Christopher Wark (00:00.142)
As a general statement, chemotherapy causes a relative increase of cancer stem cells, because let's say it's 3 % of the tumor. But now you've debulked it and gotten rid of all this rapidly growing stuff, the cancer stem cells, in the general statement, they're slow growing. They just sit back. They give the chemo, they figure out how to kick it back out and become resistant. And that's why I well, this is not working now. It's because the cancer stem cells got the exposure.

and now regulate so that they can kick the chemotherapy back out again.

Christopher Wark (00:37.708)
Dr. Christine Salter. It's great to see you. Great to have you on the podcast. How are you? I'm great. And I'm happy to be here. So we met at the Bell Jansky foundation conference in Florida a couple months ago and had a great conversation. And, in fact, several conversations that really got me excited about, interviewing you and sharing your knowledge. you've,

you're working with cancer patients and you had told me things that I had never heard before. and I think some very important things that patients need to know. and so I'm excited, to dig into your knowledge and experience and share that with my community. but why don't we start with your story first? Do you mind sharing a little bit of your background, how you, arrived at where you are now, your, your sort of health and holistic practitioner journey.

Yes, so I'm originally from the UK, born and raised in England. My parents emigrated there from Jamaica. And so in England, I did my bachelor's in biochemistry and physiology. And I was going to pursue becoming a medical doctor. And during that pursuit, I developed a neck issue. And I went to my GP, who's known me since I was a child.

and basically she didn't touch me, very sweet lady, but she didn't actually physically examine me, she just started writing, know, prescriptions, which totally didn't help and just really got worse until somebody recommended that I see an osteopath. And of course, back then, on the national health system, know, osteopathy, naturopathy, none of that, you you didn't even really know about it. And so I didn't know what an osteopath was,

my friend recommended that I see one which I did and in two treatments that pain that I've been having for like five to six weeks was gone. And I thought to myself, know, here I am trying to pursue, you know, regular medicine. My mother was a nurse and so, you know, that was the way, you know, she said, yeah, you can be a doctor so you pursue medicine. But then when that happened, I said, well,

Christopher Wark (03:02.658)
I don't want to do that, know, it didn't help me one bit. And so I kind of looked at where I could train to be an osteopath. And then that's where I found the British College of Naturopathy and Osteopathy in London. And so that's where I trained and became a naturopath and osteopath. And I want to just make sure I'm clear here, the osteopaths in England are not the same as the

osteopaths in the United States. So the osteopaths here are basically medical doctors.

I don't even think they even do the adjusting or spinal manipulation anymore. They may do it as an elective. But in England, it's the primary. That's what you do. It's not medicine. It's all natural. And this school combined both of them. So that was my training. That's what I did. That's I enjoyed. I was invited by a couple of medical doctors from Alabama, actually, to join them there to Lifestyle Institute. They were really interested in osteopathy.

They were doing lifestyle, they were from my church and so I said, of course, that's what I do. And so when I came over and wanted to stay, when I looked around to see what was equivalent to what I had done, it wasn't osteopathic medicine because I was medical doctor. So what it was, was chiropractic. Naturopaths are still not licensed and that was over 30 years ago that I came. Naturopaths are still not

here in Missouri and in several states, I want to be an unlicensed practitioner. So I matriculated from Logan College of Chiropractic, now university, and I actually joined the faculty there after graduation. And I was able to practice basically natrotic osteopathy in the way that I really wanted to do that. But then the word kind of got out that there's an osteopath. And so they kept thinking that I was like a medical doctor. had people coming to

as a medical doctor, but I wasn't trained as a medical doctor, know, in no shape or form, except, you know, good anatomy, you know, what I did, I did well, but I was not a medical doctor. And so at that point, I prayed about it, thought about it, and that's when I went to St. Louis University School of Medicine and did become a medical doctor, and then went on to be both certified in family medicine, and then integrated holistic medicine, and then just continued in that journey.

Christopher Wark (05:30.382)
So now I combine everything together. But I started seeing patients with cancer really when I went to Utapine, there in Alabama, back in 1987. And continued with that just steadily over the years and have just really, you know, gotten in real depth into it now. And so I see oncology patients, you know, along with their medical oncologist or radiation

And sometimes some of them have chosen not to even deal with them. So I will still work with them the best that I can. What's the difference between osteopathic medicine and chiropractic care? Okay. So if you talk to an, if you talk to a British osteopath, right, the real quote, they'll say, don't ever go to a chiropractor. That's what I said when we were trained. They'll go, don't, don't, don't ever go to a chiropractor. don't have to, they don't have to adjust you properly. They'll break your back. They'll do this. I'm like, wow, really?

And then I came to the US and doing the chiropractic training and they said, don't ever go to an osteopath. They don't know what they're doing. So they both said the same thing. And then it turned out that the manipulation or osteopathy says manipulation, spinal manipulation, chiropractic says adjusting. It's essentially the same thing. What they both achieve is actually,

it's not really because people talk about bones being out of place. There's no bones out of place like

It's a functional way to impact the nervous system. So everybody should be either getting chiropractic care or the original osteopathic care to have their nervous system functioning properly. So that's really what it's about. does spinal manipulation or adjustments, how does it affect the nervous system? And I imagine there's also benefit if you have muscle tension, right? you have. Absolutely.

Absolutely and part of the treatment is to, you know, we do postural assessments to see how the patient is standing and how they're using their body and then we look at the muscles. If they've got pain, you've got to identify the pain source. There's no just randomly treating, you've got to identify the pain source. But the nerves supply the muscles, supply the ligaments, okay.

Christopher Wark (07:56.076)
And so when you do work on the ligaments, the muscles, and or adjust the spine, that fires in to the nervous system. Very often when there's a problem, we call somatic dysfunction in osteopathy, there's what's called a central excite atrial state. And so everything just really kind of almost on a hyper alert. And by doing the adjustment either manually, a very quick adjustment,

or using an instrument, it basically interrupts Okay, and then of course, the nerves supply organs, right? You know, we've got the somatic nerves, we've got the visceral nerves, the autonomic nervous system. So it's very powerful. I can adjust the thoracic area and it impacts the cardiopulmonary. You so if someone's got asthma, if they've got COPD,

We have that aspect. it's just very nice to me that's true holistic, right? You're addressing all of the patients, not just, okay, well, I'm just going to deal with their muscles. Okay. Or I'm just going to deal, you know, with the ligament system structure or whatever. Everything is tied together. You just can't separate it. The nervous system, the circulation, everything is tied together.

the nerve supply, the vasculature, then we've got the lymphatics. So you've got to address everything and see really what is the problem when a patient presents. I love the fact that you have such a comprehensive medical education. mean, there are very few people out there that are trained as a naturopath, osteopath, medical doctor, and chiropractor. I mean, to me, that is just so remarkable and wonderful because you have such

diverse toolkit. know, and I know you've done even additional training beyond those, those things. I imagine it in some ways, it must be hard to juggle all that information, you know, to keep it all sorted in your mind. But at the same time, like that's the kind of person I would want to work with is someone that A is coming from a comprehensive holistic approach that's trying to do no harm and get to the root cause of my

Christopher Wark (10:21.31)

Right. And that's exactly what I aim to do. Yes, absolutely. So in working with cancer patients, one of the things that we talked about was how important you expressed this to me. And I was fascinated by it, but how there are steps that a cancer patient can take to reduce their risk of metastasis around surgery. Correct? Absolutely.

I share with my patients when they come, when you have a primary tumor, that's what's really just looming and understandably so, especially if it's a big tumor. But that big tumor is driven by cancer stem cells. So if you've got this big tumor, 95 % of it is the primary tumor. Unless it's in the brain, then that's a different thing.

But if it's not in the brain, that primatumor is not what really causes the demise. It's the cancer stem cells. They're the ones that cause the primatumor to grow and they're the ones that go and cause metastatic disease. So when a patient comes to me, I'm already thinking about how am I going to reduce their chance of metastatic disease because

from a year from now, five years from now, ten, fifteen, twenty, thirty years from now. That's what I'm thinking when that patient presents to me. Yes, we want to develop the primary tumor and there's different ways in conventional, is the three main ways now, Nose surgery, chemo, radiation. That's the bulk in the primary tumor but the literature shows that doing that actually then increases

or a relative increase of the cancer stem cells. and that's why the literature also shows that simply shrinking a tumor doesn't change the overall mortality. So, when we jump them down and say, well, the tumor shrank, the tumor shrank. In the patient's mind, they're thinking, I'm getting better, right? I'm going to live longer. The literature doesn't support

Christopher Wark (12:40.942)
So we just have to be clear on really what we're doing. We have to say, yes, we're going to deal with the primary, but at the same time, we have to address the cancer stem cell. And so in many cases, there's often a surgical resection. Now in breast cancer, they've recently changed where they do the chemo first, and they do the chemo first to shrink, and then they

the resection if the tumor is not completely gone, but usually hasn't completely gone and you still end up with a resection. Colorectal, depending on the size of the tumor, again, it's usually surgery first. And of course, depending on whether it's the right side or the left side, you just had colorectal cancer, but a right sided tumor is very different from a left sided tumor and is treated differently.

the standard of care where surgery first but it changed. But I did just see, sorry to interrupt you, I did just see a study a few weeks ago published indicating that now according to this one study that they're thinking, well, maybe the chemo first isn't helping actually. anyway. The thing is what happens with surgery and any surgery is that, first of all, the patient's stress.

the patient is stressed, heading into the surgery. Then you get to the surgery and the anesthesia that's used, just the process of having the surgery being cut on all that, it causes an immune suppression. And so when there's immune suppression, what happens on the surgery, those cancer stem cells have an opportunity to move through.

Now I've checked circulating tumor cells just after a biopsy, like after a prostate biopsy, and you have to just see them go up. Well, of course it's going to go up. It's mechanical, right? You're sticking needles in, things are going to move through. I mean, we've got our head in the sand to think that, there's nothing going to move through. So it's not, the problem isn't that the stem cells go up. But as I track them, then you just see them disappear. And why do they disappear?

Christopher Wark (15:08.972)
because the immune system goes after them and takes care of them because that's what the immune system is designed to do. So we're not going to go, my goodness, the cancer stem cells increase. No, we say, well, it's not an increase, it's just a traumatic procedure. And then the immune system takes care of it. But now, a biopsy, not under, you may have some local anesthesia, but you're not under the major anesthesia now where you've got this immune suppression. And all that happening.

So with that now, now you've got the combination of cancer stem cells moving through and immune suppression. Now that's a problem. So now the immune system is not going to do what it's supposed to do. It may see those cancer stem cells, but its ability to clear them has now been compromised, like totally compromised. And so now, and because the primary tumor will often send signals

to we call, you know, to pre -metastatic niche. They'll send it to the liver, send it to the bone, bone is a common one, right? And so they, so some of them are already gone, okay? But they're just hanging around. Now you come now with the surgery and more are released, but now you've got immune suppression, okay? So now they're not going to be removed as

And so it just takes a matter of time, right? A matter of time before you'll hear, we got everything. You know, this is great, complete resection, no lymph nodes, no this, no that, and then two, three, four, five years, it's in the lungs, it's in the bones, it's here, you said, well, when you told me you got everything, how could that be? Well, that's how it is. It's the cancer stem cells. And very often they're not even measuring them.

They're not even preparing you for that surgery, unfortunately. Maybe the medical oncologist would say something, but they've not been to the medical oncologist yet. They've seen the surgeon. The surgeon is jobless, or her job is to go in and get the job done. Let's get this out. They're not thinking about immune suppression and this, that, and the other. So with colorectal cancer in particular,

Christopher Wark (17:36.078)

There's a couple of medicines of some prescription, one over the counter. A lot of cancer cells, often you'll see an upregulation of different receptors. And one of them is for histamine, histamine receptors. Okay, and they're just upregulated. And so there are studies with breast cancer where using Claritin has improved survival. Okay.

Claretin B, antihistamine. Antihistamine, they take for allergies, right? part of what I do is called... And they'll be taking it around the surgery, taking it before and after surgery? Before and after, but with cancer, when the studies, they've just shown just using that in general for breast cancer, they've had good outcomes with that period. For colorectal, what they've used is actually simetidine.

over the counter, it's Tagamet. Tagamet. Tagamet, right? So, so I'd usually write as a prescription and then all of sudden now we can't get it as a prescription. It's just so very hard to get. I said, we know it's fine. We'll just, I just tell them, go get it over the counter. Do the proper dosing. It's usually 400 milligrams twice a day. And so the difference between the prescription and the over the counter is just the dosage.

So I can write a 400 milligram prescription to be taken twice a day. If we can't get that, then we simply go get the Tagamet and they're 200 milligrams. You just take two of them twice a day. And you start before the surgery and you continue. Those ones that were that can continue for a whole year. Okay. But you actually can just do it perioptically and do it for like a good two

I like to do when everything's all settled down, all the inflammation has kind of gone away. I like to do like four to six weeks, so just a nice amount of time that everything's nicely done. So there's that for the histamine. The second prescription medicine is a beta blocker and a simple beta blocker. I prescribe this in residency, propranolol, for people with stage fright.

Christopher Wark (19:57.518)
when they get all anxious and their heart rate is going up and they're getting all anxiety, you put them on that beta blocker, calms everything down and they can go on stage fright and stage fright. One of the drivers and a big drive of metastatic disease is sympathetic stress. So that's why when I read the study with breast cancer,

where it showed decreased progression and this whole thing by doing yoga. And so that really got me thinking. So that relaxation that happens to decrease that sympathetic drive decreases metastasis. So I will put patients on beta blockers starting a week before surgery, take them all over for surgery and then for a few days after.

If it's colorectal, for sure, I'm to do simetidine. And then thirdly, there's anti -inflammatories. Because that inflammation is also a driver that causes a suppression. it's just like a perfect storm. You've got what's going on with the tumor itself. You've got what's going on with the patient being all stressed and stressed and the system being distressed. And doing these three...

Three or four, even in breast cancer, there's studies using Biaxin, Chlorithromycin, also decreasing metastatic spread and recurrence. So for breast cancer, because the data's there, I'll do all, not Nisai Methadine, but the other three. What was the last drug you said? Chlorithromycin is antibiotic, actually. The name is Biaxin, is the name for it.

that are interested in studying breast cancer. It's so simple and that's what's heartbreaking for me. It's such a simple thing to do if the surgeons would simply do that. I work with a breast cancer surgeon locally and when I looked at the data for breast cancer,

Christopher Wark (22:21.321)
It's basically say before that first incision, you make sure you drop in a nonsteroidal. The study was done with Keturlac IV Toradol. That's exactly what she does. We have that conversation. We talk about the type of anesthesia because certain anesthesia, the inhalant anesthesia can cause more immune suppression.

So I usually have them ask for the total intravenous anesthesia. Now there is one inhalant, particularly for colorectal, ceboflurane, that one's actually protective. So you just got to know what you're dealing with, right? It just can't be just, you know, blanket, right? So if have inhalant anesthesia, we'd use that one. Or we do the total intravenous anesthesia.

And then we talk about the pain control because the opioids also cause a problem and can drive the cancer. Yeah. So you see, so I, I saved my patients very categorically. I said, you ask them, you say, I do not want any opioid medicines, right? I don't want morphine. I don't want hydrocodone. I don't want oxycodone. I don't want any opioids. want, you

I want Tylenol. Now, all these drugs have their issues, So, you know, if I have patients taking Tylenol, I say make sure you take milk siphil, Because that will protect the liver, okay? And there's that show that it does do that, okay? Or N -Asthalcysteine, that's the drug that's given when someone does a Tylenol overdose, Mucomyste, it's NAP. So, if

it's got chronic pain and having to take chronic Tylenol, well yeah, we're going to mitigate that. Non -steroidals can raise your blood pressure, right? So chronically taking non -steroidal is not a good idea either, right? But in this perioperative setting, you know, yeah, we're going to do the non -steroidal, right? Because it's not going to contribute to the metastatic spread. So if they will address the anesthesia, address the pain medicine,

Christopher Wark (24:46.621)
address what's going on with the tumor itself and then address the sympathetic drive. You've got a beautiful situation where you're going to dramatically reduce their recurrence and the surgeon, when that patient, when they get the recurrence, that surgeon's long gone. That procedure is done, boom, it's gone. Now it's on to oncology. Now it's on to the medical oncologist, right?

know, medical doctors are not thinking about surgical and perioperative this and none of that, you see. And, you know, so it problematic and becomes even more problematic if chemotherapy is added to the mix, right? Because as a general statement, as a general statement, chemotherapy causes a relative increase of cancers themselves because, you know, it was just 1 % of, let's say it's 3 % of the tumor.

But now you've defaulted and gotten rid of all this rapidly growing stuff, the cancer stem cells is a general statement. They're slow growing. They just sit back. They give the chemo, they figure out how to kick it back out and become resistant. And that's why I say, well, this is not working now. It's because the cancer stem cells got the exposure and is now regulated so that they can kick the chemotherapy back out again.

So, so if they have, especially if you're, the worst thing is to have chemo and follow it by surgery, right? Because now you've debulked, you've got relatively more cancer stem cells. Now you're going to, now you're going to go to surgery. Did you see it's, it's just a, it's that's a bad combo. and it should be mentioned that chemotherapy also wipes out a lot of your really important immune cells.

Exactly. you've gone through chemo, you have a decimated or reduced immune cell population. Exactly. have the stress and trauma of surgery. You have less suppression from the surgery. That's right. And they give you opioids with suppressor. Even more. Exactly. There's this cascade of negative effects. And I think there's a big lesson here. I just love this interview so much. I can't wait to share

Christopher Wark (27:09.975)
But there's a big lesson is that I think a lot of laypeople and doctors assume wrongly that there are that that many pharmaceuticals are benign, right? That the anesthesia doesn't make any difference toward helping your immune system or helping cancer grow or spread that the, you know, the opioids or the painkillers don't make any difference. And so using all these drugs that actually are can be pro cancerous or anti cancer.

Exactly and then also the nutrition too, that's huge when they say, it doesn't matter what you eat, just go eat whatever you want. Really? So you're going to go to do chemo when we know that sugar will lower the immune system for what, three to four hours? let's, you know, it doesn't make sense, I mean it's just, it's not being thought through.

Now there's a time and a place to eat or drink something high glycemic and I'm going to mention that now and it's right before you do the chemo, right? Right before you do the chemo. Because the cancer cells for the most part love glucose. They regulate those receptors so they can just suck that in. So the ideal thing and there's studies on

carry around the time of chemo to fast. So you fast before the chemo, so now the cells are starved. They are stressed and distressed. Some of them might even die. But there's going to

be some of them that are smart enough to say, we're going to handle this fasting, right? And so, know, don't kind of go into hibernation.

They're the ones who want to get within 30 minutes of that infusion that you drink a high, high glycemic, get it in there so it wakes up those cells so they are ready to, they're like, oh great, we've got stuff coming, right, like a Trojan horse, right, and then they get hit with the chemo. So if we're to do the chemo, we want to maximize and be smart about

Christopher Wark (29:30.965)
Okay. then the therapy strategy around this, the insulin potentiated exactly. Yes, exactly. Insulin that crimes the cancer cell. Same principle. But it's a much lower dose. So it doesn't do as much collateral damage. Exactly. And because, you know, in an ideal world, everybody would be doing that, but you know, this is a poor man's way, right? It's the way of doing it. It's like, okay, you're doing the conventional stuff. Let's do that.

We might also maximize it. Do the fasting. And again, remember to stay with the fasting. That's as long as you're not already too thin. If you're already too thin, then you can't say you're going to do the fasting. That would be counterproductive. But to do that around, it's very useful. You stress them and then you press them. And it's a better outcome that way. It's a completely better outcome.

And then what you do after, so what I like to do is that if they're doing conventional chemo and doing all that, I like to cycle through to help the immune system. You just can't keep hitting them with the immune system. Even though they say, well, okay, we're to do three weeks on and a week off. Well, when you do that week off, it should not just be a passive week off, right? Like we're not going to nail you for a week. No, it's like, no, we're not going to nail you for a week.

but we're also going to boost that immune system as well as we can. We're going to get rid of those senescent cells because those senescent cells that usually accumulate with aging, but cancer and chemotherapy basically accelerates that process. So get a whole bunch of senescent cells. And what do they do? They produce a bunch of inflammation. Inflammation drives cancer. what I do is that when on their off weeks, we go after all the, we use the synolytic.

and we just hit them hard with some analytics, clean things up, boost the immune system as well as we can, and then we're ready for the next round. And we just keep cycling through and cycling through and cycling through. It's not enough just to do the chemo and then just say, wow, I'm glad I'm gonna take a break for a week, right, and then I'm gonna get hit again. Right, we have to rehabilitate that immune system as best we can to high dose vitamin C.

Christopher Wark (31:56.011)
That's very useful. so, you know, mistletoe, there's all different things that you actually can do right along with the chemo. Mistletoe, you can do along with the chemo. Are you familiar with Belize Big? yes. I've interviewed Belize many, many Belize, okay, yes. I met her in Germany

about five years, five or six years ago, maybe seven years ago. Yeah, so it helps with surgery, chemotherapy, quality of life.

And it can be started toxic all in itself. So that should be happening all along. when it comes to that off week. about mistletoe. What is the mechanism of action in the body of mistletoe? What is this compound doing? Okay. So multiple things. Mistletoe, well, of course it's all different types of mistletoe. you say mistletoe, there's like a of different mistletoes.

Okay, and some of them have a higher lectin content so that you can elicit an immune response. Okay. And of course, it all depends. We try and target it and depending on the patient's constitution, the type of cancer, we don't want to be too aggressive if the patient is frail or too aggressive if the patient's gone through chemo. Okay. So it helps the immune system, it's immunomodulatory.

just like low dose naltrexone. Everyone should be on low dose naltrexone, but cancer. Modulated immune system becomes

decrease in inflammatory cytokines. It's great and it's so simple. You know, it can do it by injection and we can do it by IV. And sometimes we'll do both of them together. Sometimes we'll do two different types of mistletoes together, one through the IV, one they're doing at home. We want to get a nice reaction. When we see that reaction, we know that the immune system has been activated. Now it's going, now it's looking, right? And that's the issue.

Christopher Wark (34:02.349)
with a cancering state is that the immune system for some reason has just kind of gotten laid back and it's just not really seeing the cancer even though it's standing in the face. So part of what needs to happen is to activate it and so what happens we talk about those M1 and M2 macrophages, you're familiar with that right?

And it's not that one's good and one's bad, right? Because you don't want to have only M1s, right? If you had only M1s, you know, you'd react to every little thing that, you know, that came your way, right? You know, a little bit of dust, a little bit of this, anything like that. You'd be, you know, eyes running, blisters, all kind of stuff. So we don't want all M1s. We want some tolerance from the M2s. But in the cancering state, and we can look for these in the blood work to

Is it polarized more to M2? Right? Is it polarized to M2? So now, when it sees the cancer, it's just like, okay, I'm not doing anything. Okay. And then we get this upregulation of these Treg cells, which then continues to stimulate those M2s, you know, and then the cancer itself, it's just interesting the whole thing that happens with cancer, you know, upregulation, secreting cytokines that triggers

the body to go into the M2 state, right? So it's just, you know, designed to say, okay, this way we're going to protect ourselves, you know, affecting the tumor micro -environment, you know,

up -regulates glycolysis so that you get all these acids, you know, the lactate, so because all that's it, but it can't handle the lactate. So what's it do? It kicks it out into the tumor micro -environment. And so now you've got a relatively alkaline tumor, but

pretty acidic tumor microenvironment. And so now that tumor microenvironment in itself then is creating an even more of a niche to support the tumor itself. So it then sends out cytokines and chemokines to bring in the blood vessel, to bring in those tumor associated macrophages, to bring them all in so they can continue the same process. And then basically what they want to

Christopher Wark (36:28.491)
And this is something else that I want to also share with your audience. There's this thought that you've got a primary tumor, just leave it there. Leave it there because if take it out, if you take away the mother, then the children are going to go, right? And saying that you're to get metastatic disease. The point is, the longer that that primary is there, there's more of a

for the cancer stem cells to create a program that we call epithelial to mesocannibal transition, EMT. There is more time, so it's time dependent, right? And sometimes even at the diagnosis when they say, oh, it's just here, it's not in lymph nodes. In breast cancer, 30 % is already gone. Right, so the idea of saying, let me just keep this in here.

and I know I'm just going to try and do things, you know, all naturally or whatever, the way they want to do it. We need to remove that primary tumor and at the same time address the cancer stem cells. You've got to remove it because the more time it's there, it can transition, it's sending all the messages, it's preparing the bones, preparing the liver, that's what's going to happen, right? So I'm

in the camp of let's leave this and see how the body is going to take care of this because if the body could have taken care of it, it still wouldn't be there now if it could have done that. So my thing is let's assist the body in a safe way to debulk and or remove that primary tumor and at the same time address the tumor microenvironment, adjust the immune system.

address EMT, address invasion, address it all.

Christopher Wark (38:29.805)
So we're not putting our eggs into one basket. makes a lot of sense. Um, you know, there was a study, uh, that came out in 2018 that I'm reminded of that, um, where they, researchers found that the primary tumor is sending out signals and you alluded to this sending signals to the immune system that actually helped prevent its own spread. Now, granted, we know that primary tumors can spread and do spread.

But there is, there is this communication that it's alerting your immune system to the fact that there's a problem. And, and so there's a, there's a bit of a, it's almost like a, you know, a catch 22. Yes. Because it begs the question, well, if you take the primary tumor out, then does your

immune system sort of relax and go, Oh, okay. Well, the problem, no, no more problem here while you still have circulating cancer cells.

So and that's what well the point is the the immune system is usually in that m2 mode Right. So even though it's getting signal coming from the primary tumor It's still and it's still in the mode where it's not taking care of what it's supposed to do so I guess I used to be in that camp until I saw over the years what really happened Right and what I've seen really happen is not

So that's why, know, when you talk about things in theory, it sounds great. Okay, so in theory that sounds really nice. So let me just keep it there and, you know, all these nice signals and it should take care. That sounds nice and fair, but what I've seen in clinical practice, I've not seen that happen, you see. So again, my position is do it safely and activate that immune system.

And not only that, so this is something really interesting. I was just in Germany at the World Congress of Integrative Oncology and was talking about selenium and using, and I don't want your audience to run out and go and get selenium and thionine because then it will become kind of toxic. But you've got to get the right form of selenium under the care of a physician. So what the cancer cells turn out that they have, have something called parafibrin.

Christopher Wark (40:55.765)
and it's a thick coating. So it's coated by, it's got this thick coating, so the immune system can't even get to it, right? It can't get to it. So you could be activating the immune system, but it's simply not doing the job. It can't do it, it can't get to it. And so we want to unravel that and remove that parafibrin. And the four nutrients that does

and they're all nutrients, they're not prescription medicines. One is selenium, selenium -thalaminate, curcumin, EG, CG, and magnesium. So we put them on that combo. Again, each thing that you do, we don't do random stuff. It's got to be very clear what we're doing. We're doing this, then this.

We're doing this for the immune system. We're doing this for the tumor microenvironment. We're doing this for anti -angiogenesis. We're doing this for anti -metastasis. We're doing this to block EMT transition. And then as you go through, either using repurposed drugs or the botanicals or the nutraceuticals, you're going to see that it overlaps. So they don't have to take 100 supplements as long as you know what you're targeting.

And when you know and you go through your checklist, that's the one thing I like about conventional oncology, it's very crystal clear, they're doing this for this, this for this, this for this, Not overlapping and saying, well, this is great for this, so I'm going to use 10 of them. They're not, they're going to say, okay, we're doing this, this, we're doing this, we're doing this. So I like that mechanistic way of thinking.

We're going to hit all these different pathways that are so important for the process, for this

cancer process. The cancer stem cell signaling, know, the Wnt pathway, the hedgehog pathway, the notch pathway, the STAT3. You don't want to take in a ton of supplements and then you realize they're all hitting the notch pathway, they're not touching the hedgehog and they're not touching the beta captain or Wnt, right? So we want to make sure that we're doing, that we're hitting the signaling.

Christopher Wark (43:16.545)
their metabolism, everything, right? And you do it all at the same time. We don't do it sequentially because we don't want to even get used to, okay, well, okay, I can deal with it, right? We want to make sure we're hitting all those pathways at the same time and doing everything at the same time to get the biggest bank front books. don't want to give them an opportunity to say, now I can go down the notch pathway because that wasn't covered. So

touch on was you mentioned chemotherapy, shrinking a primary tumor. I think a lot of folks don't understand what's happening when a tumor shrinks because they don't know. And they have been told that a primary tumor is not a hundred percent cancer cells. A primary tumor has immune cells in it. Right. And it has not perforages in it. has T -cells it.

those cells die off during chemotherapy and that does shrink a tumor. So you can shrink a tumor with chemo and have not even killed any of the cancer cells on the tumor. It just killed the immune cells that are in the tumor. that's, you know, it's sort of like a false sense of security. Exactly. Exactly. And the converse is also true. So what can happen, you can be doing protocols

that go against, that's activating the immune system, well now we've got immunotherapy, right? Tartar therapy, we've got immunotherapy. Well, when you do an immunotherapy, it's going to cause a lot of turbulence and activity. So you may see things get a little bigger, right? But we don't jump them down about that. And that's why you have to be real cautious when you do your repeat imaging study, right?

You do all your immune stuff, even doing the high dose vitamin C and all that, and mistletoe and all that. You're basically getting the immune system to go after this stuff. so the tumor markers that don't go up, you may see enlargement in the liver or the lung, but you've got to wait. You've got to watch other things. I like to follow like VEGF, MMP9, the markers that tell me invasion is really happening.

Christopher Wark (45:39.743)
If I see those going down and in fact see a little bit of enlargement in the liver or the lung and I see the other stuff going down, that's the body fighting it. That's the body fighting it. That is not invading it. Now that's going up there and those things are going up. Now that's a different animal. again, you can't be robotic about it. Okay, you've done this. Okay, now we're going to do this imaging. it's gone bigger.

or we're going to change the protocols. Let's really make sure that this is not pseudo

progression. We don't want to change anything if it's really working. So again, you've got to do more blood work than simply do a CBC and a CMC. CBC, CMC, tumor markets, that's all you see. You've got to go a little deeper than that to say, what is happening here?

what is actually happening because you know some things when they go up like that AL2 receptor that will that without that fighting so when I see that up I say okay good it's doing what it's supposed to do in early prostate cancer if we see an elevated transforming growth factor beta we're happy about that if it's advanced we're not happy about that okay and so you've just got to look at the markers in the context of what's happening that's what we need to do and it's just

It's just not cut and dry. That's really important. Context is so important. just understanding that inflammation and pain, do not necessarily mean you're getting worse. They're also part of your body's healing response. Part of the healing response. without the right kind of testing and the right practitioner to, to really look at all of these important markers. You don't know, right? don't know. don't know. You don't know. don't don't don't know. don't

Exactly, right. Well, because we're in a pill for an ill, right? You know, I've got a headache, I need to take this. You know, I've got this, I've got to take that. Right? Instead of saying, well, why do you have the headache? Is it because you've not opened the windows and, you know, the oxygen is not great, right? And, you know, you're not breathing fresh. I mean, it's something that simple. Or is it because you're not drinking enough water? I mean, for sure, we don't have a Tylenol deficiency to give us the headache, right?

Christopher Wark (48:04.557)
So I like to see if got a headache, give them the water, do a water flush, then tell me about your headache. Usually the headache resolves. Usually the headache resolves. Go outside, get some fresh air, get up and move so you're not being stagnant, and you'll see that it goes away. So again, it's just that pill for the ill. I've got this, I'm going to give you that. Nobody wants

kind of ride it through. I've told you this quick story when I was a resident, you know, from my naturopathic training, you don't suppress the fever, right? You don't suppress, you you allow the body to move through because when you, the body creates the fever because it's trying to heal. It's creating the fever because it's trying to get rid of that microbe. But of course, you're not going to feel good, so you don't feel good.

So then of you don't feel good, I want to take some Tylenol, it's going to make me feel better. I want to some ibuprofen, it's going to make me feel better. Well you may feel better, but you're not getting better. You may feel better, but you're not getting better because the process is getting worse because now you just water what the body was trying to do. So as a resident, I would never write for the standard order for the Tylenol, because the nurse would say, I want the standard Tylenol order for temperature above one, I said no.

I need to follow the fever curve. I have to follow the fever curve and I need to know that things are getting better. Now if someone's in severe congestive heart failure where they could decompensate if they get a high fever and the heart rate goes up, well that's a different animal and we have to do that individually. But I'm just talking as a general statement, someone's in there, they're in there for pneumonia, they don't have congestive heart failure. I want to know that if I put them on an antibiotic,

that antibiotics working and if I've seen a fever, I'm like, okay, things are working, the body's mounting a fever and then when that fever breaks naturally, you know that the body did its job. But if you just cover it up with a towel and all, you have no idea what's happened. It's gonna be driven deeper and they may feel better and then the next minute they're in, because they've got something even deeper going on. So, I really discourage that, especially with children as well. It's very quick to give the children.

Christopher Wark (50:30.635)
the Tylenol or the non -steroidal and that's the worst, that's just the worst thing. parents, you don't want to see your child uncomfortable. if they could, again, when I was a resident on pediatrics, the pulmonologist, gave us this brilliant paper and it's called Feverphobia. And he said, read that and understand that, right? You've got to be able to educate the parents.

throw away the thermometer, Throw away the thermometer. Look at the child and identify, does this child look sick? Not about how high the fever is. Is this a sick child? No eye contact, doesn't want to eat, you know, right? Not doing their normal stuff. That's a sick child. On the other hand, a child can have, like my daughter when she was little, raging fever but bouncing around the house doing all the

I'm not going to give it some time. mean, she's a little chocolate drop, she's kind of dark. But when she got fever, a little cheese or something, she would bounce. mean, she's like at 102, but she was just playing bouncing around. Do think I was going to stop her or do it? No, what I did, I chased her around and gave her Distragulus and gave her Alderberry to help the process, right? To help the process. What helps me, and I'm so glad you brought this up. Thank you.

Whenever I have a fever, just remind myself, of course, it's miserable, right? You're not feeling good. You are feeling bad. Bad. Some people tend to panic when they have a fever or when their child has a fever. They kind of go into a panic mode. Yeah. I mean, if you got a 101, 102, I mean, it's like you can't sleep. Your head is pounding. Yes. Rough shape. Yeah. It helps me to remind myself that like right now, as bad as

As bad as this is as unpleasant as this is my immune system is kicking butt right exactly And I don't want to interfere with the process and that's what painkillers do is they reduce the fever and then it reduces the activity of your Exactly, it prolongs your you know, it prolongs your condition your Exactly exactly now, let me just say this so one of the feds with parents is you can get the febrile seizures Okay, but but they're thinking with

Christopher Wark (52:58.637)
that it's basically how fast you get to the change, the delta, right? So if you know like a 98 .6 and then in a few hours you jump to a 101, right? Then sometimes the child can see, okay? But the answer isn't to shut the fever down though, right? And there's a genetic...

tendency for that to happen, right, or maybe a familial tendency. that's part of the fear, but again, shutting down the fever, you kind of bite off your nose despite your face, right, because you're worried that there may be a seizure, do you see? Now what they can do is give a medicine that will kind of relax the nervous system, still allow the fever to do its thing, but then decrease the risk for seizure. So there are ways to get around

that you know, you know, just going and you know, giving them, giving them the Tylenol, give it and then what they'll do, they'll do Tylenol on this hour and then Ibuprofen the next hour and they're just really doing it around the clock to just shut this thing down. Now there's a real issue with like iron poisoning. So yeah, so because a lot of iron tablets that look like candy to children. Now that will uncouple and cause a fever, but that's a bad fever.

That's a fever, right? Because that's a toxic fever. That's not what we're talking about. And we're not talking about heat stroke either, where the temperature goes up. We're talking about the, you've got an ear infection, you've got a lung infection, you've got this infection, the body says, I've to clear that, I've got an amount of fever to do that. That's what we're talking about where we say you ride the fever curve. That's what, so I want to make sure we kind of give that clarity. Yeah. And you know, you can Google this too, by the way, if you Google

how high a fever is too high. You will find numerous hospital websites, medical websites, all sort of confirming the same thing. Like a fever up to 104 is not necessarily dangerous or something. Exactly. That's crazy. I know, but that's how the body, we're fit and wonderfully made. Right? To mount that, to do that. And it forces you to slow down. It forces you to rest.

Christopher Wark (55:24.063)
It forces you to hydrate because you lose in way. So you, you hydrate, you slow down, you sleep, you know, you do all those things that you, that you need to do, you know, you know, other thing, since we're on this topic, the other, I guess silver lining of getting the periodic flu or, you know, fever inducing, upper respiratory infection or whatever is

You know, while your immune system is fighting this fever, it's also clearing house. Exactly. mean, they are scavenging. are killing all kinds of stuff. Exactly. actually is a wonderful sort of seasonal house cleaning. It happens. Exactly. It's like, I don't, I don't enjoy it. I'm not out looking for the flu, but I get it. just like, you know what?

my immune system is going to clean house, I'm just going to get in the bed and I'm going to ride the lightning. Right, exactly. And you know what? Yeah, but know, actually some of the

hypothermia is part of cancer treatment, right? Raising the temperature because the cancer cannot handle that high temperature. And then the previous vaccines where they would give the vaccines to cause an increase in temperature.

And the coldest vaccine, that's right. And it was clear that it's human. So doing saunas and regional hypothermia and whole body hypothermia, there places in Germany where they do that. And now, some of them do it intraoperatively and they're heating up the blood because those heat shock proteins, they can't handle it. And so we give

and repurpose drugs to block that heat shock protein so that it can't do and try and protect themselves because they try to protect themselves by increasing those heat shock proteins and so we try to shut those down. But that's one of the things that mistletoe also does is that it helps raise the temperature and the body kind of in the afternoon the temperature gets a little higher so you we like to the mistletoe in the afternoon right to kind of go along with that whole thing without warming.

Christopher Wark (57:50.253)
So if they say, well, I feel a little warm, feel little fever, you say, great, right? You get a nice reaction, great. know, give yourself injections on the sauna, right? So we want to use all the tools possible to go against the cancer. I've given mistletoe, done heat, injected, know, do photodynamic therapy, but you know, just kind of do it in a comprehensive way, right, to really disable them.

you know, they're trying to get away this way. Well, we've got heat, you know, or we've hyperbaric. Now you oxygenate and then you heat them up. know, so, you know, so many things to do as long as you understand the physiology. I love that. And, know, there's a lot of the challenge with integrative therapies and non -toxic therapies. There's a lot of them and there's a lot of practitioners out there, but it,

is really important to me to find someone who understands how to best administer these therapies because many of them have very little risk of harm and that's fine. you want, the point is you want to maximize the benefits. like combining therapies together, the timing of them is important. The duration, how frequently you're doing them and then when you're doing what, you know, it's

So it can get pretty complicated for the average patient or you know, it's like, know, when I, when I was sick, I didn't do a whole lot of integrative therapies because I didn't have access to them. So the only thing that I did that would be considered integrative would be IV vitamin C. had, yeah, there was a medical doctor and an oncologist who had sort of become integrated. was in his seventies. wow. Into becoming more integrative because he had spent his whole career as a conventional oncologist and was

pretty frustrated with the results. he was doing IV vitamin C, but for patients and was looking in

and researching other non -toxic therapies and studying Eastern medicine in his 70s. Anyway, the point is I did IV vitamin C and glutathione together. What I've heard recently is that actually it's not a great idea to combine those two things.

Christopher Wark (01:00:13.165)
Here's the situation, the primary tumor versus the metastatic tumor. So the metastatic cancer actually upregulates its antioxidant response elements. So it wants antioxidants. The primary is different, although I'm looking at the literature to really make sure that really is the case. I'm kind of leaning away from doing it all together.

primary because now we know that the primaries may have already sent off, you know, micro -mets. Okay, so right now I've actually moved to position of no -glutathione with a metastatic or primary, but in the metastatic setting for sure we're not doing glutathione. We're not doing that at all. Now, could you do it like after, like you know, do chemo and then in the cleanup

I know one of my colleagues in Australia, know, during the cleanup phase, made it with glutathione, high dose melatonin, and then pull it back, and then they go back to the chemo. It's a nuance, okay? Because we don't want to help the process. We don't want to help the process. so when you, they're trying to make glutathione. They're trying to do that. So to say, well, here we go, we're going to give IV, you know,

or transdermal, a way it's taken, sometimes oral, it's counterproductive. It's counterproductive. And so you could be doing all these great other things, and on the one hand, while at the same time, you're now feeding and helping things along. And it's the same principle of autophagy. Everyone thinks autophagy is great, but not in the metastatic setting. Not in the metastatic setting. And some of the treatments that we do in repurposed drugs and the botanical,

They all increase in autophagy. Green tea, know, mabendazole, they're all increasing in autophagy. So they always must have on board an auto -veget blocker. We can't say, well, we're not going to give you any of stuff, right? So you need that stuff because it's hitting other pathways. if it's also, especially if you're doing synergistic and multiple are increasing in autophagy.

Christopher Wark (01:02:39.905)
Well, you may be hitting these pathways and they may be getting disabled. But then on the other hand, you're providing building blocks for them, right, through the autophagic process. So the FDA approved autophagic block is actually hydroxychloroquine. That is one that, if you Google and say autophagic block it, that's one FDA approved. But propranolol is also an autophagic blocker. Capsaicin.

Autophagic blockers, so yes, and we like that that's from red peppers hot exactly. There's the peppers exactly right So so we like to we like to have people on the protocol that includes autophagic blockers so that we're covering all our bases and So that that's why you hear the

stories of you know what? Do natural stuff and it seems we're getting better and then it didn't right part of that

It's doing all the stuff, but now you're operating autophagy, then the cancer then says, thank you. And then you're to see the progression. does autophagy, generally it's a good thing, but how is it, when does it become problematic? Okay. basically what autophagy does, it basically recycles cells, right?

So breaks it down, you know, the cell has done what it's supposed to do and says, okay, now we can recycle, so we'll take the amino acids, we can take this part, we can take that part, okay? And then it recycles and goes and makes new cells, right? And do we want that? Of course we want that. That happens when we do intermittent fasting, right? That's what happens and we say, well, that's great. But if you've got a process going on,

that with rapid growth and it needs all these building blocks and then you are inducing autophagous producing all these building blocks, do you see how it's going to drive that process? now the cancer is like, you know, can't handle acidity, you know, it needs more glucose, needs more glutamine, it needs more nucleotides, it needs all that, so it's like, well, this is great, you

Christopher Wark (01:05:05.229)
We're getting all this recycling going on. I'm getting all these nucleotides. I'm getting all this stuff that's in a need. You see? So that's the problem. And again, can you 100 % shut it down? Well, no, you can't shut it down 100%. Nothing's 100%. You just want to make sure that you're not just doing everything that's going to increase autophagy. Right? You're going to have to do some of it, but you've just got to be strategic about blockade.

And that's why for me, unless a person's got so low blood pressure, I put that propranol on board because not only is it going to block autophagy, it's going to help that sympathetic tone and decrease that sympathetic tone. You have to be a little more cautious with the hydroxychloroquine because it can be drug interactions. So you just have to be careful because you've got to check every little drug of their own, everything.

everything you've got to look for those cross reactions. But I can easily put somebody on propranolol and not worry about a drug interaction. So that's the whole thing with the autophagy. And again, it's one of those things that are great when everything's normal. It's not great when you've got a cancering state or metastatic cancering state. We have to pivot and do something different. We have to pivot.

Dr. Christine Salter. This has been fun and fascinating. I've learned a lot. I could talk to you for hours and hours and I hope we can do this again. I hope so too. Yeah. And just to go deeper and talk about more. Cause again, this is just scratching the surface of your knowledge. know, but I'm thankful for you. I'm thankful that you have invested so much of your time.

becoming a naturopath, an osteopath, a medical doctor, a chiropractor, and, training in all these modalities and, and that you're on the front lines helping patients one -on -one. it just, it, it gives me so much hope and encouragement, that medicine is shifting, you know, that, more and more practitioners are, seriously the younger generation are coming up with, you know, coming through medical training with a much more holistic.

Christopher Wark (01:07:26.345)
and comprehensive attitude. must have been hard. Before we sign off, did want to ask you this question. just remembered, was it hard going through medical school with the naturopathic and osteopathic training background, going through this very conventional like, gone of learning? mean, did you want to pull your hair out some day? Yes, yes, yes, I did. It was very interesting, know, one of one of my attending

but that's because he's in medical school. He had nothing good to say about chiropractic. So when I've come to class, they had no attendance policies for certain classes because I already had this other training, I didn't have to attend all the classes. I remember coming to class one day and I came in and sat down and people turned around and they were looking at me and I was like, okay, what are people looking at? Why are they looking at me like

Well, apparently the lecturer before had just denigrated chiropractic like they don't know what they're talking about, don't know what they're doing, and this whole thing. But interestingly, by the end of medical school, his attitude changed. Usually prejudice is based on ignorance. Yes. And then until you come up close and personal, things change.

once you have that knowledge and you realize, really, they really do learn stuff. They're not just jumping around and cracking backs, right? They do know their neuroanatomy. In fact, know their neuroanatomy more than medical students know their neuroanatomy, right? so, yeah, it was a challenge. And then also during residency, was a challenge because the fever curve and this and then hormones and birth control

All the different things that I'm like, my goodness, this is really messing with their physiology. It was interesting time. It was interesting time for me. Hey, kudos to you for sticking with it and hanging in there and getting through med school and yeah, because I know it would be very difficult. Well, I have my goal. have my target. We know your goal.

Christopher Wark (01:09:46.039)
keep silent, keep on going because I knew what I was there for and I knew what I could do once I was out. It's hard enough for any person to go through med school, but then going through with a sort of holistic background and all that training and not wanting to just fight every day, argue every day. know it took a tremendous amount of self -discipline, self -control. And a lot of prayer. Yes.

God's grace in your life, I'm sure, get through that. Absolutely. I would like to mention one more thing though, Chris, and that's for colorectal cancer and actually for breast cancer, lemon balm, lemon balm tea goes after cancer stem cells. Several of the herbal teas go after cancer stem cells, chamomile, green tea, ginger tea, lemon balm. So I have my

for their water intake, not only to drink water, but to drink the herbal teas through the day. And that's just a passive way of going after those stem cells. Earl Grey tea. Okay, so there's all different choices of teas that they can be drinking that are gonna hit the cancer stem cells. And so, I just encourage that and it's easy to do, right? It's not like you take another medicine, it's easy to do.

Thank you. That's wonderful. And it's, it's amazing because, if you dive into the, into the nutritional science research, you'd be hard pressed to find any plant or herb, anything from nature that doesn't have anti -cancer, you know, effects. Exactly. Exactly. It's miraculous that God made all these wonderful,

fruits and vegetables, nuts and seeds, herbs and spices, all these wonderful foods that help our bodies stay healthy. Food is medicine. really is. Well, thank you again, Dr. Christine Salter. You're amazing. You're just a brilliant, brilliant person. I'm so glad to know you and tell me how can people find you? How can they get in touch with you or maybe even work with you as a patient? My website is very simple www .drsalter .com.

Christopher Wark (01:12:05.407)
If they sign on the website, every month I send out something educational. I've talked about colorectal, breast cancer, heart disease, just different things, just practical things, lifestyle, all that, because the lifestyle is so important. So I do have that newsletter that goes out each month. But if they want to work with me directly, they can

through the

And when I first see a patient, you know, cause you've got the stories that's encouraging and so yeah, thank you for everything that you're doing. Thank you. That's wonderful. Thanks. Thanks a lot. It's great to be on the same team with you. All right. God bless. Okay. Thanks again, Dr. Salter. Hey everybody. Thanks for watching and please share this interview with people you care about. Obviously Dr. Salter just talked about some very critical things that every cancer patient needs to know.

if they decide to have surgery before going into surgery. so yeah, help us reach more people and share the video and we'll see you on the next one. Bye bye.