A Special Interview with Dr. Christine Horner

By Dr. Joseph Mercola

DM: Dr. Joseph Mercola

CH: Dr. Christine Horner

Introduction:

DM: Welcome, everyone! This is Dr. Mercola. Today we’re honored to have Dr. Christine Horner. She has an interesting journey with her health experience. She is going to talk to us today about some of the diagnostic screenings that are currently available for breast cancer, which she’s quite familiar with as really an expert on this. We’re delighted to have you. Welcome and I’m glad that you could join us.

CH: Thank you. It’s my pleasure.

DM: I’m wondering if you could tell us a little bit about your journey in health, what your professional training is, and how you got to the position where you’re at now.

CH: Sure. It’s kind of an unusual journey. I started out as a general surgeon and a plastic surgeon. So I’m board certified in general surgery, as well as plastic surgery. I started my practice in 1991. I had a special interest in breast cancer, because my mom had developed breast cancer when I was in college. Then she had another – a second breast cancer that was found on the opposite breast about 13 years later. So because of her, I got very involved with the American Cancer Society and, in fact, at one point I was the spokesperson for the American Cancer Society on breast cancer issues and also a vice-president.

DM: Is it the national spokesperson position?

CH: It was per state, so in the state of Kentucky. I was actually in practice in Cincinnati and Kentucky is right across the river there. So I had an office in Kentucky as well as in Cincinnati. I was the spokesperson for the state of Kentucky. But we were trained to say that we don’t know what causes breast cancer and we have no known cures. The best things that women can do are breast exams and mammograms.

My mom did that and she was found to have a second tumor on the opposite breast. Obviously, since she was being checked very closely, they found it when it was a very small tumor, less than a centimeter. There were no lymph node metastasis and the tumor markers were favorable. So we thought she was going to be fine. Then about five years later, she developed some pain in her leg and it turned out that she had metastatic disease from a Stage 1. She just gave up. She didn’t want to live and died about nine months later.

DM: How old was she?

CH: She was 75 years old. In her family that was very young, because everyone lived over a hundred. So that really rocked my world. In my practice, I was watching women get younger and younger and younger than when I was doing breast reconstruction on them. Finally, I was doing women in their 20s. I thought something is way wrong with this picture.
DM: When did you see a transition?

CH: Within a few years. It was probably ‘93 or ‘94.

DM: So you saw a radical decrease in the age of the patients that you’re treating?

CH: Correct.

DM: Wow.

CH: Yeah, overtime. I mean it wasn’t uncommon for me to see women in their 30s and their 40s, but finally I was doing women in their 20s. I thought that something is seriously wrong with this picture.

DM: This was when you’re in California or still in Cincinnati?

CH: No. I lived in Kentucky and Cincinnati area, that’s where I was in practice. I thought when we just looked through the medical literature and see if there’s anything that research shows that women can do that’s within our control that will lower our risks. I had no idea what I was going to find, because at the time I thought pharmaceutical companies were sponsoring all the research.

But when I looked, I instantly found thousands of studies that show exactly why we have a breast cancer epidemic, prostate cancer, colon cancer, and ill health in general, and in all the things that we’re doing in this culture to fuel those various different diseases and the things that we traditionally don’t do in this culture that are highly protective– and they’re all natural. It’s food, supplements, herbs, activities, and so forth. Everything that I was taught didn’t really make much of a difference in my general surgery, plastic surgery, medical school training, and so forth.

DM: I’m just personally curious– always curious about these issues. You were actually a plastic surgeon?

CH: Right.

DM: Treating breast cancer patients.

CH: Yes.

DM: Do you remember what triggered your journey down this path to try to find the cause? Because the vast majority of medical professionals in your row aren’t searching, aren’t going down the journey and exploring.

CH: Right.

DM: I’m wondering what motivated you. Was it your mother’s experience?

CH: Well, not only my mother’s experience. I didn’t want to get breast cancer. I thought here what we do is we tell people, “Okay, the best thing you can do are mammograms and breast exams.” What does that mean? You’re finding breast cancer when you already have it.

Even if you’re at the earliest stage, taking care of my patients can tell you it’s horrible. You have to go through all the emotional trauma. You may have to have mutilation surgery, radiation,
chemotherapy, and maybe you get to live and maybe you don’t. To me, that doesn’t sound like a very good option. Then we’re telling women that all they can do is mammogram, and it’s extremely disempowering. You feel like you have no control over it.

If you look at epidemiological studies or studies that look at groups of patients, we know that people that live in Asia have a very low incidence of breast cancer or prostate cancer. If they move here to the United States… The question is if they adapt the American diet and lifestyle, does the risk go up? If it doesn’t go up very much, we know it’s primarily genetics. If we know that it goes up a lot, then we know that it has to do primarily with our diet and lifestyle.

Even way back then, we have the studies that showed that if any Asian woman moves to the United States and adopts our American diet and lifestyle within one generation, her risk will match that of an American woman’s. It’s like “Hello? What are we doing or not doing that they’re doing or not doing that’s making such a big difference?”

DM: I guess part of the issue, too, is you’re a woman. Many of the plastic surgeons who are doing constructive surgery were men, so they were not as motivated, because it wasn’t going to personally affect them.

CH: Although men do get breast cancer.

DM: Yeah.

CH: It’s about one percent.

DM: Sure.

CH: But—yeah.

DM: Can you tell us the next step in your journey, when you were personally motivated, you found these therapies, these approaches, these strategies that you identified, and what’s your next step from there?

CH: There were all sorts of serendipitous things that occurred. One of them is that I actually started working on a legislative project back at that time. Suddenly insurance companies decided that they were going to stop paying for breast reconstruction full mastectomy. That was about 1993, I think, when I got the first letter. It was an Indiana medicated patient—actually, it was my first one. I fought bad and won that case, but it doesn’t really set a precedent. What they do is they make you fight for every single patient, which you couldn’t normally do, because it takes too much time.

The second letter that I got was on a Kentucky Blue Cross and Blue Shield patient. She was 32 years old. They said, “We’re not going to pay for breast reconstruction on your patient, because it’s just an organ with no function.” I thought, “I think you just said that to the wrong person!”[Laughs]

DM: [Laughs]

CH: I thought, you’re going to pay and everyone’s going to pay. What I did is I organized a national legislative movement to make it mandatory that insurance companies pay for breast
We started in the States to begin with, because it was right after the Clinton healthcare bill did not go through. They weren’t going to listen to anyone in Washington, and we got 35 state laws passed.

Then I discovered this loophole law through a risk of the Employee Retirement Income Securities Act, where basically people aren’t covered by state healthcare laws or all exempted. There’s about 60 percent exemptions and, of course, Medicare and Medicaid.

I thought, “Okay, who are we recovering?” At that point I thought, “This is ridiculous. We need a national law and that just needs to be President Clinton.” I asked everyone that I came into contact with for two weeks, “Do you know how I can meet President Clinton?” I met someone, who knew someone on the Federal Trade Commission that had lunch with him, and about five days later I was talking to President Clinton about the issue.

DM: Wow.

CH: It ended up being a five-year campaign. There were a lot of difficulties with it.

But the first time that I met with President Clinton, I flew back. A television crew from Cincinnati sent out a reporter to meet with me. He was a teacher of Transcendental Meditation for about 30 years and was involved in the system of medicine, Ayurveda. When he was talking to me he said, “You know, you should really learn how to meditate. I think that would be something you’d enjoy doing.” So I did that. Then I thought, “Gee! If this has these tremendous effects to it just from the initial meditation, what else is there?”

I got introduced to the system of medicine of Ayurveda. The more I learned about it, the more I thought that people really need to know this information, because there are so many really simple things that people can do that can have a dramatic effect on their health. Basically, the more you learn about natural medicine, the more you’ll realize that we’re just telling our patients lies— not on purpose, but from what we have been taught about from the pharmaceutical companies and so forth.

I pitched the television stations in Cincinnati to let me be the doctor on the newscast to talk about complementary and alternative medicine. As far as I know, it’s the first syndicated segment on the newscast on complementary and alternative medicine.

DM: Wow, congratulations.

CH: It was back in 1999 through 2002. I really submerged myself in learning natural medicine. I call it my “residency in natural medicine” because I was doing a couple of segments a week. I was really afraid that my colleagues were going to attack me for it, so I made sure I was researching everything like crazy.

DM: How did you acquire your knowledge and information? Were you going to courses or just reading online?

CH: PubMed, which is just a phenomenal resource. I was looking, researching by myself, and interviewing patients about the results that they have had using different natural approaches.

[----- 10:00 -----]
Predominantly, I was educating myself by looking through the medical literature.

I was working 14 hours a day, seven days a week, between doing my practice and doing the television segment. Because I can really work hard, I did that for three years! [Laughs] Then I had an unpredictable meltdown one day. I woke up and then, “Rargh! I can’t stand this anymore!” So I decided to quit my practice, because really my passion is teaching people how to become and stay healthy naturally and “avoid the knife,” as I’d like to say. I quit and that’s how got into natural healthfull-time.

DM: Wow, that’s quite a journey. So this breast reconstruction advocacy law that you helped put in place, that’s in place now?

CH: It is.

DM: Can you just summarize what currently exists as a result of your initiative and efforts?

CH: Sure. It’s actually a great bill. It’s something that was tagged onto the budget bill– nothing’s ever heard on this on its own right basically. [Laughs] But basically what it says is that if a woman has a mastectomy, then her insurance company absolutely has to pay for breast reconstruction. They actually have to pay for symmetry operations. Because the problem that we had before was that, let’s say, a woman has an extremely large breast on one side. You can’t match that with three constructions. You actually need to do a breast reduction in order to get them to be symmetrical, which they wouldn’t pay for.

So the bill says that they have to pay for the symmetry operations and all the stages of the reconstruction, because sometimes we have to do it in multiple stages. It covers for people that have private insurance. It’s specifically what it does.

DM: So it’s not public health, Medicare, or Medicaid?

CH: It’s not for Medicare or Medicaid, because the problem is you’ll have to put it into the budget bill. They told me it would be a complete nightmare to try to get it passed with that.

DM: Sure. If it was bad then, so it’s an order ten or a hundred times worse now. [Laughs]

CH: That’s right! You bet. [Laughs]

DM: I really applaud your efforts to make that difficult decision and really pursue your passion, because that really is the key to being successful in whatever endeavor you choose.

CH: Right.

DM: You’re really able to do what you’re passionate about, and obviously, you’re passionate about this. You have really focused your efforts in natural therapies for breast health and education. Or have you extended and made it broader than that?

CH: Probably, it’s extended. When I first did the education– obviously, it was about all of it, because I was doing the television segments. But when I left my practice, I decided that the first book I was going to write would be a book on all the natural approaches to protecting against and
fighting breast cancer. That’s because we have the answers to the breast cancer epidemic. We truly do— and it’s very simple.

If you have a terrible diet and lifestyle and you do one thing, you cut your risk in half. You do more than one thing and those things will multiply up together. They don’t add up together. They multiply up together, so it becomes extremely easy to dramatically lower your risk of breast cancer.

DM: You’ll virtually eliminate it.

CH: Virtually. I say, if you look at the statistics for rural India or rural China, where they’re still living on fresh fruits and vegetables and so forth, they’re getting exercise every day, and they’re using spices to cook with and so forth, they have the lowest incidences of breast cancer in the world.

For me, we should be able to match that, at least. Maybe even surpass that, as far as lowering the risks, because we know of all the different things that can help to protect against it. If you actually take some of those things in supplement form— because it’s impossible to get them in everyday— then theoretically, we might be able to get the rate even lower.

DM: I’d just like to broaden the scope of the discussion, specifically, because you aren’t merely focusing on breast cancer— but really, discuss breast cancer— but broaden it with the perspective of including some of the males that are viewing.

CH: Oh sure! Yeah.

DM: And mention that there is an equivalent organ— not so much function-wise— but with respect to response and characteristics, that would be the prostate.

CH: Right.

DM: Prostate being the most common or one of the more common causes of cancer in men, but also responds to the similar risk factors as breast.

CH: Exactly.

DM: Why don’t you expound on that, and then will go to the specifics about breast so that the men can listen.

CH: Correct. Breast, prostate, and colon cancer are all very similar tumors. They’re called hormonal tumors, meaning that certain hormones cause them to grow. The exact same things that fuel breast cancer are the same things that fuel prostate and colon cancer. Similarly, the things that help to protect against it are the things that are generally exactly the same things.

I would say, we’re talking about breast cancer, but everything that I found that has an influence on it— it’s about good health in general. If you avoid the things that are contributing to breast cancer, prostate cancer, and colon cancer and you do the things that are protective, your likelihood of any chronic disorder is extremely small and our ability to enjoy extraordinary health is very high.
DM: Okay. Thank you for reinforcing and explaining that.

CH: Sure.

DM: Let’s jump now into some of the diagnostic screenings that you can address preventively.

CH: Sure.

DM: Then we’ll talk about some of the specific things you can do to address and prevent. Diagnostic screenings are nice and useful, if we can find them. But with respect to prostate...Just recently, we had these expert panels that come up and say that prostate screenings are close to worthless! [Laughs]

CH: Right.

DM: The PSA test, and that maybe we shouldn’t even be doing it. I’m wondering if you can comment on that. Also, it was a year or two– I think late 2010 – where the expert panel came up and said that mammography should not be done in women under 50 unless they have a very specific risk factor!

CH: Correct.

DM: I’m wondering if you could comment on those.

CH: Sure. Okay. Looking at the diagnostic tests that are currently available, none of them are perfect. Everything has its pros and cons. None of them are perfect. The problems come with– where we look at– what’s called specificity, meaning what it finds or it looks like it’s suspicious than it actually is. It’s suspicious or it’s not a problem. And “sensitivity,” meaning “Does it actually pick up when you do have a problem? How often does it pick it up?” Like I said, none of them are perfect, so they’re missed by every single type of diagnostic exam that we have.

There are a lot of the problems that we have, if you look at breast cancer, for instance, and we look at mammography. We have a problem with the fact that mammography produces radiation, which has been shown to increase the risk of breast cancer. It’s like, “Why are you doing the test to look at a disease when it’s actually causing the disease, too?”

There’s no question that mammograms have saved lives. There’s no question about it. It does pick things up at earlier stages, but the problem is that it’s not very specific. So when it looks and it sees something where it says, “Oh my gosh! You may have something that looks suspicious,” it’s wrong 80 percent of the time.

In the United States, there’s roughly a million breast biopsies done per year, and 800,000 of them are unnecessary. Thinking about the medical expenses– not to mention the emotional upset that women have to go through, thinking that they have something. Invariably, too, they may have multiple mammograms. “Oh, come back again. Let’s look again. Let’s look again.” They get more and more radiation exposures.

DM: Which, in your understanding, of the increase to the risk of each additional mammogram?

CH: Yes. I don’t know exactly what it is. There’s numbers that people toss out there.
DM: It’s increased for sure.

CH: It’s increased for sure. I mean, we know that radiation increases the risk of breast cancers. I’m not a huge fan of mammograms, even though they have saved lives. I personally don’t get them done, because I think that there are other things that we can do that can work. Plus I do every single thing that has ever been known to me. [Laughs]

DM: Sure.

CH: Or there ever is! [Laughs]

DM: It’s not likely that you’re going to come down with it. Are you an advocate of breast self-examinations?

CH: I am.

DM: Because some studies suggest that it may not be useful. I’m wondering if you could differentiate that, because I think it has to be done properly. If it’s not, then it may not be that valuable— or at least taught properly.

CH: Sure. I think doing a self-examination is actually extremely important, because there are a huge number of tumors that are found either by the patient or by their significant other. You can’t count that out at any way that we can possibly find it. It’s something that should be employed. Although, being said, I’m not a big fan of mammograms. [Laughs]

Those are the main things that are offered through Western medicine. Secondary ones that are offered are the MRI scans, which don’t use radiation. It uses a magnet, but it’s very expensive. So to try to use it as a screening tool, it’s not practical, because sometimes it can cost anywhere between a thousand and 18,000 dollars just to do an MRI. Like the mammograms, the MRI scan is not very specific. It shows up a lot of things that looks like it’s suspicious, then it’s not and then it leads to unnecessary biopsies.

Finally, ultrasound is another technique that’s used in Western medicine. The traditional ultrasound is something that only sees if a mass is cystic or solid. Solid, generally speaking, we’re more concerned about that, because that would indicate that you’d have a higher risk of having a tumor versus a cystic— although, that’s not a 100 percent sure either. Sometimes cancer can show up with cysts in them.

Now there’s a relatively neat new ultrasound that uses a color mode to it, and it’s called elastography.

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There aren’t very many centers in the United States that use it. I actually go to the Center of the Hoxsey Clinic, to Dr. Arturo Rodriguez at Tijuana. What it does is it has a color scale on it that measures the elasticity of the cell membranes. Cancer cells are very stiff, whereas normal cells have more fluidity to them. It’ll show up as red, if it has a lot of stiffness to it as a cancer cell, or blue if it has elasticity. Dr. Rodriguez actually said that he found a one-millimeter cancer in a woman using this elastography or its color mode, which you’d never be able to find normally
with ultrasound. That’s a really good vehicle. But unfortunately, it’s, not found very often in the United States. So those are the main things.

Do you want me to talk about prostate cancer first before we go into thermography?

DM: Sure, if you could just mention that with your views on the recent recommendation of the expert panel.

CH: Sure. Okay. I can understand why it’s really confusing for the lay public to figure out what they’re supposed to do. Because we get these recommendations, where suddenly, you’re supposed to be getting mammograms every year, then they’ll say, “Oh, wait a minute, it’s of no value, if you’re under 50 years old.”

The similar thing with men where they have the blood test, the PSA test to measure. It’s one of the main things we have for checking to see if there’s an elevated risk of prostate cancer. Now this expert panel comes out and says, “Oh, maybe it’s not that valuable anymore.” People are left by what they can do in order to be diagnosed with it.

I still think there’s some value with it, because like mammograms—again, it’s not very specific. It can lead to unnecessary biopsies and so forth, but it does save lives. There are not a lot of options that we have other than doing physical examinations or using ultrasound in order to test. I still think that there’s some value.

DM: Yeah. It’s a less invasive and dangerous procedure than a mammogram, for sure. There’s virtually no risk.

CH: Yeah, absolutely.

DM: It has a relatively minor cost. But I guess the main risk is the challenge if it dumps you into this diagnostic strategy. If it’s falsely positive, then you’d go through the process of biopsy and that whole process of (22:36). It can be a challenge.

CH: Right. Nothing’s perfect. I mean that’s how we get down to it.

DM: I check mine every few years. It’s been very, very low.

Then we have the alternative options, which are somewhat controversial, at least from conventional viewpoints.

CH: Correct.

DM: For those who have studied it, it’s not very controversial. I’m wondering if you could expound on that.

CH: Sure. I think you’re talking about thermography. Thermography is an infrared picture of the breast. We can actually use it for other body parts as well. It’s something that was developed through the military. So looking for heat patterns, we’re kind of looking for the enemy at night. It’s actually fairly fascinating how much of medicine comes from the military. It kind of stimulates our progress.
DM: There’s a lot of research funding with the ARPAN and such. We’re just taking advantage of all the research.

CH: Yeah, absolutely. There was a thought that thermography might be something that will be useful in breast cancer diagnosis. Unfortunately, the way that it started out wasn’t so great, because the machines that they used were not computerized. You have to have a person doing interpretations of it.

Basically, what it’s doing is looking at heat and blood vessel patterns. Interestingly, what happens is before you even get a tumor formation, the very first thing that happens is new blood vessels start to grow into the area where the tumor may form. Those blood vessels are not normal. They grow abnormally. They grow an abnormal amount of patterns and they produce an abnormal amount of heat. That’s what thermography is checking for.

DM: Let me just comment on that.

CH: Sure.

DM: They don’t actually produce heat. It’s just the blood’s warmth. Because there’s more blood in there, it’s going to show up as heat.

CH: Right. But I’m just saying is there’s an abnormal amount of heat than what you’d have in a normal breast.

DM: Sure— it’s increased.

CH: Yeah. There are multiple problems that occurred with this, but one came where the equipment that we had was not computerized, it wasn’t very sophisticated, and people were not trained adequately on how to do that. They actually threw thermography into this huge study that was being done on mammograms, because mammograms have a similar problem earlier on, where things weren’t standardized. The machines weren’t standardized. So if you get a bad machine that gives you a reading— let’s say, it’s not seeing that there is a tumor in there when there actually is— it does more harm than good, actually.

In this huge study that was done with mammography, the effort was to standardize the machines, standardize the readings of it, and so forth so that we would get a much better examination than what was getting done before. What they did is they threw thermography into that to see what will happen, but it was very haphazard. People didn’t have the right training and so forth, so the conclusion from it was that, “Oh thermography is not of any value,” because we didn’t get the good data from it, so it kind of fell out of favor.

DM: What year was that?

CH: That was back in the ‘70s— the early ‘70s. It fell out of favor, but there were people that persevered with it, and the technology got a lot more sophisticated over the years. It became computerized. Now we have a fairly independent way that wasn’t dependent on somebody reading it. We could get the measurements of the temperature variations, which could get a lot more specific— the tens of degrees, a hundreds of degrees, rather than one or two degrees or so forth, which couldn’t get us any value.
There’s a bunch of different companies that came out with various different cameras. The cameras basically work the kind of same way. There are some variations with it.

The problem that we still have today with thermography is that we don’t have standardization. We don’t have a uniform way that people are tested and trained with uniform equipment, and so forth. There is some variation with it, which is a little bit of some concern.

But there’s definitely a movement— I’d have to say— to do standardization, also to get that technology available for women, because this is a technology that has no health detriments associated with it. It does not use radiation or anything harmful to the body. It’s just a picture basically, an infrared picture. Ideally, we’ll see that the groups will come together just like they did with mammography and get a standardization that occurs. That’s when I think we’re really going to see thermography more acceptably taking off.

DM: It would be wonderful if they did, but the challenge, of course, is there’s really some significant pressure from traditional modalities.

CH: Sure.

DM: The advocates of mammography, because they perceive this as a threat to their business model.

CH: Right.

DM: So there’s pressure against that, and those from federal regulatory agencies.

CH: Yeah. I mean there’s no question about that. It’s unfortunate. Our country is run by big business. It’s just is, so anytime we want to shift anything culturally like that and we’re going against established business, we have trouble because it’s all about money.

DM: Yes. You were the spokesperson for the American Cancer Society. As I understand it, many of the presidents of the American Cancer Society were actually members of the Radiological Association, which is the industry that’s supporting the mammography component. There’s a lot of coalition going on.

CH: We can see that everywhere. You look in the FDA. There are people from Monsanto that work in the FDA. Unfortunately, people think, “I should live in the United States. It’s not very corrupt.” But actually, it’s extremely corrupt.

DM: It’s a massive conflict of interest. In light of the fact that there the standardization has yet to occur for a variety of reasons, I’m wondering if there are any recommendations or guidelines that you could provide for someone who’s interested in using this useful tool, to make sure they’re getting an exam that is really achieving the highest standard possible today.

CH: Sure. The best that I can recommend is that there’s an independent non-profit organization called the International Academy of Clinical Thermology. They have a kind of an independent way of testing people who are the thermographers. There’s a website for them and I just recommend that people go on that website to check and see who’s certified by them. That’s the best that I know right now.
DM: Okay. Good. So they’re an independent, objective, third-party certifying agency that can tell, let people know. Are there many senators who’ve achieved the certification across the country?

CH: Yeah, almost in every state.

DM: Okay, great. That’s good to know – terrific. You have done lots of homework and research in seeking to identify…

CH: I have. [Laughs]

DM: The best strategies to minimize the risk. These preventive diagnostics are certainly useful; I’m sure they will save loads of lives.

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But even better than diagnosis is to prevent it.

CH: Correct.

DM: Literally, it’s probably an exponential order of magnitude that’s more effective to prevent disease and treat it.

CH: Right.

DM: I’m wondering if you can share with us what your research has shown to be some of the most useful strategies. Maybe even if you have found one that you could identify.

CH: It’s fifty! [Laughs]

DM: Yeah, but if you can only do one, and maybe you can’t. I think I have an answer for it.

CH: You have an answer! It’s actually a tough thing, because if you look at the studies and virtually every single thing that has an influence, it’s almost a 50 percent reduction in virtually everything.

DM: For every intervention?

CH: Almost everything. There’s about a 50 percent reduction, and if you combine them like I said, you’ll get these synergistic results where they’ll multiply up as far as their effect is concerned. I’d say the most important thing is what you do or don’t put in your mouth. That’s the most important thing, because you can have huge influences by the foods that you consume – the spices, the herbs, and so forth. The things that you avoid, that’s going to give you the biggest results. For me, you can’t just do one thing about your health and think that you’re going to be healthy. [Laughs]

DM: No, of course not. The point I was trying to make is based on the research I reviewed. The single most important one would be exposing your skin to sunshine.

CH: Vitamin D is big. But it just cuts your risk in half! Vitamin D cuts your risks in half. Turmeric and anti-inflammatory cut your risk in half. I could go through each thing, and I’m
telling you the research shows that there’s about 40 to 50 percent reduction, so with exercise and so forth. To say that one is necessarily better than anything else, that’s a really hard thing to claim.

**DM:** Well, it’s just a lifestyle change. It’s a readjustment—not only for breast cancer. It seems to affect other cancers and certainly the ones you mentioned.

**CH:** Oh sure.

**DM:** I think it’s actually more than 50 percent. It’s probably...

**CH:** It’s 50 percent. There’s a study that came our two years ago.

**DM:** In these studies I reviewed there’smore.

**CH:** There’s 50 percent reduction in breast cancer and colon cancer with vitamin D.

**DM:** You have to look at how they do it. If it’s actually sun exposure, you have to look at the levels, because the levels become protective at a certain point. If you’re just doing a study and comparing a level of 20 nanograms per MO at some point, versus someone of 30 or 40, it’s a lot different with something at 70 or 80, which can be more therapeutic and protective.

**CH:** Yeah. This study was giving people a vitamin D supplement.

**DM:** Yeah, and most of those studies are using doses that are totally suboptimum. The new research shows you need about 8,000 units. So if you’re giving a person 2,000…

**CH:** Right.

**DM:** Yeah, you might reduce it by 50 percent, but if you give them what they really need…

**CH:** Right.

**DM:** The studies really haven’t been done yet.

**CH:** I think it varies per individual. So it’s kind of tough to say exactly what dose, because it varies per individual.

**DM:** Well, we work with Carole Baggerly from Grassroots Health, if you’re familiar with her. She’s actually looked at thousands of people and has done correlations on their blood test and their dose. She’s got some pretty solid data that supports most adults need about 8,000 units.

**CH:** Right.

**DM:** I mean some may need 20,000. Some may need four, but for most part in adults, at 4,000 units of sun exposures, probably your levels are going down. That’s what her study shows.

**CH:** Right. Then you have problems in Northern climates.

**DM:** Oh that’s a whole issue!

**CH:** They probably haven’t seen the sun in years! [Laughs]
DM: Yeah, it doesn’t happen. Most people, if it was a sunny day, which is not and is unfortunately the case in Chicago frequently… [Laughs]

CH: Right.

DM: But if it was sunny—you were to go outside and we’re filming this in November—and you had to be in the sun with no clothes, you would not get any vitamin D.

CH: Right.

DM: Zero—absolutely zero – because there’s not enough UVB. I’m just assuming that you have access to have enough UVB, but that doesn’t happen.

CH: I do, in San Diego. [Laughs]

DM: Yeah, in San Diego. But even around in the next few weeks or so, it’s going to be a lot lower.

CH: Sure.

DM: There’s a window in San Diego of probably a month or six weeks that you’re not getting much.

CH: Yeah.

DM: Anyway, I’m sorry I interrupted. I’m a big vitamin D— I have a passion in vitamin D.

CH: That’s okay. I do, too. That’s what I have it in my formula too, because absolutely vitamin D is extremely important in reducing your risk of not only breast cancer, but virtually every single chronic disorder. It’s amazing, the research that’s coming out on it.

DM: Yeah. It’s an epigenetic regulator. Its influence about 2,000 to 3,000 genes.

CH: Right. Exactly.

DM: Anyway, why don’t you share with us your other insights?

CH: Sure. I always like to put things under two different categories. One is we got to stop doing things that are actually fueling the growth of breast cancer or ill disease.

DM: Right.

CH: There’s this great little saying that says, “You can never get the floor mopped up if you don’t turn off the faucet first.” The problem that I think people have is that they think, “I can take a pill or I can take an herb. Somehow that’s going to help me.” But in fact, what we have to do is stop doing the things that are creating the situation to begin with. Then all the good things that you’re doing actually have a much better effect than herbs, supplements, and so forth.

The things that we found that really contribute is number one: eating red meat. In this country, we have these horrible growing practices where we inject our cows with all sorts of antibiotics, growth hormones, and so forth. They also just get a tremendous amount of toxins in their bodies
and stored in their fat. So when you’re eating red meat, there are many different things that contribute to its carcinogenic effect. One is heating it where you carcinogens that are called heterocyclic amines, which are extraordinarily carcinogenic to our digestive tract and increases your risk of breast, prostate, colon, and bladder cancer, and so forth.

Then the saturated animal fats act as a concentrated storehouse of toxins. We definitely know that toxins are things that contribute to all sorts of different kinds of cancers, primarily from damaging the DNA. There are a lot of other mechanisms that are involved with it.

Then the iron in red meat is something that’s been found to be damaging as well. If you’re a menstruating woman, it’s fine to consume iron. But if you’re not or you’re a man, then it’s very easy to have iron levels that are a little too high. They found that iron can be very damaging to our bodies. It forms with other molecules and becomes what it’s called a hydroxyl radical, which is a very powerful oxygen free radical. They found iron in the plaques in our blood vessels, as well as iron in plaques in Alzheimer’s in our brain. Those are all part of the reasons that makes red meat as such a strong contributor.

In addition to that, another favorite one I really love to nix is sugar! [Laughs] To me, sugar has no redeeming value at all, because they found that the more we consume it, the more we’re fuelling every single chronic disease. In fact, there was a study that was done I think a year ago. They looked at all the different chronic diseases that we get from Alzheimer’s to arthritis to heart disease to cancers. And the conclusion is that sugar is a universal mechanism for chronic disease. It just kicks up inflammation. It kicks up oxygen free radicals. Those are the two main processes we see that underlie any single chronic disorder including cancers. It fuels the growth of breast cancers, because glucose is cancer’s favorite food. The more you consume, the faster it grows.

There’s another story that was done looking at groups of women who consume high levels of carbohydrates versus low levels. They found that their incidence was twice as high for breast cancer. Also, sugar is something that completely knocks out our immune system. There are multiple studies that show that if you consume a high sugary meal that you may knock out your immune system function by as much as 90 percent for five hours afterwards. So you definitely want to avoid consuming sugar.

Next is the type of fats that we consume in our diet. I already talked about the saturated animal fats, but another issue is that whatever we consume is what our bodies are made out of— the construction materials, of course. It’s always so amazing to me when people forget that or think that it doesn’t have the influence that it has. Every cell membrane is made out of fat. Our brains are made of fat. Our nerves are coated with fat.

Years ago, we used to think that we need to do low-fat diet. But actually, what’s true is that we need to be consuming good kinds of fats and not the bad kinds of fats. We really need to eliminate doing animal fats, trans fats, or partially hydrogenated or hydrogenated fats, which are the man-made fats that are very, very damaging for us. Those are things that are found like French fries, cookies, potato chips, and things like that that make them crispier and help with the shelf life. Always read the labels and make sure you’re not consuming those.

If you consume omega-3 fatty acids and omega-9 fatty acids— these are the good types of fatty acids— then our cell membranes become made out of these particular fatty acids. They function
much, much better. There’s a lot more fluidity in the cell membranes and all the various different 
functions in the cell are found to work better.

Interestingly, for instance in breast cancer, what they found is that when estrogen hooks on to the 
estrogen receptor in the breast cell and turns it on, it’s not an all-or-none phenomenon. It’s not 
like a light switch. It’s much more like a volume control.

There are certain things that turn the volume up, which will cause the cells to divide more 
rapidly. And there are certain things that turn the volume down. One of them is a type of fat we 
consume in our diets. If you are consuming a lot of saturated animal fat, trans fat, and so forth, it 
does what’s called a “booster effect” and it blasts that receptor volume way high. If you’re 
consuming mostly omega-3 fatty acids, it’s going to turn the volume way down. The types of 
fats—again—are extraordinarily important.

**DM:** I’m wondering if you could expound on the misrepresentations of mammography and the 
conflict of interest that exists in that whole model.

**CH:** By the misrepresentations, I’m assuming that we are talking about mammography as the 
greatest tool that’s going to pick up the breast cancers.

**DM:** Sure. What are the traditional recommendations, even though these expert panels— as we 
mentioned—have not advised women under 50 unless they have…

**CH:** Right.

**DM:** Which women in their 50, do you believe, should have this screening?

**CH:** Sure.

**DM:** But that’s not the perception. That’s certainly not what the traditional, multi-conventional 
is actually employing in their prescriptions.

**CH:** Right.

**DM:** Those types of misrepresentations, and how they get transferred through the whole 
physician model and implement it in a practical way.

**CH:** Right. Okay, I can see people have a real difficulty trying to figure out what they’re 
supposed to do with mammography, because again we’re getting different recommendations 
from different panels. Now we’re hearing, “Oh, you should get it every other year. Oh, you 
shouldn’t get it until your age 50.” Then it’s like, “Okay, what are women supposed to do when 
they’re younger, if they don’t get mammograms done?”

Mammograms are very bad at being able to see through dense breast tissue. The younger we are—
generally speaking—the denser our breasts are. So you can’t see anything. It’s like when people 
are asking, “Oh, let’s do a mammogram” and they’re somebody in their 20s because they have a 
high risk in their family history, it’s a pointless endeavor because you can’t see through the 
breast tissues, so you’re not going to see anything anyway.
In addition to that, younger breast tissue is more sensitive to radiation. So you’re actually increasing the risk of breast cancer far more in younger women. Also, recommending that they’re getting more mammograms over a lifetime is kind of – generally speaking– a bad idea.

But here we are. I guess, the difficulty is thinking that here, the medical establishments saying that the only best tool that we have is a mammogram, and then we keep hearing, “Don’t get it done before this age. Don’t get it done before that age. Get it done every two years.” What are women supposed to do in order to be able to monitor what’s happening in their breasts?

Which is why I am a big fan of thermography, where we can catch it at an early stage where it’s reversible.I mean another key thing for me is that oftentimes people will get tests done like thermography, where it will show that they add an increased risk. It’s like, “So what?” unless you’re also educating women about what they can do to reverse they’re likelihood of developing.

DM: Do you have any thoughts on why you believe the FDA is basically refusing to recognize this? Is it due to conflict of interest? Because it appears that thermography is superior to mammography, especially for women who have dense breasts.

CH: Absolutely. Breast implants, for sure, because you can’t see very well having dense breasts for sure. I think in following people who have had cancer and surgery, too, because if they don’t have a reconstruction–even if they do –it allows us to see through. There are many instances that mammography does not work very well. We can use it as a tool that’s way far superior for that.

Now, the FDA– you’re opening the can of worms! [Laughs]

DM: Yeah! I love to do that.

CH: He’s going for the can of worms! We live in a very corrupt…We have a very corrupt government. Like I said, people don’t realize how corrupt it is and the structure of how things have been put in place. When I was working on that legislation for breast reconstruction, it was a big eye-opener to me to see how Washington works. Even somebody who comes in with the best intentions cannot help but get corrupted by the system, because of the way that it’s set up.

The FDA is set up where people who work for corporations –where you would say this is a conflict of interest problem– are routinely working at some high positions in the FDA. The FDA is not–in my opinion– doing the best job that it could do in many different aspects, because it’s not being run in an authentic way.

DM: It’s impartial.

CH: It’s impartial! [Laughs] It’s being influenced tremendously by corporations. So we get things approved that should never get approved. We get things disapproved of, which should never even be disapproved of. It has to do with the money andcorporations.

DM: Are there any specifics you can allude to when it comes to thermography and mammograms that you’re aware of?

CH: No.

DM: Just to say in general.
CH: I have to say in general. I mean, I have worked with the breast implant issue, when that came out and the results were subversive things that were going out as well. I don’t know a specific person, if you want me to name names. I can’t do that.

DM: Okay.

CH: Yeah.

DM: There are always those types of person.

CH: Naming names! [Laughs]

DM: Because they’re definitely there.

CH: Oh, sure.

DM: There’s no question. It’s just a matter of figuring it out, but you have to be almost an insider to do that.

CH: Yeah.

DM: So you were the American Cancer Society’s spokesperson.

CH: Right.

DM: I’m wondering, at that time you didn’t have this awareness that you do now. Do you have any thoughts about the American Cancer Society and how their position is, especially with the breast diagnostic industry?

CH: Sure. Unfortunately, I think – and it’s not just the American Cancer Society, but I also ran into it in a variety of different breast cancer organizations, where once again there are conflicts of interest with corporations. Also, it’s very much driven by money and funneling money into corporations and into the cancer industry, trying to keep it alive basically. It just seems crazy, but it’s almost as if we don’t want to find a cure for cancer, because it’s such a huge industry.

There are so many companies that are involved in the production of the chemotherapies, the equipment, and so forth. There are things that are done that kind of make sure that their jobs and their companies are kept.

DM: It’s very lucrative. With all the specialties of medicine, oncology probably generates some of the largest revenue.

CH: Sure.

DM: And many of these drugs. I’m sure anyone who has had cancer, or a friend or relative with cancer may be aware that we are talking about extraordinary sources of income.

CH: Right.

DM: You talked earlier about 2,000 other fee for an MRI.

CH: That’s nothing compared to those drugs.
DM: That’s a drop in a bucket compared to some of these drugs, which can easily exceed 10,000 dollars a dose.

CH: Right.

DM: And generate bills well on excess of a million dollars. These are very large revenues from very large numbers of people that are up to extraordinary amounts of revenue.

CH: Right.

DM: There’s an incredible economic incentive to let the system continue without alteration.

CH: That’s true.

DM: When you have those sources of revenue, it wieldsenormous levels of power and ability to corrupt government officials through the political lobbying process, which is fairly pervasive in Washington. It’s a real challenge.

CH: Yeah it is. I mean all of our systems need to be changed. I think it just points that out. We’re in a revolution right now, I think, as far as looking at the whole Wall Street.

DM: Well, everything is starting to break apart.

CH: Correct.

DM: It’s all coming down. [Laughs]

CH: It’s being shown that it’s being broken apart. Hopefully, we can restructure something better! [Laughs]

DM: I believe there’s hope for that. That’s one of the reasons why we have this site, is to get people information, education, not only to inspire them, but also to catalyze movements. We’re actively involved with a number of nonprofits that are addressing some of the most significant threats that we see to be very persistent to the human race, such as fluorides, vaccines, GMOs, and mercury.

CH: Right.

DM: When you were in practice in the mid-90s, you mentioned that you noticed a change— at least from your personal observations— in that the age of the patients you were treating that seemed to drop relatively dramatically about the mid-90s.

CH: Yes.

DM: I’m wondering if you have done any further research in the data, looking into the studies and see what has happened to the incidence, the timing of it, and the many speculations you might have about that.

CH: Sure. When we find a cancer, we say that it’s been growing for eight to 10 years possibly. So, if we’re finding cancer in women in their 20s, we know that it started in the teen years.
Which we know is horribly frightening, because I had a teenager once. She’s now 27 years old. [Laughs] But— to influence them to have…

**DM:** Hold your thoughts there, if you can. Let’s just stop there, because this is an important point. It’s traditionally thought that breast cancer grows pretty rapidly.

[----- 50:00 -----]

I guess there’s a pre-stage that you have referenced, where it grows slowly. But unlike prostate cancer or colon cancer (a better example), which you could have 10 years to find a pre-tumor…

**CH:** Correct.

**DM:** Breast cancer, if you don’t find it in a few months, it’s going to go pretty rapidly and out of place. I’m wondering if you could address that and go back to the thought you were in earlier.

**CH:** Sure. It depends on the type of breast cancer, because some are more aggressive and faster-growing, while some are slower-growing. We say by the time you can actually detect it— which is about a centimeter— with the traditional Western equipment, techniques, and so forth, then it’s been there for eight years or so. Once you get to that size, you start doubling that size. It looks like it has exponential growth that’s occurring. But again, if we’re finding it in women in their 20s, it means that it started in their teen years.

There’s a very alarming trend that’s occurring in the United States and that is we’re seeing that puberty is getting younger and younger and younger. Girls are going through puberty sometimes at eight years old.

**DM:** What do you think the reason for that is?

**CH:** Definitely, there’s a problem with a multitude of different things: from the foods that they’re eating, the growth hormones that we put into animals [Laughs], and actually products, topical products that we use as absorbent to the skin. They have chemicals in them that will mimic the estrogen molecule.

**DM:** Yes— the xenoestrogens.

**CH:** Correct.

**DM:** Some of those are most commonly found in plastic storages, the BPAs, the bisphenols…

**CH:** There are case reports of five- and six-year-olds going through secondary sex characteristics because of the shampoo that they were using. It had placenta in it. There are all sorts of different sources where we’re exposed to these chemicals from our foods and from the products that we use.

What we’re seeing is younger and younger puberty. Around the world, the most average age is about 16 to 17 years old. In the United States, it’s 10 years old now or sometimes even younger. The problem is that with each menstrual period there is a surge of estradiol, which is the strongest, most abundant form of estrogen and the one that’s most associated with breast cancer.
If you start your period very young, you’ll have more periods in your lifetime than what a person would have, obviously, if they started at an older age.

In addition to that, when a girl goes through puberty, the breast cells become really sensitive to environmental toxins, radiation, and so forth. They’re considered immature. They haven’t differentiated— as a more scientific term for it— so there’s a longer period of time that they’re exposed to these toxins where they have a greater sensitivity to it. I think those are the main things that are at play in causing that.

DM: Terrific. Exactly. That’s important to know. Because if you’re a parent, you can certainly, at least partially, modify your child’s exposure to that so they don’t increase the risk as they grow older.

CH: Right, exactly.

DM: Then I would imagine part of it might be related to the fact that we have an enormous pressure on naïve, ignorant— I would go far to say— dermatologists who are recommending the massive use of sunscreens that block the vitamin D so they don’t get skin cancer, but they increase their risk of other cancers by tenfold, including breast cancer.

CH: Right.

DM: Because you need the vitamin D levels in your body, which ideally through sun exposure— it should not be swallowed in the pill. But as you have mentioned, it happens eight to 10 years before; they’re getting these exposures young. If they have low vitamin D levels because they’re slathering sunscreen on, it’s the synergy effect.

CH: Right. Then we can look at some of the lifestyle choices as well. There are many other foods to consume, like alcohol for instance. If you look at longevity studies or you look at studies that have to do with other chronic disorders, generally speaking we find that if people consume one to two glasses of let’s say red wine that is kind of the premier one a day, they actually have a lower incidence of disease and a greater longevity. Cultures that have extraordinary longevity, we find that they are all consuming some form of wine.

Now with breast cancer, however, we find that even half a glass or one glass a day, there’s a measurable increased risks. One drink a day increases the risk by 11 percent, two drinks by 22 to 40 percent, and three drinks by 33 to 70 percent.

There was a big study that just came out about a couple of weeks ago, I think, that said that the risks, if you are doing three glasses a day, could be as much as 50 percent increase. That’s because alcohol increases the amount of estrogen and the production of it in the body. It increases the amount of prolactin, which is another hormone…

DM: It just emits an enzyme that causes the estrogen levels to increase?

CH: Yes, and so with the fat. There’s stimulation with that. Also, it inhibits the liver enzyme. So we’re not processing the estrogen out of the body. The levels are staying high, because we’re not getting rid of toxins and estrogens as much as we’d like to. It also disrupts folate or folic acid, which is a B vitamin that’s involved in the repair mechanisms of DNAs.
When you knock out that repair mechanism, and there’s damage that occurs to our DNA every
day from environmental toxins, oxygen free radical inflammation, and so forth. We have these
repair mechanisms, but they become not as functional, so the damage gets passed on. Generally
speaking, the worst thing that we can see from that is the production of cancers. That’s how
alcohol contributes to it.

Interestingly, we said that men don’t get breast cancers very often. But the subgroups that have a
much greater risk are male alcoholics, because men produce estrogen, too. A lot of times, people
don’t have an awareness of that, but there is some estrogen production as well.

Being active – I know that you’re big in exercise, and exercise is another thing that…

**DM:** It’s only because most of us lead sedentary lifestyles. We have jobs that we don’t…

**CH:** We do.

**DM:** The 70 to 80 percent of many Third World countries spend their time procuring food, which
generates a lot of work. We don’t do that.

**CH:** Right.

**DM:** As a result, you have to have a substitute.

**CH:** Yeah. I mean you’re absolutely right. It’s fascinating that I’m writing a new book now,
called *Radiant Health, Angel’s Beauty.* In looking at cultures with extraordinary longevity, what
we know is that most of them are poor. They live in rural areas. They’re growing their own
foods, and they have activity incorporated into their lives, just as you said.

**DM:** And they’re not working out at the gym.

**CH:** They’re not working out at the gym, but they’re walking all day long and they’re in physical
motion. For us – where we are it’s very sedentary – it’s absolutely crucial that we exercise. The
research on it is spectacular, as far as all the results with it. Traditionally, we use to think that it’s
primarily for cardiovascular disease, but now we know, in fact, that it’s something that helps to
lower every type of disease including cancers. Women who exercise on a regular basis, does
have 30, 40 to even 50 percent reduction in breast cancer.

If you have cancer, this is something that really goes against what we were traditionally taught,
let’s say in medical school, in residency, and so forth. When someone’s going through
chemotherapy, we’d say, “Oh, take it easy with your breast, don’t exercise…” and so forth.
That’s exactly the wrong thing to tell patients, because what’s been found is that if you have
patients exercising while their getting their chemotherapy…

There is a study at Boston that’s maybe four or five years old now that showed that women who
were doing even brisk walking as a form of exercise during the time that their getting their
chemotherapy are as twice as likely to survive from their disease. So it’s extremely important.

**DM:** Terrific. I’d just like to go back to one of the other comments you made, emphasize one,
and then challenge you on the other.
CH: Okay.

DM: Because what’s not commonly known is the iron connection. I have been promoting it for a long time, and I totally agree with you. There’s a simple test that one can use. It’s called the serum ferritin level that shall screen for this. If you’re watching this, I would definitely encourage having your doctor to screen for that, because most post-menopausal women and certainly adult men do not need extra iron and we just get too much.

Fortunately, there’s this simple process, which is removing it from your body. You don’t take a supplement to remove the iron. You usually can donate your blood or get a therapeutic (59:10). You want to keep your level at about 60 or below 80, for sure. That’s a useful tool.

You have mentioned the importance of the diet, which I totally agree with. But there’s a lot of controversy on the red meat and the saturated fat issue. I agree with avoiding red meat raised in factory farm conditions, because of all the chemicals and the estrogens that it triggers. Humanely raised, grass-fed, and organic-housed could produce healthy meat even when you cook it. If you cook it at a low temperature, like the Asian reference, typically for exposure of higher flames like barbecuing or grilling, which would do that.

I just think we need to be really careful. Because a lot of studies that look at this, they don’t care to discriminate between those variables; the devil is in the details.

[----- 1:00:00 -----]

The other one–saturated fat has been demonized so much. But I think there are strong evidence that suggests that healthy saturated fat is useful. A lot of the demonization comes from non-careful discrimination between these dietary assays, which didn’t differentiate the damage from trans fats, which are perniciously evil. It should be avoided like the plague. But they tend to follow along with saturated fats, so they get unfairly criticized.

I personally have loads of fats a day, primarily from things like avocados or coconut oil. I think they can be really useful on your diet and not necessarily…

CH: Right. But there’s a distinction between the traditional animal saturated fats that we have versus…

DM: I wouldn’t even extend that to healthy-raised saturated fat, from animals that are not in these factory-farming systems, because it’s a different type of fat.

CH: It is.

DM: And there are different risk factors with it. You have to be somewhat careful on that. In a lot of the studies that you’re basing these recommendations on, if you look at the method section, they haven’t made that discrimination.

CH: Right. It wasn’t until recently, too. I mean, you have to follow people out for 20 years before you get the data regarding cancer risks.

CH: We haven’t had it widely accepted. Now, I’m a vegetarian. [Laughs]

DM: I kind of thought so from your comments.

CH: You kind of thought I was a vegetarian? I’m a vegetarian for every reason that you can be a vegetarian.

DM: Sure.

CH: I don’t eat animals, because I think they have consciousness.

DM: Yeah, but that’s a whole different argument. It’s an absolutely different argument.

CH: Again, you’re right. There’s no study that have followed people eating organically raised animals for 20 years or so. Although—I have to say this, too— if you look at the studies about the cultures that have extraordinary longevity, they don’t eat meat. If they do, they only eat it very rarely. They may eat it on holidays or someone’s birthday and so forth.

DM: I would challenge you on that. I don’t want this to go into a vegan or a vegetarian discussion. [Laughs]

CH: [Laughs]

DM: But there are studies that actually address that.

Okay, it’s great to know some of the things to avoid that increase your risk. But of course, cancer is a two-pronged approach – not only avoiding things, but then having your body incorporate items that will help build up a resistance to that. I think you’re a big fan and a proponent of flaxseeds, which I suspect is related to the lignans that’s a dietary soluble fiber.

CH: Correct.

DM: I’m wondering if you can talk about that and some of the other things that you’d recommend as active ways that we can prevent not only breast cancer, but all the other cancers.

CH: Sure. Right. Research shows that the one food that’s the most important for us to consume in order to create great health and maintain it is eating lots of plants. Plants are packed full of nutrients, vitamins, and minerals that are crucial for our health. They also have hundreds of what we call plant chemicals or phytochemicals in them. They don’t have any nutritional or caloric value, but they are like natural medicines and some of them behave exactly like chemotherapy.

The drug companies will look at plants. I always think it’s hilarious when they say, “Oh, plants don’t work,” or “Herb don’t work,” but you based your drug on it! [Laughs] How come your drug works? There are all these fascinating chemicals that we have that are really ingenious. When you look at the research, it’s spectacular, as far as understanding how far these different things work.

Every plant has some anti-cancer properties to them. There are some that are standouts. Cruciferous vegetables are something that I really recommend. They’re a family of vegetables that include broccoli, cauliflower, kale, collards, and Brussels sprouts.
DM: Is kale cruciferous?

CH: Yeah.

DM: Okay.

CH: Again, people will say with bok choy and everything, it doesn’t seem like they’re related, but if you cut across the stem, there’s a cross in it. That’s where it gets its name “cruciferous.” All of them have several different chemicals in common. They’ve got indole-3-carbinol, Calcium D-glucarate, and sulfurane. They have big anti-cancer properties to them, and they inhibit the growth of breast, prostate, colon cancer and a variety of other ones. It’s really – of all the families of vegetables to consume – one to be aware of, so that you can make sure that you’re including that in your diet frequently.

In the United States, the government has recommended it. That’s a big deal! [Laughs]

DM: They don’t recommend many of these approaches.

CH: They don’t. Eat lots of it and, as much as you can, get it fresh, organic, and even grow your own if you can, because all of those things have more nutrients. The fresher you can get it, the more locally grown, and making sure that you have it organic.

Now, there are other standout plants. As you mentioned, flaxseed is something that’s considered the most powerful food that you can consume to not only reduce your risk of breast cancer, but also inhibit the growth of breast cancer once you have it.

Flaxseeds have a variety of different distinctions about them that make them so effective. One is they have omega-3 fatty acids in them– the good kinds of fats. They also have a high amount of fiber, and fiber will bind excess estrogen that will help to eliminate it out of the body. It also helps to produce something we call “protein binders” in the blood that will bind onto the estrogen. If it’s bound, then estrogen cannot go to the breast cell and turn the breast cell receptor on.

DM: What specifically is in the flaxseeds that does this? Is it lignans?

CH: The lignans will do that, but also fiber is something that will stimulate it.

DM: Okay, so a different type of fiber.

CH: Yeah. They’ll stimulate it as well. The final thing is lignin. Lignans are very interesting substances. They help give structure to the cell wall– the firmness to it. They found that they have over a dozen anti-cancer properties to them. Flaxseeds have 100 times more lignans than any other known edible plant. Although chia seeds are kind of high now, we didn’t do that much research on them before.

Again, lignans have about 12 different ways that inhibit the growth of cancer, including exactly like the anti-cancer drug Tamoxifen and exactly like Arimidex, which is something that shuts down an enzyme in our fat cells called aromatase that converts androgens into estrogens. It’s kind of big for post-menopausal breast cancers. And then 10 other ways, from shutting off the blood vessel supply that goes to tumors to actually changing the structure of the breast tissue or
cells to make them more resistant to environmental damage, activate certain growth hormones or inhibit certain growth hormones, and help to boost the immune system as well.

There are many different ways that they work and that’s why they’re considered, because lignans are so effective. It’s one of the reasons they’re considered. It’s so wonderful, as far as anti-cancer properties are concerned.

I hear from patients, “Oh! My oncologist told me not to take flaxseeds, because they’re estrogenic or whatever.” [Laughs] Then they don’t understand actually how plants estrogens or “phytoestrogens” (as we call them) work, because there are all sorts of different strengths to estrogens. Let’s say estradiol, which is the strongest, most abundant form— if it hooks on to the estrogen receptor, it may cause a thousand cell divisions. But if a plant estrogen hooks on, it may cause one. When you flood your system with these plant estrogens, I’d say it’s kind of like a game of musical chairs. There are only certain numbers of receptors, and whoever gets their first, gets it. They’re blocking the strong estrogens from getting on, so that’s why it has an inhibitory effect.

The best research then is to look at what happens actually when you feed flaxseeds to women. One of the premiere researchers in the world on flaxseeds is Lillian Thompson from the University of Toronto. She did a study a number of years ago, where she took patients who were diagnosed with breast cancer on mammography or by biopsy, and then gave them flaxseeds to eat every day. They do like three to four ground tablespoons of flaxseeds a day. Then about three weeks later, they have the surgery to take the tumors out. In every single one of those patients, they found that the tumor shrank from the time of diagnosis to the time that they were taken out.

I’ve had some really interesting personal experience with this. One example is my business manager’s mother who was diagnosed with breast cancer. Her tumor was 1.5 centimeters on mammogram. I put her on flaxseeds and on this very potent antioxidant formula through Ayurveda. Three weeks later, we checked her tumor out, and it was one point five centimeters again on mammogram. But when we took it out, it was 0.5 centimeters. It had shrunk by two-thirds in three weeks. That’s how powerful they are.

**DM:** They’re very useful, too.

**CH:** Yeah.

**DM:** I’d just like to provide two cautions when using flaxseeds that I recommend. They should be organic.

**CH:** Absolutely, and everything should. [Laughs]

**DM:** With flaxseeds especially. It’s not much more expensive at all. Also, to use them fresh and to grind them yourself. It’s because you mentioned, of course, that it has the omega-3 fats, which are polyunsaturated fats and highly susceptible to oxidation from the air.

**CH:** Correct.

**DM:** If you have right now flax seed that’s pre-ground, you should throw it away, because it’s damaged and it’s going to hurt you.
CH: Correct.

DM: You just get them and grind them fresh…

DM: Whatever you need, a coffee grinder, it’s simple to do.

CH: Right.

DM: The devil is in the details.

CH: That is and what’s funny, too, I think, is when there are certain crackers and things where they have got the flaxseeds in them. You don’t digest them.

DM: It doesn’t work.

CH: It just passes through. You know, you have to grind them. And there are some products out in the market that actually take the lignans from the flaxseeds and have them in little capsules. So you don’t have to, you know? Because to me, I travel all the time and how are going to have a coffee grinder? But there is a way. There are some supplements that you should try.

DM: The omega-3 fats are taken out so it’s not an issue.

CH: No. You have to take those separately, which I always recommend anyway, because I think we really need to flood our systems with omega-3s.

DM: Yeah, I’m a big proponent of animal-based omega-3 fats, which can form some from things like flaxseeds and chia.

CH: Sure.

DM: But I think you need both. I strongly think you need both, and having a good source of flax is a phenomenal approach. If you follow those two principles, in my view, you’re certainly going to improve your health.

CH: Sure. Absolutely. And it’s credible.

DM: Many reasons to do it.

CH: Yeah.

DM: Because if you just take animal-based – the DHA- and EPA-based fats – and don’t take any of the plant-based ones, you’re going to run an imbalance because they’re both essential.

CH: We can talk about some other lifestyle factors, if you want, that are important besides exercise.

DM: Okay. Are there other lifestyle factors that you find useful in your strategies and recommendations?
CH: Yup. Absolutely. One thing found to have huge statistical data associated with it is sleeping. What times we sleep is just as important as the number of hours that we get. Generally speaking…

DM: This is probably coming from your Ayurveda training.

CH: You bet. So, Ayurveda—5,000 year old system of medicine—said, “Go to bed before 10 and get up by 6.” Those are the ideal hours for sleep. But what modern researchers have shown is that is, in fact, true, because we have all of those hormonal fluctuations that occur throughout the day and throughout the night. If we are riding the proper activities during those times, then we get the optimal levels. If we, for instance, go to bed by 10, we have higher levels of our sleep hormone melatonin; there’s a spike that occurs between midnight and 1 am, which you don’t want to miss because the consequences are absolutely spectacular.

Melatonin is not only our sleep hormone, but it also is a very powerful antioxidant. It decreases the amount of estrogen our body produces. It also boosts the immune system. There are many, many different things that it does. And it interacts with the other hormones.

So, if you go to bed, like I said, after 10 — so you’re going to bed after midnight, for instance — it significantly increases your risk of breast cancer. They looked at women who worked the night shift and found that those who worked the night shift had a 50 percent higher incidence of breast cancer. The longer they worked the night shift, the higher their incidence became.

And now we’ve also found that if you shorten your sleep, if you stay up late at night, you significantly increase your risk of cardiovascular disease (almost double it), diabetes, and obesity. A lot of times people say, “Gosh, I don’t eat that many calories. I’m exercising, but I’m not losing weight.” Well, how late are you staying up? So, the absolute number of hours that you sleep and the times that you sleep are extremely important.

And then another thing we have to look at, that plays a huge role, is stress. You know, in every patient that I had, there was always something major that happens in their life within, and what the research shows is if you have a major stress — let’s say that you have a death of a loved one or something equivalent to that — in the ensuing next five years the risk of breast cancer is 12 times higher.

So stress plays a huge role and to me, it’s almost unprecedented, the amount of stress that we’re subjected to right now. Not only do we have our job stresses and so forth in a very fast society, but we also have huge economic stresses now. We’ve got unbelievable environmental changes that are occurring with all the natural disasters that we are having. You know, it’s tough.

So in this culture we traditionally don’t do effective stress-reducing techniques on a daily basis — maybe exercises and so forth. But in other cultures, let’s say in Asia or in India for instance, it’s very common for them to be practicing either a meditation practice or, let’s say, tai chi or qigong or so forth. For me, because of the level of stress that we’re subjected to and the extraordinary damaging effects that can occur from it, it’s something where I feel like meditation is no longer an option, or doing a qigong or tai chi or something like that, that it’s fundamental to health to adopt one of those practices.
DM: Terrific. Meditation can be very enormously useful, including prayer and some other strategies.

CH: Yeah, sure.

DM: Just a few comments on the melatonin: I couldn’t agree more. It’s a profoundly useful hormone to optimize.

CH: Right.

DM: And I think the best way is to do it is to have your body make it and not necessarily through a supplement.

CH: Absolutely.

DM: And the devil in the details again here because the other ways you can enhance it is exposure to bright sunlight in the daytime. So if you’re wearing sunglasses all the time, you’re in the dark, there’s this contrast that actually stimulates it, and you also have to be sleeping in the dark. If you have a bright streetlight coming through your window, that will shut it off. And a point I frequently make is that many people aren’t aware of is that [1:15:45], one of the scientists that really study this carefully (the melatonin), he’s shown that if you have wavelengths of, I think, it’s over 600 nanometers (essentially the red light), that does not interfere with the melatonin production. So you can have a red flashlight or red light on your TV and that won’t interfere.

CH: Right. Or your clock radio.

DM: Or your clock radio, which shouldn’t be by your head anyway for other reasons.

CH: Right.

DM: Optimizing melatonin is phenomenal because it’s not only about breast cancer. It’s just about everything.

CH: It’s extremely sensitive to light.

DM: It’s phenomenally important.

CH: As you said. Which is why one of the reasons I think that breast cancer is higher in cities than it is in rural areas is because of the lights.

DM: And stress.

CH: So it has to be as dark. Well, yeah. Tons of that.

And then, electromagnetic frequencies – something we didn’t talk about, too. Every device that’s wired or wireless produces electromagnetic frequencies. We talked a lot about the issues with cellphones and cordless phones and computers and so forth. One of the ways that electromagnetic frequencies are damaging to our bodies is that it will inhibit melatonin. So that’s another mechanism by which that works.
Alcohol is another thing that suppresses melatonin as well. You have to kind of investigate, I think, all the different factors that can affect this, so you can get your optimal levels.

**DM:** Yeah. This is a hormone that you, I think, probably assays and tests for, but I’m not sure I’d recommend it. I just follow the things we talked about.

**CH:** Sure.

**DM:** And your body will make it normal because everything that is recommended is going to produce other benefits anyway.

**CH:** That’s right.

**DM:** So rather than finding a supplement or measuring it or trying to optimize it, it’s best to do it naturally.

**CH:** Right. And I agree with that fundamentally with everything. It can be very simple. It’s really interesting to learn all these sophisticated things and say, “This is broccoli,” but what’s the bottomline? Just eat it.

**DM:** Eat broccoli.

**CH:** Just eat it.

**DM:** Or kale. I have kale pretty much every day.

**CH:** Yeah, I love kale.

**DM:** You have a weekly podcast and some other resources that you’ve compiled. Then you’ve transitioned from being a surgeon and taking care of your patients, too, to actually educating people in a broader level. I wonder if you can talk about your podcast and some of the other resources that you have.

**CH:** Sure. Well, I just believe in using every medium, as you do, in order to educate people. Some people want to listen to podcasts, which are basically kind of similar to what you have in your website, where you can go to the website and there’s an area to click on links to the podcasts that I’ve done in the past. I’m not currently doing them right now because I’m writing another book, but those are maintained there so you can go listen to them as your leisure or download them.

**DM:** And you have them every week?

**CH:** I was doing them every week. I haven’t done them in about a year now.

**DM:** So you have an archive of them?

**CH:** Yeah. So the archives are on.

**DM:** Much of this information, of course, is timeless as evergreen as we say, and is useful to listen to.
CH: Correct.

DM: But when new information comes out, you’re going to…

CH: Sure.

DM: You’re going to plan on starting those again?

CH: Absolutely. Yeah, I will. So, there’s that and then I believe in, like I said, getting it out through every kind of medium as far as information can be distributed so that you can reach the highest number of people possible.

DM: And you also provide one-on-one consultation for individuals who are interested in having your insights in their specific – but most likely in breast cancer – issues, too.

CH: Right. Correct.

DM: Can you give us some details on that? What do you find as some of the most prevalent questions that people ask you when they consult with you?

CH: I’d say the number one consultation that I do is for breast cancer patients right after they’ve gotten diagnosed, which is an excellent time to talk to me because there’s a variety of different people that I will refer them to that can work. Integrative oncologists, for instance. So these are people that specialize in treating people with both Western and complementary and alternative techniques. Keith Block, for instance, who is almost a neighbor of yours.

DM: He’s up in [1:19:48].

CH: Yeah. He’s great, but what he’s found – because he does a lot of research and collecting his data and so forth – is that his patients on average live three times longer. If you’re combining natural approaches in addition to the western approaches you can minimize the side effects from the western approaches and maximize the effectiveness of it.

CH: I generally do consultations for people when they’ve been early diagnosed, so I can help them take on the best things that they can do for minimizing the side effects for the Western approaches and maximizing the effectiveness, and also referring them to people that can be of assistance – from patient advocates to whatever.

I also do consultations for people that are interested in just being healthy or a variety of other kinds of chronic disorders, because I do have broad-spectrum knowledge in most areas. But definitely, my specialty has been in the breast cancer area.

DM: Are there any clinicians that you found to be extraordinary in the treatment of breast cancer and that you would recommend routinely when people consult with you? Do they actually implement the recommendations you make?

CH: Sure. Keith Block, as we talked about, I’m a big fan of his. But there are places in other countries, too, where they’re doing techniques that have been found to be effective. Again, we
have this whole political situation where some of them aren’t available here in the United States. Now, cancer treatment centers of America…

**DM:** I was going to ask you about them. They’re actually in and outside of Chicago, too.

**CH:** Yeah, there are several centers of them. They have good results, and they’re doing combined efforts and nutritional supplements as well as education about what people should or should not be eating. They’re getting better results.

In the island of San Diego, [1:21:38-39] but there are several different clinics down there that are doing a variety of different techniques if you’ve been diagnosed with breast cancer. Using a whole body hyperthermia, we know, is very effective and helps to cut down on the amount of chemotherapy that you need to take and also kills tumor cells. There’s also something called dendritic cell therapy, which is kind of training cells in our immune system to be specific to attack the tumor from the tumor markers.

There are clinics in Germany, too, that have had excellent results, where they’re combining all of these different modalities together. And so their results are generally better than what we see with standard Western treatment.

Mitch Gaynor in New York City – he is another excellent integrative oncologist and combines a lot of different techniques, too. Most of the ones in the United States are doing both Western as well as the complementary and alternative medicine, and that’s actually something that I do recommend because we get much better statistics with that.

But there are ways to give the chemotherapy where you have smaller dosages. Keith Block does what’s called chronomodulation, where they found that certain chemotherapeutic agents are more effective if they’re given at certain times of the day. And again it has to do with all these different hormonal fluctuations that we have.

So Keith will give his patients those medications exactly at the most effective time and in smaller dosages and also combining it with certain foods and certain supplements that will take away the side effects. When I was working with my breast cancer patients, they had no nausea, no vomiting. Their blood count stayed normal, their weight stayed normal, and so forth, by the whole routine that I had them following. And it makes the chemotherapy more effective. That’s the point of it: to make the…

**DM:** Have you looked into the use of infrared sauna therapy?

**CH:** Oh yeah. It’s wonderful.

**DM:** From two points, it’s somewhat similar to hyperthermia and that it increases the body temperature, but then also for aiding detoxification of some of the chemicals that are seen. So I’m wondering if you can comment on that.

**CH:** Sure. Know that I’m a fan of infrared technology. So saunas and sweating are very important for a couple of different things. One, they actually found that it will kill tumor cells, so it makes our immune system more effective. We also get a detoxification, where we get
elimination of heavy metals and some other products that will come out through our skin with sweating.

Now, the cool thing about infrared technology is that I have a real interest in a kind of energy medicine or medicine that works with using frequency. In quantum physics, for instance, what we found is that the theory is that there is the super string theory, which is at the finest level of life there are vibrating little strings. Those vibrations set up frequencies in our cells, and so there are actual measurements that have been done looking at what other frequencies of cells and tissues and we can measure what the frequencies are of healthy cells and the measurement of frequencies that are unhealthy.

Interestingly, how infrared technology works – one of the ways that it works – is that it adds energy into the cells. So the cells, when they’re sick and full of toxins, they do not have enough energy to expel the toxins, but it’s adding energy by affecting the frequency of these cells that then gives them enough energy to spit the toxins out. So you get more effective release of toxins that you may, say, from a standard sauna or heat treatments with that particular technology.

DM: Then part of it, too, is that because the wavelength is able to penetrate deeper as opposed to traditional sauna.

CH: That, too, but I think that it has to do more with the physics, the energy and the frequency of it.

DM: Are there different wavelengths of infrared that tend to be particularly more helpful?

CH: There are. There are different wavelengths and there are some companies that have the ability to dial in what you’re trying to do with the infrared sauna – from helping with pains, with helping with detoxification and so forth. You can set it at those particular frequencies.

DM: Do you know the ranges?

CH: I do not know them at the top of my head.

DM: Just curious.

CH: I don’t know, top of the head.

DM: Are there any modalities that aren’t available to the United States due to government restrictions that you find particularly useful that may encourage people to consider going outside the country for?

CH: Well, we covered doing dendritic cell therapy. I don’t think it’s done here. Do cancer treatment centers of America do they do whole body hyperthermia now or not?

DM: I don’t know.

CH: I think that generally it’s not. And it’s very specific like in Tijuana and in Germany, they’re doing the whole body hyperthermia, but it’s done very specifically as far as knowing exactly what body temperature is raised for the physiological effects. There are so many things, it’s ridiculous.
DM: It’s hard to sort through. Some have a full-time job just to do that because most of the time, when people encounter these challenges like breast cancer, you’ve got a busy lifestyle and you don’t have the training – or more importantly the time – to go and sort through the enormous amount of information to make an intelligent choice and decision. So that’s why it’s nice to have someone who’s done that, someone who has professional training and experience to sort through it all.

CH: Right. It’s true. That’s why I wrote my book.

DM: Your book is called?

CH: It’s called *Waking the Warrior Goddess*, and it’s in Dr. Christine Horner’s program to protect against and fight breast cancer. It has everything that I could find in the medical literature that had good statistical data on it that were natural approaches – non-surgical, non-pharmaceutical.

DM: You’ve made some tremendous suggestions that are certainly useful for lowering breast cancer, but additionally all the other cancers, for the most part, and improving the quality of your life. So you’re living longer, but you’re living healthier with more function and ability to enjoy and do the things that you are passionate about.

CH: Yeah. Exactly.

DM: I have a question for you with respect to your training as a plastic surgeon doing breast reconstruction. Many women obtain breast implants now. I’m wondering if you could comment on those, because there are a lot of women who are viewing this who have breast implants. I’m wondering what your recommendations are with respect to the timing of them and how long they should stay in if there are any concerns or conditions, what your recommendations are to have them removed, and any precautions that you might recommend during that process.

CH: Sure. First of all, the implants are very individual, so we don’t know. Different models last at different amounts of time. Prior to 1991 or 1992, that’s when they put the moratorium on silicone breast implants. We were using predominantly silicone gel implants, and again there were a bunch of different types that were in. Sometimes, they can be in for decades and they’re fine. Other times, they might be in for 10 years and they would develop a problem. It just depended.

Then, we went through a phase of using saline implants – the water implants. I personally hated those things because you just didn’t get a natural result with it, unless somebody had a lot of breast tissue to begin with.

The next version that has come out was the silicone cohesive gel implant, where the gel is solid, basically. It can’t migrate or go anywhere in the body.

We always say that they are not meant to be for a lifetime. They don’t have necessarily a warranty for a certain amount of time, but it varies in each individual. It’s good to always be checked to make sure that they’re okay. Some people don’t need to be replaced, and in other people they may need to be replaced.
DM: There’s a physical component of whether it ruptures or not. Obviously, that’s an indication.

CH: Unless they have a cohesive gel, then it won’t rupture.

DM: The reason they put moratorium on silicone implants is a perception or an observation that there was an increased risk of autoimmune disease and other complications.

DM: Obviously, it’s a foreign body. It’s not designed to be there, and it serves no purpose other than aesthetics.

CH: Right.

DM: So, are there any concerns you have about implants generally from a medical perspective? Because you do have a pretty strong grounding in natural medicine and any encouragement to get these out sooner rather than later, I guess.

CH: I think they’re very important for certain women. I think we have them back on the market because the health effects weren’t really panned out as far as the way the research was done. With that, silicone is generally inert. It’s used in everything – from total joints to the lubrication inside the diabetic’s needles. They’re getting a lot more silicone in their bodies than what you get from breast implants. Again, to me it’s a very political thing. It’s like everything is made out of silicone. Why were the breast implants the only things that were targeted? But again, they’re back on…

DM: You’re not convinced of the data from your experience as a clinician…

CH: No, I’m not, because the statistics show that the numbers of women that have autoimmune disease with implants is the same as in the general population, so you can’t necessarily draw those conclusions. Could there be some people who have a hypersensitivity reaction? Yes. Is it widespread? No. Were those some of my happiest patients? Yes. I mean, as a plastic surgeon, when you get people that are happy (like 90 plus percent, no problems), it’s huge, and that’s what we normally see with breast implant surgery.

One of the concerns that people have is about “Do they cause breast cancer?” And we say, “Absolutely, we know that they don’t.” The polyurethane-coated implants that were used very temporarily decades ago – yes, there was an increased risk. With the normal implants that we use, there is not. In fact, fascinatingly, when we looked at various different studies and the numbers of women who get breast cancer that have implants in, there’s a 30 percent reduction in women who have implants in and they’ve repeated it.

DM: Why do you think that is?

CH: The thing is, I was actually on board with the breast implant companies and testified before the FDA, and there was an epidemiologist from the University of Southern California that was working on it. He said what he thought was that the body recognizes the implant as a foreign material, and so the local immune system beefs itself up, kind of as a chronic condition there. So, it’s more effective at finding the damage of cancer cells and eliminating it. But consistently, we had a 30 percent lower incidence.
DM: That’s interesting. That’s fascinating. You didn’t put that in your lifestyle recommendations.

CH: Get breast implants. [Laughs] No. I’d like to eliminate that concern. It does make it more difficult with detection with mammography, so here’s an excellent thing to use – thermography – in order to be able to visualize the physiological changes going on.

DM: Great. If a woman has currently a breast implant, from your experience and review of the literature, you’re not convinced that there’s a significantly increased risk and your advice would be to keep it until there’s a physical malfunction.

CH: Yeah. Unless they’re having a problem. Most of the time, it has to do with scar tissue or capsular contractures.

DM: Well, thank you.

CH: Yeah. You’re welcome.

DM: So, are there any other items you’d like to address that we haven’t touched on yet?

CH: You know there’s another technology that I’m really excited about called the Life Vessel. Have you heard of it?

DM: No.

CH: No? Okay. So it was designed probably about, I’m going to say, 10 to 12 years ago. It has FDA certifications as a relaxation device, but it’s extraordinary in being able to help in detoxification and with, as I see, making ourselves more intelligent or increasing our body’s and our healing intelligence. It works through quantum physics. It uses light frequency sound and vibration. It’s a deceptively simple looking device where you lay in a box (in a wooden encasement) and you’re on a piece of foam, and they pipe in music into the box so you’re just lying there enjoying the music.

It’s somewhat like the infrared technology. It sets up a resonance frequency in the body and it balances the autonomic nervous system. The autonomic nervous system is composed of the parasympathetic and sympathetic systems. So these are the things that traditionally aren’t under our conscious control.

One thing that’s really fascinating is that most of the research has been done in the medical literature is looking at the biochemical nature of the body and not looking at the electrical nature of the body. It’s been found that we have the 50 percent of the receptors in our body as electrical.

So we have electrical stimulation to the cell membranes as well as the immune systems and so forth. The importance about the autonomic nervous system is that it is stimulating our cells and causing reactions that then go and affect our DNA. One ability that we have or an approach for health and for balancing our body is to actually work with our electrical receptors. The Life Vessel is a vehicle for doing that. So by balancing the autonomic nervous system…Instead normally we have our sympathetic overdrive – our sympathetic system, which is kind of our fight or flight system – as a thing that is always kind of pumping out because of the way that we
live. That is actually giving electrical signals to our body that are inducing disease and causing stimulation of certain gene activations in our DNA that are prescribed for disease basically.

By balancing the autonomic nervous system, now you’re getting the ideal stimulation to the cells, and it ultimately causes our DNA to read more properly. With this particular device, they’ve had complete healings of people with Parkinson’s disease, which is huge for neurological disorders, and for kids that have ADD and autism. They even develop mentally slow kids – I just saw astounding changes associated with that. And it’s huge for detoxification, so again it’s increasing the energy in the cells.

When you walk into a room where someone’s lying in the Life Vessel, going through a treatment, it’s a one-hour treatment. It’s actually four one-hour treatments that are done over the course of three days. When you walk in, it’s like overwhelming: the smell of crayons and petroleum products likened, and things that are outgassing from this very simple technique.

DM: It sounds like it’s not something one would purchase for their home but to see a clinician who has it.

CH: No, you have to go to a clinic and there are only few in the United States right now. Santa Fe has a clinic. Scottsdale, Arizona, Newport Beach, California, Tulsa, Oklahoma and Pittsburgh and actually, a new one that just went into Boulder, Colorado.

DM: Interesting.

CH: Yeah.

DM: Sounds fascinating.

CH: Yeah.

DM: All right. Any other items?

CH: I think that’s it.

DM: Well, thank you so much for joining us.

CH: You’re welcome.

DM: If people want to consult you, what’s the best way to do that? Certainly, you’ve got a book, *Waking the Warrior Goddess*, but you have a website and your contact information is there.

CH: My website is drchristinehorner.com. And it’s “dr” – no punctuation.”Christine” is C-H-R-I-S-T-I-N-E. And my last name “Horner” is “H-O-R-N-E-R”. So, drchristinehorner.com. I have all the information on my website. If someone wants to schedule a consultation with me, they can do that through my website and the phone numbers to call.

DM: Terrific.