SKIN CANCER – ON DERMATOLOGY

I was listening to a close friend recently talk about his regular visits to his Dermatologist to remove basal cell carcinomas, it was in connection to the stench of the burning skin.

I'd just read AMD's long essay on the subject. At some point I'll have to tell him about the Dermatology racket.

In a recent conversation with a different friend, I found myself explaining "meta ideas" that multiple industries rely on to make their living.

I explained it as a wall that is required to push against. Without that wall, you cannot generate enough force to go in your desired direction.

One of the biggest meta ideas within **Cartel Medicine** is Cancer, the big C.

Cancer and **Virus** have been competing for the top spot of Meta Ideas, with Virus I think now winning in that race, but for most of the last 50-70 years Cancer has been the biggest Meta Idea and the source of most fear and the source of most industrial profit for a wide variety of Interdependent Cartels.

This stack is about the Dermatology Cartel, that has relied on the Cancer "wall" and the demonization of the Sun; to generate all the force and energy it needs progress towards its profit goals.

I have created a list of Q&As relying on the wonderful and important work of AMD, Yoho and Mercola. Without these guys doing the heavy lifting on these subjects it would be impossible for people like me to come along and synthesize this material.

These are the three articles I have relied on:

Dermatology's Disastrous War Against The Sun (midwesterndoctor.com)

FAILED CANCER TREATMENTS chapter from Butchered by "Healthcare" (substack.com)

Many Pathologists Agree Skin Cancer Is Overdiagnosed (substack.com)

But before we look at the Q and As, here are 15 of the most material statistics from the three texts.

Statistics

1. Chemotherapy added only 2.1% to the 5-year survival for US adults treated for cancer, according to a literature search by Drs. Graeme Morgan and colleagues published in Clinical Oncology in 2004.
2. By 2013, 65 to 70 percent of oncologists' income was drug charges.
3. New chemotherapy medications can be 300 times (not 300 percent) more expensive than old ones.
4. Twenty percent of all Mohs surgeries are performed on people over 85 years old, many in the last year or weeks of life.
5. Only 22% of melanomas occur in regions of the body with significant sunlight exposure, compared to 87% of squamous cell carcinoma (SCC) cases and 82.5% of basal cell carcinoma (BCC) cases.
6. Outdoor workers have a lower incidence of melanoma and half the risk compared to indoor workers, despite receiving 3-10 times the annual UV dose.
7. A 1997 meta-analysis found workers with significant occupational sunlight exposure were 14% less likely to get melanoma.
8. A 1982 study found fluorescent light exposure at work increased women's risk of developing malignant melanoma by 2.1 times, with risk increasing based on exposure duration and intensity.
9. In a survey of 115 dermatopathologists, 68% believed over diagnosis was a public health issue for atypical nevi, 47% for melanoma in situ, and 35% for invasive melanoma.
10. Dermatologists freeze millions of actinic keratoses (AKs) with liquid nitrogen, but studies show over half of AKs disappear on their own, with only 1% changing to skin cancer after a year and 4% after four years.
11. The ideal blood level of vitamin D for disease prevention is between 60 ng/mL and 80 ng/mL, while 40 ng/mL is considered the low end of sufficiency, and 30 ng/mL is the minimum to prevent disease.
12. In 2014, the average annual treatment cost for skin cancer was $8.1 billion for 4.9 million adults, a 44% increase in people diagnosed and a 125% increase in cost compared to 2002-2006.
13. Curaderm, a topical cream containing eggplant extract, has a success rate of 66-78% in treating basal cell carcinoma.

14. Valisure tested 294 sunscreen products and found 27% contained benzene, a known carcinogen, at levels at least three times higher than the FDA allows under special circumstances.
15. The 2019 and 2020 JAMA studies found that certain sunscreen ingredients (avobenzone, oxybenzone, octocrylene, homosalate, octisalate, and octinoxate) may build up in the body at unhealthy levels after just one day of use and can persist in the body.

Questions and Answers

Question 1: What did the American Academy of Dermatology do in the 1980s to raise public awareness about skin cancer?

Answer: In the early 1980s, the American Academy of Dermatology (AAD) hired a prominent New York advertising agency for over 2 million dollars to raise the public's appreciation of dermatology. The agency recommended "educating" the public that dermatologists are skin cancer experts, not just pimple poppers, and established free National Skin Cancer Screening Day.

Skin cancers are by far the most commonly diagnosed cancer in the United States, so to prevent them, the public is constantly told to avoid the sun. However, while the relatively benign skin cancers are caused by sun exposure, the ones responsible for most skin cancer deaths are due to a lack of sunlight. - AMD

Question 2: What are actinic keratoses (AKs), and how do dermatologists typically treat them?

Answer: Actinic keratoses (AKs) are skin bumps that dermatologists call precancerous. Many seniors have dozens, if not hundreds of these. Dermatologists treat millions of AKs with liquid nitrogen devices resembling tiny blow-torches, billing Medicare for each treatment.

Question 3: What percentage of actinic keratoses (AKs) disappear on their own, and what proportion develop into skin cancer?

Answer: Studies show that over half of all actinic keratoses (AKs) disappear on their own. Only one percent change to skin cancer after a year, and four percent after four years. These skin cancers are virtually all slow-growing and easily treatable.

Question 4: What is Mohs surgery, and how does it differ from older methods of treating skin cancer?

Answer: Mohs surgery is a procedure where dermatologists remove skin cancer layer by layer, examining each layer under a microscope until all diseased tissue is removed. Patients may spend a full day in an operating room, and dermatologists bill for each cut, slide preparation, and microscopic examination. Older methods involved scratching, burning, or cutting away skin cancers and following up for recurrence.

Question 5: According to Robert Stern, a Harvard dermatologist, what factors influence the decision to utilize Mohs surgery?

Answer: According to Robert Stern, a Harvard dermatologist, "The decision to utilize [Mohs] is likely to reflect the economic advantage to the provider rather than a substantial clinical advantage for the patient." He reported wide variations in usage by practice and region.

Question 6: What percentage of Mohs surgeries are performed on people over 85 years old, and under what circumstances?

Answer: Twenty percent of all Mohs surgeries are performed on people over 85 years old. Many are performed in the last year of life, and even in the last weeks before death. Demented people in nursing homes get frozen, biopsied, and operated on.

Question 7: How do dermatologists typically handle cases of melanoma, the only skin cancer that routinely metastasizes and kills people?

Answer: Dermatologists almost universally refer melanoma cases to plastic surgeons for removal and then to oncologists for chemotherapy. Few skin doctors want to get involved with a fatal disease.

Question 8: What pattern is observed when comparing melanoma diagnosis rates and mortality rates?

Answer: While melanoma diagnosis rates have increased dramatically, the total deaths from melanoma have not increased. The disease-specific mortality for melanoma has remained unchanged despite the extra procedures performed to treat them.

Question 9: What did the survey of 115 dermatopathologists reveal about their beliefs regarding the overdiagnosis of various skin conditions?

Answer: The survey of 115 dermatopathologists showed that 68% believed over diagnosis was a public health issue for atypical nevi, 47% thought melanoma in situ was over diagnosed, and 35% thought invasive melanoma was over diagnosed.

Question 10: What did lead researcher Kathleen Kerr say about the disparity between increasing melanoma diagnoses and stable death rates?

Answer: Lead researcher Kathleen Kerr said, "Melanoma diagnoses have been rising in the U.S. If there were truly an epidemic of melanoma, we would expect that deaths from melanoma to show a corresponding rise, since there hasn't been a major breakthrough in treatment during this time. Yet melanoma deaths have been remarkably constant. This suggests that the rise in melanoma diagnoses is largely due to over diagnosis."

The largest benefit was seen in smokers, to the point non-smokers who avoided the sun had the same risk of dying as smokers who got sunlight. – AMD

Note: I believe this and the cardiovascular benefits are in large part due to sunlight catalyzing the synthesis of nitric oxide (which is essential for healthy blood vessels) and sulfates (which coat cells like the endothelium and in conjunction with infrared (or sunlight) creates the liquid crystalline water which is essential for the protection and function of the cardiovascular system).

Question 11: What are the three primary risk factors for basal cell carcinoma (BCC)?

Answer: The three primary risk factors for basal cell carcinoma (BCC) are excessive sun exposure, fair skin (which makes you more susceptible to excessive sunlight penetrating your skin), and a family history of skin cancer.

Question 12: What percentage of basal cell carcinomas (BCCs) recur after removal, and what is the typical fatality rate?

Answer: The recurrence rate for basal cell carcinomas (BCCs) after removal ranges from 65% to 95%, depending on the source. Most sources say BCC has a 0% fatality rate.

Question 13: How does the metastasis and survival rate of squamous cell carcinoma (SCC) compare to that of basal cell carcinoma (BCC)?

Answer: Unlike basal cell carcinoma (BCC), squamous cell carcinoma (SCC) can metastasize. If SCC is removed prior to metastasizing, it has a 99% survival rate, but if removed after metastasis, the survival rate drops to 56%. The average survival rate for SCC is around 95%.

Question 14: What percentage of melanomas occur in regions of the body with significant sun exposure, compared to squamous cell carcinoma (SCC) and basal cell carcinoma (BCC)?

Answer: Only 22% of melanomas occur in regions of the body with significant sunlight exposure, such as the face. In contrast, 87% of all SCC cases and 82.5% of BCC cases occur in these regions.

Question 15: How does the incidence of melanoma in outdoor workers compare to that of indoor workers, despite higher UV exposure?

Answer: Outdoor workers get 3-10 times the annual UV dose that indoor workers get, yet they have lower incidences of cutaneous malignant melanoma and an odds ratio (risk) that is half that of their indoor colleagues.

Question 16: What did a 1997 meta-analysis reveal about the risk of melanoma in workers with significant occupational sunlight exposure?

Answer: A 1997 meta-analysis of the available literature found workers with significant occupational sunlight exposure were 14% less likely to get melanoma.

One of the oldest "proven" therapies in medicine was having people bathe in sunlight (e.g., it was one of the few things that actually had success in treating the 1918 influenza, prior to antibiotics it was one of the most effective treatments for treating tuberculosis and it was also widely used for a variety of other diseases). In turn, since it is safe, effective, and freely available, it stands to reason that unscrupulous individuals who wanted to monopolize the practice of medicine would want to cut off the public's access to it. - AMD

Note: the success of sunbathing was the original inspiration for ultraviolet blood irradiation.

Question 17: How does sunscreen use affect the rates of malignant melanoma, according to existing research?

Answer: Existing research has found using sunscreen either has no effect on the rates of malignant melanoma or increases it.

Question 18: What did a 1982 study find regarding the relationship between fluorescent light exposure at work and the risk of developing malignant melanoma in women?

Answer: A 1982 study of 274 women found that fluorescent light exposure at work caused a 2.1 times increase in their risk of developing malignant melanoma, with this risk increasing with more fluorescent light exposure, either due to the exposure at their job (1.8X with moderate exposure jobs, 2.6X with high exposure jobs) or the time spent

working at it (i.e., 2.4X more likely for 1-9 years of work, 2.8X for 10-19 years, and 4.1X for over 20 years).

Question 19: What did the 1987 study comparing fatty acids in the tissue of melanoma patients and healthy controls find?

Answer: The 1987 study, which analyzed samples of fat tissue from 100 melanoma patients and 100 people without melanoma, found an increase in linoleic acid in the tissue of all subjects. However, the percentage of polyunsaturated fatty acids (PUFAs) was significantly higher in the melanoma patients' tissue. The researchers suggested that increased consumption of dietary polyunsaturates may have a contributory effect in the etiology of melanoma.

Question 20: What type of fatty acid is linoleic acid, and in what foods is it commonly found?

Answer: Linoleic acid is the primary fat found in omega-6 polyunsaturated fats, including vegetable/seed oils, and accounts for about 80% of the fat composition of vegetable oils. It is found in virtually every processed food, including restaurant foods, sauces, salad dressings, and "healthy" foods like chicken, pork, and some olive oil.

Question 21: What percentage of sunscreen products tested by Valisure were found to contain benzene, and what is benzene?

Answer: Valisure tested 294 sunscreen products and found that 27% contained benzene, a known human carcinogen, at levels at least three times higher than the FDA allows under special circumstances.

Question 22: What sunscreen ingredient, found in 70% of products, is known to be an endocrine disruptor?

Answer: Oxybenzone, found in an estimated 70% of sunscreens, is a known endocrine disruptor linked to reduced sperm count in men and endometriosis in women.

Question 23: According to a Danish study, how many sunscreen chemicals allowed in the US may reduce male fertility?

Answer: According to a Danish study, 8 out of 29 sunscreen chemicals allowed in the US and/or European Union can reduce male fertility by affecting calcium signaling in the sperm, in part by exerting a progesterone-like effect.

Question 24: What did the 2019 and 2020 JAMA studies find regarding the absorption and persistence of certain sunscreen ingredients in the body?

Answer: The 2019 and 2020 JAMA studies found that certain sunscreen ingredients (avobenzone, oxybenzone, octocrylene, homosalate, octisalate, and octinoxate) may build up in the body at unhealthy levels. The ingredients were absorbed after only one day's exposure, and some persisted in the body after use.

Question 25: What blood level of vitamin D is considered ideal for disease prevention, according to the research cited?

Answer: According to the research cited, the ideal blood level of vitamin D for disease prevention is between 60 ng/mL and 80 ng/mL, while 40 ng/mL is considered the low end of sufficiency, and 30 ng/mL is the minimum to prevent disease.

Question 26: What signs and symptoms may indicate that a person has low vitamin D levels?

Answer: Signs and symptoms that may indicate low vitamin D levels include ongoing musculoskeletal pain and achy bones, frequent infections or illnesses, neurological symptoms (such as depression, cognitive impairment, and migraines), and fatigue and daytime sleepiness.

Question 27: How does the antioxidant astaxanthin function as an "internal sunscreen"?

Answer: Astaxanthin is a potent antioxidant that acts as an internal sunscreen by protecting against UV radiation exposure and gene expression changes that lead to skin photoaging, such as sagging and wrinkles. It has strong free radical scavenging activity that protects against oxidative damage.

Question 28: What other nutrients are mentioned that may provide photoprotection for the skin?

Answer: Other nutrients mentioned that may provide photoprotection for the skin include lycopene, beta-carotene, vitamin D, and vitamin E.

Question 29: What does Dr. David Elpern believe led to the over diagnosis of melanoma and an increase in expensive, low-value procedures for skin cancer and actinic keratosis?

Answer: Dr. David Elpern believes that the American Academy of Dermatology's (AAD) campaign in the 1980s to educate the public about dermatologists being skin cancer experts led to inflated health anxiety about skin cancer, resulting in the over diagnosis of

melanoma and an increase in expensive, low-value procedures for skin cancer and actinic keratosis.

Question 30: What role did dermatopathologists' perception of over diagnosis play in their diagnostic behaviour when examining skin biopsy cases?

Answer: The study found no statistically significant associations between dermatopathologists' perceptions about over diagnosis and their interpretive behaviour when diagnosing skin biopsy cases. Dermatopathologists who believed invasive melanoma was over diagnosed were slightly more likely to diagnose invasive melanoma compared to other dermatopathologists examining identical cases.

Question 31: What are the consequences of over diagnosing melanoma for patients?

Answer: Over diagnosing melanoma can have significant consequences for patients on both an emotional and financial level.

Question 32: What factors make reducing over diagnosis of skin cancer challenging, according to lead researcher Kathleen Kerr?

Answer: According to lead researcher Kathleen Kerr, reducing over diagnosis of skin cancer will be challenging as it requires cooperation between patients, primary care physicians, and pathologists.

Question 33: What did the studies from 1991, 2008, 2002, and 2011 demonstrate about the effectiveness of a topical cream containing a nightshade extract (solasodine glycosides) in treating various types of skin cancer?

Answer: The studies from 1991, 2008, 2002, and 2011 demonstrated the effectiveness of a topical cream containing a nightshade extract (solasodine glycosides) in treating various types of skin cancer, including actinic keratosis, basal cell carcinoma (BCC), and squamous cell carcinoma (SCC). The 1991 trial showed complete regression of lesions with no adverse effects, the 2008 trial found a 66% success rate for treating BCC, the 2002 English trial showed a 78% success rate for treating BCC with a short duration of treatment, and the 2011 case report showed good cosmetic outcomes for large BCC and SCC lesions.

Question 34: What is the current state of natural and alternative treatments for skin cancer, such as Curaderm, and why are they not more widely known and utilized despite their reported success rates?

Answer: There are several natural and alternative treatments for skin cancer that have been scientifically studied and have shown promising results. One such treatment is Curaderm, a topical cream containing solasodine glycosides, which are derived from eggplant extract. Studies have demonstrated that Curaderm has a success rate of 66-78% in treating basal cell carcinoma (BCC), the most common type of skin cancer.

In addition to Curaderm, other natural and alternative treatments that have undergone scientific study include topical creams containing vitamin B3 (niacinamide) and vitamin A (retinoids). While these treatments have shown potential, more research is needed to fully establish their effectiveness and safety.

Despite the reported success rates of these alternative therapies, they are not widely known or utilized in the mainstream treatment of skin cancer. This lack of awareness and adoption can be attributed to several factors, one of which is the potential threat they pose to the lucrative business model of the dermatology profession.

Healthy Sunbathing (by AMD)

One of the major mistakes Americans frequently make is the belief that if something is good for you, more of it is better. This very much holds true for sun exposure, as (assuming you are caucasian) once your skin starts turning pink, you lose the ability to utilize the sunlight you are being exposed to (e.g., you stop producing vitamin D), and in time also begin to burn (which can damage the skin). For this reason, many advise stopping sunbathing once your skin starts to turn pink and making sure to have regular small bursts of sunlight rather than intermittent large ones.

Note: *doing this often completely eliminates the need for vitamin D and is one of the things that I've repeatedly seen greatly helps with longevity.*

Additionally, there is a "good" type of ultraviolet light (UVB) and a bad type (UVA), and depending upon the time of day, different types are in prominence. For this reason, the absolute best time to be outside is between 10 a.m. and 2 p.m., which interestingly is the time Chinese Medicine recognizes that the energy of the heart peaks (an organ I believe is particularly sensitive to the energy of sunlight).

Conversely, most windows block UVB (but not UVA) so it's actually not a good idea to get your direct light exposure through the window.

Note: *specialized materials exist which don't do this (e.g., quartz glass), but they are a bit expensive and hard to find.*

Finally, something many do not appreciate about sunscreens is that two forms of them exist—ones that work by having chemicals which absorb UV light (and decrease it) and ones that simply block and reflect it. The chemicals that absorb UV light are often quite toxic, and a case can be made they are actually responsible for some of the increase in skin cancer that has been observed. With the reflecting ones, either titanium oxide or zinc oxide are typically used. Zinc oxide is the better option (people don't react to it, and it can sometimes help heal the skin), so when selecting a sunscreen, the main thing to look for is one that uses zinc oxide and doesn't have any questionable chemicals in it.

Note: *there are now beginning to be pushes to stop the use of more toxic sunscreens in areas with abundant aquatic life because they poison the reefs. This raises the point that if a small amount of sunscreen diluted in the water is too toxic for an ecosystem to handle, why would you want to put it on your skin where it can directly absorb into the body at its full concentration?*