>8</b>	<b>4</b>	<b>5</b>	<b>7</b>			
<b>Mean</b>						<b>49.7</b>	<b>2.6</b>	<b>1.1</b>
<b>SEM</b>						<b>3.2</b>	<b>0.6</b>	<b>0.1</b>

## Tumours of the digestive tract (stomach, colorect.)

Patient no. <i>Living</i>	Type of malignant tumour	Histology	Metastases	Preceding surgical treatment	Man/woman marked 1/10	Age beg.	Lived (years)	ET treatment (years)
4	Colon leiomyosarcoma							
7	Stomach adenoCa	0	1	0	0	72	4	4
8	Stomach adenoCa	1	1	1	1	57	7	1
9	Stomach Ca	1	0	1	0	48	2	1
10	Caeci Ca	0	0	1	0	65	5	1
11	Rectum Ca	1	0	1	1	54	5	1
12	Rectum AdenoCa	1	0	0	0	69	5	1
13	Ileocaeca adenoCa	1	0	0	0	49	21	1
14	Rectum adenoCa	1	1	1	1	29	11	1
15	Colon adenoCa	1	0	0	0	45	16	1
16	Rectum adenoCa	1	0	1	1	75	6	1
17	Colon adenoCa	1	1	0	1	56	13	
18	Colon adenoCa	1	0	1	1	52	3	1
19	Colon adenoCa	1	1	1	1	48	2	2
20	Colon Ca	0	0	1	0	39	3	1
21	Sigmae Ca	1	0	1	0	68	1	1
		0	1	1	1	75	1	1
<b>Sum</b>	<b>16</b>	<b>12</b>	<b>6</b>	<b>11</b>	<b>8</b>			
<b>Mean</b>						<b>56.3</b>	<b>6.6</b>	<b>1.3</b>

SEM						3.4	1.4	0.2
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Patient no. <i>Not living</i>	Type of malignant tumour	Histology	Metastases	Preceding surgical treatment	Man/woman marked 1/10	Age beg.	Lived (years)	ET treatment (years)
2	Ilea Ca	1	0	0	1	49	17	1
3	Stomach Ca	0	0	1	0	70	6	1
8	Stomach Ca	0	0	0	0	79	6	1
9	Rectum Ca	0	1	0	1	58	5	1
10	AdenoCa recti	1	0	0	1	53	8	1
2	Stomach adenoCa							
3	Rectum adenoCa	1	1	1	0	64	2	1
4	Colon Ca	1	0	0	0	42	6	1
8	Stomach Ca	1	1	1	1	48	4	1
9	Stomach adenoCa	0	0	0	1	49	1.5	1.5
10	Recti adenoCa	1	0	1	1	37	1	1
		1	0	0	1	63	3	1
								1
								1
<b>Sum</b>	<b>11</b>	<b>7</b>	<b>3</b>	<b>4</b>	<b>7</b>			
<b>Mean</b>						<b>55.6</b>	<b>5.4</b>	<b>1.0</b>
<b>SEM</b>						<b>3.8</b>	<b>1.3</b>	<b>0.0</b>

In the historical control group, the median of survival in patients with an advanced form of stomach carcinoma is 316 days.

## Lung tumours

Patient no. <i>living</i>	Type of malignant tumour	Histology	Metastases	Preceding surgical treatment	Man/woman marked 1/10	Age beg.	Lived (years)	ET treatment (years)
44	Small-cellular lung Ca	1	1	0	0	47	12	1
45	Small-cellular lung Ca	1	0	0	1	55	8	1

46	Spino-cellular lung Ca	1	0	0	1	60	8	1
47	Giganto-cel. lung Ca	1	0	0	1	65	1	
<b>Sum</b>	<b>4</b>	<b>4</b>	<b>1</b>	<b>0</b>	<b>3</b>			
<b>Mean</b>						<b>56.8</b>	<b>7.3</b>	<b>1</b>
<b>SEM</b>						<b>3.8</b>	<b>2.3</b>	<b>0</b>

Patient no. <i>Not living</i>	Type of malignant tumour	Histology	Metastases	Preceding surgical treatment	Man/woman marked 1/10	Age beg.	Lived (years)	ET treatment (years)
1	Lung Ca	0	0	0	1	61	13	
4	Lung Ca	0	0	0	1	73	8	1
5	Lung Ca	0	0	1	1	43	1	1
<b>Sum</b>	<b>3</b>	<b>0</b>	<b>0</b>	<b>1</b>	<b>3</b>			
<b>Mean</b>						<b>59.0</b>	<b>7.3</b>	<b>1</b>
<b>SEM</b>						<b>8.7</b>	<b>3.5</b>	<b>0</b>

In the historical control group, the median of survival in patients with an advanced form of small-cellular lung carcinoma is 10-15 months, 5% live 2 years.

## Urogenital tumours – kidneys-urinary bladder

Patient no. <i>living</i>	Type of malignant tumour	Histology	Metastases	Preceding surgical treatment	Man/woman marked 1/10	Age beg.	Lived (years)	ET treatment (years)
25	Papillary vesicae ur. Ca	1	0	1	0	57	2	
28	Neopl. Renis (Grawitz)	0	0	1	1	44	6	1
29	Vesicae ur. adenoCa	1	0	1	1	45	22	1
30	Vesicae ur. Ca	0	0	0	1	49	9	1
31	Vesicae ur. Ca	1	0	0	1	53	4	1
32	Vesicae ur. Ca	0	0	0	0	72	5	1
33	Grawitz	0	1	1	0	51	1	1

<b>Sum</b>	<b>7</b>	<b>3</b>	<b>1</b>	<b>4</b>	<b>4</b>			
<b>Mean</b>						<b>53</b>	<b>7</b>	<b>1</b>
<b>SEM</b>						<b>3.6</b>	<b>2.7</b>	<b>0</b>

Patient no. <i>Not living</i>	Type of malignant tumour	Histology	Metastases	Preceding surgical treatment	Man/woman marked 1/10	Age beg.	Lived (years)	ET treatment (years)
7	Vesicae ur. Ca	1	0	1	1	60	4	1
5	Grawitz	1	0	1	1	55	2	1
7	Kidney Ca	1	0	0	1	39		1
<b>Sum</b>	<b>3</b>	<b>3</b>	<b>0</b>	<b>2</b>	<b>3</b>			
<b>Mean</b>						<b>51.3</b>	<b>3</b>	<b>1</b>
<b>SEM</b>						<b>6.3</b>	<b>1</b>	<b>0</b>

In the historical control group, the median of survival in patients with an advanced form of urinary bladder carcinoma is 4.5 years.

## Urogenital tumours – ovaries + testis

Patient no. <i>living</i>	Type of malignant tumour	Histology	Metastases	Preceding surgical treatment	Man/woman marked 1/10	Age beg.	Lived (years)	ET treatment (years)
1	Ovary cystoadeno Ca	1	0	0	0	53	16	6
6	Ovary leiomyosarcoma	1	1	1	0	61	2	1
22	AdenoCa uterus	1	0	1	0	36	5	
23	AdenoCa uterus	1	0	1	0	58	5	1
24	AdenoCa uterus	1	0	0	0	45	5	1
26	Seminoma testis	0	0	1	1	31	5	1
27	Embryonal Ca testis	1	0	1	1	19	5	1
<b>Sum</b>	<b>7</b>	<b>6</b>	<b>1</b>	<b>5</b>	<b>2</b>			

<b>Mean</b>						<b>43.3</b>	<b>6.1</b>	<b>1.8</b>
<b>SEM</b>						<b>5.8</b>	<b>1.7</b>	<b>0.8</b>

Patient no. <i>Not living</i>	Type of malignant tumour	Histology	Metastases	Preceding surgical treatment	Man/woman marked 1/10	Age beg.	Lived (years)	ET treatment (years)
6	AdenoCa uterus	1		1	2	60	17	1
11	Ovary adenoCa	1	0	1	0	76	3	1
<b>Sum</b>	<b>2</b>	<b>2</b>	<b>0</b>	<b>2</b>	<b>2</b>			
<b>Mean</b>						<b>68</b>	<b>10</b>	<b>1</b>
<b>SEM</b>						<b>8</b>	<b>7</b>	<b>0</b>

In the historical control group, 20% of patients treated for an advanced form of ovary tumour live 5 years.

## Mamma (breast) tumours

Patient no. <i>living</i>	Type of malignant tumour	Histology	Metastases	Preceding surgical treatment	Man/woman marked 1/10	Age beg.	Lived (years)	ET treatment (years)
36	AdenoCa mammae	1	0	1	0	54	5	1
37	Ca mammae	1	1	1	0	44	17	1
38	Ca mammae	0	0	1	0	51	5	1
39	AdenoCa mammae	1	0	1	0	61	7	1
40	Ca mammae	0	0	1	0	33	4	1
<b>Sum</b>	<b>5</b>	<b>3</b>	<b>1</b>	<b>5</b>	<b>0</b>			
<b>Mean</b>						<b>48.6</b>	<b>7.6</b>	<b>1</b>
<b>SEM</b>						<b>4.8</b>	<b>2.4</b>	<b>0</b>

Patient no. <i>Not living</i>	Type of malignant tumour	Histology	Metastases	Preceding surgical treatment	Man/woman marked 1/10	Age beg.	Lived (years)	ET treatment (years)
12	Ca mammae	0	0	0	0	82	3	1



<b>Sum</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>			
<b>Mean</b>						<b>82</b>	<b>3</b>	<b>1</b>

**In the historical control group, the median of survival in patients treated for an advanced form of mamma (breast) carcinoma is 10-15 months.**

## Others

Patient no. <i>living</i>	Type of malignant tumour	Histology	Metastases	Preceding surgical treatment	Man/woman marked 1/10	Age beg.	Lived (years)	ET treatment (years)
2	Pancr. Nesidioblastoma	1	1	0	1	24	5	1
3	Pancreatic adenoCa	1	1	0	0	73	2	1
5	Angiosarcoma pedis	0	1	0	0	52	13	1
34	Laryngal Ca	1	0	0	1	57	6	1
35	Ca linguae	0	1	1	1	56	5	1
41	Melanosarcoma	0	0	1	0	34	5	1
42	Melanoma	0	0	1	1	38	3	1
43	Melanoma	1	0	1	0	43	2	1
<b>Sum</b>	<b>8</b>	<b>4</b>	<b>4</b>	<b>4</b>	<b>4</b>			
<b>Mean</b>						<b>47.1</b>	<b>5.1</b>	<b>1</b>
<b>SEM</b>						<b>5.5</b>	<b>1.2</b>	<b>0</b>

Patient no. <i>Not living</i>	Type of malignant tumour	Histology	Metastases	Preceding surgical treatment	Man/woman marked 1/10	Age beg.	Lived (years)	ET treatment (years)
1	Mesotelioma	1	1	1	0	41		1
6	Pancreatic tu	0	1	0	1	59	1	1

<b>Sum</b>	<b>2</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>1</b>			
<b>Mean</b>						<b>50</b>	<b>1</b>	<b>1</b>
<b>SEM</b>						<b>9</b>		<b>0</b>