MEDICAL MANAGEMENT OF PATIENTS WITH CANCURE™ FOR THE TREATMENT OF TUMOURS AT KINSHASA MILITARY REGIONAL HOSPITAL

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1. Introduction

- The name cancer was applied by Hippocrates to malignant evolving tumours, obviously for reminding some of their morphological aspects and for imaging their destructive and colonizing evolvement.

- Cancer is a disease characterized by an abnormally important cellular proliferation within a normal organism tissue, so as the survival of the tissue is threatened.

- The cells derive all from the same clone, the initiator cell of the cancer which has earned some characteristics enabling it to divide indefinitely.

- During the evolvement of the disease, some of the cells can migrate from their production site to form metastases.

- Whatsoever the variety, cancerous tissues possess common characters:
  - Morphologic abnormality
  - Biochemical cellular abnormality
  - Cells production abnormality

The cancerous cell.

- Morphologic characters of the cancerous cell:

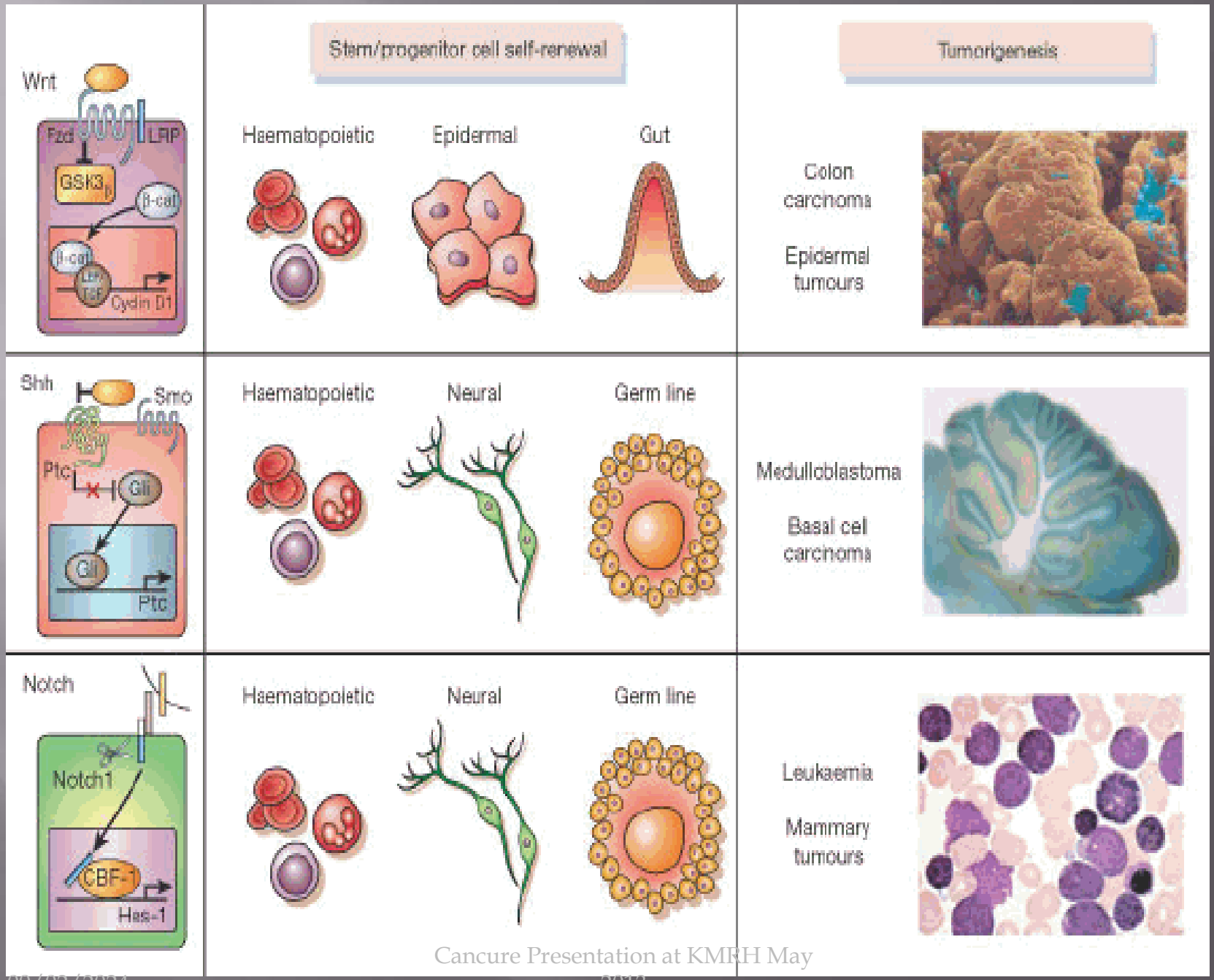
The cancerous cell possess a voluminous nuclei, irregular, very rich in chromatin; often several nuclei. An increase of the nucleo-plasmic ratio with variable alteration of the cytoplasm elements.

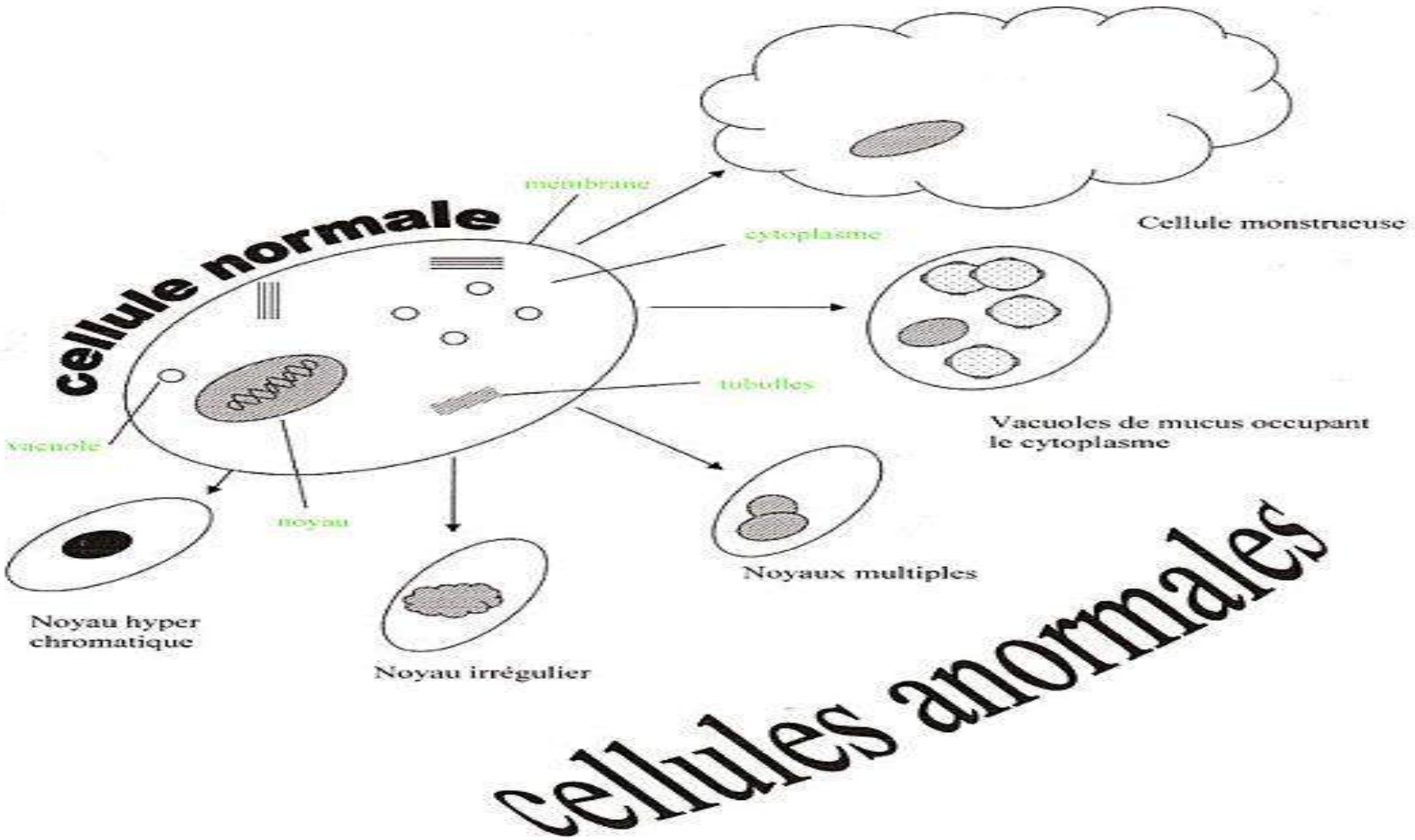
- Deviation of the cancerous cell metabolism.

These structural abnormalities, these anarchic multiplication correspond to a deviation of the cellular biochemistry resuming into the production of abnormal substances, abundant in quantity, by the cancerous cells “the tumour markers”.

- Multiplication of the cancerous cell.

The mitoses are more and more frequent in the cancerous cells.


Wnt
Fzd
LRP
GSK3β
β-cat
β-cat
Cyclin D1
Stem/progenitor cell self-renewal
Tumorigenesis
Haematopoietic
Epidermal
Gut
Colon carcinoma
Epidermal tumours
Shh
Smo
Ptc
Gli
Gli
Ptc
Haematopoietic
Neural
Germ line
Medulloblastoma
Basal cel carcinoma
Notch
Notch1
CBF-1
Hes-1
Haematopoietic
Neural
Germ line
Leukaemia
Mammary tumours


cellule normale
membrane
cytoplasme
tubules
vacuole
noyau
Cellule monstrueuse
Vacuoles de mucus occupant le cytoplasme
Noyaux multiples
Noyau hyper chromatique
Noyau irrégulier
cellules anormales

- The medical management of cancers takes in account:

- different evolving stages of the disease;
- the chemo-sensitivity or radio-sensitivity character of the cancerous cell;
- the duration of the cancerous cell exposition to the drug at sufficient concentration (the maximum tolerated dosage).

- The difficulty for caring cancers in our environment is mostly due to:
  - lack of the prevention culture;
  - late diagnosis;
  - often obsolete surgery;
  - difficulty to access an adequate therapeutic protocol;
  - unaffordable cost of the therapy;
  - non compliance and the side effects of the chemotherapy.

2. About Cancure™

- Cancure is manufactured by CREPPAT (Centre for Research in Phytotherapy and African Traditional Pharmacopoeia).
- Cancure has been implemented in RSA to a patient suffering from Leukaemia and the patient presented a very good evolvement resuming in a remission ad integrum.
- Cancure is manufactured in a tablet form titrating 30 mg of active principles.

3. Clinic cases

28 cases of various types of cancer were submitted to Cancure treatment in our clinic, among them:

- 4 cases of Cervix cancer;
- 4 cases of Breast cancer;
- 3 cases of Rhabdomyosarcoma;
- 3 cases of Haemangioma;
- 3 cases of HBP & Adenosarcoma;
- 2 cases of osteosarcoma;
- 1 case of Ocular cancer;
- 1 case of Multiple Myeloma or Kahler's Disease;
- 1 case of Parotidian tumour;
- 2 cases of Digestive cancer;
- 1 case of Malpinghian Papilloma;
- 1 case of Xerophytic tumour with Sarcomateous tendacy;
- 1 case of Prolactinoma.

3. Clinic cases

1. ***Patient NNS, 13 years, female:***

- Diagnosis: Neurofibroma of the external face of the right foot back.
- Symptoms: Very painful tumefaction at the right foot back ; operated before for the same tumour mass.
- Evaluation:
  - Rx of the right foot: No defined osteo-articular lesion;
  - Right foot ultra sound scan: Fleshy lesion on the right foot evocative of a Rhabdomyosarcoma in the first hypothesis. See Biopsy.

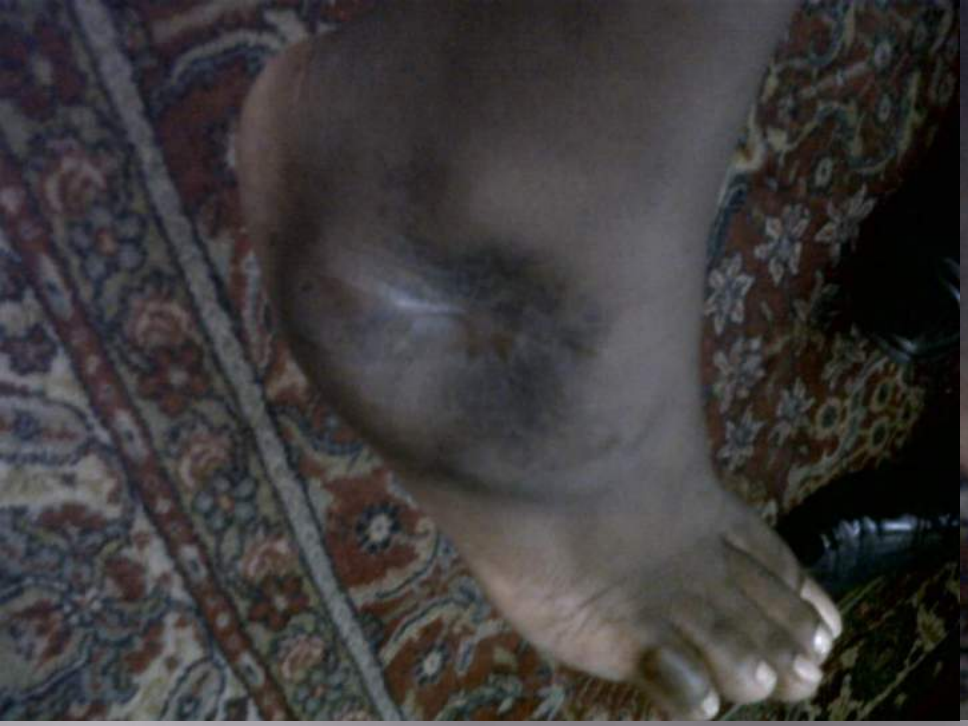
- Biopsy: the histopathological analysis of the specimen shows a site by site acanthosical epidermis, a superficial derma. Collagenized, the profound derma is the siege of a benign neoplastic process with a cell proliferation of fibroblastic tendency among which some with undulant nuclei and compatible with Shwann's cells.

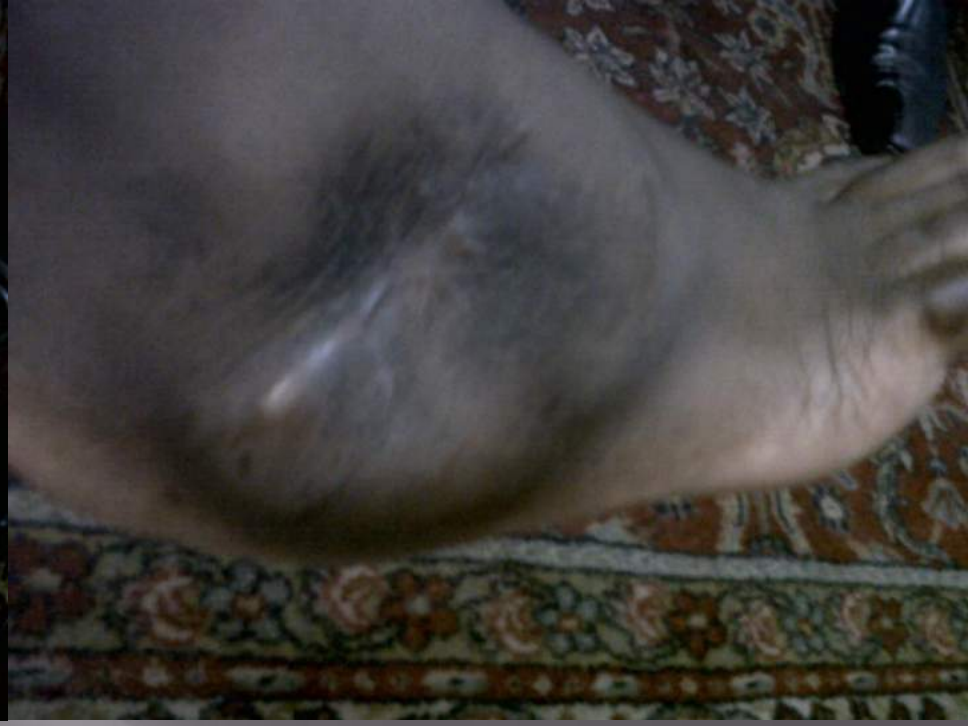
No sign of malignancy, it's a Neurofibroma.

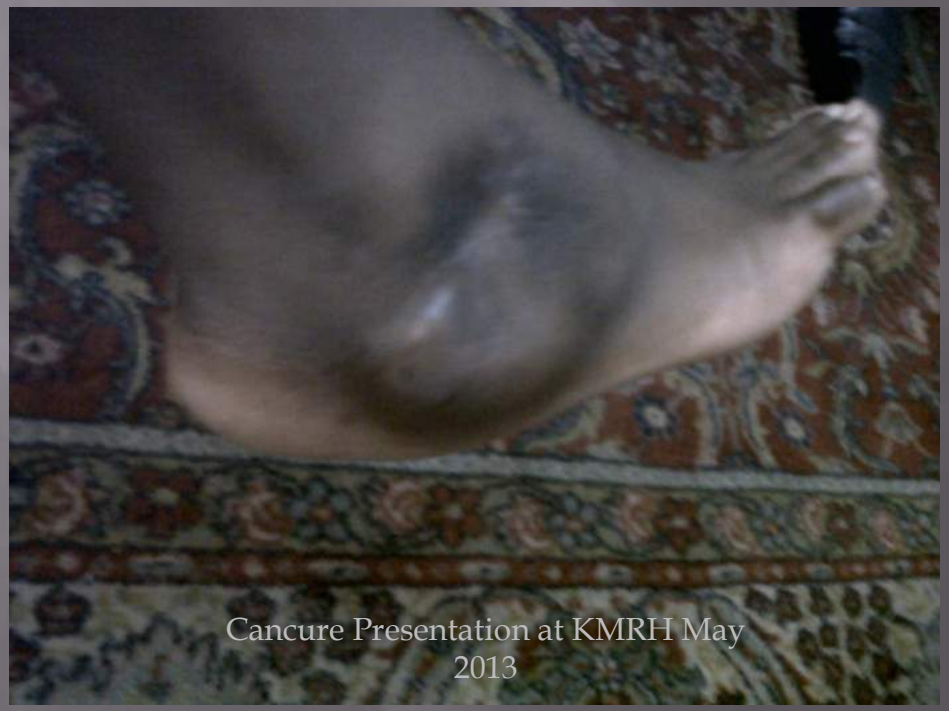
- Treatment: Start December 2012
  - Cancure 3x2 tablets/day
- Follow up: 2 months on

Regression of the tumour, pain amendment and walking restart.

- Programme: In instance of cleaning surgery.







2. *Patient Mws, 57 years, male:*

- Diagnosis: Kahler's disease (Multiple myeloma)
- Symptoms: Lumbar-sciatica and Functional impotence of both inferior limbs, bedridden invalid patient.
- Evaluation:
  - Rx Lumbar-sacrum: Osteolytic images; images showing bones demineralisation;
  - X-Ray Skull: At random geode images onto the skull;
  - CT Scan Lumbar: L2 Vertebra with cuneiform deformation by heaping and sticking together the upper and lower overlapping plateaux evocative of a systemic disease with tendency of Kahler's disease.

- Laboratory:
  - Bence Jones proteins: positive
  - Na^+: 133mmol/l
  - K^+: 2.6 mmol/l
  - Cl^-: 101 nmol/l
  - Sedimentation Speed: 120 mm/1st hour

- Treatment: Start December, 14th ,2011
  - Cancure: 3x2 tablets / day
  - Vitaminotherapy: B_1, B_6, B_{12}: 2x2 tablets /day
  - Physiotherapy: antalgics and re-education.

- Follow Up: 2 weeks on the treatment:
- Clinic: Passive mobilisation of inferior limbs and better general status;
- Paraclinic:
  - Na^+: 139 mmol/l (NL)
  - K^+: 3.4 mmol/l (NL)
  - Cl^-: 105 nmol/l (NL)
  - Sedimentation Speed: 80 mm/1st hour
  - Rx Skull: Decrease of at random geode images
  - CT-scan: the L2 vertebra heaping and sticking persists.

On admission Nov. 2011	Follow Up Jan 2012	Follow Up March 2012	Follow Up Apr. 2012	Follow Up 03 Jun 2012
▪ Functional Impotence of lower limbs; ▪Bedridden invalid; ▪ Sedimentation Speed: 120 mm at 1st hour; ▪ Hypokaliaemia; ▪ X-Ray Skull: At random geode images; ▪ Cerebral CT scan: heaping and sticking of vertebral discs;	▪ Recovery of lower limbs functions; ▪ Sed. Speed: 80 mm at 1st hour; ▪ Kaliaemia: Normal; ▪ X-Ray Skull: regression of at random geode images;	▪ Clinically good general status; ▪ Body weight gain; ▪Restoration of walk without assistance; ▪Sed. Speed: 60 mm at 1st hour; ▪ X-Ray Skull: Evident regression of at random geode images; ▪ CT scan Lumbar: heaping and sticking together of the vertebral discs images persists.	▪Delivery of a bulletin for myelogram; ▪Observation: The patient is no more showing up for consultation. He's using a 3rd person to collect his medicine.	▪ Arrived dead at HMRKin; ▪ Siblings report that the patient went for a "pray & fasting" in a traditional church for about a week time.

3. Patient Mwb, 46 years, male

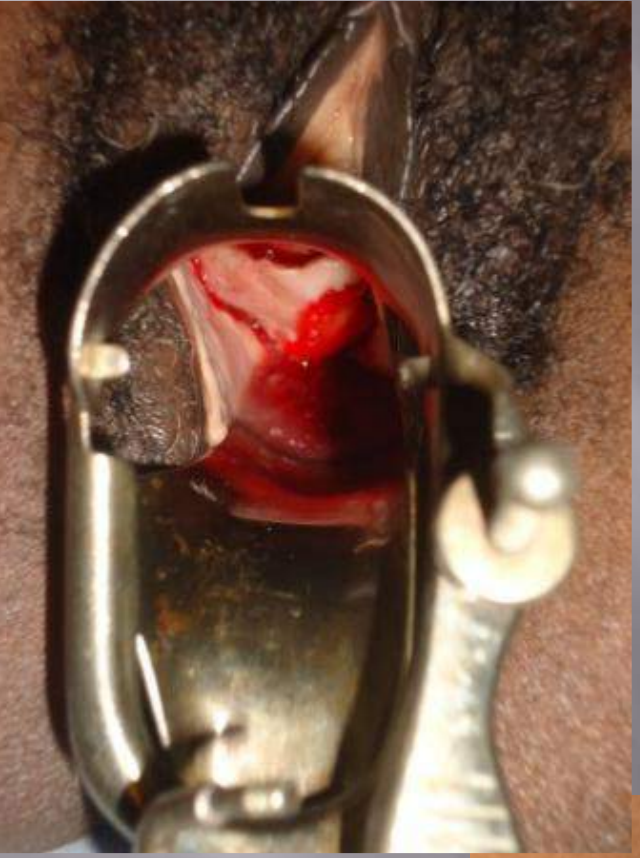
- Diagnosis: Benign prostate hypertrophy;
- Symptoms: Dysuria.
- Evaluation:
  - Rectal touch: sensible, increase of prostate volume, elastic consistency, regular surface;
  - Total PSA: 0.85 ng/ml
  - Free PSA: 0.08 ng/ml
  - Ratio: 9.41%
  - Bladder-prostatic ultra sound scan: Prostate of 33 g to the detriments of the transition zone;

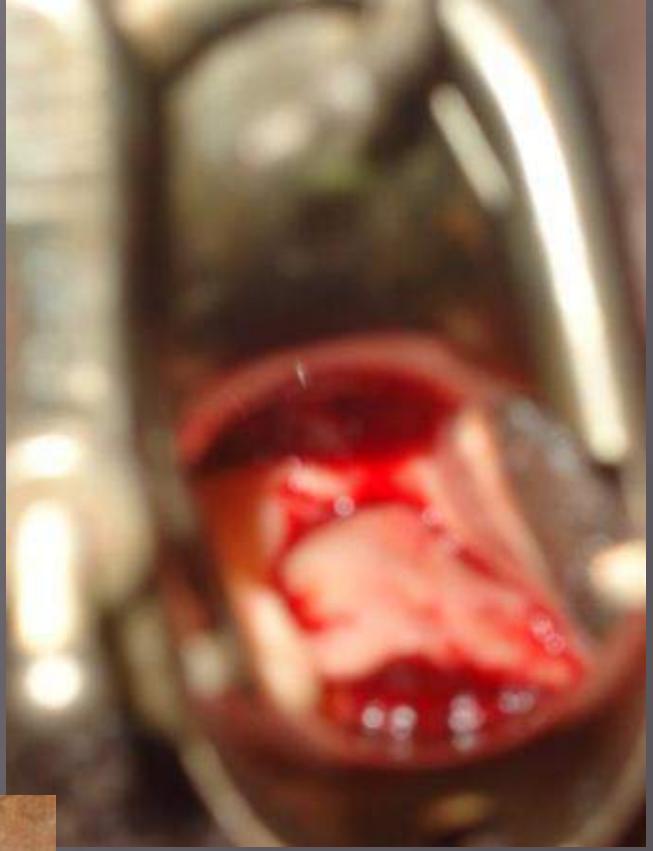
- Treatment: Start: June 23rd, 2012.
  - Cancure 3x2 tablets/day
- Follow up:
  - No more dysuria 2 months on treatment;
  - Good clinical evolvement, 9 months on (pains amendment, normal micturition) .
- Program:
  - Follow up ultra sound scan: from 33 g to 26 g, normal;
  - PSA : ratio 10%, normal

4. Patient Bin, 51 ans, female

- Diagnosis: Cervix cancer, stage 4b;
- Symptoms: Genital haemorrhage and Bladder-vaginal fistula;
- Evaluation:
  - Speculum: burgeoning cervix, ulcerated and bloody;
  - Vaginal touch: Hardened vaginal walls, communication at anterior walls.
-

- Treatment:
  - Hospitalization;
  - Cancure 3x2 tablets/day
  - Bladder probe
- Follow up:
  - 2 weeks on Cancure treatment: cease of haemorrhage;
  - 4 months on Cancure treatment in hospitalization : cease of urinary leak, closure of the fistula and micturition under control;
  - Visible gain of body weight.
- Program: We recommend an UCA





5. Patient Ndl, 52ans, female

- Diagnosis:
  - Rhadomyosarcoma upper left clavicle evolving since 3 years;
  - Lung Tuberculosis discovered during hospitalization;
  - Sugar Diabetes, probably type 2;
- Symptoms: The patient had been previously operated for the same tumour mass.
  - Axial pain radiating over the upper left member with functional impotence;
  - Bedridden invalid;
  - Productive cough with dyspnoea since 3 weeks;

- Evaluation:
- Biology:
  - Haemoglobin = 8.6%
  - White cell count: 7700 /mm^3
  - Leucocytes Formula: N69%; L18%
  - Sedimentation speed: 120 mm at 1st hour ↑↑
  - Glycaemia: 266.95 mg/dl
  - ALAT: 16.1 IU/L
  - ASAT: 23.3 IU/L
- Ziehl on spit: positive 4 crosses;
- Tumour mass ultra sound scan:
  - Heterogeneous, hypo-echogenic infiltration with rearrangement of the muscular tissue, very suspicious of a Rhabdomyosarcoma;
  - Absence of objective adenopathies.

- X-Ray Thorax:

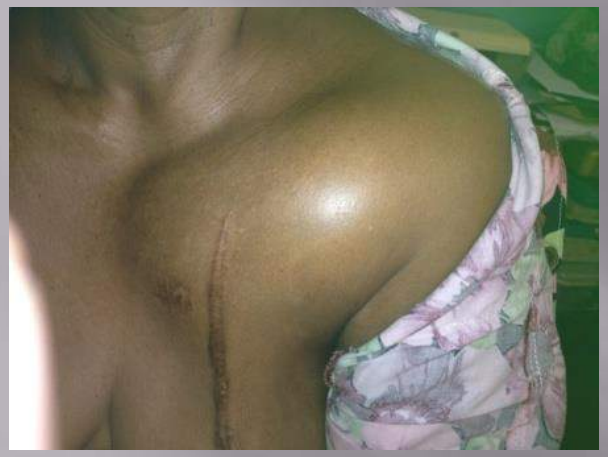
  Homogeneous and systemic opacities on to the median lobe of the right lung;

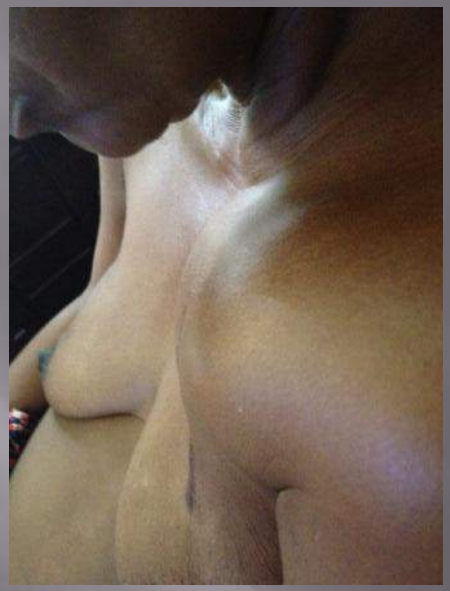
- Treatment: Start: Apr. 26th, 2012
  - Cancure 3x2 tablets/day
  - Martial supplementation
  - Anti- TB
  - Insulino-therapy

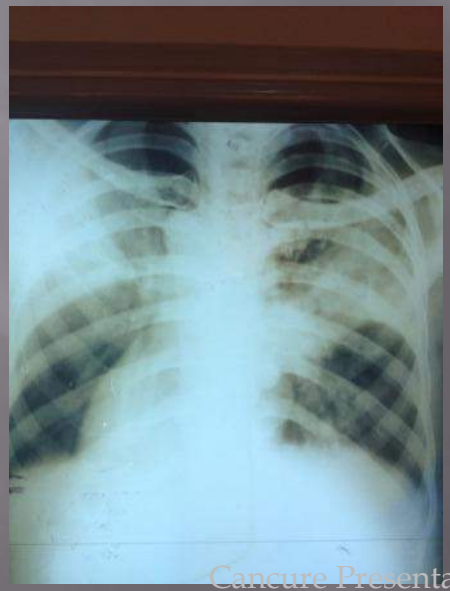
- Follow up: 6 months on
  - Good general status
  - Less pain
  - Less cough and dyspnoea; TB cured.

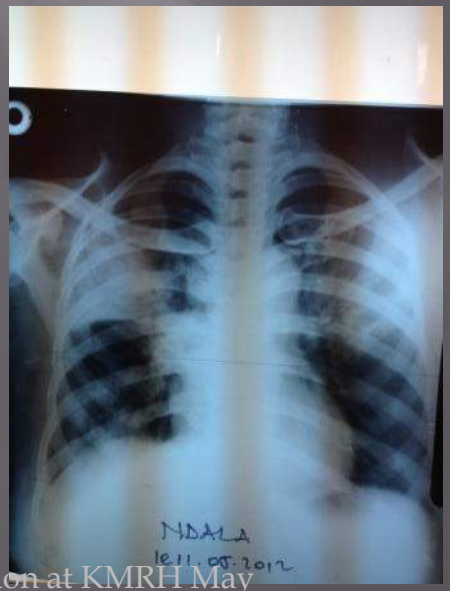
- Follow up: 9 months on
  - Important tumour regression
  - No more pain

- Program:
  - Biopsy planed after 3 months
  - Complete Blood Count
  - Kidney function exploration(Urea, Creatinine)
  - Liver function Exploration (ASAT & ALAT)
  - Glycaemia
  - X-Ray Thorax





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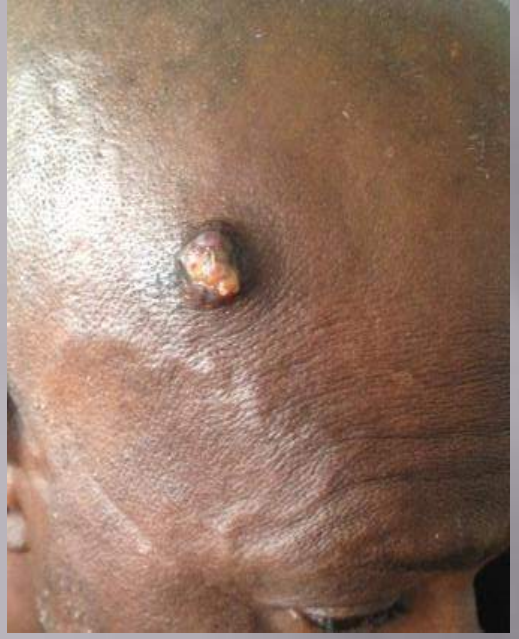
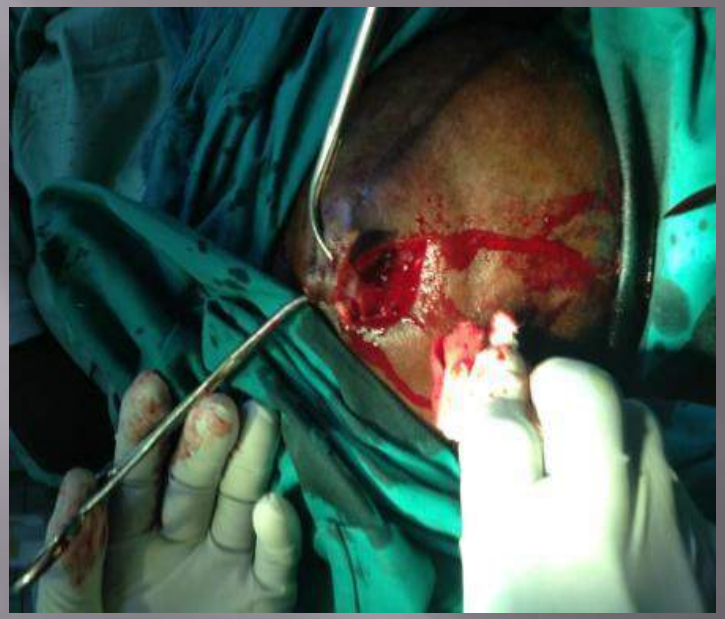
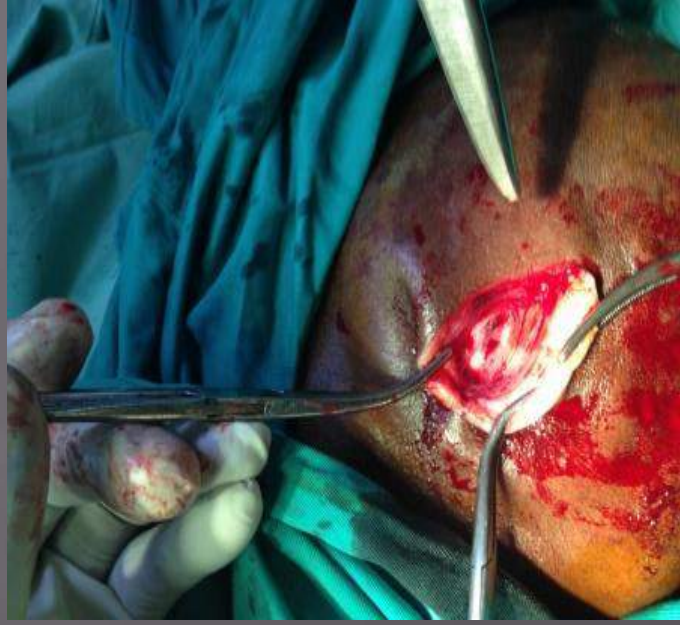
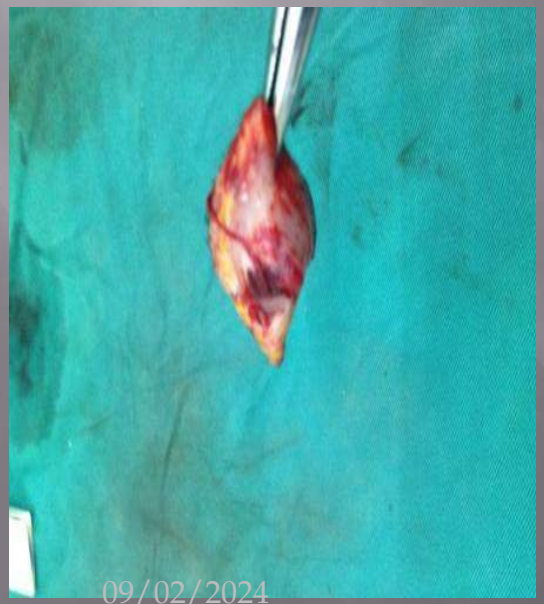
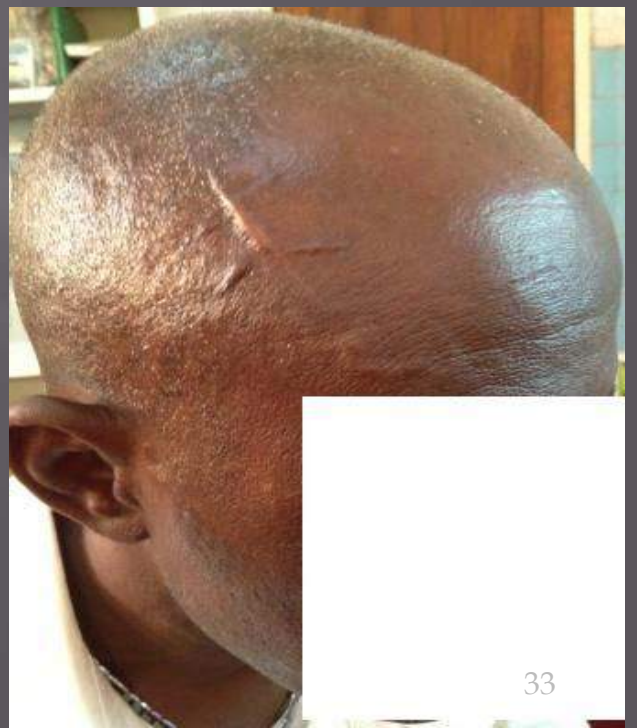
6. Patient Nwn, 56 years, male

- **Diagnosis**: hyperplasic haemangioma of the hair hide.
- **Symptoms:** Oval hardened tumefaction of about 3 cm of large diameter and 2 cm of small diameter, circumscribed, superficial to the right frontal region; migraines and headaches.
- Evaluation: anapath, hyperplasic haemangioma.

- Treatment: start May 28th, 2013
  - Biopsy exeresis
  - Cancure 3x2 tablets/day since May 2012

- Follow up:
  - Good clinical evolution, one year on: no more migraine, neither headaches.
  - Linear scar of about 5 cm in first intention, less cheloidian, no mass in place.



7. Patient KAK, 33 years, male

- **Diagnosis**: Rhabdomyosarcoma at the parietal region.

- **Symptoms:**
  - Large painful tumefaction at the parietal region of 20cm of large diameter and 18cm of small diameter, circonscribed, of irregular surface and firm consistency, sensible to palpation.
  - Migraine and headaches

- **Evaluation:** The ultra sound scan performed in March 2013 showed a Rhabdomyosarcoma.

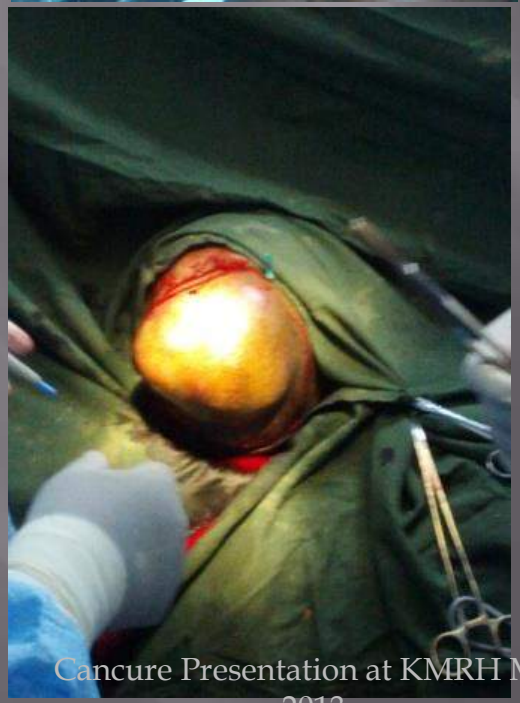
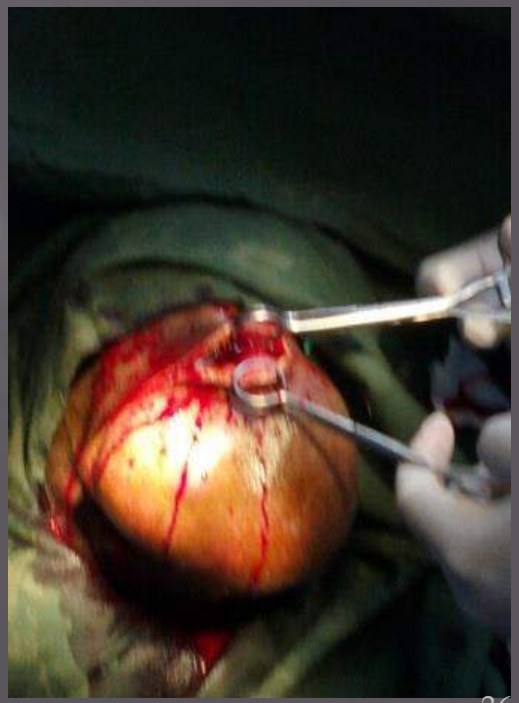
- **Treatment**: Start, end of March 2013
  - Antalgics
  - Antibiotherapy
  - Cancure 3 X 2 tablets/day
- **Follow up:**

- Good clinical evolution 5 months on: no more migraines, neither headaches

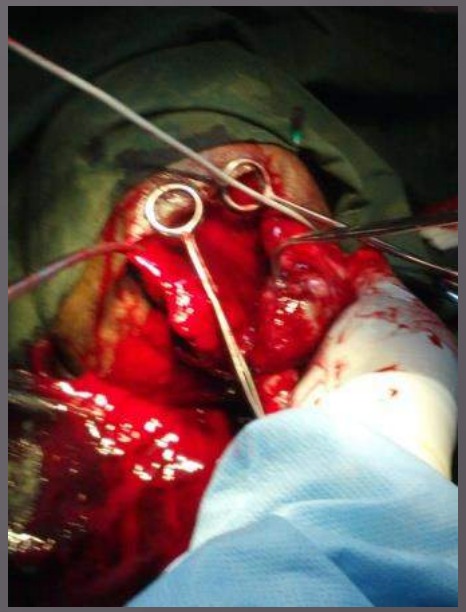
- Linear scar of about 20cm in first intention, no recidive.



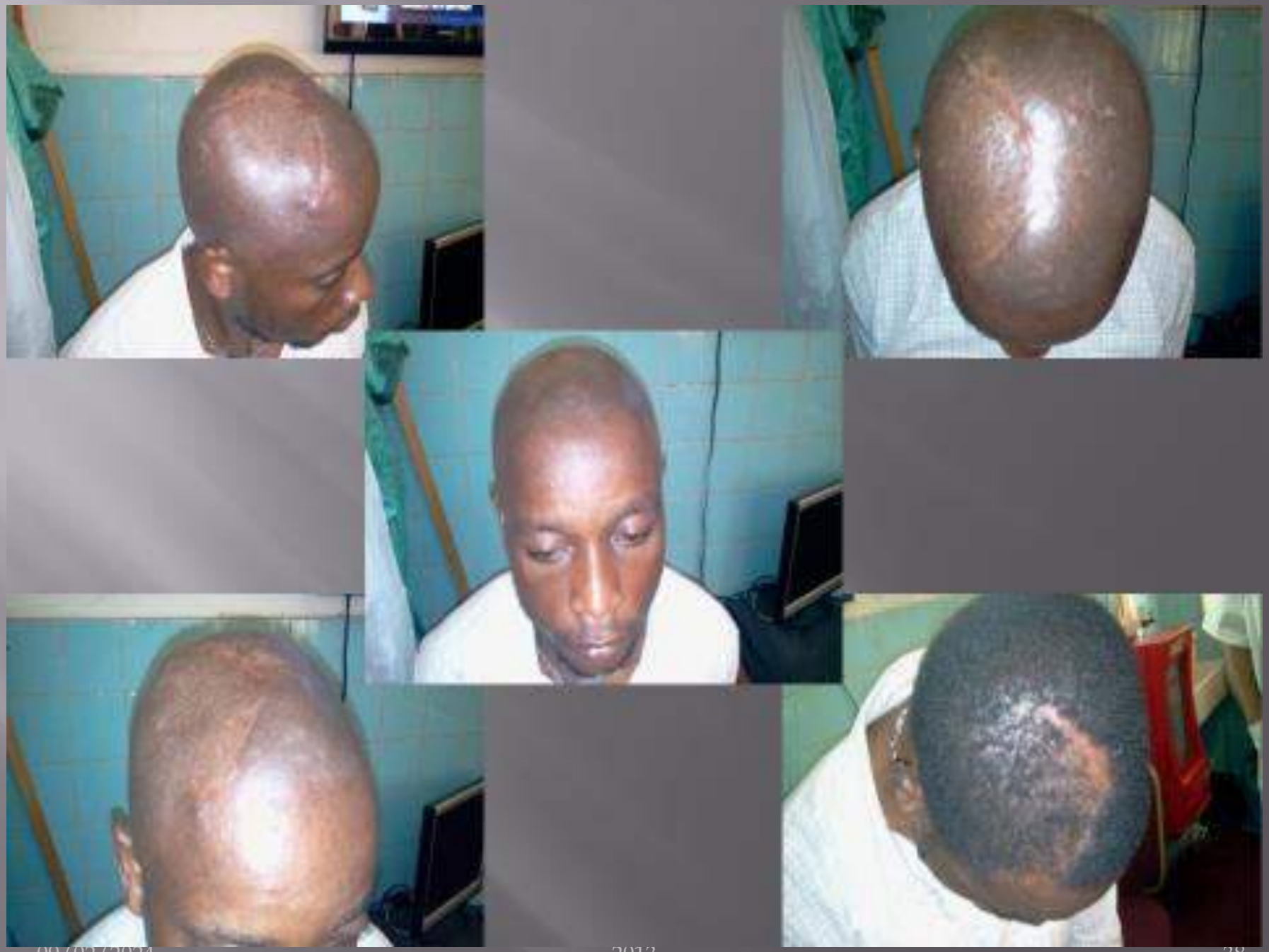








8. Patient Kim, 62 years, male

- Diagnosis:
  - Prostate adenocarcinoma;
  - Sugar diabetes, probably of type 2.
- Symptoms:
  - Drop by drop urination;
  - Lumbago;
  - Swollen prostate (43 g), non palpated median groove, fibrous consistency and painful;
  - Hyperglycaemia (312 mg/dl)

- Evaluation:
  - Prostatic ultra sound scan: discrete benign hypertrophy of 43g without kidney impact;
  - Total PSA: 1.4 ng/ml
  - Free PSA: 0.23 ng/ml
  - Calculated ratio: 16% (probability of a carcinoma)

- Treatment:
  - Cancure 3x2 tablet/day
  - Oral anti-diabetics

- Follow up with Cancure a month on:
  - Prostate ultra sound scan: 33 g: trivial test
  - Total PSA:1.65 ng/ml
  - Free PSA: 0.5 ng/ml
  - Calculated ratio: 30%

- Program:
  - Prostate-bladder ultra sound scan every 3 months;
  - PSA + ratio

On Admission November 2011	Follow up February 2012	Follow up June 2012
▪ **Drop by drop micturition** ▪Total PSA: 1.4 ng/ml ▪ Free PSA: 0.24 ng/ml ▪ Ratio: 16% ▪ Prostate ultra sound scan: 43g discrete hypertrophy; ▪ Hyperglyceamia: 312 mg/dl ▪ Unerection	▪**Micturition: Normal** ▪ Hb: 15% ▪ Glycaemia: 173.74 mg/dl ▪ Creatinine: 0.9 mg/dl ▪ Urea: 3.83 mmol/L ▪Total PSA: 1.65 ng/ml ▪ Free PSA: 0.5 ng/ml ▪ Ratio: 30% ▪ Prostatic ultra sound scan: HPB of 33 g ▪ Unerection	▪ **Micturition: Normal** ▪Ultra sound scan on June 6th: HPB of 29g (normal value for age 24±4g) ▪ Total PSA: 2.18 ng/ml ▪ Free PSA: 0.5 ng/ml ▪ Ratio: 22% ▪ Unerection

9. *Patient Mm, 72 years, male*

- Diagnosis: prostate adenocarcinoma.
- Symptoms: dysuria, hematuria, pelvian heaviness.
- Evaluation:
  - Rectal touch: swollen prostate, painful, fibrous consistency;
  - Bladder probe installed.
  - Total PSA: > 100 ng/ml
  - Free PSA: > 10 ng/ml
  - Ratio: 10%

- Treatment: Start June 14th, 2012
  - Cancure 3x2 tablets/day
  - Installing a 3-way probe

- Follow up: 6 months on
  - No more dysuria; no more haematuria; patient gone (case of therapy abandonment).

10. Patient KMJO, 62 years, female

- Diagnosis: Right breast neoplasia.

- Symptoms:
  - Presence of lump in the right breast, roughly round by 10cm in diameter, of irregular surface, of firm consistency, sensitive to deep palpation; adhering to the deep layer, located at the upper external quarter.

- No axial homolateral adenopathies.
- Evaluation:
  - Right breast mammography: presence of a high hydric density opacity comparing to neighbouring tissues; of irregular shape, with speculated outlines, measuring over 34x31mm on the right breast, containing within punctiform micro calcifications and causing architectural distortion. No retraction of nipples.

- Compatible with a right breast malignant legion of BIRADS 4 type.
- Anapath: invasive carcinoma less differentiated from right breast .

❖ Treatment:

- Right breast mastectomy
- Antibiotherapy
- Antalgics
- Anti-oedematous
- Cancure 3x3 tablets /day since September 2012

❖ Follow up: 10 months on

- No recidive
- No adenopathy

11. Patient Ygj, 50 years, male

- Diagnosis: Invasive tubular carcinoma of right breast in man.
- Symptoms:
  - right breast pain, recurring round lump of about 6cm in diameter, smooth in surface, firm in consistency, adhering to the deep layer.
  - antecedent of a mastectomy of the same breast 2 years previously, in 2011, for the same diagnosis.

❖Evaluation:

- Biopsy; invasive tubular carcinoma of the breast.

❖ Treatment:

- Chemotherapy with Cancure 3x2 tablets/day in December 2012
- Right breast mastectomy in February 2013;
- Antibiotherapy;
- Antalgics;

❖ Follow up: 8 months on

-First intention scar

- No recidive
- No adenopathy
- No pain

12. Patient NDM, 40 years, male

- Diagnosis: Rhabdomyosarcoma of the long right thigh abductor.

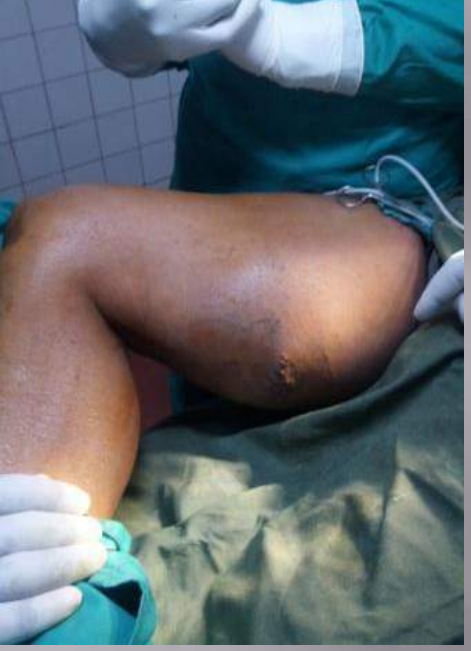
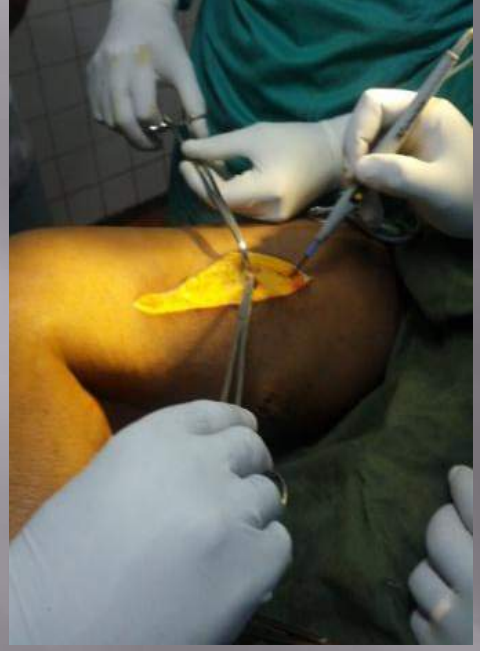
- Symptoms: a painless tumefaction of firm consistency and subject to mobility superficially, and deep by nearly 15cm from the grand diameter and 12cm from the small diameter, with a collateral circulation and turgescence of vessels around the lump.

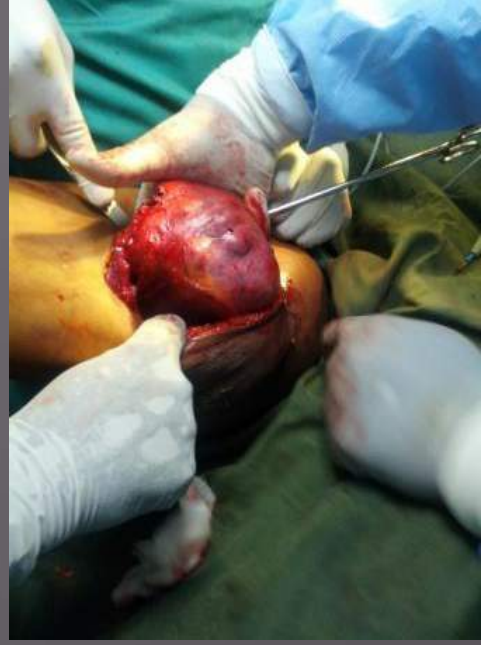
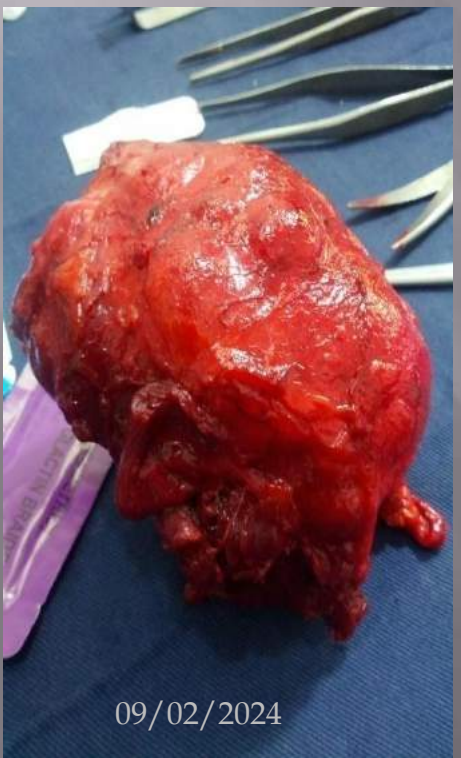
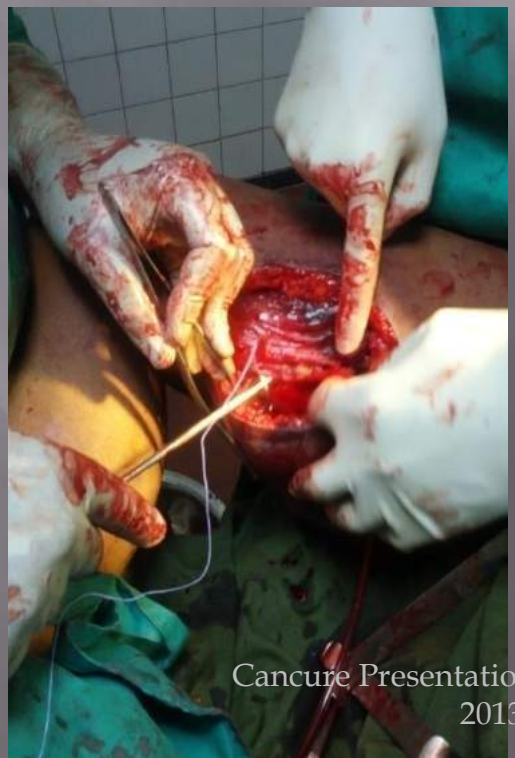
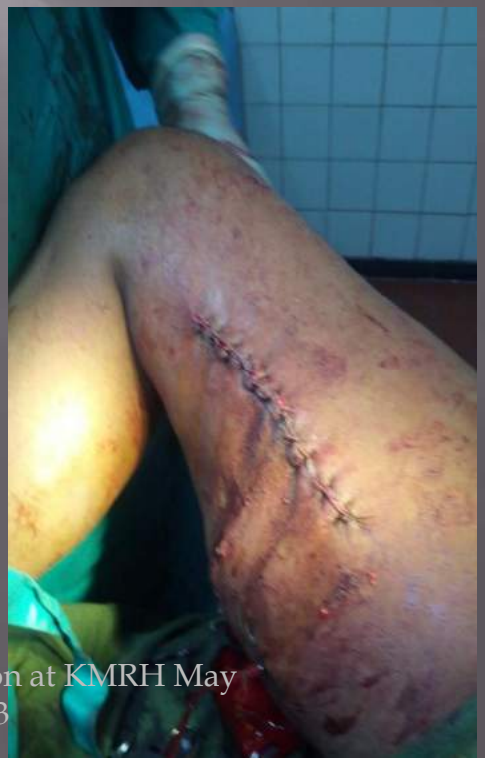
- Evaluation: Echo-doppler of the lump: big neoplasic intramuscular lump of the long right thigh abductor, recalling the Rhabdomyosarcoma diagnosis with deep and superficial varicose veins of traumatic origin.

- Treatment:
  - Chemotherapy with Cancure in February 2013 R/3x2 tablets/day
  - Tumour mass exeresis in April 2013;
  - Antibiotherapy;
  - Antalgics;

- Follow up: 5 months on
- First intention scar
- No recidive
- No more heaviness

- _Program: Mass biopsy.


13. Patient MBB,33ans, male

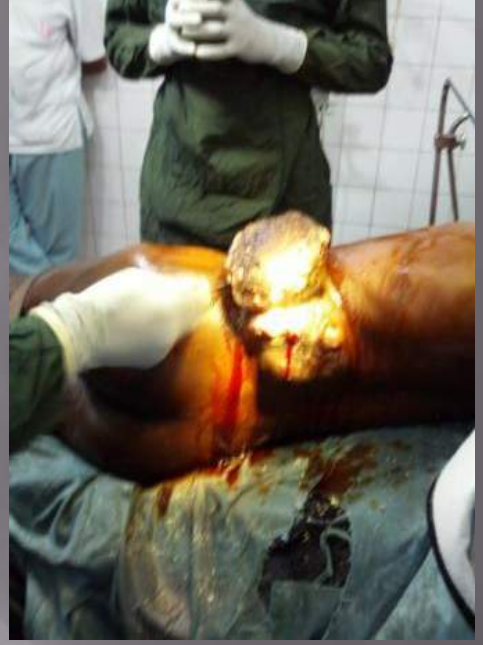
- Diagnostic:
  - Burgeoning mass of malignant tendency, located on the left side; pending precision.
  - Operated previously 8 times for the same tumour mass.
- Symptoms:
  - Burgeoning mass, very bloody upon contact, located on the left side and at the lumbar pit, stinking, with some necrotic crusts.
  - The mass is hot, firm, fibrous, sensitive around the healthy skin and adhering to the deep layer.
  - Moreover, an inguinal and axial polyadenopathy is noted.

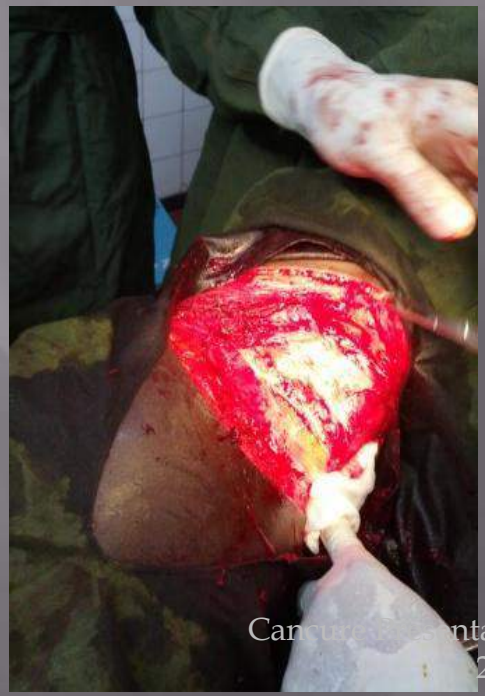
- Evaluation: Doppler ultra sound scan, X-Rays ASP, Thorax X-Rays, Inflammatory assessment, complete haematology.
- Treatment:
  - Chemotherapy with Cancure 3x3 tablets/day in December 2012;
  - Strong antibiotherapy;
  - Antalgics;
  - Anti-inflammatory;
  - Tumour mass exeresis in January 2013;
-

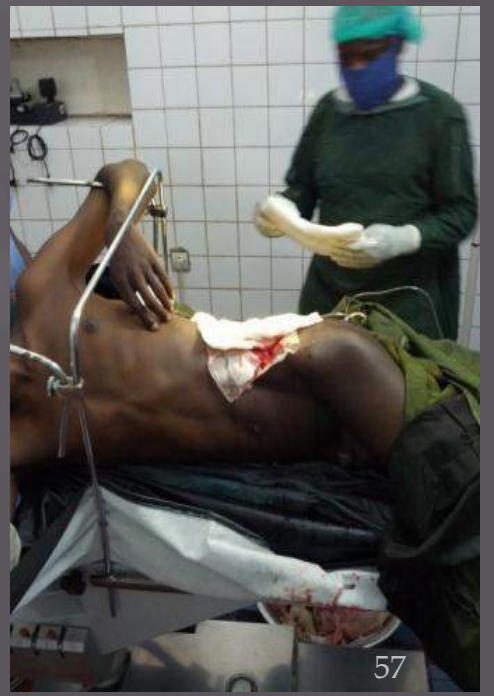
- **Follow up**: 6 months on
- No recidive
- In instance of scarification

- **Program:**
  - Extension assessment: Thorax X-Rays, Sacred-lumbar X-Rays, complete blood count, kidney and liver functions exploration.
  - Envisage the skin transplant.





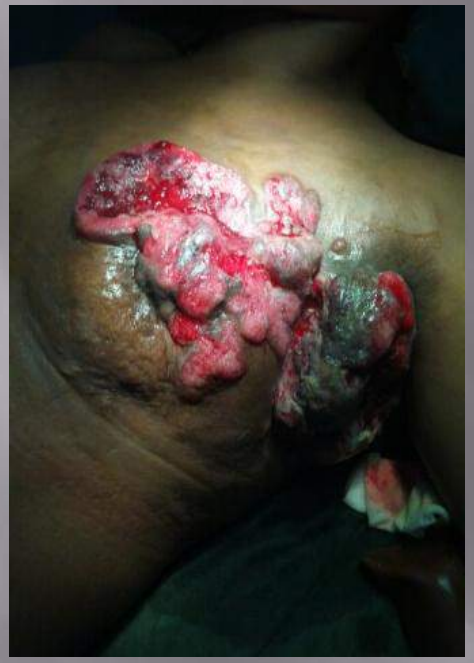


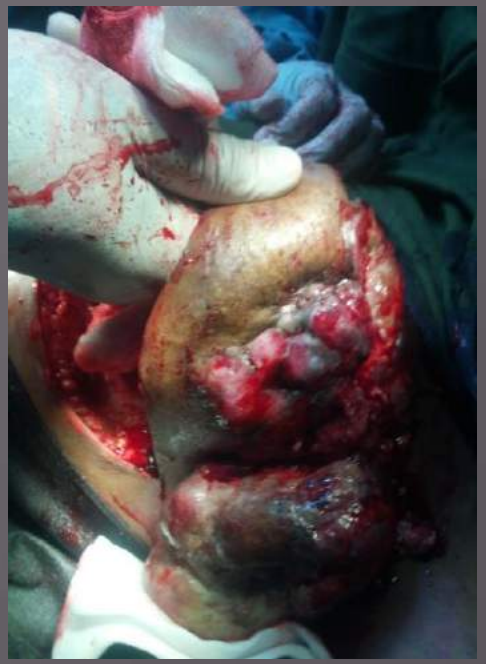
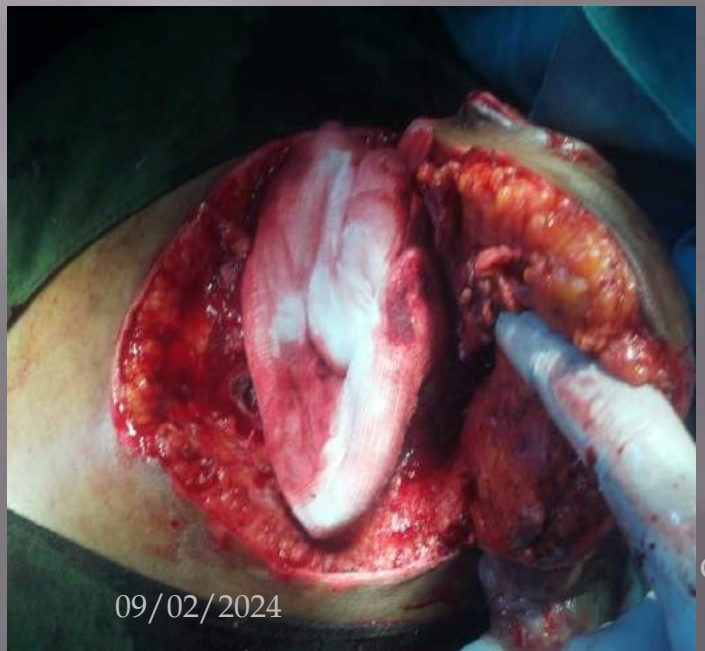
14. Patient KTZ, 31years, female

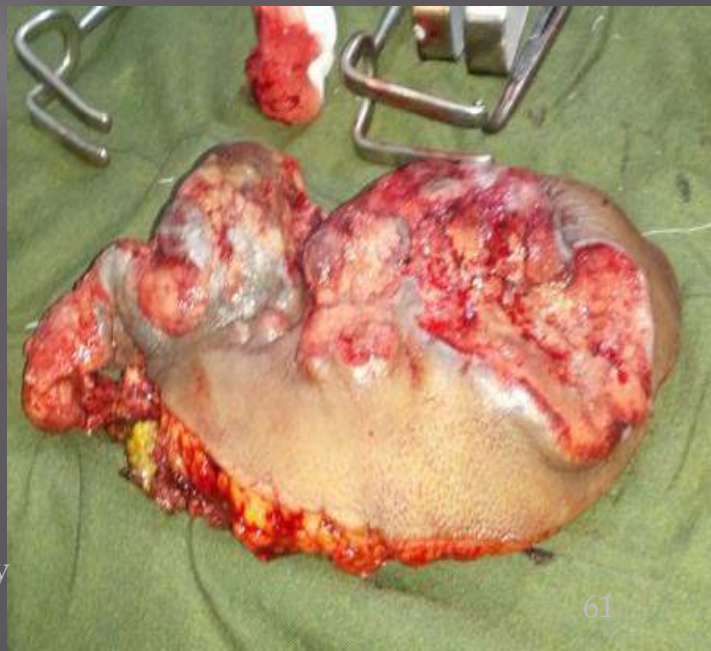
- Diagnosis: Infected recurrent left breast neoplasia.
- Symptoms:
- Antecedent of mastectomy in Uganda in 2010 for breast neoplasia confirmed by anapath.
- Bedridden invalid, septis status, anemia;
- An ulcerous wound with necrotic crusts, stinking with irregular shape;
- presence of swollen and ulcerated axial adenopathies.

- Evaluation:
  - Thorax X-Rays, Inflammatory assessment, complete blood count;
  - Urea: 2.06 mmol/L
  - Creatinine: 0.4 mg/dl
  - Haemoglobin: 8 g
  - Anapath: SBR stage 8 infiltrating tubular carcinoma corresponding to grade III.

- Treatment:
  - Reanimation measures
  - Drop by drop irrigation with antiseptics
  - Antibiotherapy
  - Antalgics
  - Vitaminotherapy
  - Chemotherapy with Cancure 3x4 tablets/day
  - Cleaning surgery.
- Follow up:
  - Good general status;
  - Visible gain of body weight;
  - Left upper limb lymph oedema.
- Program:
- Extension assessment: Thorax X-Rays, Lumbar-sacrum X-Rays, left upper limb Doppler ultra sound scan; kidney and liver functions exploration, complete blood count.



15. Patient Anm, 75 years, female

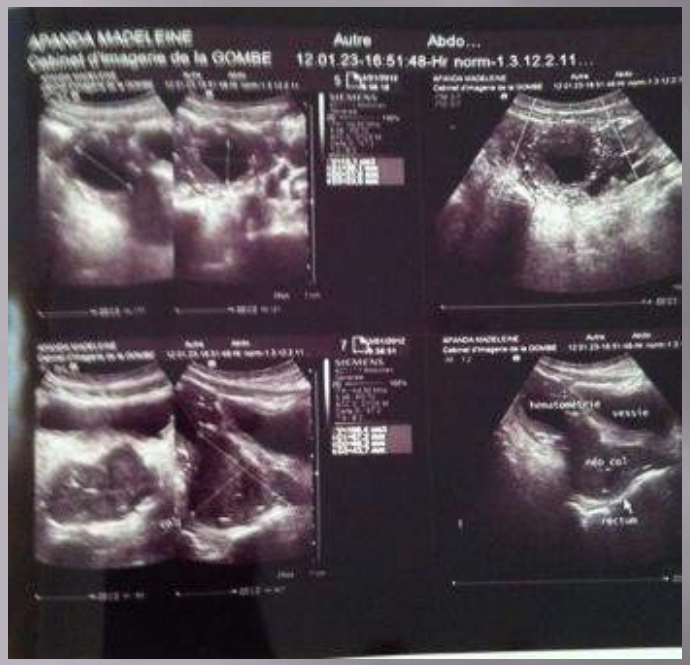
- Diagnosis:
  - Cervix neoplasia, stage 4a;
  - Arterial hypertension, Grade 2;
  - Non tolerated anaemia;
- Symptoms:
  - Genital haemorrhage upon contact;
  - Lumbar-sacrum pain;
  - Myctalgia
- Evaluation:
  - Speculum: burgeoning cervix with active haemorrhage;
  - Vaginal touch: infiltration of the 1/3 proximal vagina, cataclysmic haemorrhage.

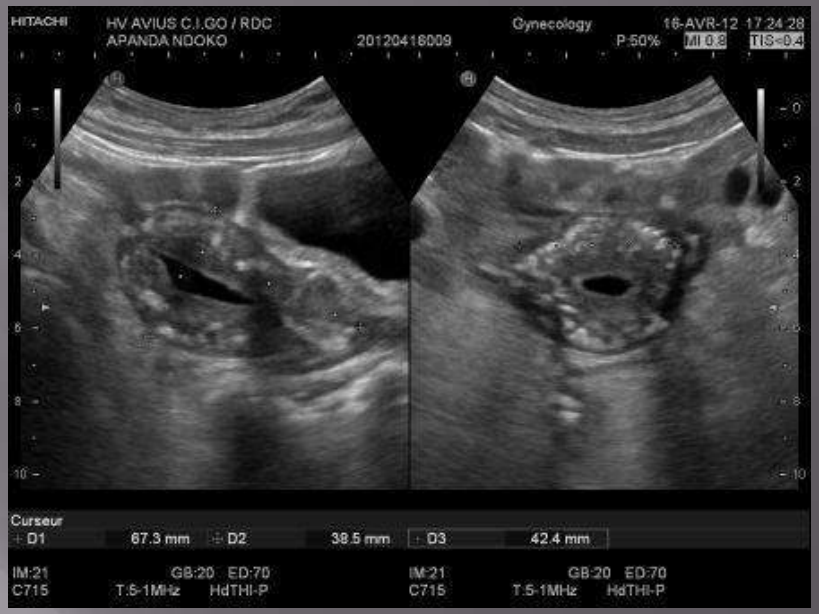
- Ultra sound scan:
  - swollen cervix
  - Important haematometra;
  - Bladder posterior layer attacked
- Conclusion: **Cervix neoplasy, stage 4a** according to FIGO classification.

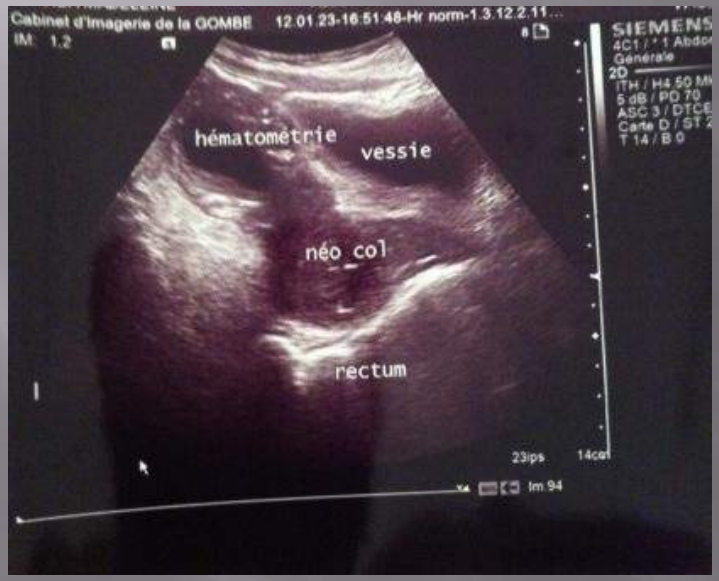
❖ Treatment:
- Cancure 3x2 tablets/day
- External radiotherapy
- Globular cells transfusion, then martial supplementation.

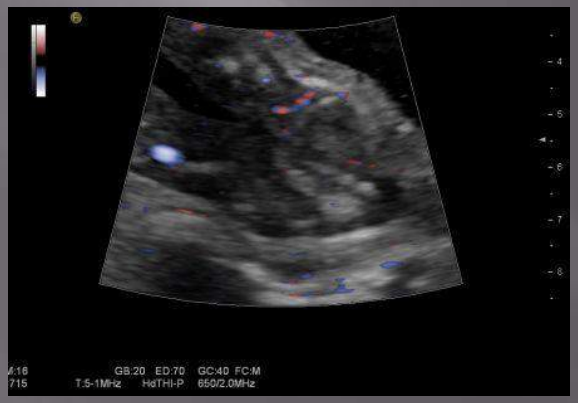
- Follow up: 3 months on Cancure and 6 weeks on external radiotherapy.
- Clinical:
  - Cessation of the haemorrhage and hydrorrhea;
  - Speculum: hyperaemia cervix place by place;
  - Vaginal touch: smoothing vaginal surfaces; no more upon contact haemorrhage;
- Conclusion: **Cervix neoplasy, stage 2b.**

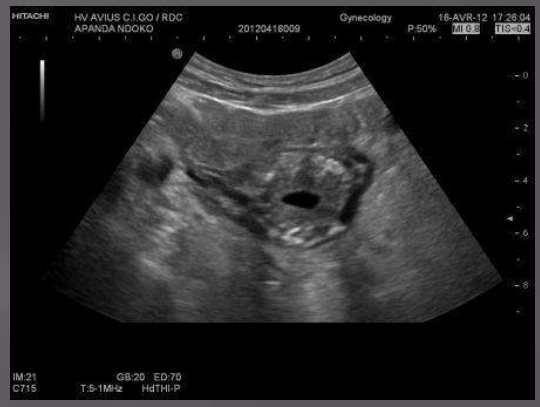
On admission January 2012	Follow up March 2012	Follow up March 2012	Follow up March 2012
▪ Genital haemorrhage & Myctalgia; ▪ Speculum: burgeoning cervix, blooding upon little contact; ▪ Vaginal Touch: Hardening of the 2/3 upper vaginal wall, haemorrhage with fresh blood; ▪Ultra sound scan: swollen cervix 67x66x46mm; haematometra of about 15ml. ❑Conclusion: **Cervix neoplasy, stage 4a.**	▪Cessation of the genital haemorrhage; ▪ Presence of hydrorrhea; ▪ Follow up radiotherapy ongoing.	▪Cessation of the hydrorrhea; ▪ Speculum: presence of some hyperaemia zones; ▪ Vaginal Touch: Smooth vaginal walls; No more haemorrhage upon contact. ❑ conclusion: **Cervix neoplasy, stage 2b.**	▪ Speculum: healthy cervix with some hyperaemia zones inside the channel bottom; ▪ Mont Venus tumefaction; ▪ Vaginal Touch: sensation of a renitent mass at the FID; ▪ No suspicious looses; ▪ Ultra sound scan: Col of 42x33x35mm in diameter, with regular outlines, with heterogeneous echostructure, with 2.5 ml haematometra. ❑ Conclusion: **Cervic neoplasy, stage 2a.**











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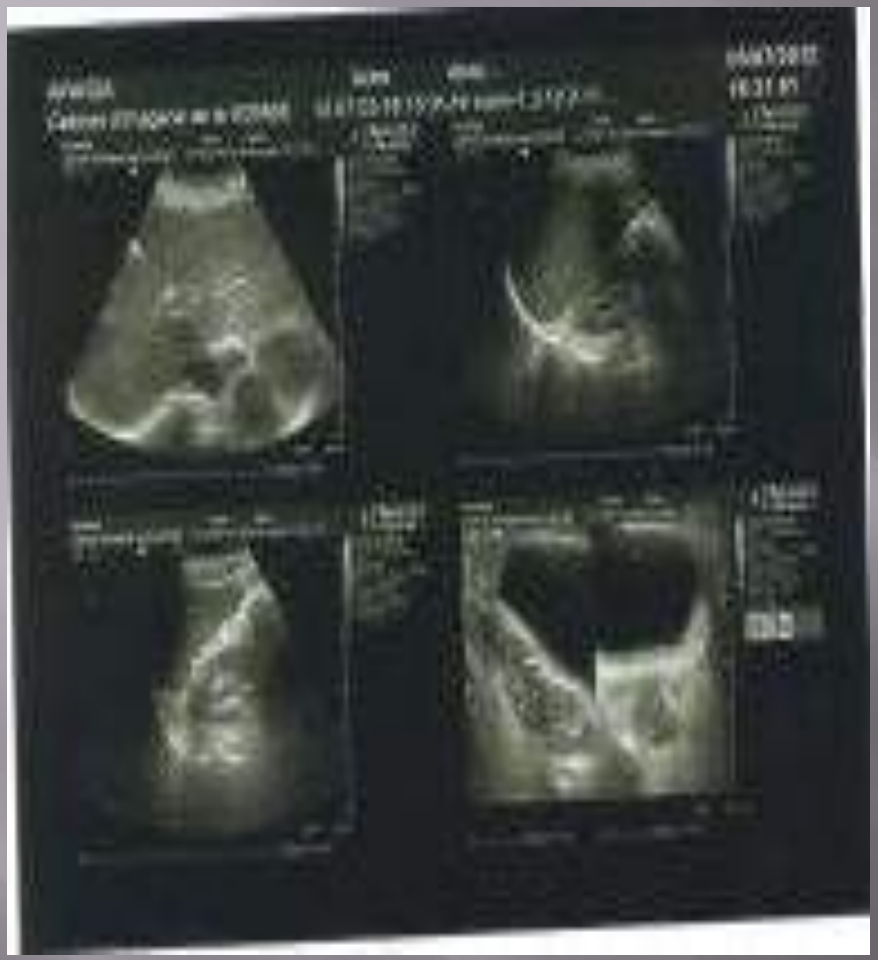
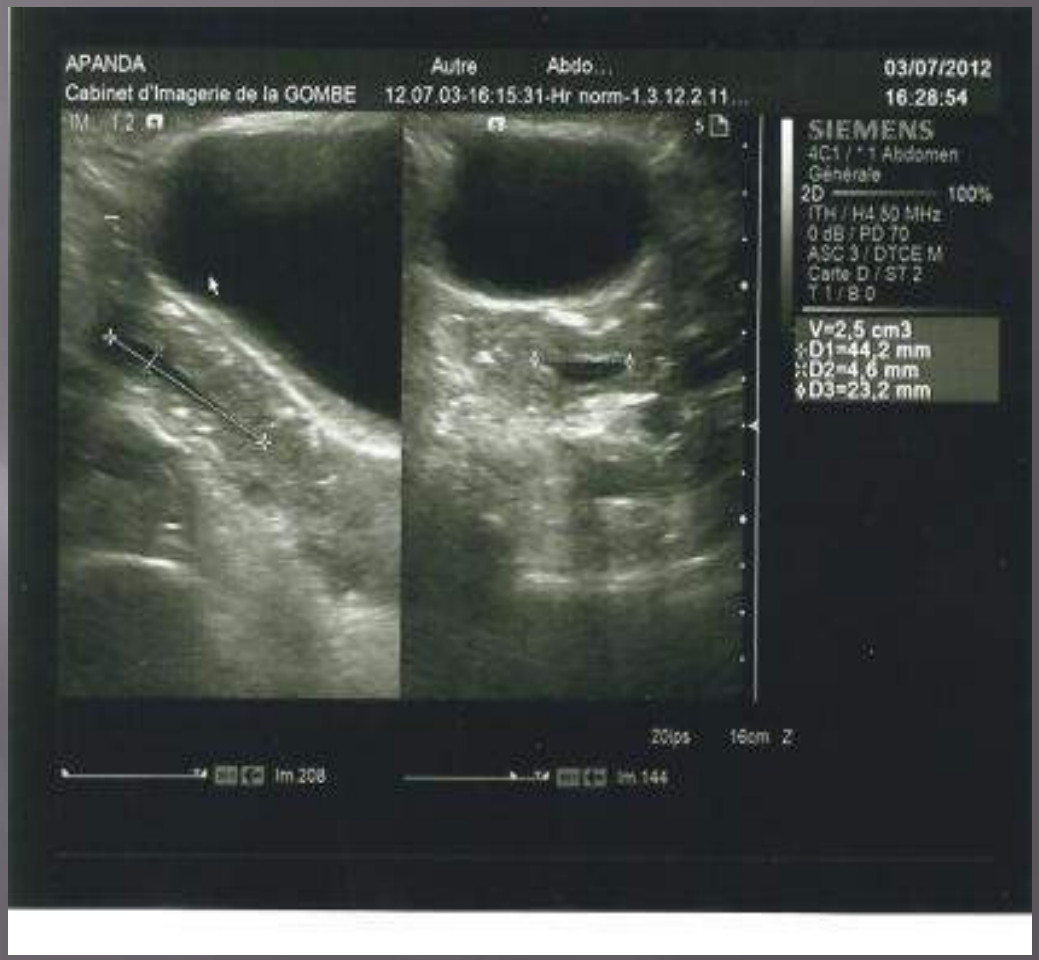
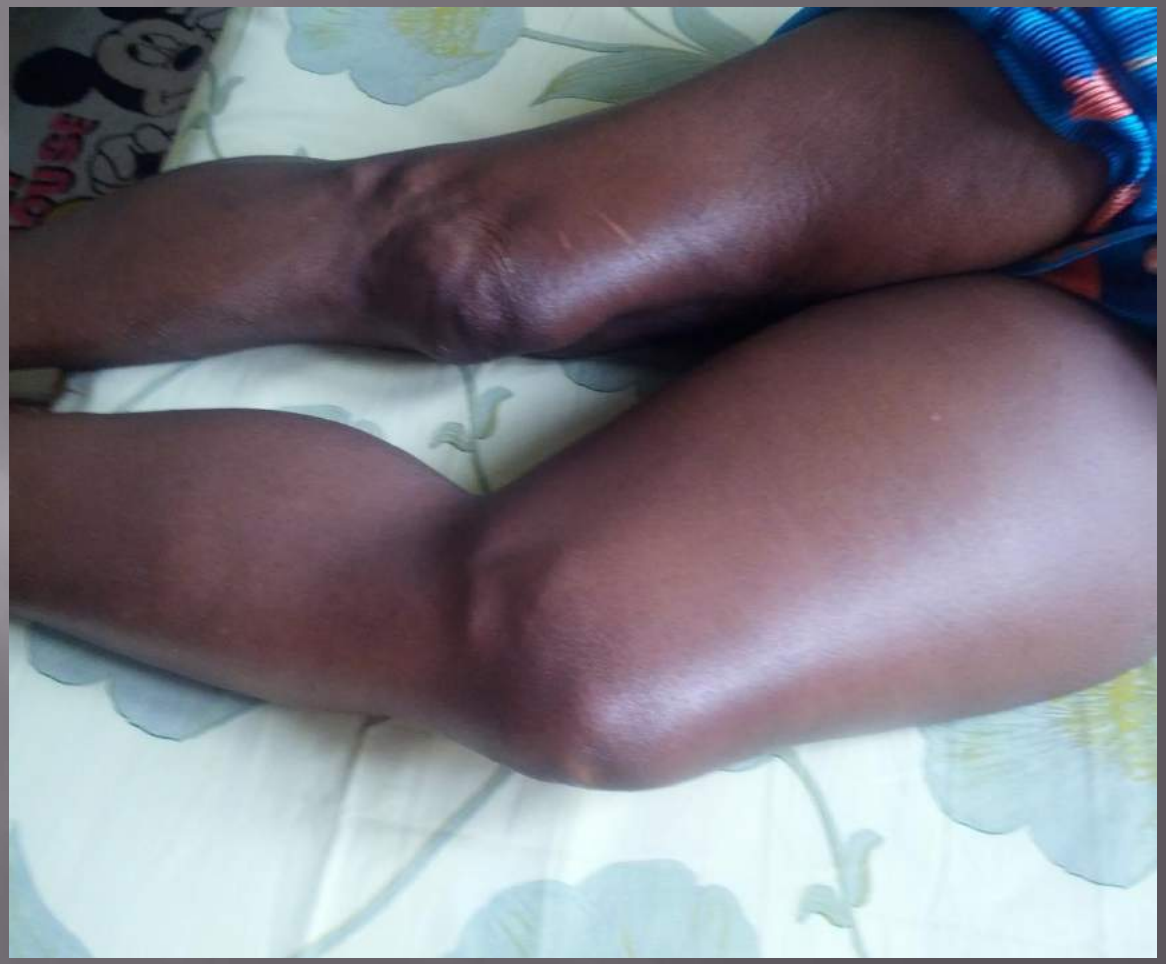
April 2012





July 2012

Cancure Presentation at KMRH May 2013



16. Patient BRM, 41years, female

- Diagnosis: Neoplasia of the right breast with ganglionary metastasis; operated previously.
- Symptoms: wasting (47kg)
- Evaluation: Biopsy: Tubular (canalar) carcinoma, averagely differentiated of Grade 2, luminal A type;
- Treatment:
  - Right mastectomy with ganglionary drilling on March 21th, 2012;
  - Antibiotherapy;
  - Antalgics;
  - Chemotherapy with Cancure 3x2 tablets/day

- Follow up:
  - 2 months on (May 2012)
    - Gain of body weight (55kg)
    - Right upper lib oedema (lymphoedema);
    - Paraclinic:
      - Abdominal ultra sound scan: Normal;
      - CA 15-3: 17.15 U/ml (NV: <30);
      - Test BR 15-3 (Beckman): 11.7 U/ml (NV: 0 – 35 U/ml)
  - 6 months on (September 2012):
    - Right axial ultra sound scan: No adenopathies;
    - Thorax X-Rays: Normal
  - 15 months on: Body weight gain: 58 kg

- Program: Mass biopsy.
  - 13 months on (April 2013):
    - Gain of body weight continues
    - Right upper lib oedema: Melted
    - Paraclinic: Test BR 15-3: 6.2 U/ml

17. Patient AMB, 49 ans, female

- Diagnosis: Left breast neoplasia, previously operated.
- Symptoms: Important wasting (63kg), intense pains upon the hemi-thorax and the left shoulder.
- Evaluation:
  - Anapath (CUK): infiltrating tubular carcinoma, of Grade 2 (SBRG);
  - Thorax X-rays: No images of “en lâcher de ballon”;
  - Abdominal ultra sound scan: Normal; No adenopathy.

- Treatment:
  - Mastectomy of the left breast (August 2011);
  - Chemotherapy with Cancure 3x3 tablets/day

- Follow up: 21 months on:
  - Gain of body weight (93kg);
  - Pains disappearance.

18. Patient KUK, 47 ans, female

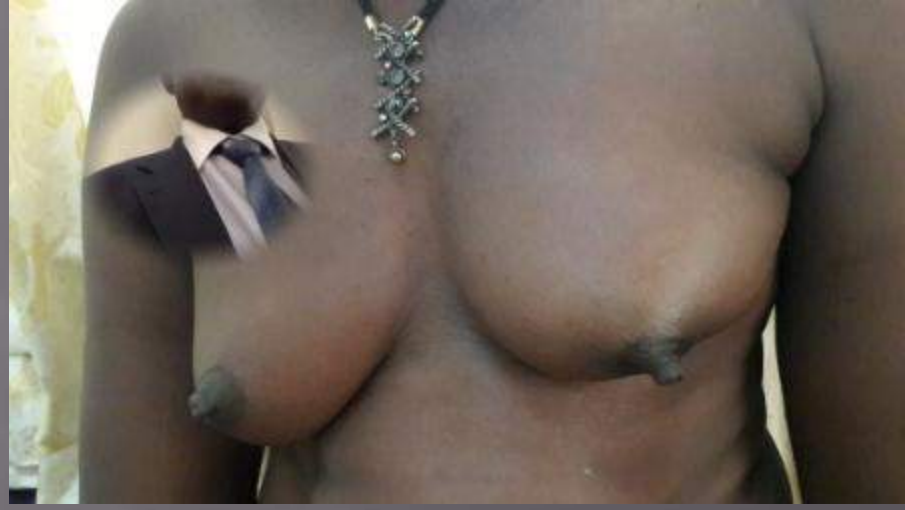
- Diagnosis: Left breast neoplasia
- Symptoms:

  - Mammal retraction onto the left lower-extrnal quarter;

  - Palpation: reveals a sensitive mass, adhering onto the layer, slightly mobil, with about 7-8 cm in diameter, of firm consistency and irregular surface;

  - No axilar adenopathy.

- **Evaluation** : Mammography : Image compatible with type BIRADS 4's lesions onto the left breast;
- **Treatment** : Cancure 3*3 Co/j (Start 24/05/2013)
- **Follow up :** Tumour mass and pain regression;
- **Program** : Mastectomy



19. Patient BOM, 66 years, male

- Diagnostic : Maxilary osteolytic tumour.
- Symptoms :

- Mass of malignant ulcero-necrotic tendency onto the palate;
- Impossibility for opening the mouth;
- Bad stinking breath;
- Facial asymmetry;

- Evaluation : **maxillo-facial scan: osteolytic tumour of the maxilla with local-regional invading of the left hemi face.**

- Treatment :
  - **Chemotherapy with Cancure 3 x 3 tablets/day Start: 26/06/2013**

- **Program : - Alpha foetoprotein**
  - ACE

CASE REPORT

20. **<u>A patient, Belgian citizen, 57 year-old</u>, male**

was referred to my specialized consultation for the management of a colic cancer in June 1, 2005.

- He was complaining for wasting syndrome (weight loss and diarrhoea), fever and asthenia.

- His colic cancer was biologically and histologically proven in Belgium in April 2005. At that moment, the level of CEA was 101ng/ml.

- Therefore, after a treatment with Cancure 30mg tablets; S/ 3x2 tablets/day for 2 months] from June 1st, 2005 to July 21st, 2005, the biological profiles of tumour markers were as follows on July 21st, 2005:

Follow up:

Clinical: Clear amendment of all the symptoms;

Paraclinical:

- CEA = 4.0 ng/ml (NL: < 5 Non smoking; < 10 Smoking)
  - CEA 125 < 4.00 U/ml (NL: 0-35 U/ml)
  - CEA 153 = 12.56 U/ml (NL: < 30 U/ml)
  - CEA 199 = < 3.00 U/ml (NL: ≤ 37 U/ml)

- The tumour markers were performed at LOMO MEDICAL CLINIC according to the BIOMETRIEUX Laboratory (France) procedures and kits (VIDAS®, CA 125II™) and to the HUMAN GESELLSCHALT (Max-Planck-Ring21, Germany CEA).
- The results are reliable and suggest an effective and strong action of CANCURE C™ on cancer cells.
- From July 2005 till now, the patient is feeling well without any symptoms.

Prof Dr LONGO MBENZA, MD, PhD, DSc

21. Patient SAMART 2007: 85 years, male

Nationality: Angolese,

Diagnosis: Prostate cancer.

- **Follow up duration: 15 September 2007 to 31 January 2008.**

DATE	WORDING	VALUE	NORMAL VALUE	HOSPITAL	COUNTRY
02/05/2007	PSA tot	59.69 ng/ml	< 4 ng/ml	LOMO Medical / Kinshasa	DRC
06/06/2007	PSA tot	82.08 ng/ml	Reference value changing with the age	Gammamedic sprl / Gembloux	Belgium
03/08/2007	PSA tot	74 ng/ml		Clinique et Maternite Ste Elisabeth	Namur / Belgium

22. UNDER CANCURETREATMENT

DATE	WORDING	VALUE	NORMALVALUE	HOSPITAL	COUNTRY
15/09/2007 **START**	PSA tot	12.4 ng/ml	< 4 ng/ml	LOMO Medical / Kinshasa	DRC
17/10/2007	PSA tot	1.82ng/ml	< 4 ng/ml	LOMO Medical / Kinshasa	DRC
18/01/2008	PSA tot	0.82 ng/ml	< 4 ng/ml		
31/01/2008	Abdominal – pelvial Echography ; HBP	56 gr, stable Post-mictional residue ; not significative.			

NEOPLASTIC SPLENOMEGALY TREATED WITH DOUBASE C™, ANTI-HIV AND ANTI-TUMORAL MEDICINE BASED ON AFRICAN TRADITIONAL PHARMACOPOEIA HERB EXTRACTS

INTRODUCTION

In Sub-Saharan Africa, splenomegaly is fairly common and easily related to sickle cell diseases and infections, such as malaria schistosomiasis and tropical splenomegaly. However, causes of splenomegaly are multiple. Medical doctors have to think of other infections such as infective endocarditis, portal hypertension, leukaemia, lymphoma, haemolytic anaemia, rheumatoid arthritis, myelofibrosis, kala-azar, chronic myeloid leukaemia, and systemic lupus erythematosus.

Since the advent of the HIV/AIDS pandemic, in general, massive splenomegaly in Africa is encountered more than in the past. Because of poverty, Africans are unable to afford the cost of evaluation and treatment of massive splenomegaly. Even for affluent Africans, complete clinical investigations are not feasible locally.

We describe a 38-year old black Congolese woman, a dental surgeon native Congolese referred to South Africa without obvious cause of massive splenomegaly. She was treated with Doubase C™, an anti-HIV, anti-tumoral Medicine Based on African Traditional Pharmacopoeia Herb Extracts (1).

Difficulties in defining the histological nature of this neoplastic splenomegaly and the improvement of hematological disturbances when giving Doubase C and performing splenectomy are discussed.

CASE REPORT

A 38-year old black female with massive splenomegaly presented on January 9th2002 with following symptoms: weight loss, night sweating, asthenia and exertional dyspnoea.

Family and personal medical histories were virgin. She was noted to be anemic with a hematocrit of 26 %, weighing 58 kg for a height of 1.63m (BMI=21.8 kg/m2).

Physical examination showed that the patient had hepatomegaly and massive splenomegaly. Her cardiovascular system was normal.

Clinical investigations revealed the following features:
- Cutireaction (PPD intradermoreaction) of 10 mm diameter;
- Chest X-ray showing an interstitial pneumopathy;
- Analysis of peripheral blood revealing 3950 white cells / mm^3 12 % of neutrophils, 88% of lymphocytes, and 20 mm / hour of ESR;
- Elisa serology anti-HIV after counseling being negative;
- Abdominal ultrasound study showing splenomegaly which reached the hypogastric region.

Thus, a probabilistic diagnosis of spleen tuberculosis was treated with Rifampicin, Ethambutol, Isoniazid and Pyrazinamide during a 6-month period with a worsening general state. A lymphoproliferative process of spleen was suspected in July 2002, and treated with Doubase C.™

This medicine is a mixture of total aqueous extracts of roots and leaves from two plants currently used in the Congolese traditional Pharmacopoeia. The raw materials, one harvested, dried, grinded and then submitted to water extraction, according to pharmaceutical art rules, had been mixed according to a galenic formulation previously described (2).

Thanks to the anti-HIV properties and lack of cytotoxicity demonstrated in vitro and in vivo both by Congolese and US teams, US Patent n£ 5,607 673 and Global Patent n£ PCT/US96/12769 were granted to this pharmacological product (1). General state was stabilized with Doubase C™.

The patient was referred from the DRC to the Department of Surgery of Prof E.L. Mazwai, Umtata, South Africa (SA), for total splenectomy and pathologic study of spleen biopsies. Laboratory results of peripheral blood performed on November 27th2002 in Eastern Cape, SA, concluded as follows:

White Cell Differential count:
White cell count: 19.2 .10^9L, neutrophils : 6 %, Lymphocytes: 90%Platelet count: 39.1 0^9L;
Splenic marginal zone B-cell lymphoma, target cells and rouleaux formation noted, no tear drop poikilocytes noted, lymphocytosis present, atypical Lymphocytes noted,thrombocytopaenia without platelet clumping on slides.
A bone marrow evaluation was then suggested to exclude bone marrow infiltration.
Bone marrow biopsy was not performed, as patient refused to have that investigation.

MACROSCOPY

On November 30th 2002, splenectomy and excision of spleniculus were performed. The nature of the first specimen (I) consisted of brownish tissue sized 2.5x2x0.7 cm. The second specimen (II) consisted of a spleen measuring 24x18x11 cm with total weight of 293 2 grams - see macro photograph Figure 1. Fibre fatty tissue was attached to the serosal surface of the spleen in one area measuring 12x8x0.3 cm. Circumscribed hemorrhagic areas were noted in the substance of the spleen, the largest 5.5 cm in diameter.

FIG 1

FIG 2

FIG 3

Table 1. IMMUNOHISTOCHEMICAL DA

VARIABLES	14/01/03	27/02/03	25/04/03	09/06/03
White cell count x10⁹/L	12.4	19.3		9.1
Neutrophils %	12	18		14
Lymphocytes %	83	58	91.9	55
Monocytes %	0.12	4.63		0.18
Platelet count x 10⁹/L	170	162	188	162
Antibocytosis	-	++		++
Alk Phosphatase U/L 37°		101	101	
Gamma GT U/L 37°			155	
ALT (SGPT) U/L 37°			37	
AST (SGOT) U/L 37°			30	
LD U/L			126	

Table 2. EVOLUTION OF BLOOD ANALYSIS

CHARACTERISTIC	%
Viability	99
CD45	84
CD4	10
CD8	4
CD22	57
FMC-7	61
CD5	40
CD23	72
CD21C	73
CD19	66
CD1	15
CD8	6
HLA-DR	58
CD20	65
CD25	26
CD10	2
CD103	70
CD52	60
CD5 and CD19 co-expression	27
Kappa	6
Lambda	40

WHITE CELL DIFFERENTIAL COUNT

COLLECTED 28/10/02

White cell count	*L	2.0	4.0-10.0 10^9L
Neutrophils %		18.0	%
Neutrophils abs	*L	0.36	1.90-7.4010^9/L
Lymphocytes %		80.0	%
Lymphocytes abs		1.60	1.00-4.5010^9L
Monocytes %		2.0	%
Monocytes abs	L	0.04	0.20-1.0010^9L
Nucleated red cells	H*	28.0	0-1/100WBC
Platelet count	*L	24	140-450 10^9L

FBC Comment: *Causes of a pancytopenia include aplastic anemia, bone marrow infiltration (eg. Carcinoma lymphoma, leukaemia) hypersplenism, myelofibrosis and megaloblastic anemia. Bone marrow examination is usually indicated. If clinically indicated, a serum B12 level may be considered.*

COLLECTED 27/02/03

White cell count	H	19.3	4.0-10.0 10^9L
Neutrophils %		18.0	%
Neutrophils abs	L	3.47	1.90-7.4010^9/L
Lymphocytes %		58.0	%
Lymphocytes abs	H	11.19	1.00-4.5010^9L
Monocytes %		24.0	%
Monocytes abs	*H	4.63	0.20-1.0010^9L
Platelet count		162	140-450 10^9L

FBC Comment *Slide submitted for further comment: Lymphocytes resemble those of a "Hairy Cell Leukaemia". As patient refuses to have a Bone Marrow biopsy, flow cytometry is suggested to confirm Hairy Cell . Please submit 2 x Heparin blood samples for flow cytometry.*

COLLECTED 09/06/03

White cell count		9.1	4.0-10.0 10^9L
Neutrophils %		14.0	%
Neutrophils abs	L	1.27	1.90-7.4010^9/L
Lymphocytes %		84.0	%
Lymphocytes abs	H	7.64	1.00-4.5010^9L
Monocytes %		2.0	%
Monocytes abs		0.18	0.20-1.0010^9L
Platelet count		162	140-450 10^9L

FBC Comment *Reactive lymphocytes present.*

HISTOLOGY

Microscopic study of both II and I was performed on October 30th 2002. Sections of both the spleniculus (I) and the spleen (II) showed expansion of the marginal zone. Medium sized cells with irregular hyper chromatic nuclei populated this zone. A more diffuse infiltrate of atypical lymphoid cells was noted in the spleen. Marked congestion of the spleen was noted.

These changes (Figure 2) suggested a possible neoplastic expansion of the marginal zone of the spleen (splenic marginal zone lymphoma?). A small piece of pancreatic tissue had been observed in the splenic hilus. Immunohistochemical stains were necessary then to investigate a possible neoplastic lesion. Immunophenotypic analysis of the selected population was performed on March 11th2003, using Flow cytometry. Table I summarizes the results of this Immunohistochemical study.

OUTCOME

Table 2 presents the post-operatively and Doubase CJ treatment evolution of selected blood investigations. As general state and quality of life were fine, chemotherapy had not been administrated.

DISCUSSION

Several interesting observations are evident in this patient referred to South Africa with modern and sophisticated facilities in clinical investigations. Clinical history of this patient was faced with idiopathic splenomegaly with hypersplenism. But the microscopic changes suggested a possible neoplastic expansion of the marginal zone of the spleen in terms of a splenic marginal zone lymphoma.

With HIV/AIDS pandemic spreading, lymphomas are actually increasing in Sub-Saharan Africa. As the patient was not infected by HIV, the diagnosis of lymphoma had not been retained. Lymphocytes of peripheral blood resembled those of Hairy Cell Leukaemia.

As patient refused to have a Bone Marrow biopsy, flow cytometry was suggested to confirm Hairy Cell. Immunophenotypic analysis of this peripheral blood sample revealed 66 % monoclonal (malignant) B-cells showing partial dim CD5 and C19 co-expression, expressing HLA-DR, CD22, FMC-7, partial dim CD23, bright CD20, bright CD52, CD25, CD103 and bright CD I IC with moderate Lambda light chain restriction. These findings were in keeping with B-cell lymphoproliferative disease, best fitting a Hairy Cell Leukaemia.

This is a neoplastic and monoclonal proliferation of well-differentiated lymphocytes. In this chronic lymphocytic leukaemia, they are almost always 99 % B cells in male patients over 40 (3). This patient was a 38-old year woman. The present high count of lymphocytes might be interpreted as a reactive lymphocytes process ofmonomucleosic syndrome with transient alteration ofAlk. Phosphatase, ALT, AST, and monocytes. Possible causes are malaria, toxoplasma, cytomegalovirus, Hepatitis virus B, syphilis, blood transfusions. Herpes virus, post-operatively process, autoimmune diseases, HIV virus (4).

Natural history of this Hairy Cell Leukaemia is characterized by a young woman who remains in status quo for years without enlarged nodes and complications such as autoimmune haemolysis, bacterial infection of the respiratory tract, and Bone marrow failure (2).

We are thinking to start with chemotherapy in order to reduce lymphocyte count. As prognosis is good for this young patient with excellent quality of life, Doubase C™ is being given till now in place of chemotherapy. Indeed, chemotherapy is not always needed, but may postpone marrow failure (2). Radiotherapy was not used in absence oflymphadenopathy and spleen. Supportive care (transfusions, prophylactic antibiotics, IV human immunoglobulin) was not necessary.

In conclusion, it appears that Hairy Cell Leukaemia had been confused with splenic marginal zone lymphoma. It is timely for Sub-Saharan Medical Centers to implement laboratories with Immunophenotypic analysis facilities: the best tool of diagnosis of Hairy Cell Leukaemia. When chemotherapy is not needed, Doubase C™, extracted from African herbs, without toxicity, could be used.

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Patient Karan, 92 ans, F

- Consultation: 09/10/2017
- Anamnesis:
- Dominant symptoms : cough, chest pain, tumor mass into the left breast, loss of weight.
- Disease history: dry cough some weeks before the consultation, starting progressively, with physical fatigue aggravated by the effort;
- Personnal history:
- Well known for arterial hypertension history;
- Presence of a tumor mass inside the left breast;

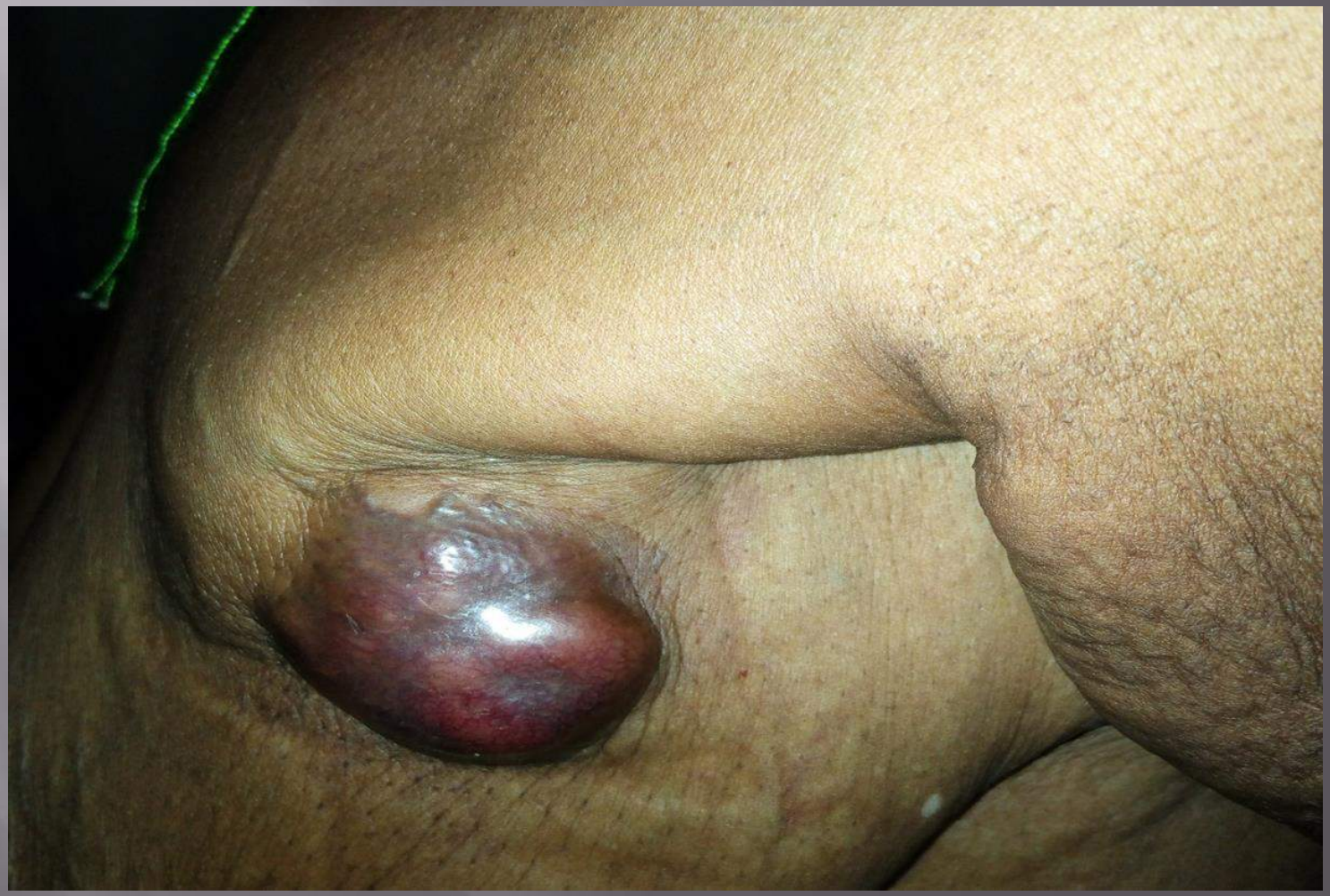
Patient Karan, 92 ans, F

- Anapath exams:
- Confirmation of breast cancer since 2015;
- Operated several times for hyperthyroïdy, cystocelis, biliary calculs.
- Physical exams: presence of a mass into the left breast, of hard consistency, non circumscribed, painful, with axial adenopathies, and presence of growls (grumbles) from the lungs, dyspnea.
- Paraclinical exams: Chest X-Ray face and profile.

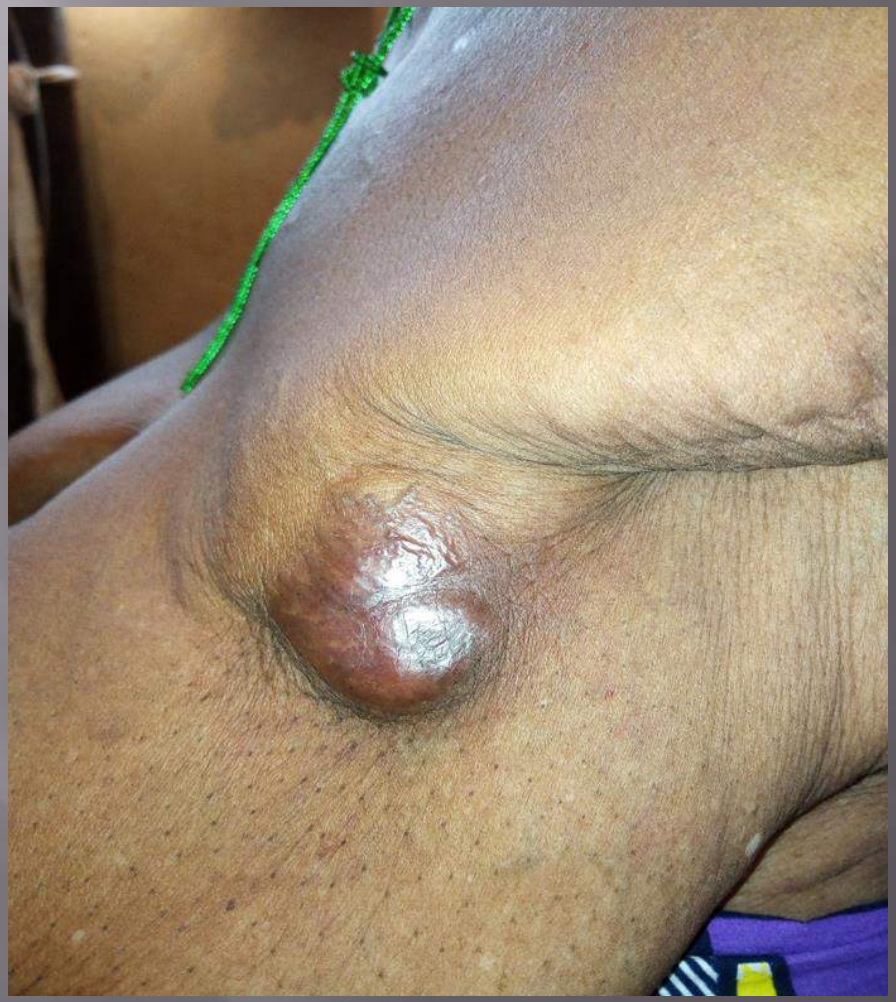
Patient Karan, 92 ans, F

- Treatment
- Cancure 30 mg 3x4 cés/jour since October 2017 till Mai 2018.
- Tumor exeresis 3 months after installing Cancure therapy;
- Evolution
- Significative and progressive resorption of the tumoral mass 2 months on under Cancure therapy;
- Amendment of growls (grumbles), amendment of the dyspnea 3 months on after Cancure therapy;
- Exeresis of the tumoral mass 4 months on after Cancure therapy;
- Scarification in first intention;
- Body weight gain;
- Amendment of axial adenopathies;
- Good clinical evolution under Cancure therapy; no complainst, no recidive, good quality of life 11 months on hitherto.

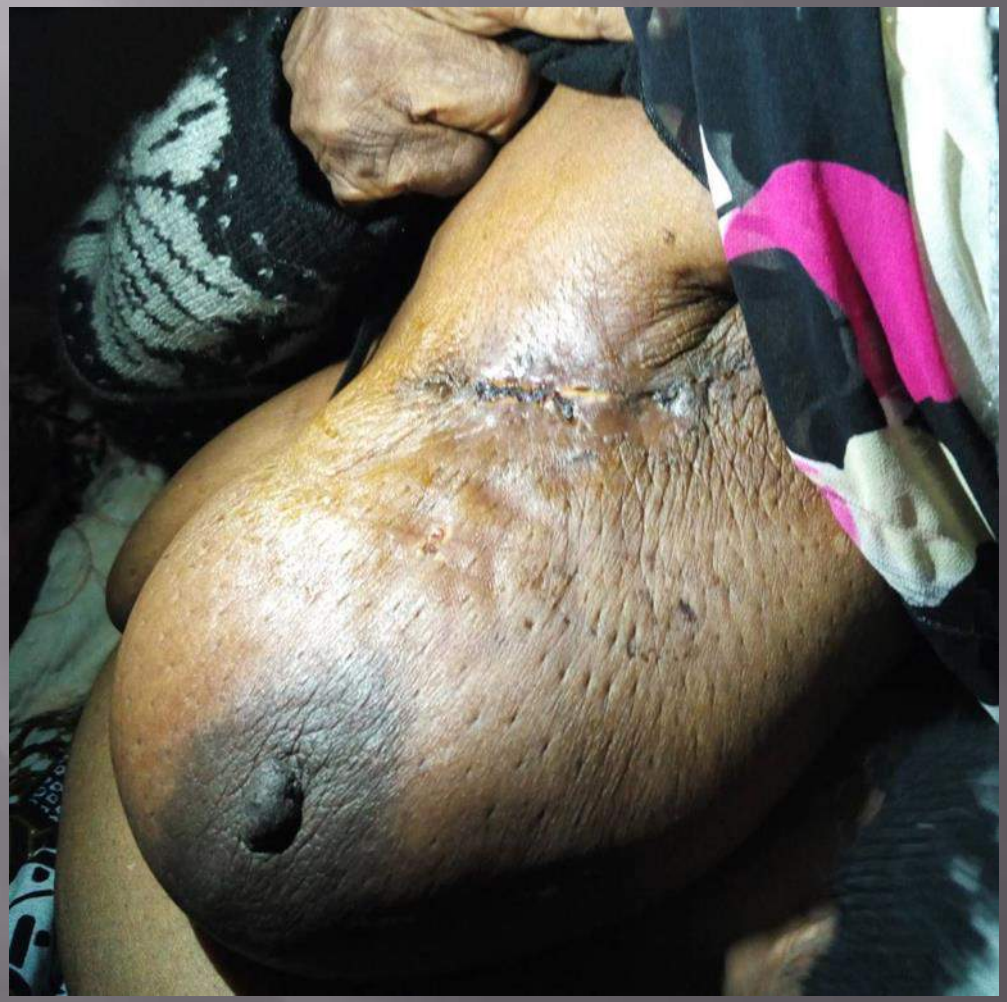
Patient Karan, 92 ans, F



Patient Karan, 92 ans, F



Patiente Karan, 92 ans, F



Patient DNJ-CT 44 Female

Cape Town

- **Clinical history** : Abdominal pain

- **Computed Tomography** : **22/08/2018**
- Abdomen and Pelvis with contrast -AP :
- **FINDINGS:**
- There is probably some subsegmental atelectasis at both lung bases;
- There is mild to moderate ascites throughout the abdomen and pelvis;
- The liver, gall bladder, spleen, pancreas, adrenals and kidneys are unremarkable in appearance other than a probable tiny 7 mm cyst in the lower pole of the right kidney.

Patient DNJ-CT 44 Female

Cape Town

- There is no evidence of retroperitoneal, pelvic or inguinal lymphadenopathy. Note is made of a marge complex pelvic mass with numerous cystic components, measuring 15x14x18 cm. There are solid components within the mass. The findings are most consistent with an ovarian neoplasm. The pelvic structures are otherwise unremarkable.
- **IMPRESSION:**
- Ascites and large complex pelvic mass, most suggestive of an ovarian neoplasm such as an ovarian carcinoma.

Patient DNJ-CT 44 F

Cape Town

- **Treatment:** **Cancure 30 mg 3x4 tab/day since 07 Sept 2018**

- **Anatomical pathology report: 04/10/2018**
- **CLINICAL:**
- Previous hysterectomy.
- Enlarged left ovarian mass;
- Right ovary and tube removed;
- Omental biopsy
- Ascitic fluid.
- **MACROSCOPY**
- Marked "left ovary" contains a multicystic ovary weighing 2307 g, measuring 220x180x140 mm. On cut section the cysts are filled with thick brown fluid.
- Marked "right ovary" has a 50 mm ovary, 50 mm tube and 15 mm cyst.
- Marked "Omentum" contains a 110 mm adipose fragment.

Patient DNJ-CT 44 F

Cape Town

- **MICROSCOPY**
- Sections from the left ovary show an extremely necrotic tumour with minimal viable tumour. The tumour shows features of serous carcinoma with high grade morphology. The tumour shows a serous, solid endometrioid growth pattern, with areas resembling a solid grade 3 endometrioid carcinoma. Other areas are more classic with marked pleomorphism.
- The architectural features are variable, including large and small papillae, slit-like fenestrations, glandular complexity, marked nuclear atypia, prominent nucleoli, stratification, Frequent mitoses and stromal. No psammoma bodies. Immune to be performed for typing.

Patient DNJ-CT 44 Female

Cape Town

- The right adnexum shows ample amounts of cortical inclusion cysts with a spectrum of other cysts also seen. Follicle cysts, cystic follicles and corpus lutea cysts seen. Small foci of endometriosis with background of haemorrhagic corpora lutea.
- The stromal displays a fibromatous pattern with areas reminiscent of an early serous cystadenofibroma.The fallopian tube shows endosalpingiosis and endometriosis with no intraepithelial atypia.

Patient DNJ-CT 44 F

Cape Town

- The omentum is unremarkable with no evidence of implants (invasive / non-invasive).
- The washings (UMN180047) show no evidence of malignancy. The background is markedly bloody with a few reactive mesothelial cells.
-
- **COMMENT**
- P53: Two areas of staining highlighted – corresponds to morphology
- Serous areas – mutation-type staining – negative
- Endometrioid areas: Wild-type staining
- P16: Patchy positive in serous areas.
- ER / PR: Negative

Patient DNJ-CT 44 Female

Cape Town

- **DIAGNOSIS**
- **(A, C, D) LEFT OVARY CYSTECTOMY, OMENTUM AND PERITONEAL CYTOLOGY:**
- Large necrotic, high grade surface tumour;
- Features of high grade carcinoma.
- **Areas of endometrioid carcinoma (Grade 3) – <10%;
- Size: 220x180x140 mm
- Pathological stage: pT1A pNx, pMO
- P53: mutation-type staining
- Ovarian surface not involved
- No omental deposits
- Peritoneal cytology status negative

Patient DNJ-CT 44 Female

Cape Town

- **(B) RIGHT OVARY CYSTECTOMY AND SALPINGECTOMY:**
- - Cortical inclusion cysts with follicle cyst and cyst follicles
- - Corpus luteum: haemorrhagic corpus luteum cyst present
- - Small areas of endometriosis and endosalpingiosis
- - Stromal hyperplasia and hyperthecosis
- ** Areas reminiscent of early serous adenofibroma
- Fallopian tube: No intraepithelial atypia

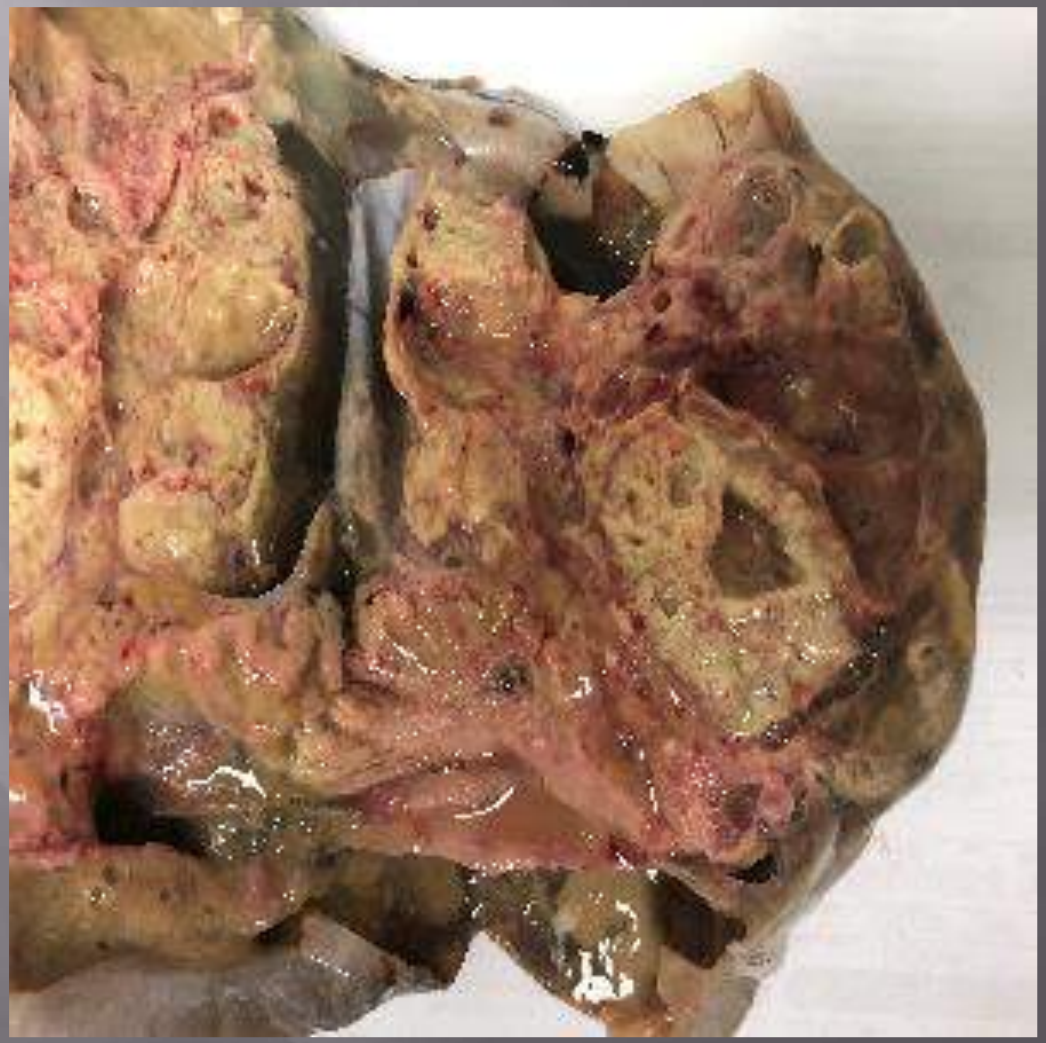
Patient DNJ-CT 44 F

Cape Town

Ovarian carcinoma
22x14x18 cm

Patient DNJ-CT 44 F

Cape Town



4. Comment

- The study demonstrates that Cancure™ has brought evident improvements to patients suffering from diverse types of tumours/cancers, such as fibroma, hemangioma, cervix cancer, breast cancer, prostate cancer, some cases of leukaemia (hairy cell leukaemia, chronicle myelomonocyte leukaemia) , multiple myeloma (although Cancure effects were evident for about 5 months of treatment, the reported patient death was unfortunately imputable to the patient's spiritual believe that lead to negligence), colon cancer, etc.

- In most of the cases, durable remission and even definitive remission has been reported.

Comment (continued)

- No toxicity index nor side effects have been reported so far, apart the secondary pharmacodynamics effects of some molecules inside Cancure which are susceptible to fall under control by using routine medical caution.
- The medicine is administered per os and the lack of toxicity and side effects makes the patient's tolerance and compliance very good.
- Some patients have been treated since 2002 and most of them from 2011 and had stopped the therapy since but still they show no clinical nor paraclinical sign of cancer.

- **What emerges from that is that:**
  - **Cancers, in our environment context, are diagnosed in late and advanced stages;**
  - **The diagnosis for cancers is difficult given the high exams cost and the lack of capacity, preventing so to perform numerous tests.**

Conclusion

Cancure™, although yet needs further experimental trials step, provides us a new perspective in the medical management of patients suffering from tumours and it's all the more since the therapy presents no side effect (as confirmed by the in vitro/vivo studies), except some controllable effects such as an acute appetite and some complaints of hypergatralgy and light diuresis amongst some patients.