My regular physician at the Tulsa VA outpatient clinic, Dr. Aletty, insisted on referring me to you for followup, even though my recent annual physical has shown me to be in excellent health, with no indications of recurrence of my terminal illness; the Burkitt's form of Non-Hodgkins Lymphoma. I am now scheduled to see you on Tuesday, August 26th. Dr. Aletty has asked me to provide my diagnostic imaging and pathology reports, together with a medical history, with specifics as to how I survived a high grade, aggressive B-cell lymphoma, which had progressed to multiple metastatic sites, after my initial left orchiectomy in November of 1996. (I had refused radiation and conventional chemotherapy. My malignancy was eradicated through use of an alternative treatment; intravenous DMSO, which the FDA has only approved for bladder instillation in the treatment of interstitial cystitis.)

As you doctors are aware, the Burkitts form of Non-Hodgkins Lymphoma is known to be triggered by the Epstein-Barr virus. I suspect that I was exposed to Epstein-Barr in 1978, when I traveled to Africa on business. The Burkitts form of NH Lymphoma is indigenous to Africa, where it affects mostly children. But EBV can remain dormant for years. My lymphoma first manifested in my left testicle in 1996, as a painless lump, which grew rapidly to tennis ball size. My spouse researched it and learned that Burkitts form of NH lymphoma, in this country, is a disease of older men—patients are in their 60's or older. Prognosis was grim; there were no known cases of 5 year survivability, regardless of aggressive treatment. My wife consulted the ultimate authoritative text; "Cancer Principles & Practice of Oncology" (4th Edition, by Drs. DeVita, Hellman & Rosenberg) which clearly states that geriatric Burkitts patients are unable to tolerate conventional chemotherapy and often succumb from the side effects related to its toxicity.

The Tulsa urologist and surgeon who diagnosed my testicular lymphoma and performed my first (left) orchiectomy in 1996 was Dr. Steven Cohenhour. (Now deceased from prostate cancer.) This doctor declined to perform the requested bilateral orchiectomy; telling my wife that her fear that the lymphoma would spread to my remaining healthy testicle was unfounded. (She was proven correct, and transferred my care to surgeon urologist Michael B. Smith, who treated my postop complications from the first orchiectomy and later performed the second surgery.)

The first surgeon (Steven Cohenhour, M.D.) expressed his concern over my intention to resume my regular injections of hGH (human growth hormone.) He objected, quite strongly, to myself or any cancer patient, taking a known cell generator, which human growth hormone admittedly is. I explained to that urologist and to my last civilian one (Michael B. Smith, M.D.) that extensive clinical studies show no evidence of hGH being a causative agent in any form of carcinoma, and that in fact, the opposite findings would apply. I pointed out that human growth hormone is a potent immune system booster, (and therefore a probable preventative or protective factor), as proven in clinical trial studies conducted by Dr. Daniel Rudman, on elderly veterans at the Wisconsin VA Medical Center. (Article on this study was published in the NEJM in July of 1990.) And I went on to explain that I firmly believed that I might never have developed Non-Hodgkins lymphoma, had my supply of injectable human growth hormone not been cut off for five months prior to the development of the primary malignancy! Both of these specialists (urologists) referred me to oncologists for followup treatment, and expressed their deep concerns over my refusal to submit to radiation or conventional chemo, and especially over my

resuming human growth hormone therapy. I need to explain some background here, for you doctors and hopefully for the benefit of your other elderly oncology patients:

Under my former name of Howard Turney, I was well known in the alternative medicine community as "The father of Growth Hormone." I pioneered its use in geriatric medicine in this country, (formerly operating a clinic in Mexico, until the FDA finally approved hGH for treatment of age related disabilities.) I once had an elderly patient travel to my longevity clinic in Playa del Carmen, Mexico, who had been diagnosed with an active malignancy. As administrator, I at first refused to allow any of our doctors to treat him, for fear of exacerbating his disease. But his daughters pleaded with me to allow him to begin receiving hGH injections, and so I reluctantly relented, when they offered to sign a liability waiver. Human growth hormone had never before been used as a cancer treatment, and I feared disaster. (Our doctors did not want a willing human guinea pig; keen on sacrificing himself for the good of humanity—the first rule of ethics in medicine is "Do No Harm!") I finally consented, with great reluctance and trepidation, because the patient's family was desperate, and the old gentleman himself pleaded the argument that he "had nothing to lose." To make a long story short, the patient was allowed to begin the hGH treatment program, ("in spite of" his cancer diagnosis, not because of it), and he experienced a spontaneous remission. Within weeks, all traces of his malignancy disappeared. Of course, he ultimately succumbed to other age related natural causes, but he lived on cancer free into his 90's, thanks to his devoted daughters, who saw to it that he received his regular injections of human Growth Hormone. I did not immediately resume my hGH injections following my 1996 left orchiectomy, due to the difficulty of finding a reliable supply source at the time. My lymphoma not only progressed to my remaining testicle, making a right orchiectomy necessary by mid summer of 2000, but as you can see from the report of my gallium scan of August 20, 1999, metastatic disease progression (abnormal uptake in adenopathy) was by then evident in my remaining testicle, plus also the left clavicle and three regions of my spine.

The gallium scan was ordered by Michael Lynch, M.D., who was filling in for my regular oncologist, Dr. Lance Miller of Oklahoma Oncology Associates. (It's a huge practice, with thousands of patients.) Dr. Miller had predicted my likely death from this disease within an estimated 3 months, unless I submitted to localized radiation treatment directed at the scrotum, plus chemotherapy. My research determined that radiation would leave my prostate gland fibrous and woody, resulting in impotence and incontinence, so I refused. When I asked Dr. Miller for contact with Burkitt's lymphoma patients who had undergone the chemo treatment he was proposing, he admitted that none had survived the methotrexate and cytosine arabinocide.

My wife and I began to investigate alternative cancer treatments. Finally we tracked down a medical maverick; Dr. Morton Walker, author of the book "DMSO: Mother Nature's Healer." And she finally found an elderly retired physician at the University of Oregon at Portland, (the leading expert on DMSO), from whom she was able to elicit the treatment protocols. The hardest part of getting my alternative treatment with IV DMSO (DiMethyl Sulfoxide) was getting a physician to write a prescription for it off-label. The FDA has only approved it for bladder instillation for the treatment of cystitis. I had to convince my personal physician that there was evidence of efficacy of DMSO in the treatment of cancer, and also prove to him that conventional chemotherapy was not survivable by a patient my age. (I was then

nearing 70, and had just undergone my second orchiectomy.) Finally my doctor agreed, nervously, and he (and other eminent doctors in the alternative medicine field) anxiously monitored my progress. A home health care nurse came to my residence three days a week to prepare and start my IVs. She injected pure, pharmaceutical grade DMSO into a 250 ml bag of Ringers Solution, mixed it well, then adjusted the drip flow so that I could tolerate it without any flushing or dull headache. (The only known side effects, experienced by some but not all patients.) My IV treatments took a couple of hours each, and I had them three times weekly (M-W-F) for 3 weeks, for a total of 9 treatments. Two weeks after my final treatment, I reported for a P.E.T. scan, in early August of 2000. As you can see, that report (final page of my enclosed medical records) showed no evidence of any metastatic disease process anywhere within my body. That was over three years ago, and I have remained in good health with no symptoms of NH Lymphoma recurrence. I have continued to receive one IU per day of hGH (human Growth Hormone) by subcutaneous injection.

One point of my medical history is especially noteworthy. The urologist surgeon (Michael B. Smith, M.D.), when informing me that my lymphoma had metastasized to my remaining testicle and that it, too, would have to be removed, gently explained that I could expect to become totally impotent, following total surgical castration. My wife was present, and remarked that it need not necessarily be so, providing I receive supplemental testosterone. Having researched Burkitt's lymphoma, she pointed out that, even though the primary tumor had manifested in a testicle, NHL, unlike prostate cancer, is not fueled by testosterone, and that I should therefore receive testosterone replacement therapy, if for no other reason than to prevent osteoporosis. The urologist seemed somewhat dubious, but he couldn't argue with her logic, so I began receiving IM testosterone injections biweekly, postop. I attribute my full sexual functioning (at age 72, 3 years after bilateral orchiectomy) to my testosterone injections and my once daily IU of human Growth Hormone. Although I now use sildanafil on occasion, I am able to function without it.

Final analysis: My high grade, aggressive B cell Burkitts form of NH Lymphoma was eradicated by use of a potent, effective but painless alternative chemotherapy: DiMethyl Sulfoxide, given by IV infusion in a 1/10 ratio combined with Ringer's Solution.

Due to the prohibitive cost of human growth hormone (Mine is provided free, in compensation for my endorsement) it isn't practical for the VA to prescribe it prophylactically.

However, it should be noted that DMSO is far less costly than hGH, and it is also well tolerated by elderly patients who cannot withstand the toxic side effects of conventional chemotherapy agents. It is my hope that the Oklahoma VA Medical Center will begin a DMSO trial treatment program for elderly veterans who are diagnosed with cancer; who cannot tolerate conventional chemo. If this alternative cancer treatment program is adopted throughout the VA system, many lives could be prolonged, with good quality of life preserved, and the cost savings could be enormous.

Original signed and dated August 4, 2003

NOTE: As of September 2005 the patient, now 75, was still in good health with no recurrence of his non-Hodgkins lymphoma. Many people have asked about the response by the Veterans Administration to

this letter. Predictably, those bureaucrats refused to acknowledge that DMSO had anything to do with this remarkable remission—even though it could not be attributable to anything else, because the patient had not received either chemo or radiation. The VA medics simply called it a "medical miracle" and said the patient "lucked out."

But the truth is that no one in medical history has ever gotten a spontaneous remission from non-Hodgkins lymphoma. The disease is notoriously aggressive and always kills—there are no 5 year survivors, with or without conventional treatment. Except this one case, and others since then, who also received intravenous DMSO.

Lazarus Long

Tulsa, Oklahoma