

Focus on Foci

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The "focus" has been described as a chronic, abnormal, local change in the connective tissue, capable of producing the most varied distant effects beyond its immediate surroundings, and therefore in constant conflict with local and general defence (Pischinger and Kellner). By this definition, even a fully-healed scar may sometimes act as a focus, spreading disease to distant parts of the body. But the foci we shall now examine will be confined to those of the teeth and tonsils - in my view, the most lethal of all foci.

The emphasis I place on the removal of devitalised teeth and chronically-diseased tonsils is one of the better-known aspects of my work, but also one of the most criticised and misunderstood. I *do not*, for instance, recommend that healthy tonsils and teeth be removed from a healthy person. But I believe if they are diseased, they cause the body's natural resistance to be lowered, thus acting as an important contributory factor to tumour development. In these cases, I insist on their removal.

It is sometimes argued that to carry out such operations on seriously ill patients is unnecessarily cruel, even irrelevant. There are some unpleasant side-effects, but in my opinion, the benefits - which I will describe - more than make up for any temporary discomfort. It is further argued that in the cancer patient, as much lymphatic tissue as possible should be preserved, and therefore tonsillectomy should not be carried out because even a diseased tonsil may retain some useful defence potential. I used to believe this was so. I do not any longer for reasons which will be evident.

The beneficial results of tonsillectomy with cancer patients were first brought to my attention in 1953, and by chance. A tonsillectomy was performed on an incurable cancer patient in my clinic who had severe rheumatic pains and a long history of tonsillar disease. The operation was done to relieve the woman's pain, but it was remarkably successful in other ways as well: general toxic symptoms disappeared and, most important of all, her pathologically rapid pulse rate was reduced. Many cancer patients have a high pulse rate, reaching 140 and even 160, and this always leads to a poor prognosis, but in the case of this woman, it was almost normalised. Soon her tumour began to regress, and ultimately she recovered from her cancer.

This unexpected but welcome result encouraged me to arrange for tonsillectomies on two further patients with tonsillar ailments, who also had therapy-resistant cardiovascular disorders and toxic symptoms. In these cases as well, following surgery, cardiovascular and many other symptoms virtually disappeared. A positive "re-tuning" of natural defence and a certain inhibition of tumour growth was also observed. This improved situation naturally allowed more time for active immunotherapy to work.

These early successes encouraged me to persevere with tonsillectomies. Before making them virtually obligatory in my clinic, forty percent of those who died there did so from heart attacks. Afterwards the figure dropped to five percent. This, I contend, is incontrovertible proof that tonsillogenic toxins find their way into the bloodstream and eventually can cause, for instance, a fatal myocardial disease. This is one reason why more people die from heart disease than from any other.

In addition, my experience shows a direct connection between dental and tonsillar foci and many of the illnesses responsible for early debilitation and untimely invalidising.

It has long been generally accepted that head foci may give rise to almost all kinds of chronic, and certain acute

diseases, such as-to mention a few-the manifold varieties of rheumatic and cardiovascular conditions. The removal of such foci is today a routine part in the conventional treatment of those diseases. However, the fact that head foci are also a contributory cause in the development of neoplasia, by lowering resistance, has received all too little acknowledgement.

The extent of the disease-provoking activity of a focus in distant parts of the body depends on whether the body is able to oppose the focus with its own defence mechanism. As long as the focal situation is kept under control by the local defence mechanism, no focus-induced remote effects will arise. On the other hand, distant effects will arise when the body's resistance has more or less broken down: control of head foci will then gradually collapse, and there will be consequential gradual increase in generalized focogenic intoxication. This will cause an inevitable deterioration of the body's defence power with a concomitant promotion of malignant growth.

Nearly everybody is confronted with dental problems at some time in their life, and even the most scrupulous dental care cannot guarantee dental health. Endogenous factors, such as prenatal damage to the embryonic dental tissue, as well as exogenous influences, such as malnutrition and toxins, must essentially be held responsible for the great number of dental diseases, be they a weak, susceptible gingival, or gum; or teeth which are malpositioned, barreled or impacted; or, worse of all, a disposition to decay.

Despite its porcelain-like surface, the crown enamel of the tooth is vulnerable to decay. Enamel defects develop especially in the grooves of the crown or on the adjacent surface of neighbouring teeth which are difficult to clean.

Decay is not painful so long as it is confined to this nerveless enamel layer. The onset of a toothache is the first noticeable sign that the decay has invaded the dentine body of the tooth which, unlike the enamel, does have nerves. If this decay is allowed to continue, sooner or later the dentine will be completely penetrated, and the pulp inside the tooth will then become inflamed.

As long as only the outer enamel and dentine are affected, the tooth can be preserved. But a tooth with an inflamed pulp can no longer be saved, and must be extracted without delay.

In an understandable desire to preserve as many teeth as possible, to maintain the masticatory apparatus and its functions, attempts are often made to save teeth which are in fact lost. There is a widespread conviction that this can be done without risk by the sterile evacuation of the pulp, and then refilling the cavity. For decades, the erroneous belief was held that, after such treatment, the tooth is an isolated, lifeless thing, no longer involved in any of the body's processes. This assumption was originally based on the premise that the pulp cavity had only one orifice to the apex of the root below, and by filling, this opening was sealed. However, the dentinal canal does not end in just one opening; instead, it resembles a tree with many branches which penetrate the tooth's body in all directions.

The finer details of the entire dental structure have been exhaustively studied by Austrian researchers. They have established that there is a lively metabolic interchange between the interior and exterior milieu of the tooth, and that this two-way process takes place along many thousands of hyperfine, capillary canals joining the pulp cavity to the exterior surface of the tooth.

Very careful conservation measures may possibly seal off the vertical central-medial-tube of the dentinal canal, but it will never reach the lateral "twigs" branching off from this tube. Nor can it ever close off the innumerable capillary canals. Some protein will always remain in these secondary spaces. If this protein becomes infected, toxic catabolic products will be produced, and conveyed into the organism.

It was established in 1960 by W. Meyer (Goettingen) that within devitalized teeth the dentinal canals and dental

capillaries contain large microbial colonies. The toxins produced by these microbes in a tooth with a root filling can no longer be evacuated into the mouth, but must be drained away through the cross-connections and unsealed branches of the dentinal and capillary canals into the marrow of the jawbone. From there, they are conveyed to the tonsils, and thus the flow systems of the body. In fact, the conservation treatment may literally convert a tooth into a toxin producing "factory".

A devitalized tooth is no longer able to perceive and control inflammatory processes even when suppuration has invaded the surrounding bone spaces of the tooth's socket; it rarely gives warning signals, for instance through pain, and therefore there is nothing to induce the patient to have this dangerous toxic foci removed. It then may be left to develop its devastating effect on the organism for decades or even for a lifetime.

When the inflammation spreads to the marrow of the tooth socket, it can cause osteomyelitis. Its further course is determined by whether and for how long the local defence is able to keep the focal disturbance under control.

If the body's local resistance is intact, the inflammation is enclosed by a capsule of connective tissue known as the dental granuloma. This membranous cyst prevents its toxic contents from spreading into the organism. Radiographs of these teeth show granuloma cysts as more or less marked transparencies at the apex of the root. This type of tooth is called X-ray positive.

If the body's local resistance is weakened to such an extent that the inflammatory process cannot be encapsulated by the granuloma cyst, the toxins will be able to advance unhindered into the marrow spaces, the tonsils, and into the body. In this case, it is proof that - as stressed by Pischinger and Kellner - the organism has become largely incapable of reaction. Radiographs of these teeth as a rule show no transparencies, and are therefore called X-ray negative.

In my cancer patients, I have found that such non-encapsulated foci - that is those who show X-ray negative - were particularly common, as one would expect from people whose body resistance has been lowered.

Today there is general agreement that dental foci should be cleared away, and it has become usual to diagnose them by X-ray. Unfortunately, only some of the dental foci can be discovered by this means. Encapsulated foci can be recognized only if large enough, and if not concealed by the tooth's shadow. And definite X-ray signs are much rarer in non-encapsulated osteomyelitic processes. It is therefore the most dangerous of all dental foci which most frequently prove X-ray negative. Even with X-ray positive dental film, only those foci can be recognized which happen to be situated outside shadows. Since X-ray negative foci often escape treatment - and they are the ones the body has failed to resist effectively - they can continue to develop their destructive effects unhindered.

My clinical experience has produced evidence of a causal connection between foci and tumour development, and in this respect, the results obtained with the aid of an infra-red test are especially significant.

Any inflammatory disease focus creates on its corresponding skin surface a pathological increase of infra-red emission; the higher the activity of the focus, the more pronounced it is. Using an infra-red sensitive instrument (Schwamm's infra-red toposcope), the intensity of this emission can be continuously monitored and measured. Observation shows a close interrelation between the infra-red emission of head foci and that of the neoplasial region. That is, after treatment, a decrease in the infra-red activity of dental foci was as a rule accompanied by a decrease in infra-red emission over the tumour areas.

From this it is clear that the advisable treatment for devitalized teeth is extraction.

But even this is not always enough. My experience has further shown that also living teeth may sometimes be so damaged that their pathogenic potential almost equals that of devitalized teeth. For instance, latent chronic

pulpitis may arise in a tooth that appears outwardly healthy, thus having a focal effect.

The diagnosis and treatment of dental foci remains generally unsatisfactory. A survey conducted at my clinic found that, on admission, ninety-eight percent of the adult cancer patients had between two and ten dead teeth, each one a dangerous toxin producing "factory". Very often we are confronted with X-ray negative dead teeth, root remnants, and residual osteitis which had not been diagnosed and therefore had not been removed.

Only total, thorough dental treatment will really succeed in giving the body's defence a chance. In addition to X-ray diagnosis, it is therefore necessary to use other diagnostic aids, such as infra-red techniques, tests, to estimate tooth vitality and periosteal resistance, and other electrometric methods.

The diagnosis of foci in teeth had been greatly improved by electro-acupuncture. It is now possible to differentiate foci not only with regard to their type and position, but also to their virulence and pathogenic efficacy. The result of focus treatment can consequently be observed and improved, before, during, and after dentistry, to an extent never known before (Kramer).

If total treatment is to be performed, it is necessary to remove not only any devitalized teeth but also any hidden dental foci remaining in the jaw.

Further, total removal of devitalized teeth and their roots must not be the end of the dentist's activities. Each alveolus - the tooth's socket in the jaw - should be radically cleared down to the healthy bone. In that way the development of the residual osteitis or of a cystoma may be prevented. It is not only the tooth which may be a focus, but the adjacent tooth-fixing apparatus as well.

There are four different ways by which dental foci - and indeed all foci - can affect the organism and contribute to the development of secondary damages:

1. The "neural" way of affecting the organism.

When a focus develops anywhere in the transit tissues, the mesenchyme, the process is centripetally projected from the terminal neural organs around the irritated area, along the neural ducts, up to the corresponding control cells within the central nervous system. The irritation originating from a focus can, under certain conditions, trigger off the mechanism of a neural dystrophy - a slow degeneration - which may show itself in localized effects in other areas, but also in a generalized dystrophic disturbance.

In the 1950s it was shown that these manifestations are based on depolarizing processes in the affected neural cells, and in the corresponding tissues of the body's periphery (Fleckenstein and Ernsthausen). By elimination of the focus, the affected tissues may be repolarised. The most striking example of this repolarisation is called "second-phenomenon".

Ferdinand Huneke, the founder of neural therapy whose remarkable contribution in this regard we shall look at in detail later, discovered over forty years ago that injection of a local anaesthetic near a primary focus may immediately remove any symptoms of distant disease induced by the focus. This effect - the second-phenomenon - usually takes place only a few seconds after the anaesthetic injection, and lasts for hours, days, or even for a lifetime. Naturally the improvement occurs only in those regions influenced by the injected focus. Nevertheless, the measure has therefore a remarkable diagnostic value as well.

Since neural therapy only neutralizes the neural effect of a focus, the focus itself must, of course, be removed after such treatment, in order to eliminate its latent toxic or allergenic action. Conversely, any focal surgery must be followed by desensitizing and neural-therapeutic measures.

The only exceptions to this rule are, for instance, featureless scars or other spots with no inflammatory change which produce only neural distant effects without at the same time causing any toxic, microbial, or allergic secondary phenomena.

2. The "toxic-way" of affecting the organism.

The toxic activity of odontogenic foci is probably far more perilous for the organism than their neural effects. The mechanism of this distant toxic activity, as well as the characteristics of the toxic compounds involved, have been largely ascertained.

Odontogenic compounds are the gangrenous contents of an inflamed pulp cavity and its adjoining spaces. It consists of detritus and decaying, formerly vital substrates which have been necrobiotically altered - commonly found in tissues destroyed by inflammation, liquefaction and microbial putrefaction. Thus there can be little doubt that they are genuine necrogenous toxins, including for instance autologous proteinic and higher-molecular fission products resulting from enzyme cleavage and other biogenic conversions.

The identity and chemical structure of certain of the biogenic amines were mainly clarified in the 1950s by Schug-Koesters, Hiller, Gaebelein and others of the University of Munich. Following similar findings in America, the metabolic and exchange processes in solid dental structures were further investigated by the German researcher Spreter von Kreudenstein. He showed that drugs injected intravenously were, four to five hours later, discernible within the intradental capillary ducts or even devitalized teeth, and in a concentration only slightly lower than in the blood.

That endodontal exchange may also take place in the opposite direction has been reported by Bartelstone (USA) and Djerassi (Bulgaria). If radio-iodine, I-131, is deposited in an evacuated pulp cavity which is then sealed off with a filling, the iodine will appear in the thyroid some twenty hours later, as can be demonstrated by taking a scintograph of the thyroid region. Similarly, dyes can be washed out of a sealed pulp cavity.

All these findings prove conclusively that within solid dental structures, there may proceed an unimpeded substantial interchange in either direction. Consequently, odontogenic toxins, wherever they may have been produced, are able to diffuse and circulate within the organism.

The pathogenic significance of these "endotoxins" has been investigated by the German study group of Eger-Miehke. They examined the changes in healthy experimental animals after injection of accurately defined, minimal quantities of the endotoxins from an odontogenous granuloma.

A single injection of a minimal dose seemed to develop a defence-activation effect. But after repeated injections, there was severe liver damage, and the animals died within weeks. Apart from the fatal liver damage, inflammatory and degenerative changes were found in all other organs, especially in the joints, muscles, and blood vessels.

These results brought clear experimental proof for the first time that focogenic toxins act as causal agents for severe diseases in animals corresponding to similar chronic conditions in man.

The most dangerous of all odontogenous toxins are undoubtedly the thio-ethers, for instance dimethylsulfide. In a series of tests performed at my clinic, it was observed that patients with odontogenous and tonsillar foci had a heightened level of dimethylsulfide in their blood. After intensive treatment of the foci, this level returned to normal in just a few days.

Thio-ethers are closely related, both in their structure and their effect, to mustard gas and other poison gases used in the First World War. The extreme toxicity of the poison gases and thio-ethers can be attributed to the

following properties:

1. They are weakly basic, therefore "electro-negative", and thus they are deposited particularly in "electro-positive" cells such as those of the transit tissues as well as those of the defensive tissues.
2. They are soluble in the lipids, and therefore have a pronounced tendency to enrich themselves in the lipid-containing cellular structures, especially in mitochondria.
3. These subcellular organelles, attached to their lipid membranes, contain the enzymatic structures responsible for the maintenance of aerobic metabolism - a precondition for full functioning power in all the body's cells and tissues. If these indispensable units are damaged, the most serious consequences will follow. Because they are the most vulnerable cellular organelles, mitochondria are a favourite and almost exclusive target for thio-ethers. The action of thio-ethers is effected in three main ways:
 - a. Since thio-ethers tend to combine with electro-positive metal ions and many bio-elements which act as co-effectors or activators of numerous enzymes of absolutely vital importance, and as our present-day average diet is deficient in essential substrates such as vitamins and bio-metals, this deficiency is enhanced. Much of the daily intake of bio-metals, usually deposited in the fluids of a focally affected organism, will be made permanently ineffective; the more foci, the greater will become the deficiency.
 - b. Thio-ethers are "partial" antigens, haptens, and thus they also tend to combine with the normal proteins in the body, "denaturising" them. Such denatured proteins become "non-self" agents which the body must deal with as such. The production of antibodies adapted to the situation will be provoked, and they will home in on the target antigens wherever they are. The process of "auto-aggression" will be set in motion: self-destruction of agents alien to the organism. Extensive structural cellular damage will result, increasing with age.
 - c. The famous biologist, Otto Warburg, twice winner of the Nobel Prize, has shown that aerobically-blocked cells - as caused by thio-ethers - will increase their anaerobic metabolism in an attempt to maintain their vigour. In doing so, they acquire the characteristics of malignant cells. Therefore, chemical agents capable of inactivating the aerobic process while increasing the anaerobic process are usually classed as carcinogenous compounds.

Druckrey (Heidelberg) found inter alia that transformation of a normal cell into a malignant cell requires a certain quantity of a carcinogen -the carcinogenic minimum dose. It does not matter whether this quantity is supplied in a single dose or in a number of smaller doses, because the toxic effects of each dose are stored, and accumulate without loss. The carcinogens held primarily responsible for the development of spontaneous cancer in man are those:

Which inhibit the aerobiosis even in minimal quantities without at the same time immediately destroying the cell, and, which are constantly present in the organism in this minimal concentration of either endogenous or exogenous origin; they can therefore accumulate during the normal life expectancy gradually and unnoticeably until the total quantity necessary for

There is hardly a carcinogen which so completely fulfils these conditions as do thio-ethers. Incessantly, from the moment the pulp is removed, hour by hour, year by year, minimal amounts of these most virulent of all the odontogenous toxins will be released into the circulation - minimal doses, but nevertheless sufficient to more or less totally paralyse the aerobic action of the cell.

The nervous system is thus doubly affected by focal intoxication. Firstly, by the increasing destruction of the neural ducts which mediate between the control centers and the peripheral areas, thus sometimes initiating neurogenic dystrophy. And secondly, by the immediate intoxication of neural cells caused by the toxins spreading through the liquid vehicles of the flow systems, such as the blood and lymph.

The more mitochondria a cell contains, the more it will be damaged by the enzyme-inhibiting effect of thio-ether compounds. Therefore it is the vital organs - the liver, nervous system, endocrine glands, heart, and reticuloendothelial system - whose cells may consist of up to one-fifth of mitochondria, that are primarily affected. Apart from disturbing regulatory control, odontogenous toxins will also cause additional damage almost throughout the body. Naturally, the higher the book-level of focogenous toxins, the more severe will be their effect.

The close interlacing of the lymphatic and endocrine systems in the head, make it unavoidable that brain cells are more intensively toxified by the circulating focogenous agents and may suffer particularly heavy damage. The lymph ducts of the head region join Waldeyer's tonsillar ring, and if there is such congestion, waste fluids will be pressed through the porous base of the skull into the lymphatic spaces of the brain. Toxogenous changes, especially within autonomic nuclei, are regularly found in cancer patients, as verified in the 1930s by Muehlmann (USSR), and they may be a consequence of a life-long inhibition of cerebral aerobiosis due to focogenous intoxication.

The cerebral damage (diencephalosis) and the subsequent loss of vitality in cancer patients is accompanied by the number of other symptoms. The emission of hypothalamic energy impulses, recordable by a Voll's electro-acupuncture device, are reduced in patients with focal disease. The autonomic vigour is relaxed, creating "regulation rigidity": carcinomas tend to parasympathicotonic derailment; in sarcomas and systemic diseases, as a rule the opposite is found - sympathicotonic derailment (Regelsberger, Gratzl-Martin, Rilling et al). the diurnal, circadian regulation of the acid-base balance is lost (Sander). At the same time, there will exist a distinct inhibition of other diurnal control functions, for instance of blood sugar, cholesterol, and mineral metabolism, and many other metabolic parameters are greatly restricted (Hinsberg).

The lack of vigour and control efficiency is not, of course, without effect on the patient's psychic condition. Vegetative disorder is therefore generally accompanied by neurasthenic dystonia - characterized by the diminishing vitality and autonomic instability.

3. The "allergic" way of affecting the organism. The toxic effects of thio-ethers overlap those caused by higher-molecular odontogenous toxins as already described.

Antibodies are formed to fight these substances, eventually leading to the destructive processes in toxified cells. Since the organ-destroying antibodies or defence enzymes are excreted by the kidneys, they can be diagnosed in the urine by the abderhalden test. In this way we can precisely deduce, in most cases, which organs have suffered secondary damage (Abderhalden, Dyckerhoff et al).

The extent of secondary lesions can also be demonstrated indirectly by vaccine treatment. Using desensitizing

vaccines made from focogenous agents, reactions are caused in regions affected by distant focal effects which may become evident in regional as well as general symptoms.

It is thus clear that the development of cancer disease is, in more ways than one, closely linked with focal events.

4. The "bacterial" way of affecting the organism.

Bacterial dissemination from primary dental foci as a rule takes place with barely perceptible symptoms, and may be followed by the formation of "secondary foci" in other regions. These include, inter alia, foci in the paranasal sinuses, gall-bladder, appendix, prostate, and renal pelvis.

Above all, bacterial dissemination tends to produce microfoci or microthrombi in veins, and they in turn have a tendency to thrombosis or thrombophlebitis, possibly with concomitant embolism.

Thrombophlebitis and thrombosis, so common in cancer patients, and generally regarded as resulting from disordered metabolism, are due not only to the dyscrasia of those patients, but also to the manifold effects of dental foci.

Shakow (Moscow), in collaboration with several clinics, has carried out an interesting investigation involving more than 1200 young pupils at a boarding school. Over a period of six years, it was seen that students with devitalized teeth had three times as many illnesses as those with healthy dentition. By removing devitalized teeth in these young patients, up to eighty percent of their illnesses were cured.

We have now seen how decisively the entire organism is affected by dental foci not properly treated, and what catastrophic results destruction of the pulp may entail. Dentists must, therefore, bear in mind that there is no root treatment which does not inevitably produce foci.

The dentists' task is only secondarily cosmetic; primarily it must be preventive and curative. The over-riding consideration must not be conservation of the tooth but preservation of its vitality. If this is impossible, even the most beautiful crown must not delude us that the lifeless tooth beneath is anything other than a "corpse in a golden coffin", whose decomposition toxins slowly but surely are destroying the organism (Bircher-Benner).

Other foci in the jaw, for instance otitis, cysts, foreign bodies, gingivitis, and malposition of teeth may also develop focal effects. It goes without saying that these foci and centers of irritation must be removed.

The dentist should always remember that he has a vital role to prevent the development of chronic illness and, most important of all, to decisively reduce the hazard of cancer.

Now let us turn to tonsillar foci.

Chronically inflamed tonsils are primary head foci which sometimes have an even more damaging effect on the organism as a whole than dental foci. They can participate in the development of chronic illness, including cancer, by the four ways already described for dental foci: by neural, toxic, allergic, and bacterial means. There are also similar connections between the development of cancer and tonsillar foci as there are between cancer and dental foci. For instance, after removing the tonsils, there is a decrease of infra-red radiation over the tumour, and sometimes even a shrinking of the tumour.

The three tonsils in man, that is, the naso-pharyngeal tonsil, or adenoid, and the two tonsils proper, the palatine tonsils in the pockets between the anterior and posterior palatine arches in the back region of the mouth, together with other seemingly insignificant lymphoepithelial organs, form Waldeyer's tonsillar ring.

The tonsils are excretion organs by which the lymphocytes, microbes, toxin-laden lymph, and other matter, are

discharged (Roeder). Even in healthy people, the tonsils may contain plugs - sometimes wrongly described as pus - which consist mainly of fatty acids, cholesterol, and other slag substances clearly characterizing them as excretion. The pale-coloured plugs form in the shallow depressions on the tonsils' surface - the tonsillar crypts - and are expelled into the oral cavity and swallowed. The excretions of the tonsils may also contain dental toxins.

The tonsillar crypts have been described as the places where the physiologically obligatory bacterial flora are hatched. This flora colonises the mucous membranes of the nose and throat and the other air passages. The tonsils also produce antibodies, and undesirable microbes and their toxins are rendered harmless. Thus they have an immunizing or detoxicating purpose and must be regarded as a functional analogue of the lymph organs of the intestinal mucous membrane, and, like the latter, as an important part of the body's defence system.

Healthy tonsils have a pale, pink, surface, and are normally almond or bean-sized. Their size and reaction capacity are determined not only by functional demands and loads, but also to some extent by each individual's inherited constitution. With an inherited disposition to lymphatic diathesis, due mainly to heavy hereditary infection, there is regularly found a congenital enlargement or hyperplasia of the tonsils. This is always accompanied by an increased disposition to inflammatory reactions. Inflammatory reactions are also caused by their physiological function. A normally subliminal, and therefore symptomless tonsillitis, thus belongs to the "normal bodily state of man" (Leuscher).

Whenever large quantities of toxic and waste substances have to be excreted, the blood perfusion and inflammatory activity of the tonsils will increase. This state is often accompanied by painful swelling and reddening of the tonsils, and is described, depending on its subsequent course, as acute, sub-acute, or if occurring repeatedly, chronic tonsillitis.

I shall now concentrate on chronic, and especially on degenerative tonsillitis, because, under certain conditions, dangerous focal processes develop from it which are of causal importance for the origin of all chronic illnesses, including cancer.

Although each case of chronic tonsillitis is due to the same mechanism, it is possible to distinguish between three different groups. The first group includes those chronic tonsillitis cases which arise in healthy tonsillar tissues capable of response, following frequent attacks of acute tonsillitis, or angina; they have been called upon to repeatedly react to infective irritation, and to excrete toxins. Each new attack leads to an increase in volume, perfusion, and activity. They are then in a high state of readiness for defence. But if such inflammations occur with increasing frequency, the tonsils gradually lose their reaction capacity and defensive power, and atrophy. Too much has been asked of them.

The second group includes those tonsillar foci which develop under certain conditions from congenitally enlarged or hyperplastic tonsils. This kind of hyperplasia can be so extensive that the fauces are completely obstructed. Unfortunately it is still common practice to reduce their size by partially lopping off these hyperplastic tonsils. The tonsils are thereby deprived of the shallow depressions - the crypts - so indispensable to their purpose; the excretory function cannot take place without an intact surface with open crypts. After a tonsillotomy lopping-off operation, the remaining crypts are always narrowed or closed by scar tissue, the substances to be excreted are cut off from their air supply (Voss), and are therefore un-aerobically decomposed with the formation of toxic decomposition products. It follows that lopping-off should not be performed. These tonsils should be totally removed, even if they are not yet causing any recognizable distant effects.

The third group of tonsillar foci, in cancer patients the most common, comprises the seemingly healthy, but small, congenitally underdeveloped and functionally deficient tonsils. A history of tonsillar symptoms is usually absent in these patients. Their tonsils are "unremarkable" , but firmly fused with their base, and cannot easily be

dislodged.

What these three main groups of chronic tonsillitis have in common is a focal-toxic effect progressively increasing with age, and a tendency sooner or later to atrophy. This process will be accelerated if there is an additional and continuous passive exposure to odontogenous toxins.

The close connection between teeth and tonsils was proven when it was observed that Indian ink injected into a sealed dental cavity appeared as spots on the tonsillar surface in about twenty to thirty minutes. These experiments showed that pathogenic substances from the jaw region, including toxins from devitalized teeth, are conducted to the lymphatic tonsillar ring, there to be detoxicated and excreted. Besides their "natural" physiological load, the tonsils are thus additionally exposed to continuous attack by odontogenous toxins provoked by the devitalisation of teeth.

We have already seen how dangerous these dental toxins are. It is inevitable that they eventually have a severe effect on the active lymphoepithelial tonsillar tissue. So long as the cells destroyed by dental toxins can be regeneratively replaced, the functional capacity of the tonsils will not be seriously impaired. But if the destroyed lymphoepithelial tissue is increasingly replaced by inactive scar tissue - by tissue unable to execute its defence function - the excretion, detoxication, and defence capacity of the tonsils will progressively diminish and eventually be extinguished.

With the loss of reactive lymphatic tissue, the tonsils lose their ability to give warning signs by inflammation; they no longer offer this usual signal for trouble. According to Kellner, this lack of symptoms signifies a definite inability to continue to further reaction. In such tonsils, the attacking toxins are no longer excreted; on the contrary, they are channeled into the organism via the vascular system.

It goes without saying that this development will take place far more quickly when less lymphoepithelial tissue is still present. In congenital tonsillar deficiency, there is, a priori, so little active tissue that its complete destruction can in certain cases be accomplished in a relatively short time. Normally developed, or hyperplastic tonsils if not lopped off, will withstand the dental infection considerably longer. But they too will sooner or later succumb.

The final stage of all three forms of chronic tonsillitis is therefore "atrophically degenerating tonsillitis". On medical examination, the findings here are small, atrophic tonsils which show no sign of inflammation but, unlike healthy tonsils, they cannot be dislodged by the surgeon's spatula. When removing them, they have to be dissected from their bed, so firmly fused are they to the surrounding tissue. Whereas with healthy tonsils the colour of the anterior palatine arch does not differ from that of the oral mucous membrane, in atrophically degenerating tonsillitis there is a bluish discoloration of the palatine arch. The uvula is mostly gelatinously thickened. The tonsils themselves, however, may still appear externally healthy.

Even normal-sized or enlarged tonsils may already have extensive degenerative changes and consist mainly of hardened scar tissue which of course is unable to neutralize toxins. There then follows the formation of usually quite latent and painless chronic tonsillar and retrotonsillar abscesses. Here we find the highly pathogenic beta-haemolytic streptococci of Group A - responsible for many chronic illnesses, and whose toxins spread through the organism and contribute to the development of secondary lesions, of resistance deficiency, and of the tumour milieu.

Apart from the directly allergenic and toxic activity of these products, continuous toxic attack always leads to an alteration of the tonsillar (lymphoid) cells. Their proteinic structure is so altered that the organism is induced to form antibodies against these, its own, cells which have become foreign to it, antibodies which finally turn against healthy lymphocytes as well, and thus considerably weaken the lymphatic defence system of the whole organism.

With the decline of the active tonsillar tissue, its biological power is also exhausted. Active detoxication, toxicopexis, and excretion of toxic substances and wastes through the tonsils is no longer possible. In the tonsillar crypts, the physiologically essential symbionts are no longer hatched. Instead, dangerous pathogenic organisms are able to spread through the body because the immuno-activity of the tonsillar barrier is lost with the destruction of the lymphoepithelial tissue.

When the dental toxins are no longer neutralized and excreted, they will infiltrate even the last remnants of functioning tonsillar tissue and cause them to die. This creates high- and low-molecular necrotoxins which, as we have already seen, are similar or identical to odontogenous toxins. Toxin formation is inevitably increased.

All these toxins, no longer inactivated in the tonsillar ring or excreted, have to be conducted to other "vents" by way of the blood circulation. Toxinaemia and secondary lesions are increased, and the humoral milieu and the body's resistance deteriorates further. The process has become a deadly vicious circle.

Since degenerated and chronically inflamed tonsils are such dangerous toxogenic foci, like dead teeth and other dental foci, they must be removed. With previously lopped tonsils, there is also a clear case for tonsillectomy.

The focogenous toxicopathy caused by necrotic-atrophic tonsillitis is of course far more dangerous than the toxic-infectious effect of a hyper-reactive tonsillitis in childhood. And if the need for tonsillectomy is accepted in children, in cases of rheumatism and other comparatively harmless diseases, should it not be obeyed all the most urgently in tumour disease, especially as a causal connection between focal and tumour events can no longer be denied?

During more than twenty-five years of clinical experience, I have found that painful, enlarged tonsils and other symptoms of chronic tonsillitis were evident in less than one-third of my cancer patients. This suggested to me early on that the others might have silent tonsillar foci in the form of atrophically-degenerating tonsils. In these patients with subjectively quite unremarkable, small, featureless tonsils, I examined their case histories, and searched for silent tonsillar foci with the aid of the infra-red toposcope, the electrodermatometer, and other methods. These observations showed that, although most of them had never suffered from tonsillitis, there were clear findings of a tonsillogenic focal toxicosis. Whenever this was compatible with the condition of the patient tonsillectomy was performed.

The findings in these healthy-looking tonsils were incomparably more serious than even those in the obviously diseased tonsils removed in usual ear-nose-and-throat practice. The tonsillar capsule always proved to show callous thickening, and was so firmly adherent that the tonsils could only be dissected out. In about five percent of the patients there were fairly large peritonsillary or retrotonsillary abscesses which had caused no symptoms. Far more frequently there were several abscesses as well as cysts often the size of cherries, full of liquid or condensed pus. The tonsillar tissue was spongy, slushy, and had a putrid smell. Histological examination of these tonsils always showed severe degenerative changes, and in the majority of cases, a complete atrophy of lymphoepithelial tissue.

All these "featureless", clinically unremarkable, small tonsils proved without exception to be foci of the most dangerous kind which, like the silent dental foci, had probably been present and unrecognized for years or even decades.

These pronounced positive effects of tonsillectomy make it mandatory to always follow dentistry with treatment of the tonsils. In every tonsillectomy performed in my clinic subsequently, we found through biopsy severe or very severe destructive tonsillar processes with more or less virulent tonsillogenic focal toxicosis.

The flourishing of patients after tonsillectomy is impressive and has been demonstrated to my clinical

satisfaction again and again.

Toxins constantly circulating in the blood in degenerative tonsillitis cause a permanent spasm of the blood capillaries, seen outwardly in the poorly perfused, pallid skin of many cancer patients. After tonsillectomy and the consequent elimination of the toxins and their neural effect, there was frequently an immediate improvement of the circulation and a simultaneous improvement in the general condition of the organism.

As already mentioned, before I began paying special attention to the tonsils, I lost many incurable patients, not as a result of cancer, but through acute cardiocirculatory failure. After introducing tonsillectomy, such deaths became much rarer.

Toxic circulatory death, however, is only one of the many dangers constantly threatening the life of the chronically sick. Phlebitis, thrombosis, embolism, pneumonia, pleurisy, and cystitis all too often complicate the course of treatment. In my experience, these, too, became noticeably rarer with the introduction of routine tonsillectomy.

Another observation, one I believe very important for cancer treatment, is that often following tonsillectomy, in a large proportion of patients, I have found that the tongue, not coated before the tonsillectomy, later has a marked yellowish, brownish, or blackish coating. Experience shows that the canalizing activity of the intestinal mucous membranes is indicated by the surface condition or coating of the tongue; a change in this coating suggests that a previously blocked "gut filter" has been opened, leading to the conclusion that tonsillar foci also disturb the detoxicating and excretory activity of the gut. Restitution of this function is of crucial importance in the treatment of cancer because the largest proportion of the necrogenous toxins which develop during tumour solution is excreted by this route.

The widespread opinion that degeneratively destroyed tonsils may still be of importance for cancer patients as detoxicating and excretory organs and must therefore be preserved at all cost has, in my experience, been quite clearly refuted. Anyone, having seen the degenerative destruction in the tonsillar tissue of cancer patients, will be convinced that, on the contrary, these tonsils have contributed in potentiating the virulence of the tumour milieu and the defence deficiency. Tonsillectomy must be followed by desensitization with vaccines obtained from dental and tonsillar foci. Neural treatment of the tonsillar bed concludes this treatment.

The increased tendency towards thrombosis in cancer patients has been reported by many clinicians. It can be assumed there is a causal connection between the two diseases. My experience is that this tendency is reduced by treatment of the head foci. I have treated cancer patients who were being given anticoagulants permanently because of their thrombosis; after treatment of the head foci, as a rule, they were able to discontinue these drugs.

In some cancer patients there is a secondary finding of therapy-resistant hypertension. Here too, following treatment of the head foci, the blood pressure generally returns to normal.

The growth of the tumour itself is very often distinctly slowed down by focus treatment. Now and then tumour development stops altogether, and sometimes even regresses. The head foci therefore seem not only to contribute to the development of secondary lesions, to the origin of cancer disease, but also to exert a direct influence on tumour growth by stimulating it. Many tumours seem to respond to immuno-therapy only when foci have been removed. The subsequent improvement in the body's defences clearly shows itself in the response to immunizing vaccines.

Nevertheless, my own unhappy experience shows that with cancer patients, foci treatment has generally been left to a very late state. In the vast majority of the patients I have treated it is quite clear that foci treatment

should have been carried out years before - and certainly long before the manifestation of the tumours.

That this was not done is a sad reminder that far too many doctors and dentists fail to recognize a fundamental truism: untreated foci can be linked to the development of cancer.

There are also other facets of our every day life-style that indirectly play their part in how the disease can progress.

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