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Tumor Therapy with *Amanita phalloides*: Benefits and Limitation

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Author's contribution

The sole author designed, analysed, interpreted and prepared the manuscript.

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Case Report

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ABSTRACT

Background: Classical tumor treatments can fail: surgeries, radiation and chemotherapy not always elongate the life span. Less destructive treatments are possible nowadays. To find and analyse the efficiency of alternate treatments, long term case reports are essential.
Aim: To determine long term analyses of Amanita treatment in patients with different tumor types.
Methods: Patients are treated with Amanita alone, as long as the tumor growth of cells can be retarded. Other anti tumor therapies are applied in addition, when the retardation of the tumor growth is not sufficiently manageable with Amanita alone. The treatments with Amanita are supported by application of Terebinthina laricina in intervals to eliminate Borrelia.
Results: The state of a patient with a thyroid-carcinoma and a rectum-carcinoma can be stabilized for ten years with Amanita alone, until her age of 90 years. The patient cannot further tolerate uptake of Amanita. Thyroid cells start to grow, rectum-carcinoma cells grow slower. The disease state of a patient with prostate-carcinoma can be stabilized with Amanita alone for six years. Other therapies are applied from then on in intervals in addition for further six years. No chemotherapy or radiation is applied. The patient died at the age of 84 with metastases. A patient with B-cell chronic lymphatic leukemia is treated with Amanita as sole antitumor therapy for eleven years. After that period, no further antitumor treatment is necessary, the patient lives now with high but stable leukocyte count for two years after the end of the Amanita therapy.
Conclusions: Amanita can inhibit tumor growth of different tumor types for a long period of time,

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elongation of the life span is possible. A synergistic effect of anti-Borrelia treatment is observed. Occasionally the tumor growth of cells stops without further anti tumor therapy, and no correlation with the origin can be identified.

Keywords: Amanita phalloides; thyroid-Ca; rectum-Ca; prostata-Ca; B-cell chronic lymphatic leukemia.

1. INTRODUCTION

A genetic and molecular study identified the central potential targets for therapeutic intervention in tumor cells: switch genes [1,2]. In tumor cells, the switch genes are over-expressed. This switches the growth of tumor to ON. All switch genes belong to the class of HOX genes, and use RNA-Polymerase II (RNAP) for their action. If the switch genes are over-expressed, RNAP is used to full extent, creating a bottleneck for tumor growth. The extract of *Amanita phalloides* contains amanitin, inhibiting RNAP. Inhibition of 50 % of RNAP switches the tumor growth to OFF, and inhibits growth of tumor cells. This has no effect on normal cells. Growth inhibited tumor cells can be recognized by the immune system and lysed. Through this approach it is possible to stabilize the state of disease for years.

Many tumor patients are looking for alternative treatments with no side effects. Chemotherapy and radiation induce severe side effects, like neuropathy or induced inflammations. Both create mutations in the cells and create resistance to the therapy at the first application.

Amanita treatment as alternative anti tumor treatment provides several advantages. It usually shows no undesired side effect, no poisoning, and does not induce mutations. It is given *per oral* with a drug stable at room temperature. The patient needs no hospitalization, and is free to travel. In addition, Amanita is competitive to all other possible treatments.

In this study over 12 years, three patients are observed to analyze the benefits and limitation of the Amanita therapy. Aim is, to demonstrate an alternative treatment, usable in any country of the world without equipment or facilities in a standard protocol.

2. THERAPY AND MONITORING

Dilutions of extracts of *Amanita phalloides* are used since 300 years, the classical indication is fear of death. After anamnesis, the patient is treated with the drug Amanita phalloides (zert. Riede) D2 [Herbamed AG,CH]. In a standard procedure, the dose is 4 x 10 drops *per oral* per day, resulting in an average uptake of 50 ml per month. The daily dose contains about 150 molecules of the active component amanitin per cell. This dose decreases the tumor growth. It is not poisoning cells, only regulates the cell division potential - a regulatory therapy. With 100 ml of this drug, about 50 % of all RNAP molecules in all cells are inhibited [3]. Usually, no side effects occur.

The therapy is monitored. A tumormarker can show the growth of tumor cells. In case of leukemia, blood cell count is applied. Degradation of cells by the immune system is monitored with lactate-dehydrogenase (LDH) levels in serum. LDH increases in case of cellular lysis. Successful treatments of mammary-carcinoma (-CA), thyroid-CA, colon-CA, prostate-CA or B-cell chronic lymphatic leukemia (B-CLL) have been described [3].

In some cases, Borrelia infections support the tumor growth of cells. In rare cases, complete remission occurs with Amanita, supported by treatment with Terebinthina laricina D1 to eliminate Borrel*i*a [4,5]. Terebinthina is applied with 2 x 10 drops *per oral* per day. A cure ends after the uptake of 100 ml of the drug, and is applied several times whenever symptoms of a Borrelia infection appear.

Sugar-free nutrition is recommended, avoiding white industrial sugar – saccharose - but not fructose in fruit. Carbohydrate reduced diet is recommended, avoiding high carbohydrate processed nutrition like noodles, but allowing some carbohydrates in unprocessed food like boiled potatoes. Overall, natural food with a high portion of vegetarian food is to the best advantage. In all patients, in addition to Amanita as the only tumor specific drug, the oral uptake of essential fatty acids is indicated. Essential fatty acids enhance the fluidity of cellular membranes, and decrease the risk of autoimmunity. No processed fats, like industrially saturated fatty acids or trans fatty acids (deep-fried food) should be eaten. Daily exercise is recommended [6].

Patients with different tumor types are selected for this study to demonstrate the wide range of capabilities of Amanita. All patients found the way to the therapy by own incentive, and remained in the therapy unsolicited.

2.1 Case Report 1

The female patient IK1930 was born in 1930. Her half-sister suffered ovarian cancer and died at 46; her older sister was diagnosed with rectum-CA but lived to be 90. The patient was diagnosed in 1995 with rectum-CA which was removed surgically. In 1999 after relapse, she obtained a stoma. Neither metastases were found, nor affected lymph nodes. She obtained chemotherapy. In 2009 thyroid-CA was diagnosed. After radiation therapy, a tumor (50×38×42 mm) was removed. Another radiation followed in 2010.

Amanita therapy begins in October 2010 (Fig. 1, time 0 years). A PET/CT scan shows a tumor in the jugular area, 37×42×36 mm, as well as a prominent lymph node (55 mm). Her weight is 100 kg. LDH and the tumormarkers CA19.9 (pancreas, gallbladder, intestine) and thyreoglobulin (TG, thyroid) are monitored. Both tumormarkers are elevated, both tumor cell types still actively growing. Year 0,25, after uptake of 200 ml D2, she experiences fever, vomiting, cough, and diarrhoea (Fig. 1, arrow A). After a year an MRI shows that the original tumor around the trachea and the prominent lymph node have disappeared (Fig. 1, arrow B). After successful remission, the patient decides, to continue Amanita therapy, but not to follow the dietary suggestion to avoid saccharose and other carbohydrates. This results in an increase of CA19.9 (Fig. 1 Arrow C and Fig. 2 arrow A), TG levels are not affected. After continuous increase of CA19.9 to the threefold value, saccharose free and carbohydrate reduced diet decreases the CA19.9 levels again (Fig. 2, arrow B). The patient decides to continue Amanita therapy lifelong in conjunction with saccharose free diet [7].

During the year 3, after a car accident, TG increases rapidly (Fig. 3, arrow A). In the year 4, borreliosis is diagnosed, and treated with a cure of Terebinthina (Fig. 3, arrow B). In year 6 Herxheimer reaction is diagnosed with kidney involvement (Fig. 3, arrow C). Antibodies against Borrelia IgG decrease from 150 U/ml to 91 U/ml during this period. In year 7 a kidney stone occurs. The patient is treated in an interval with Chelidonium majus D1 2 x 10 drops daily, a cure ends after a total uptake of 50 ml. *Chelidonium majus* contains antibacterial, antiviral substances, and active molecules to inhibit cell growth [8].

In year 8 the patient suffers in addition from mycosis and round worm affection. This correlates with a higher increase of TG (Fig. 3 arrow D). Repetitive Terebinthina cures are applied. During this time, her body develops an intolerance against Amanita. Chelidonium cure is applied in an interval without Amanita (Fig. 3, arrow D). In year 10, after her 90th birthday, she cannot tolerate Amanita any more. Her body reacts with immediate vomiting after the uptake. Terebinthina still is tolerated and remains applied from time to time. During the years she loses 28 kg of her body weight. Because she lives alone, she decides to move to a nursing home. Until today she shows no symptoms from the tumor growth.

2.2 Case Report 2

The patient WD1936 was born in 1936. His mother died with a stomach-CA at the age of 91, his brother died from prostate-CA at the age of 59. No other predisposition for tumor formation was identified. In July 2004 prostate-CA was diagnosed by biopsy. No operation and no radiation took place [9]. The duplication time of the tumor cells is 3 months. From August 2004 to December 2007 antihormone treatments occurred. Beginning of 2008 Amanita therapy starts (Fig. 4 time 0 years). Body weight is 110 kg, remaining stable during Amanita therapy and increasing during anti-hormone treatments. Prostate-Specific Antigen (PSA) and LDH are used for monitoring. For six years, always with a minimal dose to inhibit tumor growth of cells, Amanita alone is sufficient to keep PSA level below 10 U/ml, the action control limit for the “watch and wait” strategy. Then intervals with 5-alpha-reductase inhibitors – always in a minimal dose - and without Amanita - are applied. Never two drugs are applied at one time, to avoid resistance development. The more drug is applied, the higher is the selective pressure on the tumor cells, the faster resistance against the drug develops.

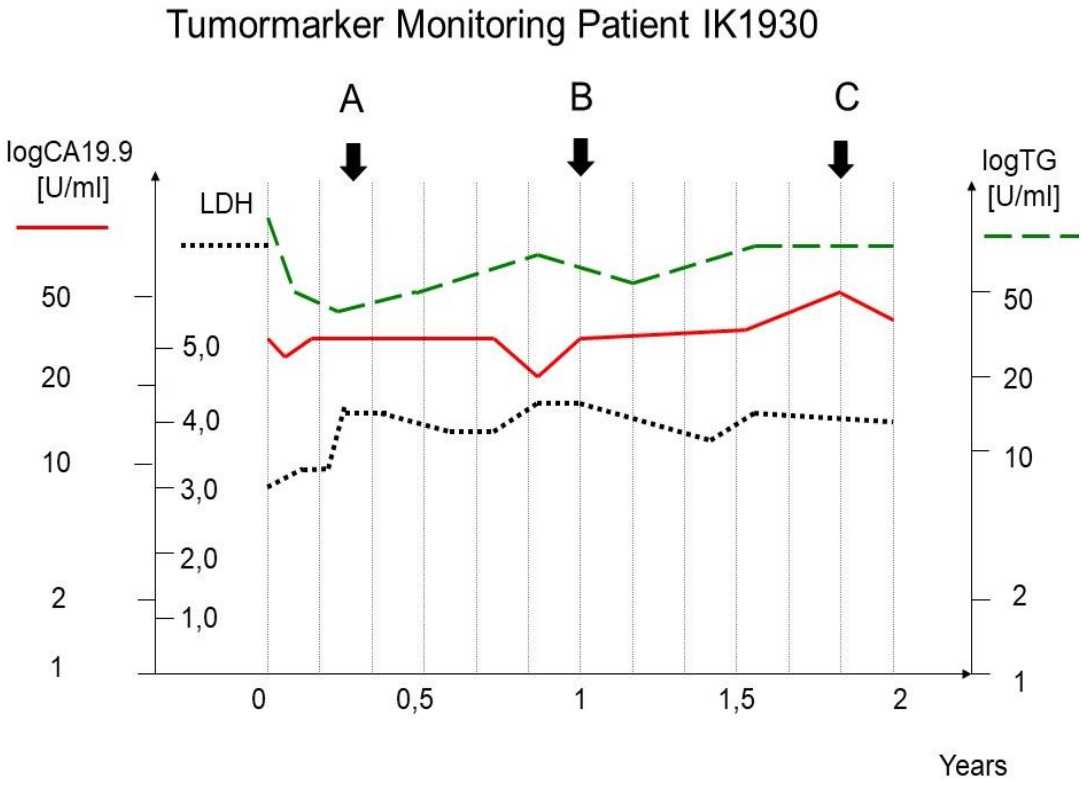

Fig. 1. Tumormarker monitoring, remission

TG (green) indicates the activity of thyroid-CA cells, CA19-9 (red) shows the behaviour of colon-CA cells, and the LDH (black) shows cellular lysis. After the begin of Amanita, TG and CA19-9 dropped slightly, showing success of the therapy. LDH remains higher throughout the therapy, showing continuous activity of the immune system to digest tumor cells. TG and CA19-9 respond a bit differently. This indicates, that the two tumor cells have different reaction times to the therapy, but both are stabilized by Amanita

The softer the selective pressure on the cells is, the longer the therapy is effective. This strategy is detailed in [10].

In year 7, his wife is diagnosed with a Borrelia infection. She suffers a stroke after a tick bite. Antibodies against Borrelia cannot be found in the patient´s serum. Several cures with Terebinthina are administered for the patient and his wife. The patient adds methadone to the treatment. A cure with Chelidonium is applied end of year 7. Beginning of year 8 his wife dies. He disrupts the Amanita therapy, and eats curcuma and apricot kernels instead.

In year 9 Amanita and methadone are not sufficiently effective to suppress tumor growth. Even duplication of the standard dose to 4 x 20 drops of the D2 per day cannot further keep PSA levels down. Anti-hormone treatments take place, and can further stabilize the PSA. The patient consequently abstains from eating carbohydrates, and applies mistel infusions. Despite this success, and no clinical symptoms, beginning of year 10, metastases in lung and bones are diagnosed, the prostate has grown to 65x55 mm. He obtains leuprorelin infusions and has to move to a nursing house. He suffers from severe side effects, and tries another interval with Amanita alone in year 11. Treatment fails, and abirateron treatment follows. The patient died in year 12 at the age of 84 years.

2.3 Case Report 3

The patient KH1957 was born in 1957. B-CLL was first diagnosed in 2005, appearing to be slowly progressive. No familial or other risk for tumor formation could be diagnosed. Amanita therapy starts at the end of 2007 [10]. Stabilization with Amanita alone occurs for 7 years without side effects. His body weight is 77 kg and remains constant until today. He subsists on vegetarian food. In year 6 and 8, several

experimental intervals with Chelidonium and Melatonin are applied, to add alternative therapy possibilities for the patient. Whereas Chelidonium treatment adds positive effects for the patient, Melatonin is not effective [8]. In year 7 a Borrelia infection is diagnosed with anti-Borrelia IgG 24 U/ml, IgM negative. Several cures with Terebinthina are applied, followed by intervals omitting Amanita. Other patients occasionally lose the leukemia growth of cells after the Terebinthina treatment against Borrelia [4]. Here, this treatment cannot stop continuous leukocyte growth. End of year 8, despite a double dose of Amanita, leukocyte count increased over 200.000 [cells/µL]. The patient is highly stressed through his employment, he travels a lot. Infections occur, the ora mucosa shows vesicles. In one further period, in year 11, leukocyte level is over 200.000. This time, the death of a friend causes emotional stress. During the therapy, the patient often tries to stop Amanita. This fails until year 11. Beginning of year 12 the patient stops Amanita without trying other anti tumor treatments. Until today, leukocyte level is stable, meaning the tumor growth of cells stabilizes without further treatment. Leukocyte levels remain high. Until today the patient never suffered from a symptom typical for leukemia.

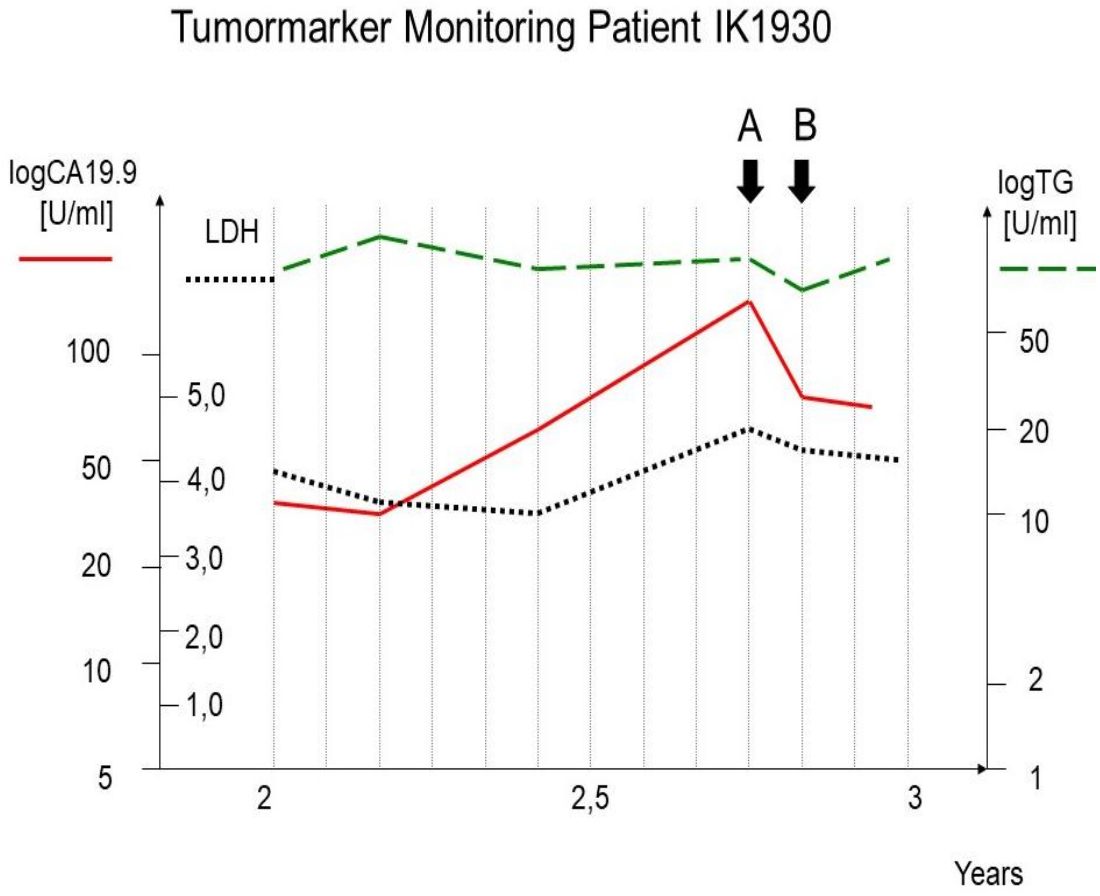

Fig. 2. Tumormarker progress with carbohydrate and sugar nutrition

After stabilization and remission, the patient starts to eat sugar and carbohydrates in excess. Whereas the TG level (green) remains stable, CA19.9 (red) increases threefold. Carbohydrate reduced and saccharose free nutrition (arrow A) reduce colon-CA cell activity again (arrow B)

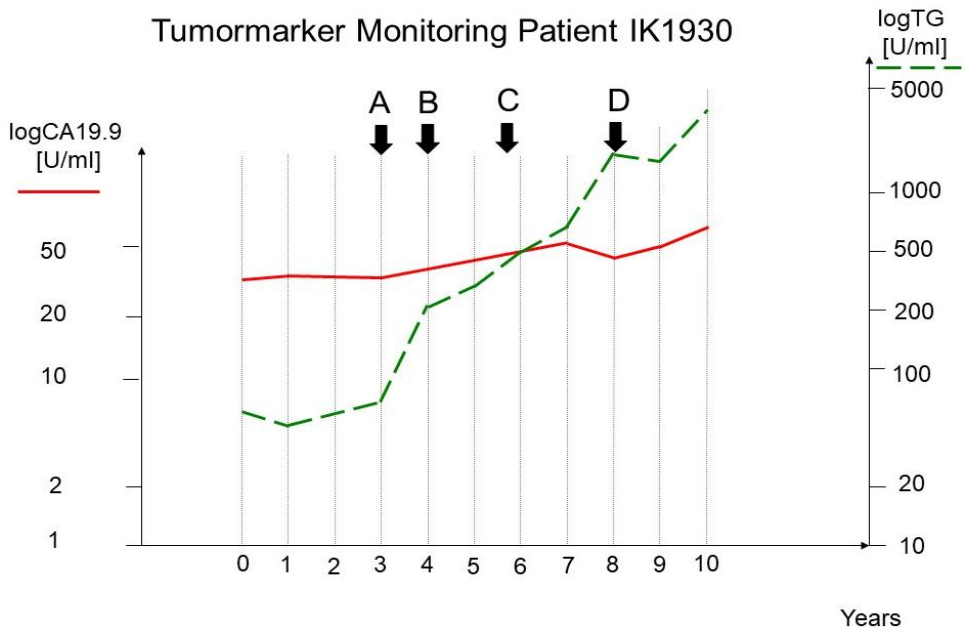

Fig. 3. Tumormarker monitoring over 10 years

After a significant increase of TG (green) in the 4th year (car accident, arrow A), Borreliose treatment with Terebinthina (arrow B) coincide with a slower increase of TG. Whereas the colon-CA still is silent, the thyroid-CA cells are less inhibitable by Amanita

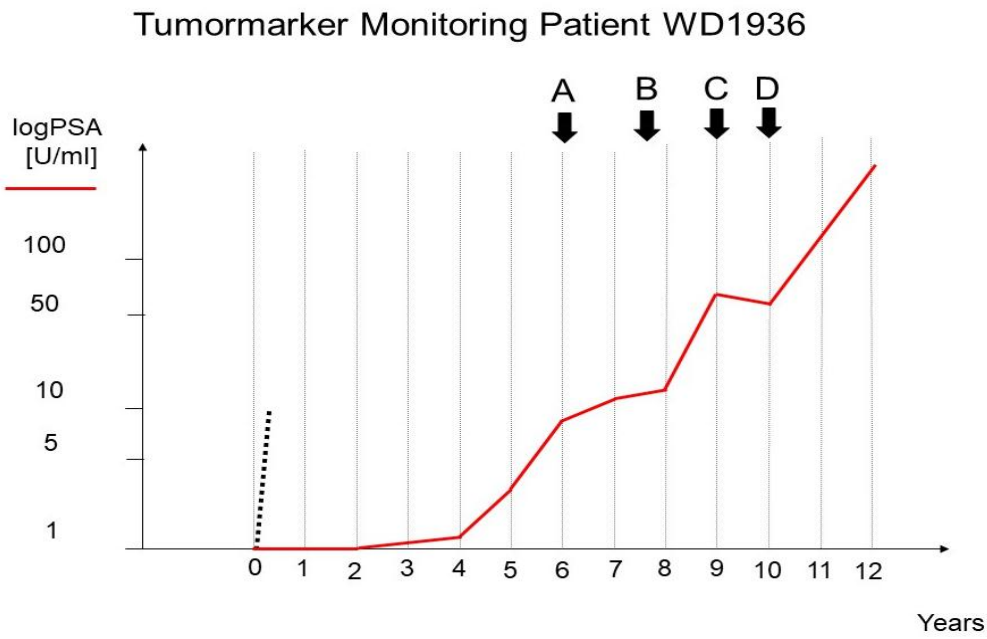

Fig. 4. PSA monitoring during tumor therapies

The dotted line indicates the duplication time of tumor cells without treatment. The line shows PSA level over 12 years. For the first six years, Amanita alone is administered. Arrow A shows the beginning of the interval-therapies with 5-alpha-reductase inhibitors. Arrow B indicates a cure with Chelidonium. The following faster increase of PSA correlates with the period of the death of his wife and Amanita abstinence. In year 9 "classical" antihormone treatments occur in conjunction with Amanita (Arrow C), without further possibilities to avoid resistance development. Arrow D indicates the final increase, despite all possible medical intervention

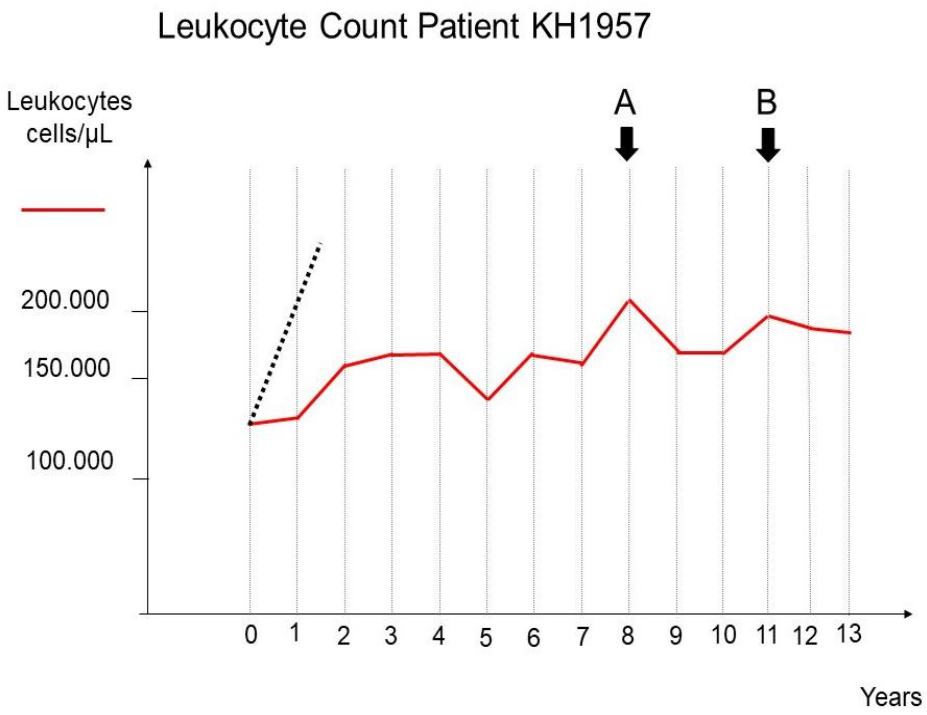

Fig. 5. B-CLL stabilization

At year 0 Amanita therapy starts. Duplication time of the leukocyte count at this time is exponentially 21 months (dotted line). Arrows indicate an increase over 200.000 cells/µl

3. DISCUSSION

Borrelia are discussed to support tumor growth, even induce leukemia [4]. A patient with squamous cell carcinoma as well lost his tumor cells by a therapy with Amanita phalloides D2 and Terebinthina laricina D1 [11]. In a case of a patient with Leukemia through a Philadelphia chromosome, a genetically induced tumor, elimination of diagnosed Borrelia seemed to have advantages [12]. The therapy against Borrelia in patient IK1930 reduces the growth of thyroid-CA cells significantly in year 4 to 7. In patient KH1957 repetitive Terebinthina treatments in addition to the Amanita treatments cannot cease the tumor growth of the leukocytes as in previous cases, but might reduce the tumor growth to a minimum, thus that the level in the blood remains constant today, without therapy.

In Patient IK1930 for the years 0-1 both tumor cell types from rectum-CA and thyroid-CA do not overgrow, the tumormarkers run in parallel. In year 2 the rectum-CA cells grow faster due to carbohydrate nutrition. Over the years, with carbohydrate reduced and saccharose free nutrition, these cells grow significantly slower than the thyroid-CA cells. This means that carbohydrate reduced nutrition can inhibit growth of especially rectum-CA cells.

Long term, the thyroid-CA cells grow faster, and can be less influenced by Amanita. In 2009 and 2010 radiation of the thyroid gland took place. Radiation enhances mutation rates, and mutations can support a certain resistance to Amanita.

Stress, either emotionally or employment induced can possibly reduce the action of the immune system, and let tumor cells overgrow. This can be observed in case of IK1930 after a car accident, in KH1957 after the death of a friend, and in times of excessive labor. Possibly the higher increase of PSA in patient WD1936 is correlated with the death of his wife, anyhow during this period the patient stopped as well with Amanita as anti-tumor agent.

Long term stabilization with Amanita is possible, because the drug is always applied at the lowest effective level possible. This leads to a low selective pressure on the cells to develop resistance. Combination therapies with high

concentrations of drugs should be avoided, to keep the tumor cells sensitive for the treatment as long as possible. Objective of a pharmaceutical tumor therapy is, not to destroy as many cells as possible, but should stabilize a state for the longest time possible. This leads to a longer life span, and – what is most important – to a high quality of life.

The five years survival rates of the patients with these tumor types is rated 62% (colon-CA), 90% (thyroid-CA), 89% (prostate-CA) and 57% (CLL) [13]. Continuous effort of most anti tumor clinical trials focus on the elongation of the life span through diagnosis and treatment [14,15,16,17]. Amanita therapy can open future possibilities, especially because it is simple and robust in application, and affordable. More clinical and statistical data are requested than single cases. In any case, already today monitoring of each single case shows the advantage for the individual patient.

4. CONCLUSION

Benefits: Amanita can slow down the activity of tumor cells for a long time without side effects. The benefit is an elongation of a lifetime with a high quality of life, without hospitalization. The drug is stable at room temperature, the patient is not dependent on a technique or place. Anti-Borrelia treatment shows a synergistic effect.

The limitation is seen in elderly. The immune system might work poorer. A saturation of the body might occur after 10 years, even if the liver enzymes do not show any poisoning. Another aspect could be, that prostate-CA cells are near the germ line. These cells might have a higher growth rate from nature, and therefore could be more difficult to halt.

CONSENT

For publication patient consent has been received.

ETHICAL APPROVAL

As per international standard or university standard written ethical approval has been collected and preserved by the author.

COMPETING INTERESTS

Author has declared that no competing interests exist.

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