"SEF" Chemo Medicor Patient Data (first 17 consecutive patients treated, no exclusions) – updated Dec 2019

	Pt.	Cancer Type	Stage	Prev Chemo	When Started	Survival (months after starting SEF)	Reason Stopped	Total Cycles	AUC q2wks	Response	Gr 3 or 4 Side Effects?
1	H. S.	Lung (non-small cell)	4	Y	8/2013	3	DVT, pericard effusion	5	3	Partial response (imaging – CXR rapid visible improvement on PA films)	DVT/PE (from hosp/immobility)
2	A. Y.	Lung (non-small cell), brain mets	4	N	9/2013	13	Patient request	19*	5	Partial response (clinical, CTC from 14,250->0, PET/CT)	No
3	P. A.	Lung (small cell)	4	Y	10/2013	74 (alive)	Cost	9	5	Partial response (NED – CTC reduction only)	No
4	M. G.	Lung (non-small cell)	4	Y	8/2013	6	Low cell counts, progression	8	3 - 5	Partial response (clinical – rapid decr SOB, imaging –U/S)	PLT=15
5	A. B.	Breast	4	Y	11/2013	4	Progression	7	5	Progression (imaging, clinical)	No
6	K. B.	Pancreatic	4	Y	1/2014	6	Fever/Infection (not neutropenic)	6	5	Partial response (imaging – U/S, 4.5 of 5 masses dead after 4 cycles)	Serosal mets/bowel perf most likely due to rapid chemo action, occipital CVA in hosp after RBC transfusion
7	W. P.	Pancreatic	4	N	11/2013	4	Cachexia	6	5	Partial Response (pre-CT 6.4x3.4x4cm, post-U/S 3.1x3.6cm)	Wt. loss, Gr 3-4 vomiting (req iv Haldol/fluid bolus in office)
8	F. H.	Cervical	4	Y	11/2013	64	Completed	31*	3 - 4	Complete Response (imaging, blood markers, CTC)	ANC=0.3, vomiting requiring iv fluid bolus in office
9	G. K.	Colon	4	Y	11/2013	6	Low cell counts	6	3 - 5	Progression (imaging, clinical)	PLT=41
10	M. L.	Gastric	4	Y (MTX for RA)	8/2013	6	Progression	10	5	Partial Response (imaging – Dec U/S loss of vascularity and decr size)	ANC=0.8, PLT=38
11	H. P.	Sarcoma	3	Y	9/2013	5	Progression	7	3 - 4	Progression (imaging, clinical)	No
12	E. J.	TCC Bladder + NE pancreas	4	Y	9/2013	> 26 (lost to follow-up)	Low cell counts	10	3 - 4	Partial Response (imaging - Pancreatic mass Pre-CT 2.7cm, Post-CT 1.2cm)	ANC=0.7
13	J. F.	Melanoma	4	N	4/2014	69 (alive)	Carbo Allergy	12	4	Partial Response (CTC)	PLT=44, Gr 3-4 vomiting (req iv Haldol/fluid bolus in office)
14	T. M.	Colon	4	Y	7/2014	-	S.O.B., jaundice	4	-	Not evaluable	-
15	Y. P.	Liposarcoma	4	Y	7/2014	36	Low counts	16*	3 - 4	Partial Response (CTC 4250->500)	No
16	R. T.	Prostate	4	N	7/2014	66 (alive)	Completed	37*	3 - 5	Partial Response (PSA 0.61->0.2, decr CTC)	No
17	L. L.	Breast	3	Y	2/2014	22	Decr Response	24*	4 - 5	Partial Response (visual - skin mets only)	Gr 3 N/V

Responses: **Partial Response (PR), Complete Response (CR), No Response (NR)**

Modification of RECIST definitions required since immunotherapy + some patients are N.E.D. and only have CTC +ve

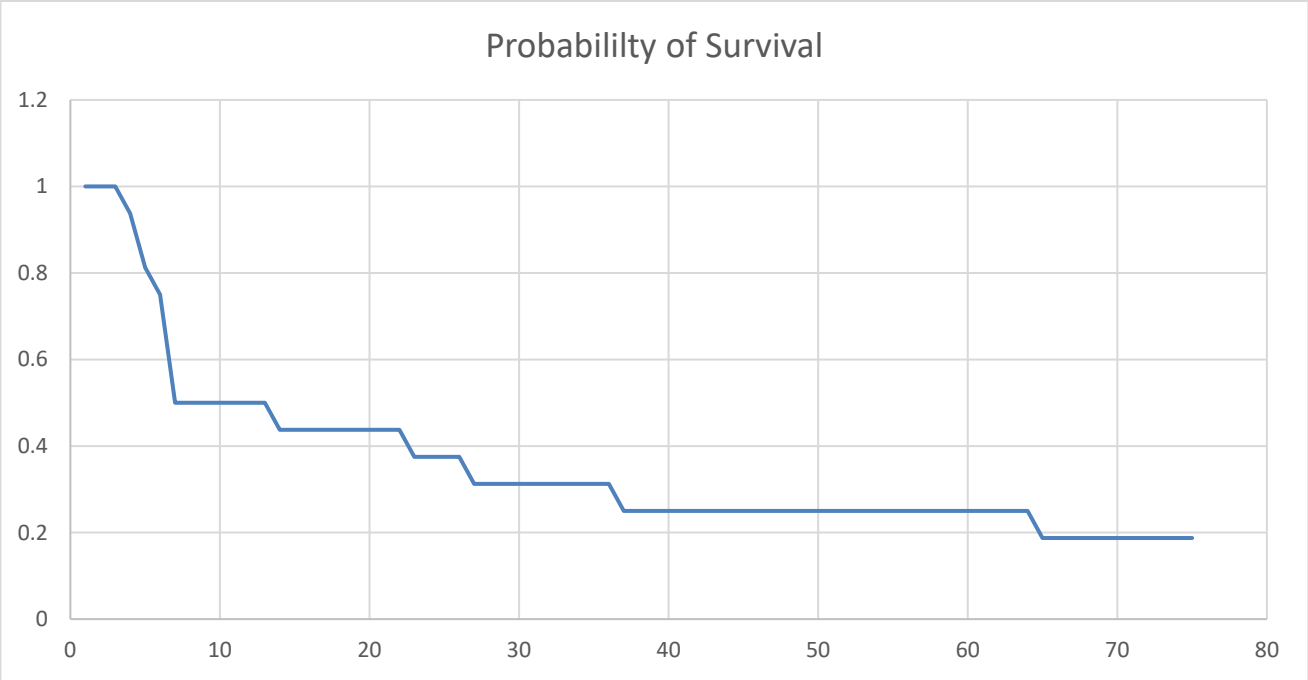
P.R. 12/16 (75%) C.R. 1/16 (6%) N.R. 3/16 (19%)

Total responders (PR+CR): 13/16

*** this high number of cycles of carboplatin is impossible in conventional oncology (without marrow protection of nanoparticle mesna), the patient would die from chemo complications long before reaching this many cycles**

RESPONSE RATE=81% **MEAN OVERALL SURVIVAL = 25 months** **5 YEAR SURVIVAL = 25%** (more than double the avg 5 yr survival for untreated stage 4 cases given conventional therapy)**

** American Cancer Society Cancer Facts and Figures 2019 (pg. 21, table 8)



Composite Survival Curve for first 16 SEF Chemo Patients, 2013 - 2019

cancer types: breast, colon, lung, pancreas, cervix, gastric, sarcoma, bladder, melanoma, prostate

stage 4 patients: 14
stage 3 patients: 2

stage 3 patients expired after 5 months and 22 months
long-term survivors are all stage 4 (prostate, melanoma, lung)

5 yr survival is 25%

SEF chemo 5 yr survival is more than double the weighted average 5 yr survival for the same cancer types, for stage 4, untreated cases (i.e. from the time of diagnosis). Likely even better when compared to cases that have failed all conventional therapy.

Comparison data: *American Cancer Society Cancer Facts and Figures 2019 (pg. 21, table 8)*

Table 8. Five-year Relative Survival Rates* (%) by Stage at Diagnosis, US, 2008-2014

	All stages	Local	Regional	Distant		All stages	Local	Regional	Distant
Breast (female)	90	99	85	27	Oral cavity & pharynx	65	84	65	39
Colon & rectum	65	90	71	14	Ovary	47	92	75	29
Colon	64	90	71	14	Pancreas	9	34	12	3
Rectum	67	89	70	15	Prostate	98	>99	>99	30
Esophagus	19	45	24	5	Stomach	31	68	31	5
Kidney†	75	93	69	12	Testis	95	99	96	74
Larynx	61	78	46	34	Thyroid	98	>99	98	56
Liver‡	18	31	11	2	Urinary bladder§	77	69	35	5
Lung & bronchus	19	56	30	5	Uterine cervix	66	92	56	17
Melanoma of the skin	92	98	64	23	Uterine corpus	81	95	69	16

*Rates are adjusted for normal life expectancy and are based on cases diagnosed in the SEER 18 areas from 2008-2014, all followed through 2015. †Includes renal pelvis. ‡Includes intrahepatic bile duct. §Rate for in situ cases is 95%.

Local: an invasive malignant cancer confined entirely to the organ of origin. **Regional:** a malignant cancer that 1) has extended beyond the limits of the organ of origin directly into surrounding organs or tissues; 2) involves regional lymph nodes; or 3) has both regional extension and involvement of regional lymph nodes. **Distant:** a malignant cancer that has spread to parts of the body remote from the primary tumor either by direct extension or by discontinuous metastasis to distant organs, tissues, or via the lymphatic system to distant lymph nodes.

Source: Noone AM, Howlader N, Krapcho M, et al. (eds). *SEER Cancer Statistics Review, 1975-2015, National Cancer Institute*, Bethesda, MD, http://seer.cancer.gov/csr/1975_2015/, based on November 2017 SEER data submission, posted to the SEER website April 2018.

Risk factors: The most important risk factor other than age is a strong family history of breast or ovarian cancer. Women who have tested positive for inherited mutations in cancer susceptibility genes, such as *BRCA1* or *BRCA2*, are at increased risk. Other medical conditions associated with increased risk include a personal history of breast cancer, pelvic inflammatory disease, and Lynch syndrome. Modifiable factors associated with increased risk include excess body weight, menopausal hormone therapy (estrogen alone or combined with progesterone), and cigarette smoking, which is associated with a rare subtype (mucinous). Factors associated with lower risk include pregnancy, fallopian tube ligation or removal (salpingectomy), and use of oral contraceptives (OCs), with risk reductions of 40% among long-term (10+ years) OC users. It is unclear whether genital talc-based powder use increases the risk of ovarian cancer, in part because most of the evidence is from case-control studies, which are especially prone to bias, and because the type of body powder (i.e., with or without talc) women in the studies were using was not always clear.

Early detection: Currently there is no recommended screening test for ovarian cancer, although clinical trials to identify effective strategies are underway. Women who are at high risk or have symptoms may be offered a thorough pelvic exam in combination with transvaginal ultrasound and a blood test for the tumor marker CA125, although this strategy has not proven effective in reducing ovarian cancer mortality.

Signs and symptoms: Early ovarian cancer usually has no obvious symptoms. However, studies indicate that some women experience persistent, nonspecific symptoms, such as back pain, bloating, pelvic or abdominal pain, difficulty eating or feeling full quickly, or urinary urgency or frequency in the months before diagnosis. Women who experience such symptoms daily for more than a few weeks should seek prompt medical evaluation. The most common sign of ovarian cancer is swelling of the abdomen, which is caused by the accumulation of fluid.

Treatment: Treatment includes surgery and often chemotherapy and targeted therapy. The goal of surgery is to stage the cancer and remove as much of the tumor as possible, referred to as debulking. It usually involves removal of both ovaries and fallopian tubes (bilateral salpingo-oophorectomy), the uterus (hysterectomy), and the omentum (fatty tissue attached to some of the organs in the belly), along with biopsies of the peritoneum (lining of the abdominal cavity). Additional abdominal organs may be removed in women with advanced disease, whereas only the involved ovary and fallopian tube may be removed in younger women with very early-stage tumors who want to preserve fertility. Among