Successful tumor therapies using the bioresonance method

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Introduction

Brain stem gliomas are tumors that occur in the region of the brain referred as brain stem, which is the area between the sylvian aqueduct and the fourth ventricle. The literature divides brain stem gliomas into three distinct anatomic locations: diffuse intrinsic pontine, tectal and cervicomedullary. Intrinsic pontine gliomas carry a grave prognosis. Longer survival is associated with the tectal and cervicomedullary gliomas.

Pathophysiology

These tumors have a predilection to originate from the left side. Most are located in the pons; however medulla and midbrain may be involved as well. Brain stem gliomas are highly aggressive brain tumors. Anatomic location determines the pathophysiological manifestation of the tumor. With tectal lesions, hydrocephalus may occur as a result of fourth ventricular compression, With pontine and cervicomedullary lesions, cranial nerve or long tract signs are observed commonly.

Frequency

Brain stem gliomas have been reported to make up 2,4% of all intracranial tumors in adults and 9,4% of intracranial tumors in children. Brain stem gliomas account for approximately 10-20% of all childhood brain tumors. The incidence in adults is lower than that in children younger than 16 years. A tendency for brain stem gliomas to follow a more indolent course in adults than in children has been noted; in adults, these tumors are more likely to be low grade and they remain localized.

Morbidity/Mortality

Morbidity is due to the location of the space-occupying lesions and compression of surrounding structures: because these structures regulate basic body functions of blood pressure, respiration and swallowing as well as motor and sensory functions. Compression can produce substantial neurological disability.

Sudden death can result from increased intracranial pressure and subsequent cerebral herniation. This may be the consequence either of edema induced by the tumor or of hemorrhage into the neoplasm.

Sex

Some reports have suggested a slight male preponderance, whereas others have failed to observe any sex predilection.

Signs and symptoms

Common presenting symptoms include double vision, weakness, unsteady gait, difficulty in swallowing, dysarthria, headache, drowsiness, nausea and vomiting. Rarely, behavioral changes or seizures may be seen in children. Older children may have deterioration in handwriting and speech.

Pontine lesions usually present with any or all of the above signs and symptoms, depending on location an extension. Midbrain, lower brain stem and upper spinal cord signs and symptoms may be seen with extension of the neoplasm to involve these structures.

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In infants and children presenting with failure to thrive, pontine glioma should be considered in the differential diagnosis. Tectal lesions typically present with headache, nausea and vomiting.

Hydrocephalus is a common presentation, especially for tumors in periaqueductal or fourth ventricle outflow locations, because these regions have less tolerance of growth and higher risk of obstructive hydrocephalus.

Cervicomedullary lesions usually present with dysphagia, unsteadiness, nasal speech, vomiting and weakness.

Common clinical findings can be summarized as consulting a triad of cranial nerve deficits, long tract signs, and ataxia (of trunk and limbs). Papilla edema may be observed.

Sixth and seventh cranial nerve are involved commonly. Facial sensory loss and primary position up-beating nystagmus may be observed. Involvement of cranial nerve III and IV suggests a mesencephalic component.

Tectal lesions may present with diplopia reflecting an internuclear ophtalmoplegia, indicating involvement of the medial longitudinal fasciculus. Parinaud syndrome also may be seen, with paralysis of upward gaze and accomodation, light-near dissociation (loss of pupillary reflex to light with preservation of pupilloconstriction in response to convergence), eyelid retraction and convergence-retraction nystagmus.

Cervicomedullary lesions may present with sensory loss of the face (involvement of trigeminal nucleus), dysphagia and dysphoria from lower cranial nerve involvement (commonly IX-X), long tract signs, and ataxia. Down-beating nystagmus and oculomyoclonias often are seen with medullary involvement.

Certain factors affect prognosis and treatment options

1. The type of brain stem glioma
2. Where the tumor is found in the brain and if it has spread within the brain stem
3. Whether or not the child has a condition called neurofibromatosis type 1
4. Whether the tumor has just been diagnosed or has recurred

There is no standard staging system for brain stem glioma. Instead, the plan for cancer treatment depends on whether the tumor is diffuse or focal.

Diffuse intrinsic pontine glioma is a tumor that has spread widely throughout the brain stem. A biopsy is usually not done for this type of brain stem glioma and it is not removed by surgery. A diffuse intrinsic pontine glioma is usually diagnosed using imaging studies.

Focal or low grade glioma is a tumor that is in one area of the brain stem. A biopsy may be done and the tumor removed during the same surgery.

CASE REPORT

Case 1: Female patient, F. T., aged 22

The patient came to my practice with a symptom of drowsiness and syncope of unknown aetiology in June 2008. She had had a cervical MRI. This MRI suspected an Arnold-Chiari-Malformation. Herniation of cerebellar tonsil from foramen magnum was 2-3 mm. I wanted to see the cranial portion. In this MRI we saw triventricular hydrocephalus and at the left side of the mesencephalon an intracranial mass (brain stem YKL).

The patient's symptoms were sudden onset vertigo, neck and head pain. The neurological examination of the patient was normal.

Bioresonance treatment

I did not begin to treat with bioresonance firstly. I sent the patient to another neurosurgeon. This neurosurgeon said that the only treatment of this kind of tumor is to control it with MRI. Other means will have no effect. Now I started to treat her.

Firstly I tested the patient with bioresonance CTT (Combined Test Technique).

What was responsible for the tumor?

1. Virus: VF 20 (Reoviridae)
2 Heavy metals: amalgam, mercury, nickel, palladium
3. Allergy: milk
4. Hamer zone: left temporal region

With the CTT test kit degenerated cells I found:

1. Degeneration encephalon
2. No dispersion
3. The nature of the tumor: lymphogranulomatosis and cysts

Electroacupuncture testing revealed an acute stage disorder in the nervous system. Firstly I treated the patient once a week. I prescribed milk diet. Firstly I began the treatment with the CTT test kit degenerated cells. I cleaned the patient from the heavy metals. Hamer zone treatment is important for me in all of the tumor and autoimmune patients. I did the the Hamer zone treatment until it became negative. The Reoviridae I treated with program no 926 (for tumor treatment). I treated her using all these programs until all became negative.

In January 2009, after all these tests were negative, I wanted a control cranial MRI. There was no tumor evidence. The cranial MRI displayed a negative result.

I have five more tumor patients. All of them were operated and treated with chemotherapy. After their chemotherapy, I started treating them using bioresonance therapy, toxin elimination and further restoring and rebuilding therapies. Compared with those patients without bioresonance therapy, my five patients are all doing very well.