P5 Protocols – Dr. Abdul Slocum

[00:00] DLE – Welcome to P5 Protocols, where we seek out practitioners and researchers who are materially helping people now! Our mission is to provide you with the answers to two age old dilemmas of: I'm Sick, Now What?! and…. "I seriously need to improve my life, what the heck do I do?"
We do not provide medical nor high-performance advice, but we do introduce you to people, companies and ideas that help some, may help many and certainly give hope!
We are at the verge of figuring out what best works for each and everyone of us - so we hope you will keep joining us in our journey through this world of healing and high performance at www.p5protocols.com or @p5health on Twitter

I recently had the pleasure of speaking with Abdul Slocum of the Chemothermia clinic in Istanbul, Turkey. I first heard of Dr. Slocum through Dr. Thomas Seyfried, who, last year, was guest #2 on the P5 Protocols podcast. Dr. Seyfried had just come back from a conference where Dr. Slocum had presented and had reams of data, pictures and scans of patients who had done particularly well on his protocols that mixed traditional therapies with metabolic support such as HBOT, a ketogenic diet (as also used by Dr. Kris Smith who was in Episode 14), insulin before chemo, hyperthermia (meaning high heat) and other methods. You can find the team, multiple testimonials and the basics of their approach at Chemothermia at www.chemothermia.com. Their data, which we have not verified but some of which has been published, has led to a longer and higher quality of life for many; though note that most of their patients already are stage IV when they arrive and thus often come to them when near hospice care. Dr. Slocum and his team never promise full health, but assuming their reported outcomes are accurate, they are materially better than typical western care. Certainly, there are many ideas to consider that in many types of cancer have been shown to improve outcomes - such as the ketogenic diet - which has been used by even some major medical institutions for over 50 years.
On a side note, the quality of this podcast is quite poor. I could not get to Dr. Slocum and he does not typically come to the U.S. Going to our website and getting the transcript may be your best bet! I promise you: no more podcasts of this audio quality! And with that, here is my interview with Dr. Abdul Slocum of the Chemothermia Clinic in Istanbul Turkey.

[02:44] Welcome to the next edition of P5 protocols. I am very fortunate to have here today Dr. Abdul Slocum who is an oncologist in Istanbul, Turkey and has a what I would call a more advanced approach to treating cancer that is inclusive of both theories and before I go any further I'm actually going to introduce you here. Thank you for joining me.

[03:18] [AS] Thanks David, thanks for having me.

[08:18] [DE]. It's a pleasure. And especially because the other people who we had last fall on our podcast keep referring to you and the results you're having. And so you know, you and I've had several conversations leading up to this so I'm just very excited to finally have you on the show.

AS – thank you

DE - So I'd love it if you could start and give us a background of you briefly. You are originally from the US even though you grew up in Turkey and perhaps just briefly give us your background and how you came to your approach and that would be a great way to just set things up for our audience.

[04:19] [AS] I am Dr. Abdul Slocum from Istanbul Turkey. I am originally from about the United States, my family came to Istanbul many years ago. I was born and grew up in Istanbul. I completed my medical education in Istanbul also. [2.7] Besides myself, I'd like to introduce our clinic and our team. We are the Chemothermia Oncology Center located in Istanbul. Our clinic was mainly founded by two physicians, Professor Prof. Bulent Berkarda and Asst. Prof. Mehmet Salih İyikesici and also are medical oncologists and I like to also show and explain these two physician's history, especially for Dr. Berkarda. he is right now 87 years old and he is the first medical oncologist of the Turkish nation and founded oncology in Turkey back in the 70's. He completed his American oncology residency in the United States at University of Rochester. He came to his homeland and founded oncology in Turkey. Now how did we come to apply such therapies. Now Professor Barcarda is a practicing oncology right now, for over 40 year or so and Dr Iyikesici is also practicing oncology for over 20 years. How did we come to this, the main thing is all of us have come to a point of being dissatisfied with the outcomes achieved by the standard protocols and started asking questions. We believed in the treatments that we applied such as conventional therapies but we also saw the shortcomings. So we started asking questions: the main question was "how can we improve our outcomes?" and then we started reading. We read research publications and the history behind cancer and how the story behind all of the therapies. Around this, we came across metabolic theories behind cancer, which was first explained by Otto Warburg in the 1920's and we believed in his theories and started reading about the subject. And he has a book on this theory…

We came about a treatment protocol that provides treatments, both genetics approach to cancer cells but also mainly a metabolic dis-regulation that's seen in these cells also. So what I can say is we, as a team believe in conventional medicine and that cancer is a genetic disease, we believe in this also – that cancer cells…[mutate] from other cells and have more treatment we see genetic defects from normal cells; meanwhile what we say is that these defects are downstream effects from metabolic dysregulation seen in cancer cells also. So what this means for effective treatment is the main targeting of this metabolic dysregulation which we do while targeting downstream genetic defects seen in these cells with conventional therapeutics. So, with our treatment, we combine treatments that target genetic defects but also target metabolic dysregulation so when we combine the metabolic hypothesis of cancer together with the genetic hypothesis of cancer also in our treatment and that is the main uniqueness of our clinic as conventional physicians we both apply conventional therapies and also complementary therapies that metabolic dysregulation of cancer cells

DLE - As I mentioned in the call we had I think back in June that some people have said that your preference would to just be using metabolic approaches as you said in that call that is not the case at all. Maybe… Go go ahead.

AS - We have many questions that come across us about this and in our experience and what we can say is that in our experience is that there is a war against cancer and this war is not being won. So what we say is that to win the war we have to combine every therapy that is reported to be beneficial. Everybody must leave their feelings and personal preferences aside and combine everything that can be beneficial to win the war. So, in our experience we see / use at the current that all conventional therapies are beneficial. Meanwhile, we also see and extensively use complementary therapies such as something that seems very basic… but which we find very important. We use hypothermia and hyperbaric oxygen, we use supplements. This is as a basic example. Cancer is a disease to harm the person…. Now this is just like fighting a professional boxer.

We should consider which is just like fighting a professional boxer. Cancer is a professional boxer and I have never trained in fighting. So, if I fight him alone, the boxer will knock me out. Meanwhile, you, me, maybe a couple of other guys get together, we can knock the guy out. Somebody that seemed to be

very big, which may be, can be an example…. Can be a very small thing – when these small things get together can be a big strength against a disease. When these small things are gathered up together, this big guy can be knocked out.

[12:24] DLE - That's a great analogy. So, I'd love to briefly talk about the types of patients you get and then get into the actual protocol that you use; and I know you adapt it to each patient, [AS: of course] but love to… maybe start with who comes to you. It's far. Istanbul is far.. more far I think not in distance but in time and energy of travel especially for someone ill.

[12:55] AS – Of course, what I can say is we have patients from everywhere, from United States, form Europe, from our home country, Turkey, from China, New Zealand, Australia, Israel, everywhere. Meanwhile, percentage wise, Turkish is 50% / international patients 50%. Country-wise around 75 percent of international patients are a four hour flight [or closer] and 25% are from farther. Some conditions – distance can be important. Aesthetic cancer surgeries – distance can be important.... Generally, distance is not much of a concern for such patients if their well-being is good enough to fly. If the patient is fit to fly, no matter the distance, they come. And about, disease condition, around, over 80% or 90% are Stave IV patients; unfortunately… and because patients start looking for more therapies after progressing under standard treatments, they find us.

AS – We wish they had found us much sooner after initial diagnosis; they find us after more advancing. We accept them and try to be helpful to whoever comes.

[20:26] DLE - And so of the Stage IV, I think you said earlier in a previous conversation a lot of them have had, the majority of them have had a lot of treatments are ready to their US. So a lot of them presumably are coming to you in a weakened state.

[15:46] AS – Yes, yes, of course. Generally, our patients, most of our patients are patients that have received prior treatments and they progress under standard therapies and have come to us for treatment. Of course, these patients, because they have recurrent disease they have resistance issues also. In our treatment, what you see is sometimes a patient – a patient comes at such a stage that they receive [any possible] drug, maybe chemotherapy or immunotherapy – so all of our drug choices have already been used and applied to the patient, but sometimes starting the patient out with the same chemotherapy protocol that they have already received before but in our application method the same chemotherapy combined with our complementary therapies. Sometimes even though the patient has received the same drugs (they received) as before and progressed on it, in our application, with this combined treatment principle, sometimes, they respond very well and go into remission.

[17:14] AS – Because on our protocol, the drug choice for chemotherapy is very important. We are applying many treatments together. This is a totally different approach, it is just like the analogy to the boxer – where together we might knock him out. So drug choice is important, but even with a patient that had progressed on a treatment, even if they received the same drugs, they have a chance and have seen many patients to respond to such a protocol.

[18:17] DLE – OK, so you have you have patients, they come to you, or a patient comes to you, and they are stage 4, and they're going to get your combination of therapies. First of all, just talk briefly… when you sit down with the patient because I imagine a lot of them are upset (and) they don't want to be on chemo anymore. What is the other difference in terms of side effects, when someone comes to you, and they get the same chemotherapy, and yet you give them supportive treatment do they typically have much fewer side effects as my understanding or yes.

[18:59] AS - Now this is an important question. Now when a patient comes to us or goes to any health center, what do people want? People go to a medical center to feel better actually and live longer. When a patient comes to us, we tell them that we are on the same side of the table. We have a disease against us that we want to fight together. In our experience, when we apply chemotherapy together with complementary therapies, almost all of our patients respond much better compared to their prior experience with chemotherapy. Because many patients are in advanced stage, Most of them come to us in severe pain, and that more chemo … in our treatment protocol, most of these patients, some of them respond so quickly that they are off all of their pain medication. We see this very frequently. Side effects nausea, pain, cancer is not seen, can be seen, it is seen much less compared to standard treatments. So it can be better tolerated.

[21:00] DLE – And so, as you said earlier, you are still a big believer in using the treatments but your range, the amount of chemo that you may give, can you explain the approach you use there?

[21:11] AS – Now, what we do is we combine conventional chemotherapy… Our chemotherapy application method is different from standard chemotherapy. We have applied chemotherapy in a metabolically supported fashion. Its name is metabolically supported chemotherapy. What is this? This, the patient, has tried conventional chemotherapy…. This combines insulin application prior to the chemotherapy application. The patients come into our clinic for the chemotherapy application. We check their blood sugar levels, and apply insulin to get the blood sugar to get the insulin levels even lower to cause metabolic stress on the cancer cells. Dosage wise, for every chemotherapy drug, there is a dose range… for each diagnosis. For this diagnosis, you will use this medication between 60 mg/m2 to 100mg/m2. So, there is a dose range. Generally, we prefer the lowest dose recommended… So, we apply treatment in the dose range recommended by guidance. Meanwhile, … dose application is the physicians choice… and lower dose

[23:02] DLE – And what is typically in the US? Is that typically at the high end?

[23:17] AS – Worldwide, there are very slight differences between American and European guidelines and they are generally the same… And any standard… generally for higher efficacy, as physicians, prefer to apply the highest dose the patient can tolerate, because if the patient can tolerate it, why not give more… which will increase our chances that the patient will respond, but our approach is much different than that one. What we see is… even when we apply the lower dose, our response rates can be much higher because of the combined therapies.

[24:14] DLE – And I recall you saying that you can actually keep someone on because you have minimized side effects? You can keep someone on longer?

[24:26] AS – Yes. We have patients that have maintained treatments of chemotherapy for many years. Standard chemotherapy… Tolerance…. Long term application once, the patient can only tolerate such high doses once. Meanwhile, in our experience, because initially we are applying treatment at the lower dose scale… also combined with complementary therapies, the tolerance is much better and can be applied for much much longer than ever expected. Patients are able to receive treatment for a much longer time than compared to some treatments.

[25:22] DLE – So, if someone comes to you, because I have listened to a bunch of your testimony, sand listened to case studies, and all cancer disappears, sometimes very quickly, how much longer would you keep that person on a chemotherapeutic or a standard drug to prevent recurrence? What is your after-care?

[25:52] AS – Yes. This will change for every patient… It is based on the patients' prior treatments, also disease, response to treatment, the stage and everything… meanwhile the treatment will be sometimes for a year and then slowly after completing a year of treatment but then it may continue but with a much different schedule. In our treatment, the initial three months, just as with any treatment, the initial three months, just as with any treatment, is very important. When a patient comes to us, initially we do a work up, which beside blood counts, includes a PET CT scan. Based on that, we start to choose his treatment. For three months… another PET CT scan will be done. And based on the evaluation, further treatment, every three months a PET CT scan will be done to see the patient's response….

[27:22] DLE - And if you see nothing, in other words… let's say after three months you see nothing and another three months you see nothing…

[27:32] AS – After each PET CT scan, the patient's treatment, schedule and dosing will change. Sometimes, the schedule will be the same but the dosing will decrease. Sometimes, the dosing will stay the same but the time between each cycle will be longer which will be based on the patients' individual condition. But following every patient's PET CT scan, every aspect of the patients' treatment will be evaluated.

[28:07] DLE – Got it. So let's, perhaps let's talk about the combination of the things you do, because some people may listen to this and say I want to do certain things now or do certain things now or certain things alongside and I can't get to you, and these are non, I actually do a lot of these things on my own. I occasionally not frequently enough but occasionally do hyperbaric oxygen; I am on a very low carb diet; I have an infrared sauna in my house which I probably don't use enough lately but I go through cycles. Ok. So we talked about the way you're using insulin and some minimum fasting before chemo. What are the ongoing things, the non-invasive things: hyperbaric oxygen…. How often do they get hyperbaric oxygen?

[29:21] AS – Well, like, varies by patients but two, three times per week. Each session will be an hour.

[29:42] DLE - Is that at 29PSI or how many atmospheres.

[29:47] AS – 7PSI

[29:57] DLE – Ok, so that is hyperbaric oxygen. Then, hyperthermia. You are using a machine that you have on your web site that I was not previously familiar with. And how…

[30:12] AS – We are using a hyperthermia from two different companies. One is Heckel… the other is Oncotherm device is used for local hyperthermia and is a Hungarian device and very widely used in Germany and is an electromagnetic hyperthermia device. It uses electromagnetic waves and focuses on the tumor tissue to increase the … heat in that area. And Heckel devices are German devices and again … these Heckel devices we use for whole body hyperthermia. This is mainly used for … infrared device. So, Heckel is infrared hyperthermia and Oncotherm is for local and is electromagnetic based.

> [From Chemothermia Site @ http://chemothermia.com/therapies/hyperthermia/] Cancer cells are more sensitive to heat than normal cells and hyperthermia takes advantage of this to weaken them and make them more sensitive to other treatments by increasing the temperature, either of the whole body (full-body hyperthermia) or of the part of the body with the cancer (localized hyperthermia). Using modern electromagnetic heating methods this can be carefully controlled and targeted to trigger cancer cell death without causing significant side effects.

When combined with radiotherapy, research shows hyperthermia has a complementary and additive effect. Extensive research also shows that hyperthermia improves the efficacy of many chemotherapeutic agents.

At the same time hyperthermia has been shown to support the immune system in forming an effective immune response to the cancer.

[31:20] DLE – And if someone is coming to you and there with you for three months, how often are they doing these treatments?

[31:32] AS – It's mainly based upon their chemotherapy schedule and sometimes some diagnosis the patient will be on a protocol for ten days on and ten days off and some diagnosis are three days on and ten days off. On the ten day regime, generally, on the first day at 8:30 (AM), the patient will receive chemotherapy and then… receive hyperbaric oxygen and hyperthermia sessions and every day the patient will be using supplemental therapies and they will also be on a ketogenic diet, always during a… cycle, all the time. They will also be using supplements, always.

[32:40] DLE – So, the supplement therapy, are those mostly infusion or a combination of oral and infusion?

[32:47] AS – The supplements will be oral medications… with a high concentration of natural…. The patient will also be receiving infusion therapies, which will be high dose vitamin C and… to minimize treatment side effects. So, the patient will be coming to the clinic every day and they will be evaluated by our medical team and a physician from our team, and based on the patient's daily condition, sometimes the patient has some nausea and these issues will be handled according to that. And, sometimes a patient will say they have some pain today… This part of our treatment is actually very important for us because compared to standard conventional settings, the patients are seen by their physicians once every three days or two weeks. In our approach, we see our patients every day during the treatment cycle. So, if they are ten days on, ten days off, during the treatment period, the patient will be seen by a physician every day and every day based on their condition, that treatment will be individualized for their condition, and this has many a very important part. Not only are we treating the patient's daily condition, but forming a human relationship with their physician, because the connection between a physician and a patient is one of the most important parts in the process for our patients, so we see our patients every day and try to form that human relationship… with each patient.

[35:12] DLE – Since you are looking at everything and doing a lot of things to bring oxygen into the system, have you looked at just in a purely supportive way, meditation, breathing, things that stimulate…

[35:32] AS – We very much believe in that and highly recommend it to our patients and recommend it for some patients in Turkey, this isn't much common, but with some of our patients… We as a medical team very much believe in this and we also try to guide that patient to meditation and breathing therapists….

[36:12] DLE – Excellent, and on the ketogenic diet, which you recommend, you have a slightly different version I know than some other people I have talked to and can you just talk about that… it's a little more…

[36:26] AS – I'll talk about this… the diet in our approach is a very important part of our protocol and the diet changes on a patient by patient based on the individual condition of the patient and starts with the treatment and the diagnosis. With the ketogenic diet, there are different versions that can be applied and if the patient is a new patient, we prescribe a ketogenic diet, which we highly recommend, but sometimes

we have very advanced patients that come to us, some at 35 kilograms are hardly able to walk… For these patients of course, we are not able to apply this for these such patients, so we apply a modified ketogenic diet. It is a modified diet for minimum carbs so no pure carbs, but a patient has unlimited fat and protein as much as they can eat, so based on diagnosis, by eating the fat changes on an individualized approach but the underlying approach will always be minimum carbohydrates but eh fat and protein percentage will change individually on a patient's' condition, but the basic principle will always be minimum carbs because the main energy source of cancer is glucose.

[38:29] DLE – Understood, so, maybe we can talk a little bit about your results because they are pretty amazing.

[38:42] AS – I will start off with… We started out with asking questions and the main question was how can we improve outcomes and … see if we are improving the outcomes of patients suffering from the most… of all diseases and until now we have published papers with patients on our protocol and we are working on four more papers this year… Hopefully publishing these papers within a year's time. Our first publications on our treatment protocol was in 2016 and stage III and IV pancreatic cancer patients, and such a diagnosis median survival time expected is six to eleven months and in our publication… we published about 34 patients that received treatment at our clinic and the median survival time for each patient was 19.5 months and much longer than standard treatment and with this diagnosis there are mainly two chemotherapy treatments that we've used. One is fourteen months. With these protocols, the one year survival rate is 20% to 48.4%, which is based upon… The one year survival rate for our patient group was 82.5%, so a much higher one year survival rate and much longer median survival time.

[41:22] DLE – And I am sorry to interrupt but how do you break that down between people who have come to you already through a lot versus those who have come to you earlier before their body, cause I know several people who have been through it and it is pretty abusive therapy.

[41:42] AS – Patients that come to us as a first resort, so when we are applying treatment to the patient, these patients respond much better of course. Patients who have gone through multiple therapies before, even though they respond less than patients who are receiving treatment for the first time, again, their response rates are higher than standard treatments. This patient group, some patients have received standard therapy, may include surgery or chemotherapy also and that patient group has metastatic disease so are stage IV patients and pancreatic cancer is one of the most aggressive diagnoses unfortunately, and in that patient group, we published the longest median survival time ever published worldwide and that is with 32 patients. We also published two case reports, one was regarding a stage III rectal cancer patient and the reason we published about that patient, there were two reasons mainly, one was the patient was 81 years old, and at that age generally patients are not so eligible for any sort of treatment because of their age, we offered to show that patients at that age will also be eligible for treatment in our approach and besides that the only curative approach published about… cancer is surgery. This patient came to us at age and she was one of the first in the Turkish nation, and she was 81 years old when she came to us and she would "rather pass away than have surgery and is there anything that can be done to treat my condition without surgery I am open to it so please try to treat me…." We applied a chemotherapy protocol combined with hyperthermia and … therapies at that time and she had a complete response and we published that in our paper and she was in complete response for 27 months… The paper showed that the non-surgical treatment showed complete response in a stage III rectal cancer patient is possible, and I would especially like to remind that this patient was 81 years old and unfortunately patients at that age because of the heaviness of the standard approach… they generally don't receive any sort of treatment. She tolerated our treatment very very well and had.. complete response. And our third publication … last year. That paper was with professor Thomas Seyfried, a good friend of ours, and we published about a triple negative breast cancer patient who was 29 years old and there are many subtypes of breast cancer

and this is one of the most aggressive types and she was a patient who came to us at the very last stage, an end stage patient, with widespread disease and a very large tumor in her liver and abdominal region and that publication showed a patient at such an advanced stage is treatable. At the end of three months, she went into complete remission. She had complete response to our treatment and we have continued to follow up with her treatment also. So, until now, we have made three publications, these being pancreatic cancer, rectal cancer and breast cancer and these papers we explain our approach and tried to show outcomes can be improved with a wider approach to treatment of such patients, and our protocol, and our review of patient's treatment is based upon recommended supported chemotherapy… includes hyperbaric oxygen, a ketogenic diet, a patient's good mood is very important also and … Sometimes the patient will come to us at the very last stage but they are looking for treatment and we will take that patient on and sometimes that patient is at a much earlier stage, but a more advanced patient surprisingly will do much better compared to a case than some who come to us at a much earlier stage sometimes. So, that they are going to live and positive attitude is very important also in our experience.

[48:49] DLE – It's… It can be everything for some people.

[48:57] AS – It's actually everything…. To my knowledge and our current knowledge, a treatment… is the treatment that gives the best chance for the patient. Meanwhile, the publication… Gives the best chance because they combine everything that … both conventional, also complementary therapies. Meanwhile, even though our protocol combines everything possible, we tell the patient that our treatment can only be 49% of your treatment. The other 51% is your half. It is your approach to treatment and your attitude. So, more than half of the treatment is the patient's half.

[50:04] DLE – Well that's actually… I love that, because you're empowering the patient. Some people may find that daunting. And one of the things as I have spent a lot of time over the years with the microbiome and you get these radical treatments and the patients wind up on antibiotics and you're killing off a lot of the good bacteria that naturally create a lot of the neurotransmitters that might make you optimistic. So it's like a double… it's a double whammy because we forget that hope and other things can be… are at least supported by natural chemicals that should be occurring in the body. And so that's why would I like giving oxygen therapies. You're supporting other good bacteria and things that you're just increasing the odds so. And I know that there have been studies on immunotherapy and looking at microbiome diversity in the gut and tying them very close to survival rates. And I would imagine that while we never discussed it. I wouldn't suspect that you're checking the microbiome on a regular basis I would be very curious to know and certain studies in the future whether it's yours or others that copy I'm sure will look at diversity in the gut and that's impact as well.

[51:34] AS - I think that would be an important part to research in this space also.

[51:39] DLE – Well, this has been wonderful. As I said to you before we started I may come back to you maybe even to do an addendum to this.

[51:51] AS – If any part is missing, we can do an addendum or a new recording…

[52:19] DLE – That would be great. My goal here is to give people the complete picture here as much as possible. It's amazing… Are you coming back to the states any time soon?

[52:35] AS – There are some invitations but it's so far for me. The whole thing is. Because we are such a small team, if one of us goes, it is a bigger and bigger problem for the patients. We have 55 patients at the clinic so we are quite busy and their life is enhanced. I might be coming in a year or so, but I haven't made any promises. I see patients in London every two to three weeks. Some patients that want to have

consultation I see them in London and I plan some consults in London and I just fly in and fly out same day……

[54:15] Great. Well thank you. I really appreciate your time and I'm sure those that are listening or reading our transcript are grateful, and I may ask you for off line for some more statistics that I will post on the show notes, and I very much appreciate your time and your dedication to your patients and your efforts.

[54:42] AS - Thank you. The transcript. If you can arrange to have it include Dr. Slocum from the Chemothermia Oncology Center and that would be better. Don't be focused it on me.

[55:12] DLE – I well understand, I totally understand it is a team approach.

[55:17] AS – It is a team and it is not mine. It should be presented that way… Because Professor Berkarda is 87 years old now and he has some health problems also, so you never know… his experience has brought us a lot and when something is presented without him it can be heartbreaking. Same for my other colleague, Dr. Salih, also. We are a team. So, … that is important.

[56:17] DLE – I completely understand and I will make sure the notes and the link to your web site and everything.

[56:27] AS – The interview is Dr. Slocum from Chemothermia Oncology Center and that is the best way.

[56:41] DLE – OK. You got it. I absolutely will. Well thank you very much for your time.

[56:48] AS – You are welcome David and if any questions come up, I can do another recording as well if you want anything else, just email me and we will schedule it.

[57:01] DLE – Wonderful. Thank you.

[57:04] AS – You're welcome. Have a nice day.

[57:06] DLE – You too…

[57:10] DLE – This has been an amazing interview for me. Having lost my father to cancer in 2011, and recently his sister at 85 years of age, I have a particular interest. As someone who was long ago diagnosed with an autoimmune condition, I too have an increased risk of cancer. But my zeal for my podcast and investment efforts really stems from my desire to help others figure out the best yet least invasive ways to improve outcomes with one focus: peak health. Not just remission. Not just good health. Peak health. The world needs more people with an audacious goal with a grounded approach. I recently came from Shanghai where I attended an Abundance 360 conference (see www.a360.com). There were some great futurists and people doing novel things in technology. They are also doing a lot in longevity. Their goal is to get people to live to 180 years of age with age 120 as a stop that can be achieved in the near term. This would include a better healthspan as well. I love these futurists and am inspired by them. I had some great ideas that came out of it. These conferences also embolden me to always think bigger. But, for my father, my sister who passed away last year and countless others I know, I want doctors and other providers who have figured out combinations, or as I like to call them: adaptable protocols, that are getting results now – while we wait for the futurists and technologists and researchers to create the future. I am what I might call a pragmatic Pollyanna. I do not believe that a cancer or Alzheimer's or ALS diagnosis means you are going to die. Up to a point, and a very advanced point at that, there is always an opportunity to heal, or to live longer with a better quality of life. For the life of me, I cannot understand why doctors,

particularly at major medical institutions, do not use the tools and protocols that Abdul Slocum and his mentors have developed at Chemothermia – particularly because they are based on protocols developed here in the US. These non-invasive, supportive therapies, add to quality of life – big time! – and they lower the odds of complications and side-effects, while giving the patient longer periods while s/he can stay on the therapy, increasing the odds of success. What are these doctors afraid of? What is the risk to them? The treatments are quite inexpensive and have near zero risk. But they don't have consistent results because they are not consistently or rather methodically and adaptively applied. Lastly, they do not have a clinical trial to prove them. And as I discovered long ago, for most doctors, if there is no clinical trial, there is nothing to try. We can get into incentives and who makes money and we can also get into the risks of being sued and put out of business, but the fact is: for cancer and other serious patients, there must be real-time low-risk trial and error. We must rapidly develop adaptive protocols, or in this case, use and improve what Dr. Slocum and his colleagues both at Chemothermia and in the broader metabolic therapy community have already created. And last I checked, there are some major medical institutions that started using ketogenic diets in the 1950's! Somehow, we have come to view cancer strictly as a genetic disease. From a common-sense perspective, that myopic theory holds little weight and effectively has been disproved. Same as a carbohydrate based diet in the US has led to us having 2/3 of our population anywhere from pre-diabetic to morbidly obese.

Please make a point of registering on our Medium page and subscribing to our Twitter feed at P5Health. We can always be found at www.p5protocols.com and for our investment business at www.p5hv.com. At P5 Health Ventures, we are investing in the very platforms that will pull all of these great treatments and diagnostics on to one platform that can truly know exactly what works for each person and the right time. We call this disease management and on a preventive basis population wellness and it all falls under the broader concept of Digital Health. For all of the research, diagnostics and treatments out there, it will be digital health platforms that pull all of that information together and create better outcomes that are affordable and accessible to all. We are excited to be one of the firms leading this charge.

http://chemothermia.com/about/

Chemothermia was founded in 2010 by Prof. Bulent Berkada and Asst. Prof. Mehmet Salih İyikesici, two of the most experienced medical oncologists in Turkey, to deliver world-leading cancer treatment using the latest integrative approaches.

In order to deliver the highest levels of cancer care we develop personalized protocols for each of our patients integrating both genetic and metabolic approaches to the condition and delivering outstanding treatment outcomes.

Our treatment protocols use conventional therapeutics alongside supportive approaches to maximize their efficacy by targeting the metabolic weaknesses present in cancer cells while reducing their side-effects.

The therapies we use include:

- Metabolically Supported Chemotherapy (MSCT)
- Hyperthermia (Local and Whole Body)
- Hyperbaric Oxygen Therapy
- Special Infusion Treatments
- PhytoPharmaceutical Supplements

- Oncological Diet

Since our foundation we have published a number of papers sharing details of our treatment and results and continue to actively research and integrate the latest developments in the field.

While 95% of our patients are stage IV we welcome enquiries at all stages after diagnosis and for all types of cancer.

As at http://chemothermia.com/our-team/

Prof. Bulent Berkarda

Professor Berkarda was the first medical oncologist licensed to practice in Turkey and founded the Department of Medical Oncology at Istanbul University in 1974, the Turkish Society of Oncology and the Turkish Society of Chemotherapy. He also served as the Dean of Cerrahpasa Medical Faculty (1979 – 1982) and the President of Istanbul University (1994 – 1998).

In recent years, Prof. Berkarda has been studying complementary methods of cancer treatment along with the standard orthodox therapeutic protocols. Unfortunately, it is well known that standard chemotherapy is usually ineffective especially in Stage IV cancer. More specifically, Prof. Berkarda M.D. has been

investigating the roles of diet, nutraceuticals, hyperthermia and insulin potentiated chemotherapy to balance the inadequacies of standard chemotherapy.

Asst. Prof. Mehmet Salih İyikesici

Assistant Professor Mehmet Salih İyikesici M.D. completed his medical training at Uludag University, School of Medicine in Bursa, Turkey. He later completed his Internal Medicine residency at Haydarpasa State Hospital under the guidance of the Hematology-Oncology specialist, Professor Aydogan Albayrak M.D. He later completed his Medical Oncology residency program at Marmara University, School of Medicine in 2006 during which time he contributed to securing the first oncology quality certification in Turkey.

Following completion of his residency Dr İyikesici founded the Medical Oncology Department at Diyarbakır State Hospital and undertook advanced training in hyperthermia at centers in Germany and Switzerland.

Dr. Abdul Kadir Slocum

Dr. Abdul Kadir Slocum M.D. is originally from the United States but grew up in Istanbul, Turkey and is fluent in both English and Turkish. He has a particular interest in helping patients suffering from cancer and exploring new ways of addressing the disease.

Since completing his medical training at Marmara University, Istanbul he has been working with Assistant Professor Mehmet Salih İyikesici M.D. and Professor F. Bulent Berkarda M.D. on the development and application of conventional as well as innovative treatment modalities for oncology.

Links to Other Interviews with Dr. Slocum

Dr. Mercola, Dr. Slocum and Travis Christofferson on the Dr. Mercola Podcast

Other Links

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5589510/

P5 Protocols - Interview with Dr Thomas Seyfried
P5 Protocols - Interview with Travis Christofferson