Pancreatic cancer: a split type therapy idea

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Despite decades of research, non-resectable pancreatic cancer remain uncurable with 5 year survival rate not more than 8% of patients. Factors behind that unsatisfactory statistics could be split to: 1) genetical, 2) physiological, 3) metastatic, 4) unreachable place and 5) dangerous environment within pancreas. Tumors in pancreas are poorly accessible to chemotherapy, their hypoxia and low blood supply adds to chemical resistance. Metastasis are growing fast, giving unbelievably low blood pH and high levels of tumor growth driving lactic acid. Pancreas is hard to access from skin for methods of complementary medicine. Injections in pancreas could trigger dangerous pancreatitis.

Mainstream is clearly lacking adequate ideas here, help could probably come from holistic approach (cf. Wang et al, 2015 ’Therefore, rather than investigating methods of eliminating cancer cells, we should be looking into methods for inhibiting cancer growth and metastasis. Instead of starving cancer cells by inhibiting angiogenesis, it may be preferable to ‘feed’ cancer cells by promoting blood circulation; and instead of inducing apoptosis of cancer cells by targeting the anti-apoptotic proteins, it may be preferable to prolong the lifespan of cancer cells through overexpression of these proteins, as living with cancer may be preferable to dying from cancer’.

Limited experience of myself and others had shown, that even after radical pancreatic tumor reduction with combination therapy it comes back, because some questions of holistic biology are not answered.

Analysis of available literature let us propose a split type therapy idea:
1) for metastasis- killing with low-dose chemotherapy or metabolic therapy,
2) for patient- to rise blood pH and lower concentration of lactic acid. Detox the body and look tightly to hepatobiliary system. Locally boost blood supply and blood oxygenation. Reduce inflammation,
3) for tumor in pancreas- act trough the artery, which feeds pancreas. Controlled drug release 24/7. Reduce effects from hypoxia and reduce tumor smartly with metabolic therapy/phytotherapy,

After getting out of initial crisis appropriate questions of holistic biology should be formulated and answered.

References.


Hurwitz H. et al. Two randomized, placebo-controlled phase 3 studies of ruxolitinib (Rux)+ capecitabine (C) in patients (pts) with advanced/metastatic pancreatic cancer (mPC) after


Madden J. Infinity Reports Update from Phase 2 Study of Saridegib plus Gemcitabine in Patients with Metastatic Pancreatic Cancer. Infinity Pharmaceuticals; Cambridge, MA, USA: 2012.


O’Reilly E. et al. Phase IB trial of cisplatin (C), gemcitabine (G), and veliparib (V) in patients with known or potential BRCA or PALB2-mutated pancreas adenocarcinoma (PC) J. Clin. Oncol. 2014;32:4023.


Regine W., et al. (2008) Fluorouracil vs gemcitabine chemotherapy before and after fluorouracil-based chemoradiation following resection of pancreatic adenocarcinoma: a randomized controlled trial. JAMA 299: 1019–1026
Wang J. et al. Erlotinib is effective in pancreatic cancer with epidermal growth factor receptor mutations: A randomized, open-label, prospective trial.


