The 3E-Programme in Combination with Papimi instead of Palliative Intervention

Lothar Hirneise

Summary

From June 30, 2008 to March 30, 2009, 73 cancer patients participated in a five-weeks 3E-programme. The course's objective was and is to mediate final stage cancer patients what other patients have done to come back to life again despite this unfavourable prognosis. Six of these 73 patients came to the centre after surgery without having called upon any further conventional therapies before. At the time of admission, all of the remaining 67 patients had conventionally diagnosed tumours. 19 patients thereof had inoperable tumours, while 16 patients had a R0-resection, but with recrudescences. 32 patients had undergone surgery, treated by means of chemotherapy and/or had been irradiated and had tumours/metastases again.
At the effective date of the survey (March 30, 2010), 36 (53 per cent) of 67 final patients were still alive. On average, this means a triplication of the lifetime expected. Seven patients with partly multiple metastases and one patient with an inoperable glioblastoma were free of tumours. 15 patients had a "stable disease" without any further tumour growth and the PET of two patients with a pancreatic head carcinoma furthermore revealed a normal SUV-value. This means there was no tumour mass reduction, but a significant decrease of the tumour activity. Only three patients of 36 reported they were feeling worse than at their discharge. All six patients having arrived free of tumours felt very well and no one experienced recurrences.

3E-Centre

At the 3E-Centre in Buoch near Stuttgart (Germany), the 3E-programme according to Lothar Hirneise is taught. It is based on the evaluation of clinical records of thousands of people having survived cancer at a very late stage and on the author's kausanetic considerations why people suffer cancer. These evaluations revealed that nutrition and detoxification therapies have played an important role for many final stage survivors. However, these results have above all shown that as of a certain stage of the disease there did no longer exist any substance (chemotherapy, vitamin C etc.) by which third persons such as doctors could heal cancer patients. At this late stage, very specific changes in life or energetic processes are taking place in order to bring seriously ill people back to life. The 3E-Centre is a seminar house (not a hospital!) where this knowledge is taught within a five-weeks course.

Papimi

Papimi was developed by the Greek scientist Prof. Dr. Pappas in the early nineties. It is a high-frequency device exerting influence on the disordered, diseased cell membrane via ionic magnetic induction, activates idle metabolic processes and therewith self-healing of the cell. Like many other frequency scientists, Prof. Dr. Pappas assumes that cancer is a energetic disorder that can be brought back to original balance by means of magnetic induction. This concept fits perfectly in the energetic focus of the 3E-programme and is therefore considered as an optimal supplement to the 3E-programme.

Rethinking of the palliative approach in oncology

By far the largest proportion (91 per cent) of all patients addresses to the 3E-Centre at a – from the conventional point of view – given up / palliative stage. Most cancer patients have been treated with sur-

gery, chemotherapy and/or radiation before, but their tumours continued to grow or recurred. Therefore, many patients are disappointed by conventional medicine and are urgently looking for alternatives for their cancer disease since classic medicine cannot help (any more). A palliative approach as usual today is refused by the 3E-Centre for the following reasons:

1. Palliative means giving up the patient, that means there are no healing prospects any more. Without a doubt, this happens much too often, but this does not apply to all patients and no one is completely sure in advance who will belong to this group. In the past, this was proven by many documented final stage survivors and is demonstrated by this survey as well. Therefore, it is also strived for healing even at a stage where conventional medicine fails to offer curative approaches.

2. For social, financial and communicative reasons, it is often recommended to patients with palliative intention to try the one or the other conventional therapy as well, usually oral chemotherapeutics, antibodies or angiogenisis blockers. This frequently makes the patient believe another treatment attempt is carried out. However, the patients do no longer have the chance to decide in favour of these actually exclusively palliatively applied therapies or not. By mistake, the patient supposes that the therapies recommended could really involve healing. However, this is a great mistake, since 99.99 per cent of conventional palliative therapies sooner or later will lead to death. Without a doubt, palliative therapies sometimes may prolong life as well, but the significant disadvantage is that this way does not offer any chance of healing at all.

3. There is a great difference how a patient spends his or her final days, i.e. with or without hope. Experience has shown here unmistakably that desperateness deteriorates dying, since cancer symptoms substantially increase at energetic level and people therefore suffer more. For this reason, the 3E-Centre intensively works on the mental level (stress reduction) on the one hand, but also on the physical level by strict oil-protein diet and by energy supplies based on Papimin. Thanks to this combination, final patients have substantially more energy.

4. Usually, palliative therapies consist of chemotherapy, radiation and pain meds. All those three therapies involve enormous adverse effects and every person in this situation should consider exactly whether to put up with that variety of adverse effects, hoping this therapy will make him living a little bit longer. However, this is often a fallacy because the majority of patients at best live some days or weeks longer, but instead have to spend a majority of this time at hospital or to cope with extreme adverse effects.

5. Unconventional doctors are often blamed for not being prepared to tell dying people the truth and to even earn money with that. However, in two respects, this is not the truth. First of all, evaluations of the author (1) clearly show how important it is that patients at a late stage are spending their time with people believing in their recovery. First of all, to a decisive extent this includes the treating therapists. And secondly, it is above all conventional medicine having been producing incredibly high costs during the past months (2, 3, 4), by the way above all for medium-aged adults and not for the very old ones (5). As demonstrated by one of the largest surveys ever carried out with regard to this subject, the problem is not only the high amount of costs involved, but that more than every fourth palliative patient dies earlier from chemotherapy. Within the famous NCEPOD survey (6), 115 of 429 palliatively treated patients (27 per cent) died from chemotherapy and not from their tumour.

Patient groups

From June 30, 2008 to March 30, 2009, 73 cancer patients attended a five-weeks 3E-programme at the 3E-Centre. Six of these patients came to the centre after surgery without having undergone any further conventional therapies before.

At the time of admission, all the remaining 67 patients had conventionally (pathology reports and imaging techniques) diagnosed tumours.

* 19 patients thereof were inoperable, since their tumours had already reached a very advanced stage.

* 16 patients thereof had a R0 resection (total hysterectomy of the tumour), but with tumours having locally and/or metastasizingly grown again.

* 17 patients thereof underwent surgery and chemotherapy with tumours occurring again one or several times.

* 15 patients thereof underwent surgery, chemotherapy and radiation with recurring tumours.

Metastasis

37 of the 67 patients had metastases, 19 patients thereof multiple metastases in at least two, partly even in four or five organs. 30 patients had regionally recurring tumours, i.e. one or several tumours have grown again at the place of origin. The official (stated by doctors) expectation of life of all 67 patients was a few weeks up to twelve months at the most, six months on average.

Situation at admission

Apart from the six patients without tumours having received surgery, all remaining 67 patients had in common that their treating doctors had only proposed them a palliative, but no curative therapy any more. For this reason, the patients were looking for an alternative, since they were not prepared to accept this statement. 31 patients found the 3E-Centre when reading books about alternative cancer therapies. 14 patients attended the 3E-programme as proposed by doctors and alternative practitioners and six guests found the way via an Internet research. 22 patients came because of recommendations of prior course participants or their friends.

Types of cancer

The most frequent type of cancer was breast cancer (n19), followed by intestinal cancer (n9), Non-Hodgkin (n4) and bladder cancer (n4). Further types of cancer were: pancreatic cancer, gliobastoma, bronchial carcinomas, prostate cancer, thyroid cancer, melanomas, stomach cancer, sarcomas, ovarian cancer, uterine cancer, tongue cancer, oesophageal cancer and primary liver cancer.

Treatment objectives

The approach of the 3E-programme in principle is a curative one, even – from the conventional point of view – in the event of an already palliative situation. Exclusion criteria for a curative approach at the 3E-Centre are not – like usual in conventional oncology – the quantity or the size and activity of tumours, but the energetic status of the patient, because it happens quite often that patients even with larger tumours or in a metastasizing condition are in a very good energetic status quo. On the other hand, there are patients with a relatively small tumour mass accompanied by a very poor energetic status. The observation of the body on an energetic side and the observation of the mind with regard to a future objective target are considered as top priority of the 3E-programme.

The following interventions have been mediated on physical level:

Oil-protein diet

The 3E-Centre is currently the only centre in Germany offering the consequent implementation of the oil-protein diet, which within the overall concept is considered as the optimal basis of a nutritional therapy for cancer patients. Taught by Mrs. Dr. Johnna Budwig, the author of this study has personally familiarised with this diet for many years. The substantial fact of this diet is that trans-fatty acids are completely excluded and that easily digestible and easily combustible, high-valuable fats get in touch with proteins (cream cheese, linseed oil and milk mixtures) instead. These lipoproteins in combination with further anchor points of the oil-protein diet have a positive effect on the cellular respiration and enable the body to better accept, store and release electrons as requested. Attention: this diet has nothing in common with different oil-

protein-rich imitator therapies as recommended by other authors.

Papimi

Today it is indisputable that mitochondria play an important role in both the development and therapy of cancer. Above all the disordered sodium-potassium pump has been appreciated in literature as a specific cancer problem for more than 60 years already. Papimi is a pulsed magnetic field therapy device releasing short electromagnetic impulses via a coil. Within this process, two charged capacitors in the nanosecond range are discharged in a special plasma chamber via a spark gap.

This magnetic impulse is fed to a treatment coil via a flexible, strongly isolated cable. As a consequence, a very low ground potential develops in the coil. Depending on their charge, the ions respectively the molecules and tunnel proteins ionised for transport can be infiltrated into or discharged from the cells along the magnetic flux lines, of course involving an increase of the membrane potential of the cell which must be considered as an extremely important effect for cancer patients.

Another outstanding feature of the Papimi application is that there do not develop any differences in temperature at the cells, since the impulse takes just a fraction of a second during which no kinetic movements are taking place and therewith no molecular friction either.

On average, the patients received a Papimi treatment of about nine minutes. The spinal column and the tumour areas received priority treatment. In special cases, treatments have been extended by up to 20 minutes or repeated at the same day (for several times). The main objective of the Papimi treatment within the 3E-programme is a general energetic increase. In some events, however, Papimi was also applied as a symptomatic therapy for acute problems. For example, incontinence of a female patient disappeared within a few weeks by sitting on the coil for ten minutes per day. Papimi was applied as pain treatment as well. Partly very fast improvements have been particularly achieved in the event of bone pain. For cancer patients, this represents an enormous advantage, since this may partly or even completely avoid the application of pain relievers. In contrast to the WHO pain-therapy guidelines, due to negative effects on the mitochondria and on the intestine, pain relievers within the 3E-programme are exclusively recommended if urgently needed. In addition, coffee enemas, mental techniques and the pain therapy according to Liebscher & Bracht have been increasingly applied.

Detoxification measures

For the acceleration of energetic processes of the body, detoxification measures play an important role. Within the 3E-programme, preferential consideration is given to and therapies applied for three areas above all. The acid-base balance predominantly takes place via an increased supply of right-turning lactic acid, strict compliance with oil-protein diet and oil pulling. In addition, as far as allowed by the energetic condition, all patients take a natron bath at least once a day or carry out one to five coffee or natron enemas per day. Intestinal cleansing is done twice per week using Colon Hydro therapies and the dental condition of every patient, above all the root canals is basically investigated and if required, it is strived for a necessary restoration / improvement.

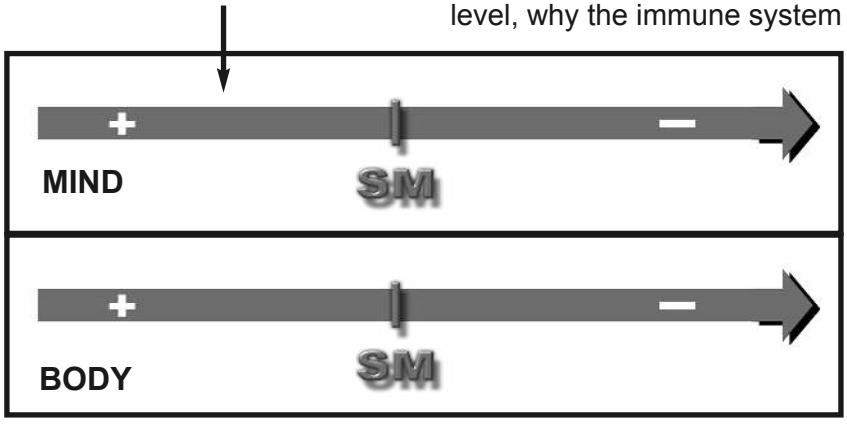
Mental interventions

Apart from fully physical processes, particularly the energetic ones often make the difference between life and death of cancer patients at an advanced stage (7). Therefore, the following three techniques are applied at the 3E-Centre, all of them pursuing the objective to activate the healing powers of an individual.

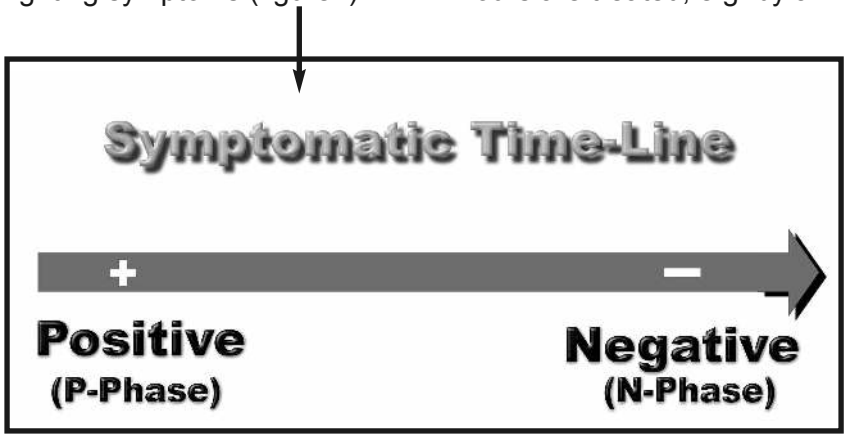
1. Kausanetic

Kausanetic plays a significant role within the 3E-programme. The kausanetic core principle is that evolution has created far-reaching regulatory mechanisms for ensuring the short- and long-term survival of species. From the kausanetist's point of view, all symptoms or more accurately, all regulatory mechanisms, first of all serve

for the top principle of evolution: the survival of species. Similar starting points could be found in the past in analytic psychology, TCM or during the past years by meta-medicine. However, kausanetic is rather different since it is based on the assumption that symptoms develop a symptomatic momentum within the course of a disease. The symptomatic momentum may be rudimentarily compared with the Survival of the Fittest of Herbert Spencer. In the kausanetic approach, a symptomatic momentum may occur on a physical, but also on a mental level, independently of each other. For example, a symptomatic momentum may already have been arrived on the mental side, recognisable by great fear and insomnia, while on the physical side there is just a small, slowly growing tumour, not yet having developed any symptomatic momentum (figure 1).



From the point of view of kausantics, every symptom changes from a positive symptom to a negative symptom one time. This means the same symptom having provided for a longer survival at first, will provide for death at a later stage. Unfortunately, conventional health professionals consider each symptom (every regulation) as negative and therefore today's medicine completely aims at fighting symptoms (figure2)



On the other hand, kausanetists analyse first of all whether a symptomatic momentum has occurred or not. Only then they will make their decision whether it is required to fight a symptom for the purpose of winning time / life extension or, like in most oncogolical events, there is sufficient time left for causal research. Nowadays, it is still discussed at both the conventional and alternative level, why the immune system does not identify "bad" cancer cells and destroy them. However, since from the evolutionary point of view cancer cells are never "bad", but part of an ingenious regulatory system, cancer cells only die if there is no longer anything left for their regulation. The importance considered by our body for "its tumours" for short-time survival (9) becomes also evident from the fact how preferentially tumours are treated, e.g. by angiogenesis (recreation of blood and lymph vessels) or based on the preferential treatment of glucose uptake. This provides evidence as well that today's cancer researchers are currently at a dead end, because pharmaceutical companies have been increasingly trying to develop e.g. angiogenesis inhibitors. However, instead of understanding cancer processes at an early development stage, it is tried to develop new drugs which only intervene when a symptomatic momentum has already occurred.

Visualisation

Since several studies (10, 11, 12) in all over the world have proved that cancer patients having consequently applied visualisation techniques, either lived longer or had other benefits (less pain, less adverse effects etc.), the importance of visualisation tecniques is not even questioned in conventional medicine any more. However, despite a better knowledge this is not yet realised at least in Germany so far.

Unlike at the 3E-Centre, where even several visualisation techniques are applied. Apart from techniques of the kausanetics approach, Russian programmes of the gene transfer technology are applied and predominantly the Mind-Store Programme. All patients of this study have run through the following points for five weeks:

During the first week, it was dealt with the analysis of the actual situation of the disease and the patient's general life.

During the second week, clarity with regard to the life objectives was gained.

During the third week, all patients dealt with possible mental blockades (persuasion, attitudes and feelings) and during the fourth week the first decisions for a changed life in the future were taken.

During the fifth week, it was dealt with stabilising the confidence in the new life to such an extent that the patients were even at home in the position to repose and to be confident in doing those things necessary for them.

Synergetics

Synergetic healing according to Bernd Joschko is done by self-organisation of neuronal energy pictures. The principle of this innovative curative treatment is based on bionics. The basic concept of bionics is that nature in millions of years of evolutionary processes has provided optimised biological structures by means of mutation and selection. Also the human psyche is subject to bionical basic principles, because the brain is the product of an intensive development over millions of years. Like in kausanetics, in synergetics it is not dealt with healing the patient but to activate new processes at physical and mental level in order to induce the development of healing processes. Approximately 90 per cent of all patients were in the position to see pictures during the usually two-hour sessions and to work with them. The patients partially reacted with physical symptoms within a few hours, which however is considered positive in both the synergetic and kausanetic approach. Many patients appreciated working with two synergetic therapists.

Outcome

At the final day of the study (March 30, 2010), 36 patients of 67 final patients with an average life expectancy of six months having been admitted between June 30, 2008 and march 30, 2009 were still alive. On average, this corresponds to a triplication of the expected life. Seven patients with partly multiple metastases and one patient with an inoperable glioblastoma had no tumours any more. This was detected by conventional doctors and imaging procedures such as MRI, CT and PET.

15 patients had a "stable disease" without any additional tumour growth. Two patients with a pancreatic head carcinoma additionally had a normal SUV-value in the PET. This means there was no tumour mass production, but a significant decrease of the tumour activity. Eight persons suffered a further tumour growth, but without any deterioration of life quality and just three patients of 36 reported they were feeling worse than at discharge. All the six patients having arrived without tumours felt very well and no one had a relapse.

Summary

Even if the study was carried out with only 73 patients and the period between first admission and last statistics (May 31, 2010) was just 23 months, the existing data allows important conclusions.

1. Never give up

All the eight patients who are free of tumours today and also those patients with a standstill of tumour growth have not been proposed any or just a palliative therapy by the treating doctor before. However, this study and the overall documentation of the author show that it possible to become healthy again even at a very late stage or still to live with a high life expectancy for many years. Patients should understand that their doctor's statement "I can no longer help you" exclusively means that based on conventional therapies he is familiar with, such as chemotherapy, radiation or antibodies he is only in the position to propose a purely palliative ap-

proach. Unfortunately, these therapies can no longer be applied curatively for metastatising cancer. However, this does not mean that there is really no way left for healing on principle.

2. Five per cent = one hundred per cent?

Dealing with survival rates, they are often stated in percentage. However, there is one consideration often disremembered. If e.g. 15 patients of the study survive five years, this corresponds to just twenty per cent of all patients. However, for these patients that means that they have survived at one hundred per cent and not at twenty per cent. And from the statistical point of view, this would be a rate of increase of 1500 per cent in comparison to conventional therapies. Here the author would like to put the question on the table: ”And if just one single patient survives? Would efforts have been worth it?”

3. Not making any predictions

Although the author has now intensively been dealing with given up cancer patients for years, he is not yet in the position to make any prediction which patient will survive. Multi-causality of a cancer disease is substantially more complex than often assumed. For this reason, doctors should stop telling their patients how long they are still estimated to live. This exclusively activates additional “death programmes” (13), which only put strain on the patient and sometimes even squash his/her hopes of final chances of healing. This is absolutely contrary to the highest principle of medicine: Primum non nocere, (avoid harming the patient first of all).

4. Required discipline

Within the study it became distinctly obvious that surviving patients required a higher degree of discipline for approaching their (newly) found life objectives in the direction of happiness and for keeping to the intended detoxication efforts (enemas, baths,...) and to a strict diet. The more disciplined patients kept to the 3E-programme, the greater were their chances of survival. Many cancer patients, however, are faced with challenges with the high requirements to daily discipline or/and the realisation of the required changes of life above all from the mental point of view.

5. There are no spontaneous remissions

From the conventional point of view, cancer patients surviving at a final stage, are considered as patients with spontaneous remission. Officially (12), however, only every thousandth patient has a spontaneous remission. Converted to the 3E-Centre, this would mean that patients of the 3E-Centre have a tens of thousands higher rate of spontaneous remissions than comparable groups. However, this is surely wrong and rethinking is required here into the direction that spontaneous remissions do not exist.

During the past twelve years, the author travelled to many countries for questioning doctors and final stage survivors. These investigations promptly revealed that all survivors without an exception had undergone different non-conventional therapies.

Since no nutrition or detoxification therapies, and no mental or spiritual therapies either are approved by conventional doctors as oncological therapies, such patients have been pegged as spontaneous remission or miracle healing. The great advantage thereof is that in conventional medicine success of non-conventional colleagues can always be dismissed as a spontaneous remission instead of dealing with the question why these patients have gotten well or what survivors have in common.

Final consideration

Unfortunately, war is still waged between traditional and alternative medicine on the backs of patients. And an end is really unforeseeable. Therefore the author finally takes the liberty to contribute the following consideration for a future discussion about the fundamentals:

“It is obvious that patients having survived their cancer

disease at a late stage, never underwent a conventional therapy, but exclusively non-conventional therapies. Wouldn't it be possible that also – or particularly those! – patients still at the initial stage of their cancer disease could benefit from concepts such as the 3E-programme or other successful non-conventional therapies?"

References:

1. Lothar Hirneise: Chemotherapie heilt Krebs und die Erde ist eine Scheibe

2. Nooren, J.E.A.M. und René van Vliet (1994): Sterfte: een verdeelkenmerk voor normuitkeringen?, in: Tijdschr. Soc. Gezondheidsz, Jahrgang 72, S. 221–230.

3. Lubitz, James D. und Gerald F. Riley (1993): Trends in Medicare Payments in the Last Year of Life, in: New England Journal of Medicine, Vol. 328, No. 15, S. 1092–1096.

4. Emanuel, Ezekiel J. und Linda L. Emanuel (1994): The Economics of Dying. The Illusion of Cost Savings at the End of Life, in: The England Journal of Medicine, Vol. 2, S. 540–543.

5. Dr. Konstantin Beck , Dipl. math. Urs Käser-Meier Managed Care 2003, S. 24-26.)

6. National Confidential Enquiry into Patient Outcome and Death Studie 2008.

7. Lothar Hirneise: Chemotherapie heilt Krebs und die Erde ist eine Scheibe S. 527 – 619.

8. www.krebstherapien.de/kausanetik.pdf

9. See here the book: Ein medizinischer Insider packt aus; S. 182 - 183.

10. Vann Williams Donaldson[1] (1) Center for Stress Management, 602-S Jones Ferry Road, Carrboro, North Carolina

11. (Malignant Melanoma: Effects of Early Unstructured Psychiatric Intervention; Recurrence and Survival 6 Years Later. Archives of General Psychiatry: 1003;50)

12. (Tusek, DL et al: Guided Imagery: A Significant Advance in The Care of Patients Undergoing Elective Colorectal Surgery. Dis Colon Rectum, 1997; 40:172-178)

13. See here the publications of Dr. John Diamond / USA und Dr. Dingyin Huang / Taiwan.

14. Hobohm, U. Cancer Immunol Immunother 2001) 50: 391-396DOI

Contact address of author:

www.3e-centre.com