

Real Health Podcast

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Episode #39: The Trifecta with Dr. Nasha Winters, ND, FABNO

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Intro: This is the Real Health Podcast brought to you by Riordan Clinic. Our mission is to bring you the latest information and top experts in functional and integrative medicine to help you make informed decisions on your path to real health.

Dr. Ron Hunninghake: Well, once again, welcome everyone. It's Dr. Ron Hunninghake, and we're back with the Real Health Podcast here at Riordan Clinic. And today we have a really special treat. And to make my introduction, I want to tell you something that I say to my nurses all the time, if you want something important done, ask a farm girl to do it. And here on our show is the Kansas farm girl that is really sparking a revolution in integrative oncology, Dr. Nasha Winters. So Nasha, thank you so much for being on this program.

Dr. Nasha Winters: You kind of bring me to tears because this is something really special for me. It's like a giant circle has come fully around here and that my roots do start in Wichita, Kansas. My early roots with Dr. Riordan, 16 years old on Fridays at the center, having lunch with this guy who just took a shining to me and was just so kind and supportive and encouraging for me to beat to a rhythm of my own drum. Who knew I'd ever go into naturopathic medicine and into integrative oncology all these years later? But here we are. And I love that I get a be here with all of you.

Dr. Ron Hunninghake: That is just crazy fate. Just, it's not fate, it's got to be planned. The cosmic plan.

Dr. Nasha Winters: Yeah.

Dr. Ron Hunninghake: So anyway, thank you so much for being on. I want to kind of bring everyone that's listening maybe for the first time we've had a series on the Terrain 10 just going here, and it's been great, but maybe tell us a little bit about the metabolic approach to cancer and where you came into this. I think most people know that you started really young with the whole cancer journey.

Dr. Nasha Winters: Yeah, yeah. I had a lot of health issues growing up, and like anybody, I didn't really think of that as having health issues because everyone just put another pill or another potion layered on top of it, and it was just the way you did things. So it wasn't weird to me that that basically as baby, I was put on lots of medications for digestive issues, and then it just layer-caked over time. And by the time I graduated from high school, I had been given the diagnosis of endometriosis polycystical variant syndrome, early onset rheumatoid arthritis, IBS. Those are what we had then, and the layers of medications, including birth control pills and medications for digestive upsets and whatnot. That was normal. It didn't even occur to me that I was sick per se, because it was just so normalized.

So fast forward when I was diagnosed with stage four ovarian cancer, right before the early part of my sophomore year of college, I thought it was just more of the same, kind of a continuity of these symptoms that I had, but they were progressing in such a way that everyone else was missing the boat as well. And by the time we figured out what was going on, it was frankly far too late. And so didn't expect to survive it. I was given several months to live and instead of thinking I was going to fight it and overcome it, I got curious and I decided to explore why. Why would a 19 year old, almost 20 year old back in 1991, have the privilege of having the diagnosis of stage four ovarian cancer? It was a very rare occurrence back then. Sadly, not so much today, but it surely was back then. And so that's put me on this 30 year-plus path to understand the why for myself, as well as for the thousands and thousands of other patients I've had the absolute honor and privilege of supporting them on their why, their path forward.

And so that's led to this sort of understanding of a few sort of things that have contributed to my health or my disease, which is part of how you guys started to share about the Terrain 10, and these sort of Terrain 10 drops in the mitochondrial bucket are what I've pulled together over decades of my own experience, my own research, what the literature supports, what the modern medical marvels are supporting, and I guess the rest is history.

Dr. Ron Hunninghake: A lot of people might ask, well, how is this metabolic? And maybe you could tell us a little bit from the conventional point of view because they're looking at it as just a genetic malformation of some sort. And yet, when we say metabolic, that implies it's there's something going on inside of us that maybe we have control over.

Dr. Nasha Winters: Yes, yes. And I think you spoke to that just so perfectly right then and there in that if we continue to subscribe to the somatic mutation theory, AKA the gene theory, that leaves us more as sort of a sitting duck, right? In fact, there are researchers out there who say that it's simply a game of Russian Roulette that you will get and deal with cancer in your lifetime. And statistics are currently showing that one in two men and one in 2.4 women expected to have cancer in their lifetime and a doubling of cancer rates worldwide by 2030, so I don't choose to take that sitting duck ideology. In 1914 is when that idea struck, right?

That's when it landed by Theodor Boveri. And it was only a few years later that Otto Warburg, a famous German physician, was having a different experience, a different understanding, a different aha moment in the lab, where he started realizing that cancer cells had a very different need for different types of energy than our healthy cells. And therein started what's now a well over a hundred year experiment there as well to realize that the problems didn't start at the genetic level, they started at the energy demand level, down at the cellular level. And even more specifically, down to the little organs within those cells, these organelles, at the level of our mitochondria, and even down to the level of what those mitochondria are swimming in. It's known as the cytoplasm. We might call it the cellular jelly or the cellular goo. You might know it as the extracellular matrix. Sometimes we call it things, like in my world, we call it the terrain, but that is where we're learning that actually may be where the magic is happening versus at the genetic level.

And super briefly for your audience, the way we started to realize that genetics weren't the issue is that if it was genetic, we would take the hard drive out of a cancer cell, right? If this was a genetic issue, we would put that hard drive into a healthy cell, replacing its hard drive, the nuclei. And if this was truly a genetic issue, we would turn that healthy cell into a cancer cell. The same would be true if this was a genetic issue. If we took the healthy nuclei out of a healthy cell and we replaced the unhealthy nuclei of a cancer cell, we would turn it back into a healthy cell. Neither of those things happen. We were surprised over and over and over again with these nuclear transfer studies that, in fact, that did had no impact on whether a cell was cancering or not.

What had the impact was the milieu, that cytoplasm, that jelly, that that little hard drive landed in is what called the shots. And that's when we started to realize this is a metabolic process, not a genetic process. And interestingly enough, it's that metabolic process that protects our genome, that protects the genes. So it's not that we throw out the genetic concept, it's that it's not the first in line. We want to care for our cytoplasm. We want to care for our mitochondrial health first to reinforce and support our genetic expressions.

Dr. Ron Hunninghake: Yeah. And we look around and it's no big surprise that it seems like most of the world, and it's either 50 to 70%, are struggling with their weight, and this is called metabolic syndrome. And so we start to say, "Okay, how does that metabolic disorder, which is basically prediabetes or diabetes, insulin resistance syndrome, how does that suddenly connect with all of what you're talking about here?" We're shifting from genetics to epigenetics in terms of what the choices are that people are making, because you can have identical twins, same genes, and both of them leave home. Twenty years later, one comes back and he looks completely different, has completely different manifestations. And it's because of the choices he made or didn't make in terms of taking care of himself.

And so, a lot of this metabolic theory involves people beginning to make more active choices in their own care. They're not just a passive recipient of cancer care. They are a very full blooded, whole person care that we need to shift into and empower people to realize that they can make a difference in their cancer care.

Dr. Nasha Winters: Exactly. We're far more powerful than we may be led to believe in this department. And there's so much we can do. The real cure for cancer is prevention, right? So you spoke to that 70, 80% of the population. In fact, the studies show that it's actually 88% of the population that is metabolically broken, meaning we have a higher waist to hip ratio. We have poor blood pressure numbers. We have poor blood sugar numbers. We have poor activity levels. We're really deconditioned. We can't basically work out without being extremely fatigued. We have poor energy status and poor resilience. Those are all sort of symptoms of metabolic health. And so that means that 88% of us are broken in that department, meaning that less than 12% of us have done a good job on this. That's vast majority of our population. And when we get to that place, we become vulnerable for all of the chronic conditions that take our lives today, that lower our longevity.

And in that, in doing that, and becoming a body that is metabolically broken, in part from a lot of the dietary lifestyle choices we make or do not make, we then set the table for a process such as cancer, and we make it much more difficult to put that cancer into a manageable disease state or remission state without a lot of input. And the input we typically use today is still a very cytotoxic, tumor-centric approach. And it can push back the tumor burden and make scans look pretty good for a while and make labs look okay for a while. But the reality is many of those patients will be faced with another secondary cancer or a cancer recurrence if we do not correct that cytoplasmic jelly and that mitochondrial function in which the tumor was able to take seed in and sprout.

So that's where we differ, is we focus not on the tumor or on the tumor cell. We support that. We'll support those therapies. And of course, we're interested in that, but where we put our primary focus is what's going on in the swimming pool, right? What's happening at that level and how can we foster that resilience and that metabolic health and that metabolic flexibility that is missing in the vast majority of us?

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Dr. Ron Hunninghake: One of the pioneering things that Dr. Riordan did can be summarized in one word, co-learning, where he empowered patients to become part of the process and to manage for themselves through information, namely we did a lot of nutrient testing. We still do, but we've expanded that to more of the metabolic therapies research as well. But how does this play out in terms of this new science of integrative oncology? How does the lab work with this? Because I know that's an important part, and maybe most people are wondering, okay, great. I'm ready. I want to be empowered. What does that really mean?

Dr. Nasha Winters: Sure. What that means here is for us to be effective. We need to understand where the patient is in the moment. We need to understand what got them there. So we take an extensive intake. As you are well aware and probably your patients are well aware, we have a lot of questions we want to ask. We want to know about you. We want to know about your family. We want to know about your mental and your emotional wellbeing. We want to know about your childhood adverse events. We want to know about your day to day intake of nutrients, supplements, medications, foods, dietary and lifestyle factors. We take all of that information in. If we're lucky enough, we also take in information about your epigenetics, like the blueprint in which you were born with. We also take in information, if we're lucky enough, of your tissue itself, like your tumor assay or your liquid blood biopsy.

And then we overlay that information with some basic labs. So you talked about all the nutrition labs and whatnot that Riordan has run for years, which are an additional set of functional labs to help people know how to optimize their health. But we can even use some very standard labs, such as your complete blood count, your metabolic panel, your markers of inflammation, such as C-reactive protein, lactase dehydrogenase, and sedimentation rate. Those five labs are fundamental to get a good pulse on what's going on with that patient. That little bit of data that's typically covered by insurance and not considered esoteric lab testing can really show us how far down the rabbit hole the patient has gone, how well they're going to respond to whatever therapy they choose to do, because for instance, an elevated CRP is a poor prognosis for how you're going to respond to standard of care oncology.

So we as terrain-based providers know how to assess you in the moment, whether you've started therapy or not, whether you're trying to prevent cancer or not, and even trying to prevent a recurrence or a brand new cancer down the road. So the testing is helping us really determine where you are in the moment. So my mantra, that you guys also adopt and use, the test, assess, address, don't guess is how we know if any therapy has done its job. And if not, how do we need to pivot to make it have a better outcome for the patient? And so this approach is our methodology that is tried and true. And what you'll find is that it doesn't matter if the patient chooses standard of care oncology or integrative oncology.

We need to know where the patient is in that moment and pivot on a dime if necessary. And so that's where the testing can really help us. And then we get away from the guessing where patients think they're fine until they're not, or doctors think their patient are fine until they're not.

Dr. Ron Hunninghake: And it also gives the patient that sense of security that they're on the right path, because that's the biggest questions that patients have asked me all along as long as I've been with the Riordan Clinic, is how will I know if I'm doing better, doctor? Because otherwise they don't until they get the next scan, which may be three to four months down the road. They want to know much sooner than that, so that they can make a switch and change something up for the better.

Dr. Nasha Winters: Yeah. And two to three months can be life-changing and life-giving. And so it's really powerful when we're looking monthly at folks going through this process. We are able to see, are we on the right path? Are we not? Do we need to adjust it? Do we hold steady? How are we doing here? So it's a feedback loop for the practitioner as much as for the patient.

And what happens is, you said it so perfectly, it's the co-learner opportunity. We're both in the front seat together. The patient's behind the wheel. The practitioner's the GPS or in the passenger seat and we're cruising down this road, this path together, and we're learning along the way and we're adjusting our course as needed. It becomes truly personalized, precision medicine. And it's a very empowering and very exciting experience to share that with another person, with a patient, with another provider, when they see that outcomes change significantly.

And then we can lower even the cost of care because we're not just throwing a bunch of protocols at it and hoping something sticks. We actually get to qualify what protocols are appropriate, win. And that's one of the things I appreciate about what you guys do, is you have so many offerings and you can now help a patient go through all of their own data and determine what is the best approach at what timing, what dosing, what frequency, and know how to assess what's going on and change it if need be.

Dr. Ron Hunninghake: When did this occur to you in your career? And you give this a very interesting name, the trifecta. How did that all come about?

Dr. Nasha Winters: Well, the trifecta was actually coined by my patients.

Dr. Ron Hunninghake: Ah.

Dr. Nasha Winters: But where I started to learn, I started to learn all these little pieces throughout my own recovery, throughout my own medical school training. We started doing lab analysis. Y'all started doing blood draws and whatnot in med school, but we all would get our labs back and pretty much say, "You're fine," to the patient and then walk away. But then I started having teachers like Dr. Datis Kharrazian and Dr. Dicken Weatherby and others who said, "Wait a minute, you can look deeper through these labs. And remember that the labs are based on the average of the population in the region in which they're being run," which means that labs, say, in Alabama are going to look different than lab ranges in, say, Colorado, just because of the nature of where we line up on sort of the health continuum in our rankings in the United States, that what is maybe looking healthy in Alabama may look like a disease process in Colorado.

And so these are where we even have to throw that out and start to look at the functional, optimal ranges. And that's when we can start to pull the reins in and do more preventative care and more therapeutic care with people. So I started to see that early on in my medical school training, that we were not really utilizing labs to their fullest potential. And then I started taking extra courses and reading

everything I could in biochemistry. It also helps that I'm married to a biochemist who's very interested in these topics as well and started to learn things over 30-plus years of attending conferences and medical school trainings and continuing education trainings to learn that we could use labs in a very dynamic and proactive and actionable way.

Dr. Ron Hunninghake: Yeah. Yeah. So, hey, I've got one question that I've been thinking about for a long time in the 10 terrains. The last one, namely emotional trauma and stress, may be the most important one. And I'm just wondering in terms of laboratory testing, have you ever looked at a connection between that and serum cortisol levels?

Dr. Nasha Winters: I love this question. If I had to choose my own hierarchy of how to place those Terrain 10 bucket drops in the bucket, I would put the mental emotional first. But I've been at this long enough, and I know you have Dr. Ron, that if we started there, our patients would never walk in the door.

Dr. Ron Hunninghake: Yeah.

Dr. Nasha Winters: We like to start with the tangible. Even our lovely colleague Dr. Kelly Turner who shows the radical remission thrivers, there's out of the nine or 10 patterns that are successful in patients who are radical remission survivors. Seven of them are non-tangible, but everyone wants to start with the diet or with supplements. So we start there, we start with labs and start with the tangible, then we work our way outward. So to your point, it is a very critical drop in the bucket. And it should absolutely be addressed in every single patient, preferably at first, but whenever it comes onboard, it's going to be helpful.

So this is a great question you ask, because we're actually in the middle of creating a clinical trial on collecting data on ACE scores, adverse childhood event scores, along with baselines of IgG IgA IgM, so our immune system markers, how well our immune systems are working, along with AM cortisol, and even times 4 cortisol patterns, blood sugars, et cetera, a kind of a pallet of labs that are easily responsive to stressors. Okay? To stress response. And so we're going to look at that and then start to, we actually are bringing in therapeutic interventions that address the trauma or the stress. So whether it is EMDR or EFT or vasovagal work, activities, body talk, acupuncture, homeopathy, doesn't matter even the tool, but we're getting the quantifiable data to show that we can in fact change the outcomes.

And this is not a new idea. In fact, this idea is coming out of the sixties and more deeper research into the eighties and nineties by people like Dr. Robert Adler, who's considered the father of psychoneuroimmunology, and further down the road, Dr. Candace Pert, and even further down the road, people like Dr. Bruce Lipton. And we do now understand that our thoughts do impact our immune system, our inflammatory markers. And when we can start to show the metrics of the lab value with changes in our belief systems and our thought patterns, we change our health, and we know that to be true. We see it as clinicians all of the time, but some people need to see that data more firsthand.

Dr. Ron Hunninghake: Tangible, yeah.

Dr. Nasha Winters: Yeah.

Dr. Ron Hunninghake: Hey, we could go for many, many hours. Can I give you the last word? What in your heart is the strongest thought or feeling that you have that drives you forward in this mission to change the world of oncology?

Dr. Nasha Winters: Hmm. I think because I was someone who told there was no possible way of surviving, to be told that it is an absolute, "Nope, you cannot pass this point," I really want people to remember that they are not a statistic, that they have it within themselves, with whatever resources they have available to them to overcome sort of insurmountable. And so that's what drives me, is that I don't accept mediocre. I don't accept standard. I don't accept the middle of the road or the standard deviation. I want everybody to be outliers to know that they have the potential to do the same.

Dr. Ron Hunninghake: Dr. Nasha Winters, I'm honored to be working with you.

Dr. Nasha Winters: Back at you, my friend. Lovely to be here.

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