TUMOSTERONE by Dr. Hans A. Nieper[1]
Silbersee Hospital, Hannover, Germany

The efforts to control cancerous disease have in essence failed. This is what the facts say. Even if surgical procedures result in a certain percentage of rescue for cancer patients the toxic and short-time nature of surgical interventions will never solve the problem.

Toxic chemotherapy and radiation have even more chance to fail because of their systemic, accumulating toxicity. Immunotherapy of malignant disease even when based on the most modern procedure to activate cell-bound immunity, and on the enzymatic decomposing of shielding and blocking factors is limited in its effect. Unfortunately, the proportion between tumor cell load and defense capacity often is such that the immuno defense can not overwhelm the disease. The author of these lines is known for having more than 25 years of experimental extensive clinical experience in this field.(1)

At this time only very experienced oncologists can manage the patient to profit from the sometimes marginal chances offered by the aforementioned therapeutic concepts. I personally(2) do not believe that efforts to revive - as a result of the verdict from the U.S. Senate research on transfer factor, interferon, properdin , thymosin, and tumor necrosis factor will result in clinical and -more so- economical feasibility.

In contrast to this I may predict a very important step forward in a successful, feasible, and economic control of cancer on the basis of the so-called TUMOSTERONE concept. It was elaborated and presented by the German chemist Klemke(3) who has been working several years in the United States. For reasons of scientific caliber and of his personal devotion the work of Klemke merits great admiration.

In 1969 McKinney, et al(4) had reported that the implantation of leopard frog kidney tumor cells into enucleated eggs result in the development of normal tadpoles. More recently, 1975 Mintz and Illmensee(5) reported the formation of genetically normal mice out of mouse teratoma* cell nuclei. These are two of quite a few experimental findings which show that in contrast to earlier belief the nucleic genomes in cancer cells lack established defects or mutations. Since on the other hand, in the case of cancer important nuclear aberrations both structural and functional are obvious, these aberrations must be of some kind of "superimposed falsification". Klemke has defined the chemical mechanisms of this endogenous falsification. And more important: he conceived a principle which may possibly inactivate the "superimposed falsification" and revert the genome to normal function and readout: A kind of a "chromosome cleaning".

---

[1]*teratocarcinoma

According to Klemke the disturbance of the chromosomal reduplication and of their functional readout is caused by certain aberrated steroids. These again are produced by the oncogenic destructive processes in the mitochondrial membranes of the respective cells. The concept may be the way (to) explain why certain bile steroids may become oncogenic.

The aspect of great importance, however, is the aforementioned chromosomal "falsifications" in the case of malignancy and possibly also in some other acquired diseases are reversible in nature. It is very likely that the organism provides substances which are able to do so. The most important of these compounds is named Tumosterone. Klemke defined it as a sterone connected to a tetrahydrofurane and carrying an endiol-function. The "chromosome cleaning" property of the molecule is connected to this structure.

Tumorsterone is believed to be an essential tool of killer lymphocytes. Its direct chemical precurser is Thymosterine, a thymosin-activated steroid essentially found in the thymus gland. The chemical precurser of thymosterin again are substances like ergocalciferol, vitamin D_2, and some steroids out of the adrenal cortex.

There is ample clinical evidence for the likelihood of the Tumosterone principle.

Over the decades it has been repeatedly observed that malignancies of important volumes which by far exceeded the defense capacity of the immune system regressed or disappeared entirely. This especially in the course of the development of both essential (adrenal) and renal hypertension. A hypertensive (high 17-keto-steriod) condition in patients is negatively correlated with malignancies.

Most important is the fact, that prednisone which carries an enol-function could to a smaller extent overlap the effect of tumosterone. Other cortisones do not have this property, their enol-function is either blocked (triamcinolone) or it lacks entirely (e.g.methyl-predisolone). This throws an entirely new light on the empirically well-known carcinostatic effect of prednisone. The new knowledge favorizes an early-protective-application of relatively small doses of prednisone in all cases of malignancy.

For over a year we had a new look on cortisone long-time treatment of malignancies and got the following impressions: Methylprednisolone and triamcinolone do not have the longtime carcinostatic effect observed with prednisone. The necessary doses of prednisone is to a certain extent defined by the size of the malignancies. The typical cortisone side effects of prednisone do practically not show up in cancer patients in contrast to the treatment of cancer patients with methy-prednisolone, given at equiefficient doses.

Various plant saponins have been found, the agluconic steroid of which have similarities with the tumosterone structure. Some of these saponins are empirically known for having an anti-cancer effect, others proved so experimentally, two of these saponins out of ginseng root.

Until we will have tumosterone available and applicable our efforts have to be focused on the boostering of the endogenous tumosterone production in the patient. This requires an all over activation of the cellular immune system of the kind I have already reported plus the continuous application of tumosterone precursers in important quantities such as vitamin D_2 and adrenal cortex extracts in i.v. or i.m. injections.

The remarkable "R-case" which was the first one to receive such a treatment gives me hope: A lady, spouse of an American M.D., was brought to Hannover in November 1976 because of an advanced chronic lymph. leukemia. Huge spleen, WBC 100,000-200,000, Hb 8.4 gs. In addition to the mentioned immuno program the patient received daily injections of an adrenal whole extract and cod liver oil in capsules containing vitamin D_2 (not D_3 !). After about 15 months of treatment there was no sign whatsoever of leukemia disease according to a department of hematology of a midwest university medical school. A check up in our laboratory in 1979 revealed even a freedom from immune interaction against possible malignancy.

The system of "chromosome cleaning" based on Tumosterone and similar compounds would be an excellent example for what we have in mind when we speak of preventive and protective therapy of cancer and of acquired degenerative and inflammatory diseases.

Based on results which we achieved recently by investigating the interaction between immuno defense and bone metastisation in breast cancer we assume that there is a non-immune anti-cancer surveillance system which is adrenal cortex and/or steroid connected. Again another outlook which focuses light on the tumosterone concept.

1. Nieper, H. A., J. Academy of Preventive Medicine July 1979

2. New York Times, June 14, 1978

3. Klemke, R., Nontoxic Therapy of Cancer Vol.15, p.80
   Series Krebsgescheben, Fischer publishers, Heidelberg 1977

4. McKinney,

5. Mintz, B. and Illemensee,, K., Proc. Nat. Acad. Science USA 72, 3585-3589 (1975)

-- Hoppe, P. and Illmensee, K., Proc. Nat. Acad. Science, USA