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<td>槇殿, 順</td>
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放射線照射の生物学的作動機構未だ充分明かにされていないのに，又病を操る抗癌原体についても生物学的未だ充分に解明されていないのに，放射線発生装置ばかりは高圧高エネルギー大線量装置に向って発展し，且つ之によって集中照射して病巣線量の増大を計る事によって今日抗癌射治療の世界の趣勢とされるのは全く「不合理」であると思さねばならぬ。もし，世界を風靡しているこの照射法が合理的であったならば現段階に於ては癌は放射線照射で治らばならぬならばあると思う。併し事実は宛ら逆の結果であるか之は如何？ 他面，過去の放射線治療を回顧してみると，今日の1/10乃至1/100の低圧で不充分な病巣線量の時代であったが，今日に優るとも劣らぬ治療成績を挙げた症例は洋の東西を問わず常に癌難を来してきたのである。

然らば之は「一体何が狂っているのであろうか」と，吾々の疑問を解明することこそ癌の治療成績を向上させる上に最も重大な事であり，之を検討することこそ医学放射線学を専攻するものの義務と責任であろうか？と私は考えざるを得ない。

私はこの問題と核組、先づ放射線照射の生物学的作動機構を解明せんと企て，次に抗癌原体が正常個体と如何に異なるかを生物学的に追及せんと企て，実験的並びに臨床的研究を行い次の如き結論を得たのである。

先づ放射線照射の生物学的作動機構については，放射線照射を受けた癌細胞にその一次的作用によって物理的に破壊される。面してこの変性死滅した癌細胞の分解産物にその燃焼個体に対して自身抗原として働き，之に対して自家抗体が産生されて放射線照射の效果を純二次的生物学的に免疫的に増幅される。と，放射線照射による癌細胞の崩壊度は一次的的作用に於ては勿論病巣線量に比例するが，純二次的生物学的作用は全身的な要素を問うて免疫性（例えば免疫，物質並びにエネルギー代謝等）全身的な抗癌因子）に関連して左右される事を発見し，故に当然各個体に対して適宜な照射量（病巣線量）がなければならぬと云う限界の存在を確認したのである。従ってこの防衛能力の如何によって癌細胞の崩壊度が左右される事を認めた。以上の生
物的利用機構の基礎機軸を私は「自家抗体説」と名付けました。

他面、私は照射を受ける側、即ち癌細胞の生物学的性質を含む、癌の発生発育による個体の変調を確認し、この変調は放射線照射によって誘導される事実に基づき、癌の発生発育による個体の変調を確認し、その変調の程度により個体は断してその発症を防ぶことができる。斯く去るも放射線照射の生物学的性質を通じて私共は色々な新知見を得た若千の理由を挙げて、於て個体の発症を抑制する事が可能である。斯くて個体を於て病調を抑制する為に個体の変調を抑制し、個体全体の自己防衛能を呑めて治療的にみる事は要されるのである。

従って個体に於て適調に癌細胞を抑制させる方法が他にあるなら、その方法は放射線療法と何等変わりなく有効であるべきであり、私は自家免疫説を示してこの事実を実験的に実証して既に報告した通りである。

然で私はこれ等の事を実際において癌の新らしい治療法を考察した。

1）術前照射

2）滴出照射療法の治療的抑制法を正規の癌の治療法と定め、日常適度に作ら以上の理論の正しさか否かを批判して来たのであるが、今日その両法を体験しつつある我輩である。以上の実験的並に臨床上の事実から放射線照射療法の中に免疫が重大なる役割を演じている事を充分理解する事が出来るが、この事実は今日迄抗癌の実在についてとかく不明瞭であった諸点を解明し、若し癌免疫の實在には異論のない事を実証したと云えよう。之は全く予期せざる大収穫と云わねばならぬ。

然て顧かに疑問の解明を企てておく必要がある。現在世界を風信する超高圧電子エネルギー大線量集中照射法が、なぜ予期の果を挙げ得ないかを反省して見よう。

読者の中に於てはこの大線量照射法が良い成績を挙げている方うらしく思う。この方々が私の論文に対して、この事実を如何に説明するかと反問される訳ではない。私よりの自家免疫療法を持ってあるのである。

余し之は初期癌か、多くは可視領域に存在する既発癌の癌の場合であるが、於ても、逝きに述べた自己防衛能が至高流下した症例のねばは有効でこそあらゆる症状を緩和なる治療を外科手術に於ける「メス」の代用として使ったと同様なことであつて、何等理論はなく、結果的に速よく良好な成績を挙げたに過ぎないので、而して決定した放射線生物学的作役機構に則った正規の放射線照射療法とは云えない。勿論癌の癌の正規の治療法をもってすればより容易に可能な旨である。

癌の放射線療法に当てはよる癌の個体の状態を知り、この自己防衛を向上させるべく行はるべきであり、初期期発癌の実態を把握することもなく、減癌果量線のみを考えて病巣に集中照射を行う照射療法の如く、角を割って牛を殺すの類を襲われても止むを得ないであろう。

過大な癌果量線によって過剰な細胞の増殖産物が血中に放出されれば、之によって個体の自己防衛術は障害されるのであらう事はカスパリ・教授の示唆を逆にもなく御体験の通りである。兹で治療の限度の線は照射する側より受照射される側にあると云っても過言ではない。従って治療の重大なる問題点は癌個体の自己防衛能に如何にしろ由知かと云う事になるのである。之は又放射線照射療法を如何に判定するかと云う事にも通ずる。

この全く不明な癌個体の自己防衛能は術前照射を行って見てみると、組織所見に依る手しごとを、臨床所見に之を対し重大な示唆を与えてくれることを知つたのである。即ち私は臨床症状の改善度から第Ⅰ型から第Ⅱ型に癌態を分類し、この各型の精密検査成績、諸治験成績から凡その病態を考証することが出来る事を確認したのである。例えば第Ⅰ型
There is a foremost problem that must be resolved in not only the utilization of radiation in therapy but also in the study of late effects of radiation in atomic bomb survivors and of methods of preventing radiation damage. The biological action mechanism of radiation—the changes that develop in an irradiated individual—must be elucidated. Radiation therapy is widely used and various studies on radiation are in progress despite the fact that this basic problem is yet not sufficiently solved. This I consider to be not only illogical but also dangerous.

From 1935 I have been engaged in studies to elucidate this basic mechanism and recently confirmed that radiation therapy of cancer is a kind of active immunity therapy. Cancer therapy that I have conducted according to this new concept has brought about remarkable results and therefore I keenly feel that this would introduce an important turning point in cancer therapy.

First, experiments were conducted to determine the effect of X-ray irradiation on substance metabolism of malignant tumors. In these experiments using transplantable Kato strain rabbit sarcoma, I first directed my attention to changes in inorganic base metabolism and energy metabolism of major organs due to the development and growth of tumors, and then the subsequent changes in these metabolisms as the tumors following X-ray irradiation became smaller in size and disappeared.

Through these experiments it was ascertained that abnormality favorable to tumor growth developed in these metabolisms simultaneous with tumor development and growth, but X-ray irradiation caused the tumors to become smaller in size and disappear, the abnormal metabolisms to normalize, and the life of the tumor-bearing individuals to be remarkably extended.

These experimental findings were also confirmed in my recent clinical experiments. This secondary biological action of radiation exposure was demonstrated experimentally 30 years ago. (1).

It is the current trend in radiation therapy of cancer throughout the world to focus attention on how to increase focus dose. This trend only stresses the primary action effect of radiation exposure and gives little regard to the generalized secondary action effect of radiation.

Further comment on cancer therapy is pertinent. As described earlier, with the development and growth of tumor various changes develop in the tumor-bearing individual and such changes vary greatly from the initial to the terminal stage of cancer. In radiation therapy a number of variables are involved, such as radiation ray quality, radiation dose and irradiation procedure. Therefore, the effect of cancer therapy is dependent on the complicated combination of these factors. I am not in accord with cancer therapy of the present day which is conducted without due consideration of these basic conditions. It is evident without further elaboration that the various problems in radiation therapy of cancer cannot be resolved merely by studying the question of focus dose. This is the reason why I completely disagree with "massive doses of supervoltage and high energy radiation" and why I believe that cancer therapy should:
at earliest possible date be performed with full recognition of the biological action mechanism of radiation.

There are cancer patients whose general physical condition would continue to aggravate by increasing focus dose and who would die earlier than expected, but on the other hand some cancer cases would respond most favorably to what could be considered to be an insufficient focus dose. Any clinician engaged in radiation therapy of cancer would encounter such cases in his practice. I am at a loss why it is the current trend throughout the world to continue to direct attention only to focus dose without attempting to learn the reasons for such important and interesting therapeutic results in cancer patients.

From the beginning of this century Professor Caspasi has attached much importance to the foregoing generalized secondary action and based on his clinical findings he developed what is called the "necrohormone theory." Being in accord with his theory, I have applied it toward developing my own assumption, but detailed review of his necrohormone theory has revealed that various clinical findings could not always be logically explained. This led me to re-evaluate his necrohormone theory.

Necrohormones defined by Professor Caspasi is the name given to the decomposed products of cells physically destroyed by the direct action of radiation exposure. However, no new hormones are produced by radiation. The composition of these necrohormones is extremely complicated, containing all the elements making up the cells, such as proteins, lipids, and carbohydrates. For this reason it cannot be considered that these necrohormones are simply disposed, but instead in the process a strong reaction must be brought about. This led me to study how the decomposed products of these cells are disposed within the body in my attempt to elucidate the biological action mechanism of radiation. As the decomposed products of these cells were originally a part of the living body, they should have been a completely harmless component of the body, but when cells die, they become so to speak an "alien substance" to the body. Therefore, it is reasonable to assume that the living body would show some response against such products. I have assumed that auto-antibodies are produced in response to the decomposed products of these cells.

According to the auto-immunity theory, in the normal living body antibodies cannot be produced for its cells, but if cells degenerate and die, antibodies for such cells can be produced. It goes without saying that following irradiation, degeneration develops in the cells causing their death and the decomposed products of these cells, being alien substance to the body, serve as auto-antigens and produce auto-antibodies.

Regardless how logical this theory may be, it cannot be accepted unless the production of antibodies can actually be demonstrated. I have therefore conducted the following experiments in order to demonstrate these antibodies.

In 1962 the cancer tissue of a gastric cancer patient who responded favorably to pre-operative irradiation was quick-frozen and antigen-antibody reaction was made between the auto-antigen produced therefrom and the serum of this individual. Both the precipitation reaction and complement fixation test were negative, but by Boyden's tannic acid treated sheep erythrocyte agglutination test auto-antibodies were demonstrated, confirming the production of antibodies (2). No antibody could be discovered in the cancer patient not given pre-operative irradiation nor was there any reaction against the antigen of another individual, but in the patient having large ruptured tumors a minute amount of antibodies could be demonstrated. It is assumed that through the production of auto-antibodies the changes brought about by the development and growth of cancer were normalized, the size of the tumor was reduced and life was remarkably extended.
This auto-antibody theory was further verified by using rabbit kidneys and the results were reported in Hiroshima Igaku (Journal of the Hiroshima Medical Association) Vol. 16, 1—12, 1963 under the title "Experimental Study on the Radiobiological Mechanism." This I have reported as "Auto-antibody Theory."

Based on the foregoing theory, the biological action mechanism of radiation in cancer therapy can be summarized as follows. The cells exposed to radiation are directly and physically destroyed by the primary action of radiation and then the decomposed products of cells which have degenerated and died act as auto-antigens on the body to produce auto-antibodies. The primary action effect of radiation is thus amplified secondarily and biologically (immunologically) by these auto-antibodies.

To pursue this question further, I have made a comparative review of the primary action and the secondary biological effect of radiation therapy. Our results of treating cancer show that the primary action of radiation persists for only 20 days and from 50 to 160 minutes when 2,000 r is given in divided doses and during this period some of the irradiated cells degenerate and die. Nonetheless, the course of the cancer patients is favorable for 6 months and even 1 year and at times permanent cure is brought about. We have observed through radiation therapy a major change in cancer patients bringing about a complete improvement in their constitution. This cannot be explained merely by the primary action effect of radiation, but is attributable to the aforementioned secondary biological action effect which persists for an extended period after the death of irradiated cells. To this date this phenomenon could not be adequately explained by the necrophore theory nor by other theories, but it can be readily understood by the auto-antibody theory.

If following pre-operative irradiation cancer tissue is surgically extirpated, would the body no longer have the ability to produce antigens? If so, would antibodies no longer be produced in the body? How can this production of antibodies be made to persist for an extended period? With regard to these pertinent questions, the foregoing theory and results of my experiments pointed out the following important points. The aforementioned secondary biological action effect is not directly dependent on ray quality, radiation dose nor irradiation procedure, but is a purely secondary biological change attributable to "death of cells." Regardless of method in which the cells are destroyed, auto-antibodies are produced so long as cells die. This points out that it is only necessary to kill an adequate amount of cancer cells at the proper time. If this can be done by means not causing any pain, radiation need not be considered. Mechanical procedures, heat and drugs may be employed to accomplish this. If the effect of anti-cancer drugs can be localized to kill tumor cells rather than acting on the entire body, it can be expected to produce the same effect as the purely secondary biological action of radiation.

Next, my interest was directed toward developing a method of utilizing the extirpated cancer tissue toward killing cancer cells. This inquiry necessarily led to the discovery of a completely new therapeutic method—the therapeutic transplantation of the extirpated cancer tissue. The foregoing serves to describe the historical course leading to the need of moving from radiation therapy to immunity therapy in treating cancer.

Based on the foregoing theory and findings, from the latter part of 1960 I have administered on cancer patients pre-operative irradiation followed by therapeutic transplantation of the extirpated cancer tissue. I was invited to read the first report covering the results for the recent four years at the symposium "Biological Foundations of Radiotherapy" of the 11th International Congress of Radiology held in Rome.
on September 1965. The response to the report was most favorable (3).

The regular therapeutic procedure we currently employ in treating cancer involves (1) pre-operative irradiation and (2) therapeutic transplantation of extirpated cancer tissue. (One week after quick-freezing at \(-25^\circ\text{C}\), the tissue is subcutaneously transplanted on the thigh.) It is evident from the foregoing description that both of these procedures are active immunity therapy.

In reviewing the literature regarding immunology of cancer, since Ehrlich's report made in 1906 at the International Congress of Cancer held in Frankfurt, Germany describing his successful attempt in experimentally inducing active cancer immunity, this question of cancer immunity has attracted widespread attention. From the beginning of the century 23 workers have reported in literature the results of active immunity therapy using cancer tissue, but nonetheless it appears that neither the theories involved nor the methods employed have been favorably accepted. On the contrary, the results I have obtained during the recent five years have begun to verify that the method of ours is not only very logical but safe.

The foregoing provides clinical evidence that radiation therapy is a type of active immunity therapy, the basis of which is death of cells induced directly by the physical destruction of cells through irradiation. In determining the optimum correlation between the cancer bearing individual, tumor and irradiation, we would face a "barrier." If massive irradiation of the cancer bearing individual does not affect his self-defense ability, it would be proper to irradiate the tumor cells intensively and extensively.

Therefore, it would be pertinent to inquire into the reasons why the currently employed supervoltage and high energy irradiation method does not necessarily bring about favorable results.

First, review should be made to ascertain if the heretofore method of evaluating irradiation effect is proper, illogical or erroneous. In order to determine the proper irradiation condition, the criterion to evaluate radiation effect should be established.

At present the degree in which the cancer cells are destroyed as determined from the histological findings of irradiated cancer tissue is used as criterion. There is no argument against this criterion, but errors are introduced because no consideration is given to the period following irradiation when the cancer tissue is extirpated for histological examination. My studies have shown that the effect of irradiation, that is the direct and primary destruction of cells by radiation, is evident only while the cancer bearing individual is being irradiated and thereafter it is the secondary biological action which causes the cancer cells to be destroyed. An evaluation criterion which ignores this important time factor is of little significance. For example, evaluation of effect based on cancer tissue extirpated 1—2 weeks following irradiation is useless, because if the irradiation dose is small, cell destruction would be negligible, while if the dose is large, there would be considerable cells degeneration at such time. Inasmuch as the current evaluation criterion is based on the destruction induced by primary action of radiation, this criterion cannot be satisfied unless a large dose of supervoltage and high energy radiation is administered. Therefore, it is the current practice to give dose large enough to satisfy this criterion, but results contrary to what is expected are brought about. Why have workers in the past not reconsidered and reviewed the reason why favorable results are not introduced by such therapy?

As described earlier, the secondary biological action which displays a tremendous effect is based upon the death of cells. There must therefore exist a close correlation between the degree of "cell death," that is focus dose, the amount of resultant decomposed product, and biological action effect. With regard
to this point, from the early part of the century Professor Caspari has pointed out that the decomposed products (necrohormones) of cells follow the Arndt-Schulz's law like a kind of drug in demonstrating its biological action. If cancer cells are adequately destroyed by the primary action, auto-antibodies are produced in the entire body as the tumor becomes smaller in size and with the lapse of time cancer cells are further destroyed, bringing about a favorable course. If, however, the cancer cells are ever-irradiated, the tumor will temporarily but rapidly decrease in size, but the excessive amount of decomposed products will act on the body as "toxin", bringing about so-called radiation toxicosis (formerly called radiation hangover) and deterioration of the general physical condition, such as anorexia, hematologic changes (leucopenia, abnormal protein and salt metabolism) and abnormal laboratory tests. Finally, contrary to expectation, this is followed by cachexia. It should be noted that this excessive amount of decomposed products affects the production of antibodies. That is, even though the tumor may temporarily decrease in size, the self-defense ability of the body is lost, giving rise to early metastasis and various other disturbances. These unfavorable results evidently suggest that the current practice of radiation therapy of cancer is erroneous. It has now become the apparent aim of radiation therapy to destroy cancer cells to the adequate level through proper irradiation and to bring about anti-cancer status through the intensive secondary biological action, or more specifically to cause a proper level of cell death.

It is very vital to administer the proper dose of radiation, but how can this be accomplished? As irradiation inevitably causes cells to degenerate and die, it is not necessarily difficult to administer the proper dose so long as a massive dose is not given at one time. In view of the fact that studies have not demonstrated the need for massive single dose, I determine a daily dose not causing any "discomfort" to the patient and give it in divided doses to bring about a high cumulative dose. For example, in a gastric cancer patient, at present I give as pre-operative irradiation a daily fractional dose of 50 r—100 r to the focus (skin dose of 100 r—200 r) for a total dose of 1500 r—2000 r. For large tumors I use the multiple small field simple fractional dose procedure. Our newly developed criterion is employed in evaluating the effect of irradiation, but the results of our method have also been confirmed by histological examination of the extirpated tissue. For tumors of other sites a daily dose of 200 r—300 r for a total dose of 2000 r—3000 r is usually given. In some cases radiation is given every 2—3 days rather than daily to avoid unnecessary effect on the patient.

The foregoing describes the cancer therapy developed on the basis of the fundamental mechanism of the biological action of radiation. However, for cancers of the early stage and superficial cancers (that is of nose, throat, ear, skin, female organs) massive doses of radiation are sometimes administered with the aid of destroying all cancer cells directly by the primary action of radiation without any regard or ignoring the aforementioned secondary biological action. I have experienced very favorable results with this procedure, but these are limited to special cases, chiefly cancers of the early stage. In these special cases in which massive doses of radiation prove successful, it may be considered that the radiation beam was substituted for surgery or cauterized the cancer. This cannot be radiation therapy in the true sense, but in applying it to cancers of the mouth and skin I have also obtained good results.

In summarizing the foregoing, it can be assumed that radiation therapy of cancer is a type of active immunity therapy. This is the reason why in the treatment of cancer we must move from radiation therapy to cancer immunity therapy.

On the basis of the aforementioned research results, work is in progress toward passive immunity
therapy of cancer of the terminal stage. A preliminary report will be presented.

It is not an understatement to say that the results of treating cancer patients are governed from 60% to 70% by fate. "Early diagnosis-early treatment" does not imply that a treatment method has been established for cancer, but merely suggests an ideal in treating diseases of any kind. If cancer is discovered at the early stage and treated at the early stage the results are generally good, but if not, nothing can be done at the present time.

As described earlier, in some cancer patients after radiation therapy reduces the size of the tumor, the general physical condition is improved and life is extended. These are confirmed to cases having self-defense ability, that is to cases in whom therapy is possible. However, in cancer cases of the intermediate and terminal stage, the regular therapeutic procedure of pre-operative irradiation and therapeutic transplantation has no significance and on the contrary in some cases it induces early death. This applies to all cancer patients and thus it is natural that favorable results cannot be obtained by the current therapeutic procedure which does not give any consideration to the self-defense ability of the individual patient. In reviewing those cancer cases in whom the results were favorable, it was found through laboratory tests that their self-defense ability had not been impaired. The results of cancer treatment are influenced only from 20% to 30% by therapeutic procedure, clearly indicating how feeble is medical care for cancer. Nonetheless, patients with terminal stage cancer cannot be neglected, but nothing could be done for these cases to this date. Cancer immunity therapy was evolved from the auto-antibody theory and therefore the last alternative available for cancer treatment is, I believe, passive immunity therapy. In pursing studies on passive immunity therapy I have developed the following two methods which are at present being applied clinically. It is the aim of passive immunity therapy to produce antibodies against cancer not within the individual's body but to produce them elsewhere for application on the individual.

(1) In the first method, humans are used. This I have called blood transfusion method.

(2) In the second method, antibodies are produced in animals and then purely isolated. This I have named antibody isolation method.

As the details are published in Hiroshima Igaku, Vol. 18, No. 11—12 (Journal of the Hiroshima Medical Association) under the title "Active and Passive Immunity Therapy of Cancer", only the general outline will be given here.

(1) In the blood transfusion method, the quick-frozen cancer tissue is transplanted on another individual with compatible blood type and the antibodies produced in this individual are returned to the original patient by blood transfusion.

(2) In the antibody isolation method, antibodies produced in an animal are purely refined and then employed. Here, homogenate or vaccine produced from the quick frozen cancer tissue is injected into the breast of milk cow or goat and about 2—3 weeks later antibodies in the form of lactoglobulin are secreted in the milk. They are used after refining.

In both methods, the help of a surgeon is required in extirpating the cancer tissue from the patient, while the support of a biochemist is needed in the chemical processing of lactoglobulin. We now have available both the quick frozen cancer tissues and the tes: animals.

On the basis of the results obtained during the last 30 years from experimental and clinical studies and observations, I have devised a most logical therapy for cancer.

It is not an exaggeration to say that the effect of treatment of cancer patients is dependent more on
the self-defense ability of the patient himself than on the therapeutic method employed. It depends largely upon whether or not the patient himself has the ability to recover, whether or not he possesses what are called anti-cancer factors, and whether or not he is predisposed to cancer. These, as explained earlier, are governed by fate. The heretofore therapy for cancer gives little concern to self-defense ability, though most vital to cancer therapy, and therefore once a patient is diagnosed to have cancer, massive doses of radiation and surgery are invariably administered. This, being a reckless procedure, cannot, I believe, always bring about favorable results.

I therefore have developed a criterion of my own to evaluate the effect of irradiation which is not dependent on the heretofore criterion based on histological findings. In carefully studying the clinical findings brought about by the destruction of cancer cells by pre-operative irradiation, irradiation serving as a stress test introduces a number of changes. As described in an earlier report, the results of pre-operative irradiation can be classified into three types according to (1) improvement of clinical conditions (2) reduction of tumor size and (3) normalization of laboratory test results. In reviewing the results we have obtained according to the foregoing three types, type I should the best results, followed by type II and type III with the poorest results.

As the evaluation of the disease by pre-operative irradiation can be simply made by observing the clinical findings during the course of our regular cancer therapy, this method may be said to be a great discovery. Using this evaluation criterion we have been able to estimate the self-defense ability of cancer patients and have obtained good results.

By summarizing these various new findings, it can be assumed the development, growth and even therapy of cancer are always governed by the immunity of the cancer patient. This brings to mind the famous statement made by Professor Caspari to the effect that “Die Disposition ist das Spiegelbild der Immunität.”

In reviewing the literature, the 600 odd cancer patients who spontaneously recovered as reported by Kidd, Cole, Everson et al. are especially noteworthy. During the last 30 years I have experienced 24 cancer patients who spontaneously recovered. Furthermore, there has been an evident improvement in results through this new therapy, attributable to the many cases in whom life was extended to the level not experienced before. Further review of these cases suggests that cancer develops from the individual’s cells, that is from abnormal cells of the body. Therefore, if the individual develops a generalized anti-cancer status, the abnormal cancer cells might become normalized. For example, the undifferentiated cells might mature and remain or might lose their malignant character and disappear. The development of cancer is still a riddle and the process of therapy might also be enveloped in a riddle. It might be possible that no only the development but also course and therapy are governed by immunity.

For cancer patients belonging to type I and type II classified according to the condition of cancer, pre-operative irradiation will strengthen the self-defense ability of the cancer patient and introduce anti-cancer status, while after surgery antibody titer can be maintained by therapeutic transplantation of cancer tissue. If this condition can be maintained for an extended period, the cancer cells would have to change their abnormality and spontaneous recovery would be brought about. Inasmuch as radiation therapy of cancer is effective, I have firm conviction that this theory would be established.

Surgical removal of cancer tissue immediately after diagnosis leads to recovery only in cancer of the early stage. It should be emphasized that surgical removal alone cannot bring about cure, and in this
sense cancer therapy has come to an important turning point. I wish to stress that in the treatment of cancer be it radiation therapy or surgery the factor of "immunity" must be taken into consideration.

Reference