QUESTIONING THE METASTASIS THEORY

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> "How cancer cells become metastatic still remains a mystery."
>
> Yale University (2008)

The metastasis theory is one of the most persistent dogmas of modern medicine. According to the theory, a "metastatic cancer" occurs when tumor cells of a primary cancer break away from the site and travel through the bloodstream or the lymph system to another organ where they cause a second cancerous growth.

A brief historical perspective

In the seventeenth and eighteenth centuries, tumors were considered "morbid material" which, if not normally excreted, could accumulate, turn "malignant", and cause death if it spread to other areas of the body. When the cancer was thought to have spread from one organ to another, it was called "metastasis". Medical therapies such as lancing, purging, blistering, bleeding, and poisoning were applied to aid the drainage of the "deadly" substances.

In the nineteenth century, microorganisms were included in the catalog of "morbid materials", and Pasteur's germ theory became the prevailing rationale that supported the metastasis theory. In the twentieth century, supposedly mutant, rogue, cancer cells were added to the list, joining bacteria, fungi, and viruses as disease-causing agents.

In today's medicine, both allopathic and naturopathic, it is still assumed that cancer cells and microbes act *against* the human organism. To this very day, the human body is believed to be at war against evil forces trying to harm and to destroy it (see immune system theory). The most basic axiom upon which the medical theory rests remains rooted in dark-ages of fear and superstition, ignorant of the creative intelligence that pervades Nature and the human body.

THE METASTASIS THEORY IN LIGHT OF DR. HAMER'S DISCOVERIES

The psyche-brain-organ relation

The metastasis theory entirely discounts the fact that every cell of the human body is controlled from the brain; instead, it treats each cell as a sentient organism doing its own thing. A century of medical research has confirmed that the brain is the "coordinating bio-electrical center" that regulates all biochemical processes, including "pathological" changes in organs and tissues. Even "infectious diseases" cannot progress when nerves to the affected organ are severed (Robert H. Walker: *Functional Processes of Disease*, 1951), which demonstrates that the activities of microbes are also directed by the brain.

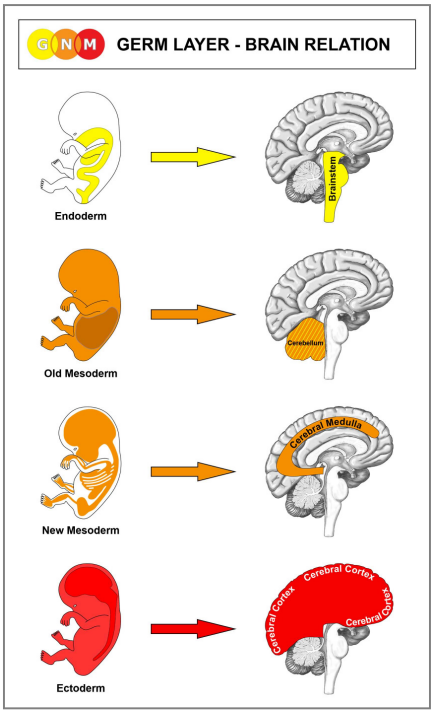
Dr. Hamer discovered the psyche as a third component that interacts with the brain and the correlating organ. Through the analysis of his patients' brain scans he found that a "conflict shock" (DHS) occurs not only in the psyche but impacts simultaneously in the area of the brain that correlates to the particular conflict. The moment the brain cells register the conflict, the information is immediately transmitted to the corresponding organ and at this instant, a Significant Biological Special Program (SBS) is activated to assist the organism, both on the psychological and physical level, during that crisis. Hence, each cancer or tumor growth is a meaningful biological response to a very specific conflict situation. By comparing tens of thousands of his patients' brain CTs with their medical records and their personal histories, Dr. Hamer was able to identify the exact location in the brain from where each type of cancer is controlled.

Firmly anchored in the science of embryology, Dr. Hamer's findings provide the scientific evidence that this brain-mediated correlation between the psyche and the body is inherent in every organism. That is to say that *all* species respond to a "death-fright conflict" with lung cancer, to an "indigestible morsel conflict" with colon cancer, to an "existence conflict" with kidney cancer, or to a "nest-worry conflict" (mammals and humans) with breast cancer.

The reason why all creatures respond to the same type of conflict with the same organ is that, whether fish, reptile, mammal, or human, all organs of all species can be traced to one of the three embryonic germ layers that develop during the very first period of the embryonic stage. To be exact, the lungs or heart or bones of every living organism are formed from the same type of germ layer and are therefore of the same tissue type. This is why we speak in GNM of biological conflicts rather than of psychological conflicts.

Cancer cells don't cross the germ layer threshold

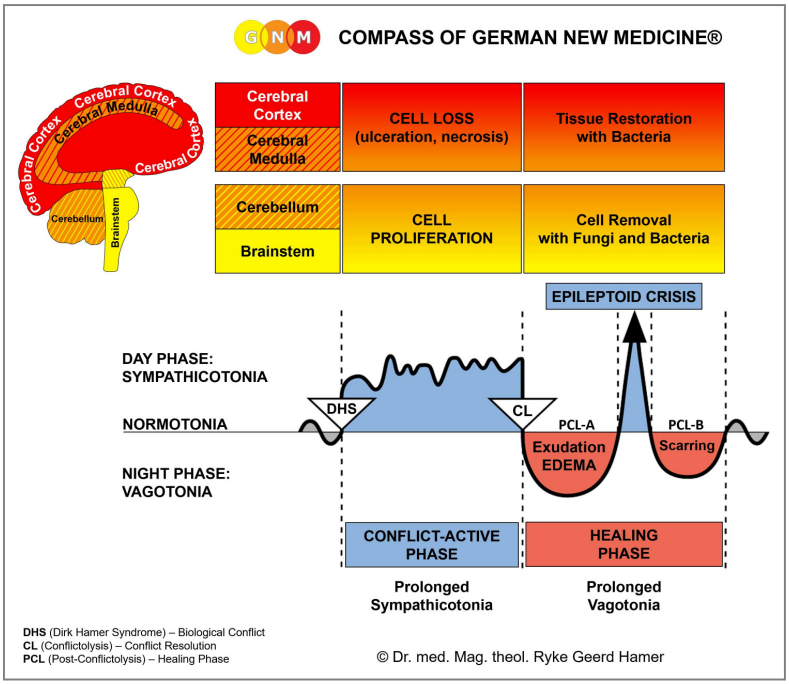
In the course of his research, Dr. Hamer also discovered that the individual brain control centers are arranged in the brain in a systematic order. The precise locations of the brain relays show that all tissues that derive from the same embryonic germ layer are controlled from the same area in the brain.



All organs and tissues that derive from the endoderm (lungs, colon, liver, pancreas, uterus, prostate) are controlled from the brainstem; all mesodermal tissues (breast glands, ovaries, testicles, bones, muscles) are controlled from the cerebellum or the cerebral medulla; all ectodermal tissues (skin, bronchi, larynx, cervix, bladder, rectum) are controlled from the cerebral cortex.

Thus, every cancer always involves a very specific area of the brain that controls the conflict-related organ or tissue. Under no circumstances are cancer cells able to “metastasize” to an organ or tissue that is controlled from a different, unaffected brain relay; neither can cancer cells “spread” to a tissue type that derives from a different germ layer. Cancer cells are absolutely bound to the specific organ for which the brain has activated the Biological Special Program.

The Third Biological Law of GNM offers, for the first time in medicine, a reliable system that allows a classification of all diseases according to their tissue type. Regarding cancer, the “Ontogenetic System of Tumors” shows that a cancer (tumor growth) develops either



a) in the conflict-active phase in old-brain controlled organs (brainstem and cerebellum), in which case the tumor has a biological significance as it enhances the function of the organ to facilitate a conflict resolution

b) in the healing phase in cerebrum-controlled organs (cerebral medulla and cerebral cortex), where the tumor is the result of a natural healing and replenishing process after the related conflict has been resolved.

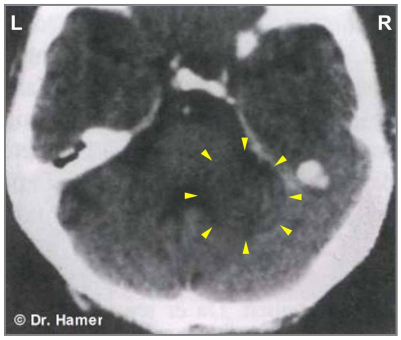
Either way, and this is the quintessence of Dr. Hamer’s discoveries, **cancer is always part of a *meaningful* biological process, and can therefore no longer be considered a “disease”, let alone a “malignant disease”**.

Making sense of secondary cancers from the GNM perspective

German New Medicine does not dispute the existence of secondary or multiple cancers. As we now understand, second cancers are not caused by “spreading” cancer cells but are the result of simultaneous or further conflicts involving the organ that is biologically linked to the respective conflicts. This applies, without exception, in *every* case of cancer.

According to the National Cancer Institute, the most common “metastatic” cancers are those that have “spread” to the lungs, liver, bones, lymph nodes, or the brain. In light of Dr. Hamer’s discoveries, it is readily apparent why this is so.

Lung cancer is biologically linked to a “death-fright conflict”. As a secondary cancer, lung cancer is most often the result of a diagnosis or prognosis shock perceived as a death sentence. Considering that each day thousands of cancer patients are literally scared to death by a cancer diagnosis shock or a negative prognosis (“You have three months to live”), it should not come as a surprise that lung cancer is, in modern medicine’s terms, the “No. 1 Killer”.



This brain CT shows the impact of a death-fright conflict in the area of the brain that controls the lungs. The moment the conflict impacts in the brain, the lung alveoli cells, in charge of processing oxygen, immediately start to multiply, because in biological terms the death-panic is equated with not being able to breathe. The biological purpose of the cell proliferation – the lung cancer – is to increase the capacity of the lungs so that the individual is in a better position to cope with the death-fright.

Lung cancer in PCL-A

Based on the psyche-brain-organ relation, smoking cannot be the cause of lung cancer, unless smoking cigarettes is related to a death-fright ("Smoking Kills"). The toxins in cigarette smoke, however, can make the healing phase much more difficult, particularly when a healing process is taking place in the respiratory tract.

Multiple cancers also occur when a DHS has more than one aspect. If a man, for instance, loses his job unexpectedly, he can simultaneously suffer a "starvation conflict" ("I don't know how to provide for myself") and an "existence conflict" ("my livelihood is at stake"). Each conflict impacts in the conflict-related brain relay and in this case two Biological Special Programs will be activated. If the conflict activity is intense, a liver tumor and a kidney tumor develop during the conflict-active phase. After the conflict has been resolved (for example, with getting a new job) both tumors will undergo a natural healing process.

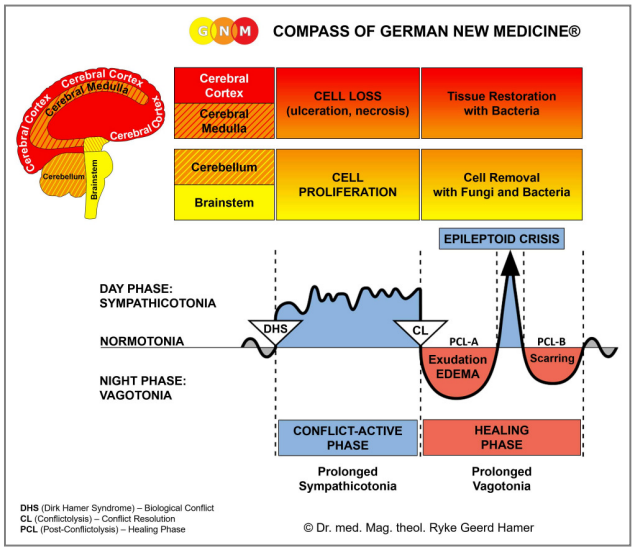
Bone cancer is, according to Dr. Hamer's findings, linked to a "self-devaluation conflict", which cancer patients typically experience because of feeling "worthless". During the conflict-active phase, the bone(s) or joint(s) closest to where one feels "useless", "sick", or "inadequate" generate a loss of bone tissue (termed "osteolytic bone cancer"). This explains why after a prostate cancer diagnosis men often develop bone cancer in the pelvis or lumbar spine, which are nearest to the prostate (60% of all "bone metastases" in men are prostate related). Similarly, women who suffer a loss of self-worth because of a breast cancer diagnosis or a disfiguring mastectomy, typically develop bone cancer in the ribs or the sternum (70% of all "bone metastases" in women are related to breast cancer). Considering the physical and sexual self-devaluation that men often feel when dealing with prostate cancer or women when facing the loss of a breast, it is obvious why conflicts affecting the bones are so common in these areas. The same applies to the development of **lymphomas**, typically in the axillary lymph nodes as a result of a "breast self-devaluation" or in the pelvis area in connection with prostate cancer.

Contradicting metastasis theories vis-à-vis Dr. Hamer's research

The current medical theory is that metastasizing cells are of the same kind as those in the original tumor, i.e., if a cancer arises in the breast and "metastasizes" to the bones, the cancer cells in the bones are believed to be breast cancer cells. However, in 2006, Dr. Vincent Giguère, a cancer researcher at the McGill University Health Centre in Montreal, stated the opposite: "Breast cancer cells, for example, often move to the bones. This is quite a feat since they first have to morph from breast cells into bone cells", says Dr. Giguère, "He and his colleagues are trying to figure out how they do it" (*Globe and Mail*, November 28, 2006).

Based on Dr. Hamer's discoveries, neither of the two metastasis theories can be scientifically verified since both theories assume that cancer originates in the body, where healthy cells supposedly mutate – all of a sudden and for no reason – into "malignant" cells. This concept fails to recognize that cancers, like all bodily processes, are controlled from the brain and that all cancers originate, in reality, in the psyche as an integral part of the human biology. In view of this new understanding of the nature and origin of cancer, secondary cancers cannot be the result of cancer cells spreading by way of the blood or lymph system to other organs because under no circumstances are cancer cells able to bypass this well-established biological system. The standard metastasis theories (aside from their embarrassing contradictions) also entirely ignore the histological association of each and every cancer to one of the three embryonic germ layers.

Let's look, for example, at intra-ductal breast cancer and bone cancer:



The ectodermal lining of the milk-ducts, including intra-ductal tumors, are controlled from the cerebral cortex whereas the bones, which derive from the mesoderm, are controlled from the cerebral medulla. An intra-ductal breast cancer is linked to a "separation conflict" and develops exclusively during the healing phase, whereas bone cancer is an indication of conflict activity of a "self-devaluation conflict". Thus, if the bone cancer is a secondary cancer after breast cancer, the bone cancer can only be caused by a "self-devaluation", experienced at a time *when the breast cancer is already in the healing phase*!

What makes the concept of "breast cancer spreading to the bones" even more irrational is that a so-called "osteoclastic metastasis" (a primary cancer, such as a breast cancer or prostate cancer, which has "spread to the bones") is by definition not a tumor growth but the opposite, namely a loss of bone tissue. How breast cancer cells are supposed to create "cancerous" holes in bones without the involvement of the brain, has yet to be explained.

"Metastasis" tests under scrutiny

> "Over the years many hypotheses were developed trying to explain the inefficiency of the metastatic process, but none of these theories completely explain the current biological and clinical observations."
>
> *Breast Cancer Research*, 2008

Pathologists claim that they are able to detect the origin of a secondary cancer through the analysis of tissue samples (biopsies). The current practice is to use stains and antibodies to identify proteins that are typical of a specific tumor. This method is called the "immuno-histochemical technique". A critical look at this method, however, quickly reveals that this procedure does not identify metastasizing cancer cells but only *proteins*, released from a tumor. A comment on the UCLA educational website admits to this obvious discrepancy: "Although the analysis may be simple, it often suffers from low sensitivity or specificity, and does not provide adequate functional measurements concerning tumor

cell behavior". From the GNM point of view, the release of proteins from a tumor is a natural part of the healing process, particularly when the tumor is decomposed by tubercular bacteria during the healing phase, in the case of a glandular breast cancer for example. As the body breaks down the now superfluous cells, proteins are released into the bloodstream (proteins are already detectable in the blood during the conflict active phase; these constitute the real tumor markers). The immuno-histochemical technique is *only tracking these proteins*, and yet we are given the impression they are tracking live cancer cells.

However, there has never been an observation of live cancer cells in the blood or lymph fluid of a cancer patient. Only *antibodies* have been identified, and these do not prove the presence of viable, "metastatic" cancer cells (the same "indirect evidence"-method is used in trying to "prove" the existence of viruses as a cause of "viral infections").

Cancer cells from a primary tumor have never been observed naturally attaching to another organ or tissue and growing a new tumor. Again, only "antibodies" or "proteins" have been traced to a secondary cancer.

In experiments where researchers inject millions of multiplying, "malignant" cancer cells from a growing tumor directly into the bloodstream, secondary tumors rarely occur. "Using a model in which human breast cancer cells were grown in immuno-compromised mice, we found that only a minority of breast cancer cells had the ability to form new tumors" (Dept. of Internal Medicine, Comprehensive Cancer Center, University of Michigan Medical School, Ann Arbor, MI 48109, USA). Source: *Proceedings of the National Academy of Science of the U.S.A.*, 2003

Common-sense questions we should ask:

- If it is true that cancer cells travel via the bloodstream, why is donated blood not screened for cancer cells, and why is the public not being warned by the health authorities of the risks of coming in contact with the blood of a cancer patient?

"Researchers at the European School of Oncology have concluded that **it is unlikely that cancer is spread through blood transfusions from patients with undiagnosed cancer** [emphasis added].

"Before donated blood is used in transfusions, it must undergo rigorous testing to ensure that it does not carry any disease. However, although the risk of transmitting infectious agents is well known, **it is more difficult to determine whether** chronic diseases such as **cancer can be transmitted from a donor to a recipient**.

"A team of researchers led by Gustaf Edgren relied on data relating to transfusions and cancer diagnoses in Denmark and Sweden to see if there is any connection between the two. … The team found **no evidence of increased risk for patients who had received blood from people who had any of the cancers thought to carry an increased risk of blood metastases** (lung, liver, skeleton and central nervous system)."

Comisión Europea, CORDIS, Resultados de investigaciones de la UE, July 23, 2007
https://cordis.europa.eu/article/id/28090-blood-transfusions-unlikely-to-spread-cancer-finds-study/es

These observations confirm Dr. Hamer's findings (Third Biological Law) that cancer cells do NOT use the blood as a route to "spread" to other organs, neither within an organism nor to organs of a blood donation recipient.

- If it is true that cancer cells migrate via the bloodstream, why are cancers of the blood vessel walls or of the heart not the most frequent cancers, since those are the tissues that would be most exposed to cancer cells traveling in the blood?

- If it is true that cancer cells metastasize to other organs by way of the lymph system, how is it possible that a "metastasizing" cancer develops in the bones (statistically one of the most frequent sites of "metastatic tumors"), although the bones are not supplied with lymph fluid?

- If it is true that secondary tumors are caused by cancer cells migrating through the blood or lymph system, why do cancer cells of a primary tumor rarely travel to adjacent tissues, for example, from the uterus to the cervix or from the bones to neighboring muscle tissue?

The "brain metastasis" theory vis-à-vis Dr. Hamer's discoveries

Dr. Hamer established already in the 1980's that so-called "brain tumors" are not, as assumed, abnormal growths in the brain but instead glial cells (brain connective tissue) that naturally proliferate in the second half of the healing phase (in PCL-B), precisely, in the area of the brain that undergoes – parallel to the healing organ – also a repair process. This restoration process in the related brain relay occurs during ANY given healing phase, whether it is a skin rash, hemorrhoids, a common cold, a bladder infection, or a cancer. It is a clear indication that the conflict has been resolved and that the psyche, the brain, and affected organ are healing all at once.

Questions we should therefore also ask:

- If it is true that cancers metastasize to the brain, why are cancer cells allowed to pass the blood-brain-barrier that functions as a vital filter to prevent harmful substances from entering the brain?

- Why do we never hear about "brain tumor" cells metastasizing from the brain *to* an organ, let's say, to the prostate, to the bones, or to the breast? Based on the prevalent doctrine this would translate, for example, into brain cancer cells causing lung cancer!!

Dr. Hamer's German New Medicine is the biggest challenge the medical establishment, including today's medical science and a profit-driven medical industry, has ever faced. Aware of this threat, the health authorities, supported by the justice system and the media, are using their power to silence Dr. Hamer's medical discoveries and to persecute, vilify, and criminalize its originator.

Source: **www.LearningGNM.com**