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AIDS Changed America with the Twin Breast Cancer Epidemic: Exploring the Consequences of Condomization

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1. Introduction

Breast cancer as an epidemic disease which suddenly emerged along with the AIDS in the United States at the beginning of the 1980s, continued its unabated rise ever since and steadily continued its unprecedented epidemic advance worldwide. Initially affecting mainly the advanced, developed and 'rich' countries of the West, the breast cancer epidemic is now increasingly affecting the developing, less-advanced and 'poor' countries of all parts of the world. The 'latent period' of transition from the 'West' to the East and South, took less than a decade to extend. The epidemic of breast cancer along with the other accompanying, widespread diseases in women of all ages became better apparent now and is increasingly attracting more attention and concern

More than 34 years ago, a case-control study was initiated and completed in the U.S. in order to test an *a priori* hypothesis that a reduced or eliminated exposure to human seminal factors during the reproductive life-spans of women is an etiologic risk factor of developing breast cancer in American married women (Gjorgov, 1978a,b; Gjorgov, 1979; 1980, 1990, 1991, 1994a,b,c, 1996, 1998b). The hypothesis-testing study was jointly carried out at the University of North Carolina, School of Public Health (Epidemiology), at Chapel Hill, NC, and at the University of Pennsylvania School of Medicine and Hospital, in Philadelphia, PA, between 1974 and 1978, more than eight years before mutual epidemics of AIDS and breast cancer ever emerged. The results of the study corroborated the evidence of a significant association between exposure to barrier contraception (condom use and withdrawal practice) and the development of breast cancer in American and other women. In addition, the results provided evidence of a potential for primary (non-chemical) prevention/protection against breast cancer at individual, familial and community levels. Quantifying the risk, the results of the study indicated that women who used condoms and/or practiced withdrawal had a risk of developing breast cancer of 5.2 times greater (95%CI 3.1 - 8.7) than women who used non-barrier methods for fertility-control and family-planning purposes (diaphragm, IUDs, rhythm, oral-contraceptive pills, cream-jellies, and tubal ligation). By using Bayes' conditional theorem, it was estimated that 17% of women in the mainstream population using condoms / withdrawal were likely to develop breast cancer, versus 3.9% of women using non-barrier contraceptive methods. The evidence challenged head on the widespread misperception that all women are at an 'equal risk of

breast cancer' and that the disease is a 'random' event in the lives of women (Gjorgov, 1980; 2009b). The newly revealed carcinogenic and other devastating effects and consequences of condomization of female sexuality showed to be operative even at a frequency of use of 50% of condom use. The quantification in the study of the latent period of development of breast cancer was shown to be between 2½ and 5 years, rather than the prevailing arbitrary assumptions of 15-20 years. Almost 80 percent of the etiologic fraction of the putative risk factor, which could indicate a potential preventive gain, was attributed in the study to the condomized and coitus interruptus birth control. One of the most favored inferences of the study was that the marriage is a profoundly biological woman-man union, with physiologic impact on spouses/couples, particularly on woman, along with the customary definition of marriage is a social, economic, psychological, traditional, and legal man-woman unit. Anticipation turned postulate has been that condomization could adversely affect this oldest human institution, the marriage.

The major unforeseen development in the epidemiology of breast cancer, lingering during the past three decades, beginning from the early 1980s, and continuing through the 1990s and 2000s, is the introduced policy of condomization of women's sexuality, as a supposed 'safe' prophylaxis against the HIV/AIDS transmission in the populations. As postulated, the newly introduced mechanical device, the condom, in the intimate (sexual) reproductive ecosystem, has substantially changed (corrupted) the primordial inter-human microenvironment, by eliminating the postulated putative protective factors (the prostaglandins?), that is, by introducing on an unprecedented scale technical effects of absolute male sterility in intimate (sexual) woman-man communication and other marital relations. The new development seem almost for certain to have had substantially supported / confirmed both an indirect causality of the tested evidence of the condom to breast cancer link, and the potential of primary (non-chemical, natural) prevention of the current, excess and unabated breast cancer epidemic.

There is a variety of gender- (sex-) specific diseases or dysfunction in women of all ages, related or not to the perpetual changes of the physiology of the reproductive system and changes of functions and events during the women's the child-bearing life-span. The definition of female-specific diseases is a pragmatic one and consists of specific female organs and systems (the internal and external reproductive organs), and mutual organs in both genders (breast, thyroid, bones) which are preponderantly and 'specifically' present in female. The central postulate is that the condomization is deleterious to all of the normal life functions of women and their reproductive events.

By entering the New Millennium, the beginning of the 21st Century in particular, the twin epidemics and burden of the HIV/AIDS transmission and breast cancer epidemic are likely to remain a major medical problem and great public health burden. The objective of this study was to try to explore the magnitude of the unknown impact and "unintended consequences" of a social action (Fox, 2004), such as the mass condomization, upon the health and lives of women. Accordingly, the study will attempt to provide answer(s) to what is the problem and what has to be done about the worsening morbidity and mortality of women in the changing world, what has been done--or not done--in the past, and especially what seems to be needed to investigate and to be done in the future, in terms of prevention and protection of reproductive health, life processes, truthful birth control, and (un)happiness of women in today's contemporary societies. The methods of the study are assessments of the trends, postulated etiology (root causes), epidemiology and the potential

of primary prevention of the most frequent diseases of women of all ages, the cancer of the breast as an epidemic diseases, especially in the industrialized and affluent world of the West, in the last three decades, since the early 1980s, and ever since. Cancer of the breast is the truly a major marker of the condomization impact upon the health and lives of women in urgent need for solution. Other manifestations of the ill-effect of condomization of women’s sexuality are also taken into considerations. All-inclusive data of female specific diseases and phenomena were collected from epidemiologic and clinical studies as well as from psychological and social investigations of female predominance, higher incidence, prevalence and mortality rates, and female to male ration (F:M) of various conditions and diseases (**Table 1**). Because of data limitations, only some of the most frequent afflictions of women and girls were subject to review in the study.

Exclusively female diseases and dysfunctions:
Ovarian cancer, (incidence and death rates), cysts, polycystic syndrome (PCOS), and dysfunctions, Endometrial cancer (incidence and death rates), other pelvic tumors-fibroids Cervical cancer (incidence and death rates), and lesions Vulvodynia, Pain during sex Endometriosis, Female sexual dysfunctions (FSD), Dysmerrhea, menstrual irregularities, cessation, breast pain, hot flashes, craps Abortion: Spontaneous, habitual, artificial, and ‘missed abortion’; Pseudocyesis Chronic pelvic pain, Pelvic congestion syndrome, Bloating
Specific, predominantly female diseases: Ratio female : male
Breast cancer, incidence cases and rates is 100 : 1 in males; Thyroid cancer, incidence cases and rates is 3.5 - 7 : 1 in females to males; Osteoporosis, fractures, prevalence, more than 80 : 20 in female to males; Anorexia-bulimia (‘eating’) disorders, prevalence, in 90 : 10 girls / young women to boys / young men.
Other female predominant diseases: Ratio female : male (referred)
Thyroid disease (Hashimoto), prevalence 10 : 1 Graves disease, prevalence 7 : 1 Sjogren’s syndrome, prevalence 9 : 1 Lupus erythematosus, prevalence 8 : 1 Rheumatoid arthritis, prevalence 2.5 : 1 Scleroderma, prevalence 3 : 1 Multiple sclerosis, prevalence 3 : 1 (National Academy of Sciences,,2011)

Table 1. Comprehensive woman’s health: specific sex- (gender-) diseases in women, and female-to-male ratios

It should be mentioned here that some of the gender specific morbidly is also observed in domestic female animals, such as the **BSE**, *bovine spongiform encephalopathy*, and created in laboratory animals’ mammary carcinomas and other tumors as well. It has been assumed, perhaps with some justification, that the persistent disproportion of higher female prevalence rates and aggregates of the specific gender diseases in females is also related to their specific, reproductive and natural functions. (Gjorgov, 1996b)

2. Evidence-based and theoretical etiology of the breast cancer epidemic

The provided evidence and inferences of the initial, hypothesis-testing study of etiology and prevention of breast cancer showed to be new and different from the widely and routinely accepted conceptions about the women's ill-health. The etiological link between the use of condom and breast cancer development in American and other married women, corroborated in a field study, was subsequently confirmed in a dramatic way by the explicitly predicted, natural experiment of the breast cancer outbreak/epidemic and the perplexing, rapid rise (Dinse et al. 1999), related to condomization campaigns and rumors for prophylaxis against the emergent mysterious infections.

The biological plausibility of the purported causal link of the carcinogenic effects between the use of barrier methods of contraception, that is, use of condoms and/or withdrawal (*coitus interruptus*) and breast cancer in American and other women has been also corroborated elsewhere (Lê et al., 1989 in France, and Pikhut et al, 1991 in the former USSR). The indirect causality of breast cancer exposure to condom use was defined as an inverse ecological risk factor due to the absence, elimination or reduction of certain protective biological factors in the seminal fluid (the prostaglandins?), thus inducing technical effects of absolute male sterility in the prime biological woman-man communications. It has also been observed that the dichotomy of sexuality and procreative functions of female is much more complex, moving through incrementally deteriorating phases, than it has been presumed. Although intertwined, the distinct sexuality and reproduction capacities in women might offer a 'window of opportunity' to act coherently in achieving the imperatives of both control of the individual fertility and control of the global population growth.

Population-growth control could hardly proceed successfully by applying incorrect, deadly, and deceptive values of the technological method. The carcinogenic effects and life-threatening consequences of the barrier contraceptive methods, such as the new/old, high-tech condom device, along with the ancient technique of withdrawal, are cases in point: they cannot be assumed to be appropriate methods upon which a mass application of a proper population-growth control policy could be maintained. The contemporary social life and norms are practically incompatible with the bygone tradition of large families and multiparity households. It has been calculated and observed that a woman has to have at least eight or more full term normal pregnancies (FTNPs), i.e., children, in order to be virtually protected against breast cancer. The Nature has not changed and made no adjustments to facilitate the modern human tendency for reduced reproduction. The modern medical history, not yet written, has already shown that any misconception and even inadvertent error in the sphere of human reproduction is bound to inflict tremendous harm on women and society, such as the mass condomization of female sexuality in the mainstream population. It is the purpose of this study to try to clarify the damage of the condom-related "reproductive freedom" fallacy and the scientific and individual ignorance and errors in condomized control of fertility, without passing judgment.

Although the main attention and concern has been focused on the 'hormonal,' oral contraceptive pills, the condom use and the uncritical campaigns for its use in any situation resulted in grave consequences on health and lives of women and girls, in terms of the ongoing breast cancer epidemic and rampant 'eating' disorders. Even though the use of condoms dates for more than one century (in England at least), the condoms have been overlooked as the possible cause of the widespread ill-effects and grave consequences in women. The introduction of mass condomization of female sexuality has completely

corrupted and destroyed the micro-environment of intimate (sexual) human ecosystem, by creating technical effects of sterile mating and un-physiological primordial woman-man communication and other relations. The unspoken ideas and intuitive popular knowledge of sex as a necessary part of life, health and survival of woman in marriage, and perhaps her beauty, was replaced by a conceptual vacuum in research, attitude and mindsets of sex and sexuality as a trivial, only 'recreational' gender activity.

3. Sources, population and methods

3.1 Sources

Global breast cancer data are updated in five-year reports published by the World Health Organization International Agency on Cancer Research (IARC), in Lyon, France, titled: "Cancer Incidence in Five Continents" (CI5s), volumes III-IX. (Waterhouse et al, 1977, 1982; Muir et al., 1987; Parkin et al, 1992; Parkin et al., 1997, 2002; Cirado et al., 2007). For achieving the objectives volumes III to IX, 1968 to 2002, inclusive, in duration of 35 years for most centers.

3.2 Population

Population under study consists of contingencies of women affected by breast cancer and other malignant diseases, collected by the national or regional Cancer Registries in 180 to 300 countries and population situations globally, with data quantified in average incidence rates (crude and age-standardized), collected in five-year periods, and reported by the regular editions of the WHO-IARC CI5 volumes.

3.3 Methods

For appraisal of existing, reliable and controlled data, collected internationally by the World Health Organization throughout several decades. Common statistical procedures [means, standard deviations, 95% CI (confidence intervals) of the risks, correlation coefficients, two-way statistical significances at $P < .01$ and $P < .05$ levels] were used for testing the differences, the temporal and spacial changes of the epidemic disease. Correlation and regression analyses, in order to test the statistical significance of the trends and rates of the diseases, and possible extrapolations. The necessary graphical figures and tables of the results and trends are also presented. The analysis of the multitude of data was done by using the SPSS (Statistical Package for Social Sciences), Version 16, 2008.

4. Epidemiological and clinical results and consequences

4.1 Perplexing breast cancer incidence rise worldwide

The rapid rise of breast cancer in the U.S. was first noted by the media, perplexed over the "highest breast cancer incidence rate (of 92.1) ever seen" in the U.S., in 1984. The type of tidal wave ('tsunami') onslaught of breast cancer heralded an emerging, unprecedented epidemic of a malignant (not contagious) disease in the medical history. Thus reaching for a first time in human medical history an unprecedented epidemic of malignant disease. Starting by 1987, the crude incidence rate (based on the number of new cases) was almost entirely replaced by age-adjusted incidence rates (computed on out of sight number of new cases). Correlation between the breast cancer incidence rates and prevalence rates of condom use were invariably positive at statistically significant levels, as presented in **Table 2** (Gjorgov, 1998; Gjorgov, 2000; UN Secretariat, 1994):

Region and number of countries/centres	Breast cancer age-adjusted incidence rates,+ 1983-1987 (Lowest and highest rates)	Condom-use prevalence, estimates, in %++ 1987	Correlation coefficient (Spearman r)
• WORLDWIDE (166)	6.4 - 104.2	1 - 15	.860**
• NORTH AMERICA (46) (USA and Canada)	52.2 - 104.2	10 - 15	.748**
• SOUTH AMERICA (12) (Columbia, Costa Rica, Cuba, Equador, Paraguay, Puerto Rico, Martinique, Brazil and other)	26.2 - 40.5	2 - 3	.548*
• WEST EUROPE (42) (Portugal, Spain, Italy, France, Norway, Finland, Denmark, Sweden, Holland, Iceland, West Germany, Switzerland and other)	35.7 - 73.5	5 - 13	.777**
• EAST EUROPE (17) (Czechoslovakia, GDR, Poland, Estonia, Latvia, Slovenia, Romania, Russia, and other)	31.1 - 43.7	3 - 5	.438
• UK, AUSTRALIA, NEW ZEALAND (22)	56.1 - 64.3	10 - 14	.564**
• AFRICA and ASIA (27) (Algeria, Gambia, Mali; China, India, Japan & other)	6.4 - 24.6	1 - 3	.558**
• DEVELOPMENTAL STAGE			
Developed regions (140)	35.7 - 104.2	5 - 15	.834**
Developing countries/regions (25)	6.4 - 43.7	1 - 3	.594**
• RACE			
White women (131)	31.1 - 104.2	2 - 15	.855**
Africans & Afro-Americans (12)	10.2 - 71.6	1 - 12	.541*
Orientals (23)	16.9 - 64.0	2 - 3	.821**
• URBANIZATION			
Urban populations (21)	31.1 - 104.2	3 - 15	.907**
Rural populations (26)	6.4 - 58.8	1 - 10	.932**

SOURCES: Parkin DM et al. 1992; United Nations Secretariat,1994; Gjorgov AN., 1998, 2000 *p < .05 (significance level); **p < .01 and/or **p < .0001 (significance levels)

Table 2. Breast Cancer: Age-adjusted Rates (per 100,000) and Condom-Use Prevalence (percentages), 1983-1987, and Correlation coefficients, by Global Regions, Developmental Stage, Race, and Rural-Urban Places,

Quantifying the impact of condomization on breast cancer epidemic, it was estimated that an increase of condom use by 1 (one) percentage point, the gradient of increase of the breast cancer incidence will correspond to rate of 3.85 per 100,000 female population, globally. For North America, the increase of breast cancer incidence would correspond to a rate of 4.4/100,000 per one percent condom-use prevalence increase, and increase between 2.1 and 3.6 breast cancer incidence rates for various European countries. (Gjorgov, 1998a).

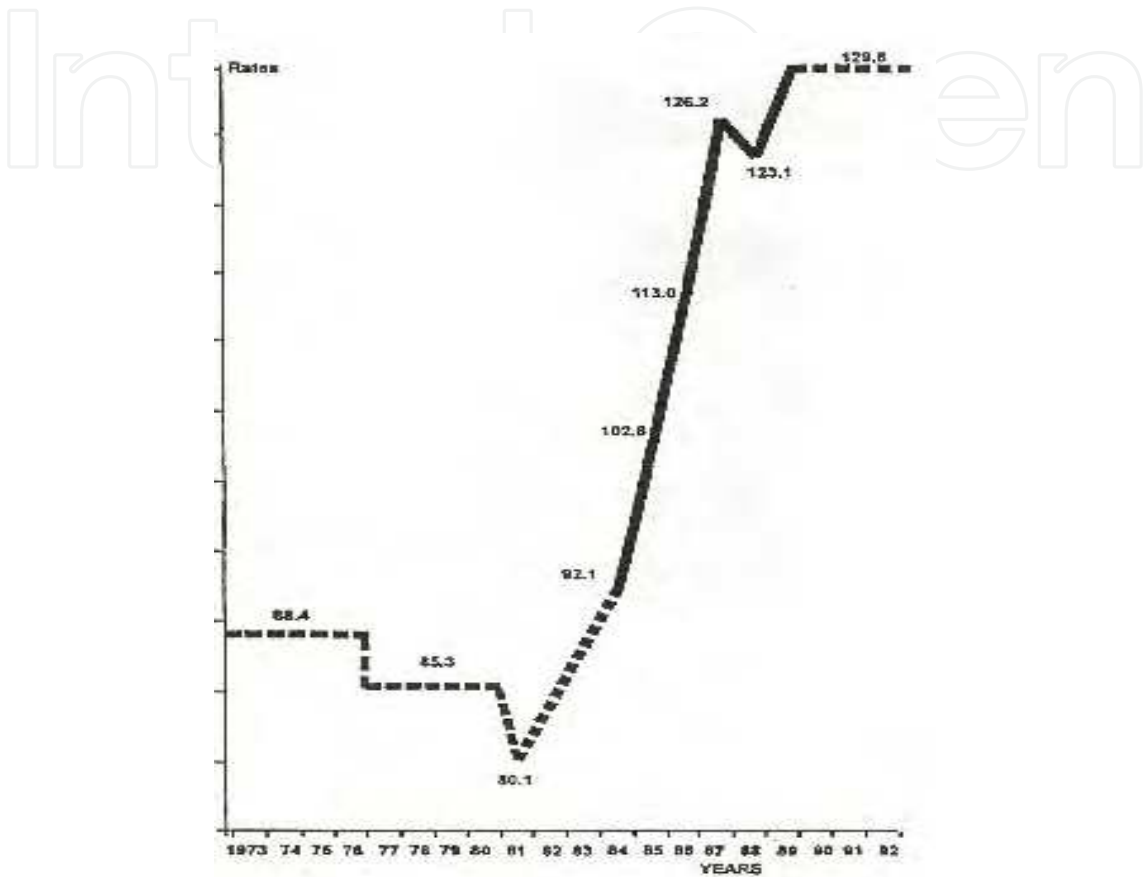


Fig. 1. Breast cancer rise in the United States, 1973-1987. Crude incidence rates, per 100,000 (female) population

Whether the condomization was intended for the feminist's allure only and latter adjusted for prophylaxis of the newly discovered HIV virus, is hard to come by. In one of available sources, the assertion about 'political decision' for condom-use promotion remained ambivalent: Ehrhardt "For the male condom, no controlled trials were demanded before it gained approval as an HIV prophylactic" (Ehrhardt, 1992). Globally, the average number of breast cancer cases rose by 22% in the last two periods, between 1993-1997 and 1998-2002 (between CI2 VIII and IX Editions), showing difference in the medians of cases 1893.0 and 2735.5, and mode between 595 and 1840, respectively. The upsurge of breast cancer as an epidemic disease emerged rapidly in the United States after 1981, the first and 'the highest ever recorded' reported by the mass media incidence rates, foreboding the trends during the time period 1981 and 1986 and later. The escalation of breast cancer of 57.7 percent increase was recorded in a short period of six years between 1981 and 1986, with 80.1 incidence rate (per 100.000 female population) and 126.2 incidence rate, respectively (**Figure 1**).

4.2 Breast cancer epidemic changes in time, places and populations

The force of the rising incidence of breast cancer has been seen all over the world, the attempts of denigrating its surprise emergence and astonishing effect and magnitude notwithstanding. The new development of breast cancer as an epidemic disease could be best seen in **Figure 2**, as recorded for **Connecticut**, in the last 35 years.

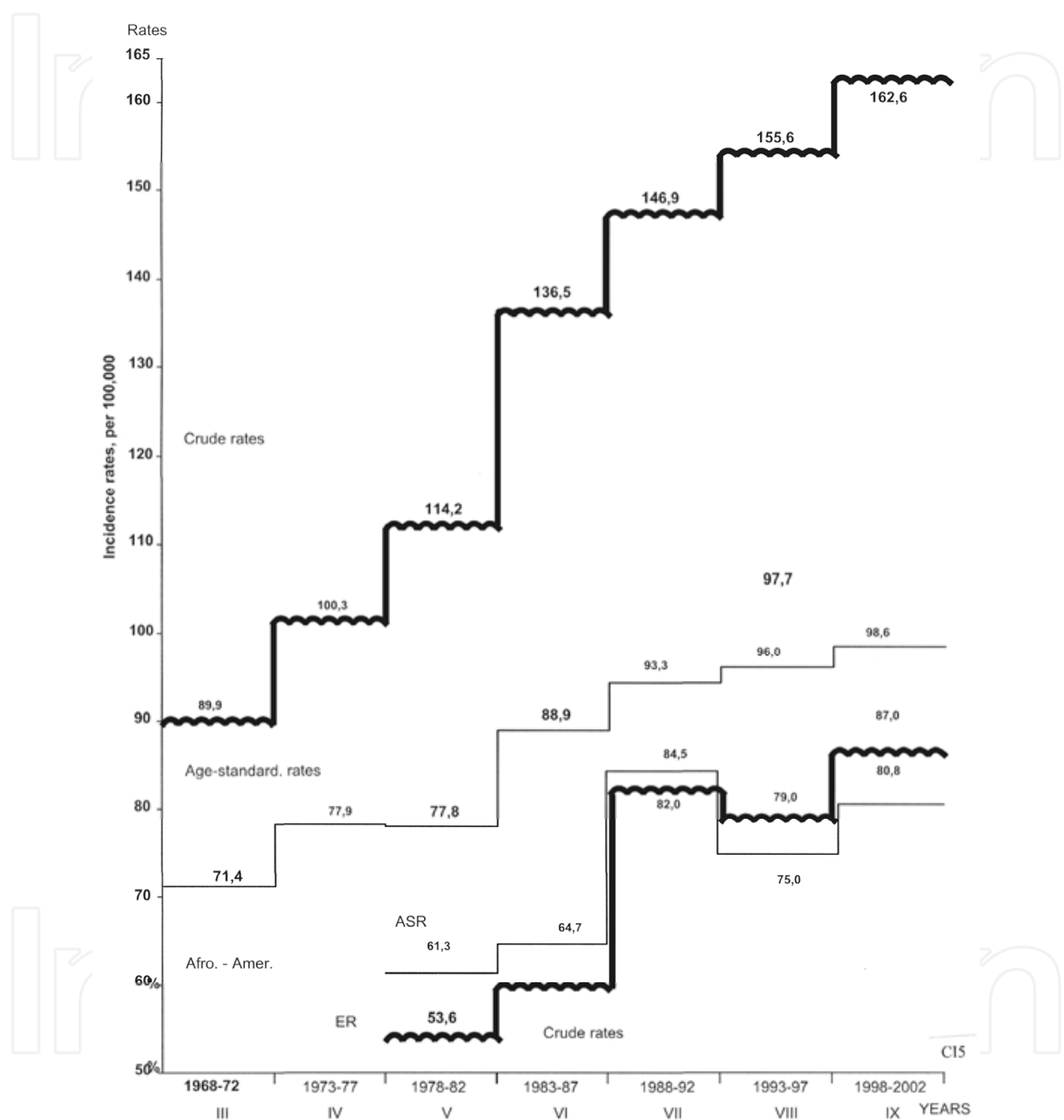


Fig. 2. Breast cancer trends in Connecticut, 1968-2002. Crude and age-adjusted incidence rates, per 100,000

The **Figure 2** reliably confirms the fact of a steep and steady increase of the breast cancer epidemic, for both races, since the Cancer Registry of Connecticut in New Haven, was first cancer registry in the world, established in 1936. (It may be of interest to note that there was a fluctuation of the breast cancer incidence rates for the Afro-Americans, an event rarely observed before.)

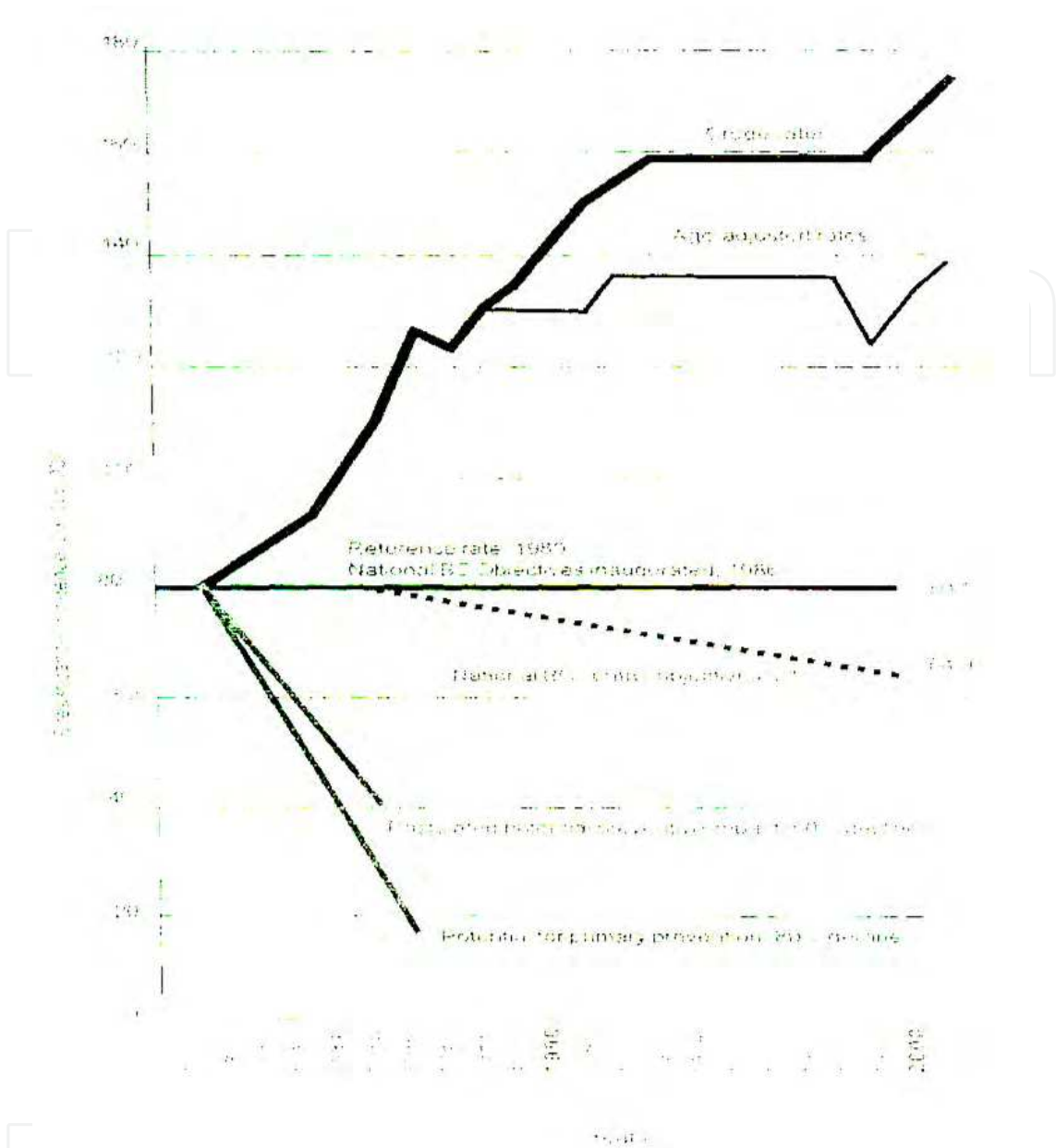


Fig. 3. Breast cancer trends in the U.S., 1980-2002. Observed crude and age-adjusted incidence rates: Projected 21% decline 1986-2000, and Postulated preventive impact, in percentages tested.

The overall epidemiology of the breast cancer epidemic in the **United States** is presented in the **Figure 3**. There is a dual presentation of the trends of the breast cancer progression in the past two-and-a-half decades, from 1980 to 2002. The breast cancer rising trends are presented in crude and age-adjusted incidence rates. The two incidence rates differ considerably, mainly because the age-adjusted rates, showing lower rates, were derived according to moving U.S. census populations, instead to the conventional World Standard Population 1960 (WSP). In the same **Figure 3** is presented the official, wrong prediction (in 1986) of 'declining' breast cancer trend until 2000, and also are presented two personal predictions of the future, postulated downward trends of 50 to 80 percent of breast cancer in the U.S.

Additional data support the analogous development of breast cancer rise in other parts of the country, such as the **San Francisco Bay Area (Figure 4)**, which was subsequently and perhaps justifiably called “the Breast Cancer Capital of the World,” for the highest incidence in America in the 1983-1987 period, reaching the excess incidence rate. The first, the NCI confident forecast of decline of breast cancer incidence rates between 1986 until 2000, by 21 percent, was patently wrong from the outset. The predicted decline of breast cancer, published in 1986 proved to be quite off center: the incidence rates of the disease almost doubled by the end of the 20th Century. The wrongly computed forecast of decline probably reflected the same percentage of decline of the disease during the 1970s, and was computed maybe before the statistical data were in following the 1981 unexpected breast cancer jump; The second prediction of decline of the breast cancer incidence rates between 50 to 80 percent, as related to the 1980 situation, remained theoretical estimates, based on etiological fraction percent, contingent on implementation of primary prevention and elimination of the corroborated etiological risk factor of semi-official policy of condomization of the mainstream population(s) against the HIV/AIDS transmissions, along with the application of Bayes’ probability theorem computation, and yet to be

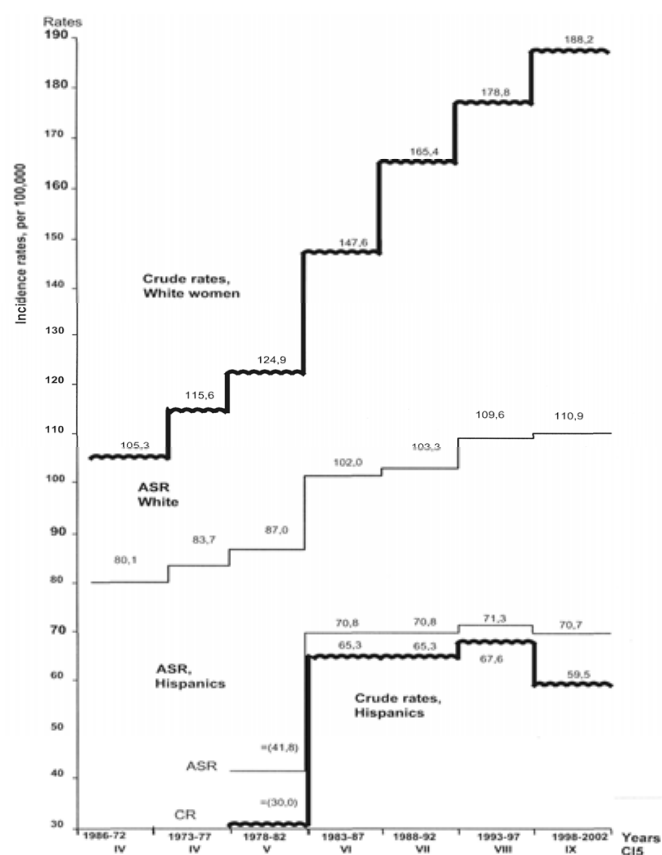


Fig. 4. Breast cancer in San Francisco Bay Area, CA, 1986-2002, by race. Crude and age-adjusted incidence rates, per 100,000

The same pattern of rapid rise of breast cancer was recorded in **Seattle, WA**, with an extraordinary jump of 27.8 percent of crude incidence rate (from 95.8 to 121.8) within one period of 1978-82 (before AIDS epidemic) to 1983-87 (the initial tide of the AIDS outbreak in the U.S.). (Figure not presented.) According to the data in the latest (IX) volume of the CI5, it

seems that the infamous title of “Breast cancer capital of the world” has shifted from the San Francisco Bay Area to the Ferrara Region, Italy, with a crude incidence rate of 201.8 in the 1998-2002 period, and an increase of 263 percent in the number of breast cancer cases (from 527 to 1833) since 1998-1992.

In other parts of the Western world, the **Oxford** Region, the UK experienced immediate high increase of breast cancer and without apparent delay after the U.S. (**Figure 5**). The steady rise of the breast cancer incidence has been happening continuously and all 5-year time periods after 1980. In the mid-1990s, the Cancer Research UK organized, in cooperation with other European countries and North-American regions, so-called population-based, chemo-preventive community trials against epidemic breast cancer, by giving the drug *tamoxifen* to great number healthy women, in duration of five years, The enthusiastic chemo-preventive trials ended prematurely, with impractical results for breast prevention. No other idea or projects were envisioned or proposed for testing a potential primary (non-chemical) prevention of breast cancer. Circumstantial and fragmentary evidence seems to suggest that the idea of global condomization has originated at the ‘R. Doll’ Institute of Epidemiology in Oxford, probably thought of during the decade 1960s.

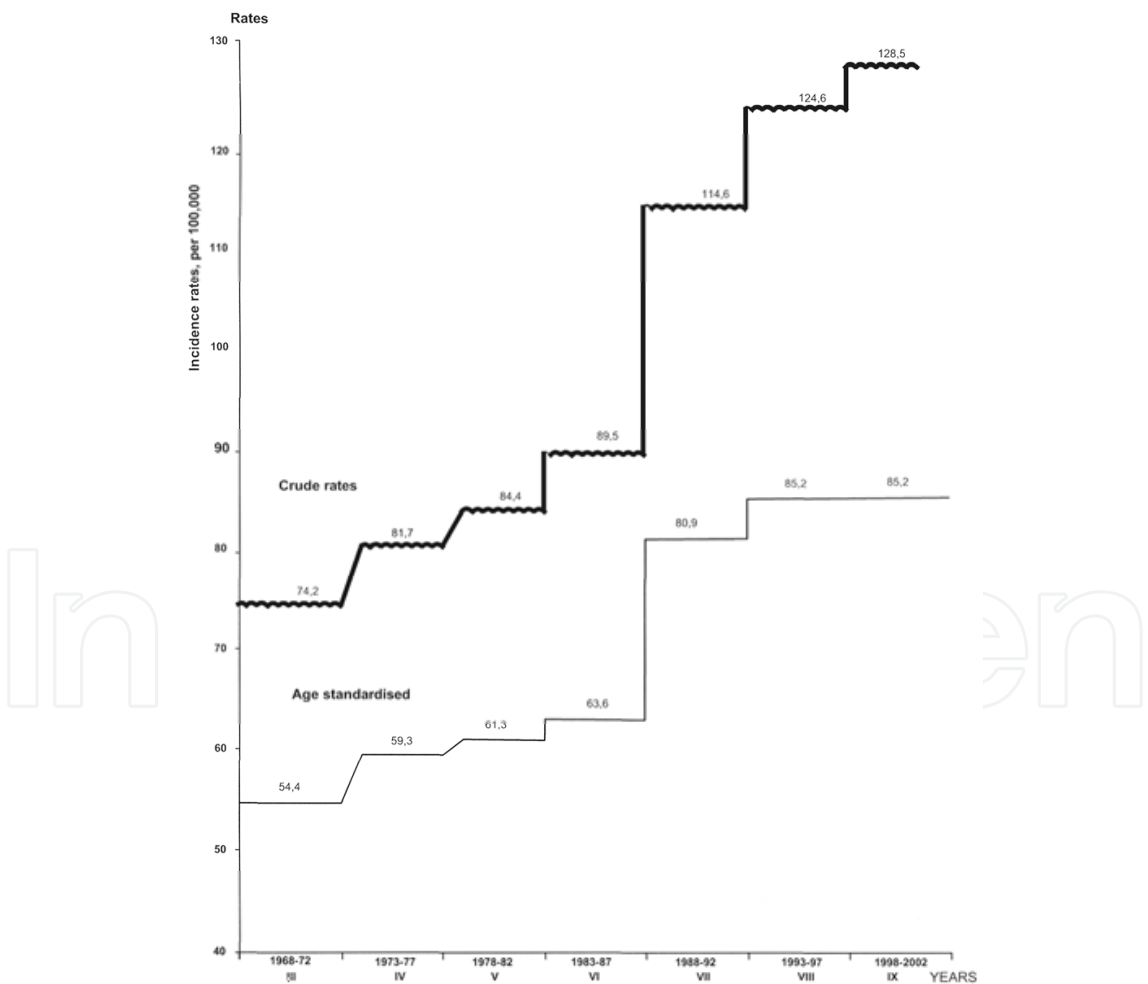


Fig. 5. Breast cancer in Oxford, UK, 1968-2002. Crude and age-adjusted incidence rates, per 100,000

At least two more high-risk regions of breast cancer epidemic in Europe deserve mention, in France and Sweden. The breast cancer epidemic in **France (Figure 6)** may prove of interest because of the fact that the North-Rhine Region is both one of the best developed regions, and one with the highest incidence rates in EU. The City of Strasbourg, where the multinational European Parliament is located, is also an important place where much of the debates and policies about breast cancer control, mainly for rectifying the early-detection screening policy, has been and is expected to continue to eventually consider primary prevention of the breast cancer epidemic soon.

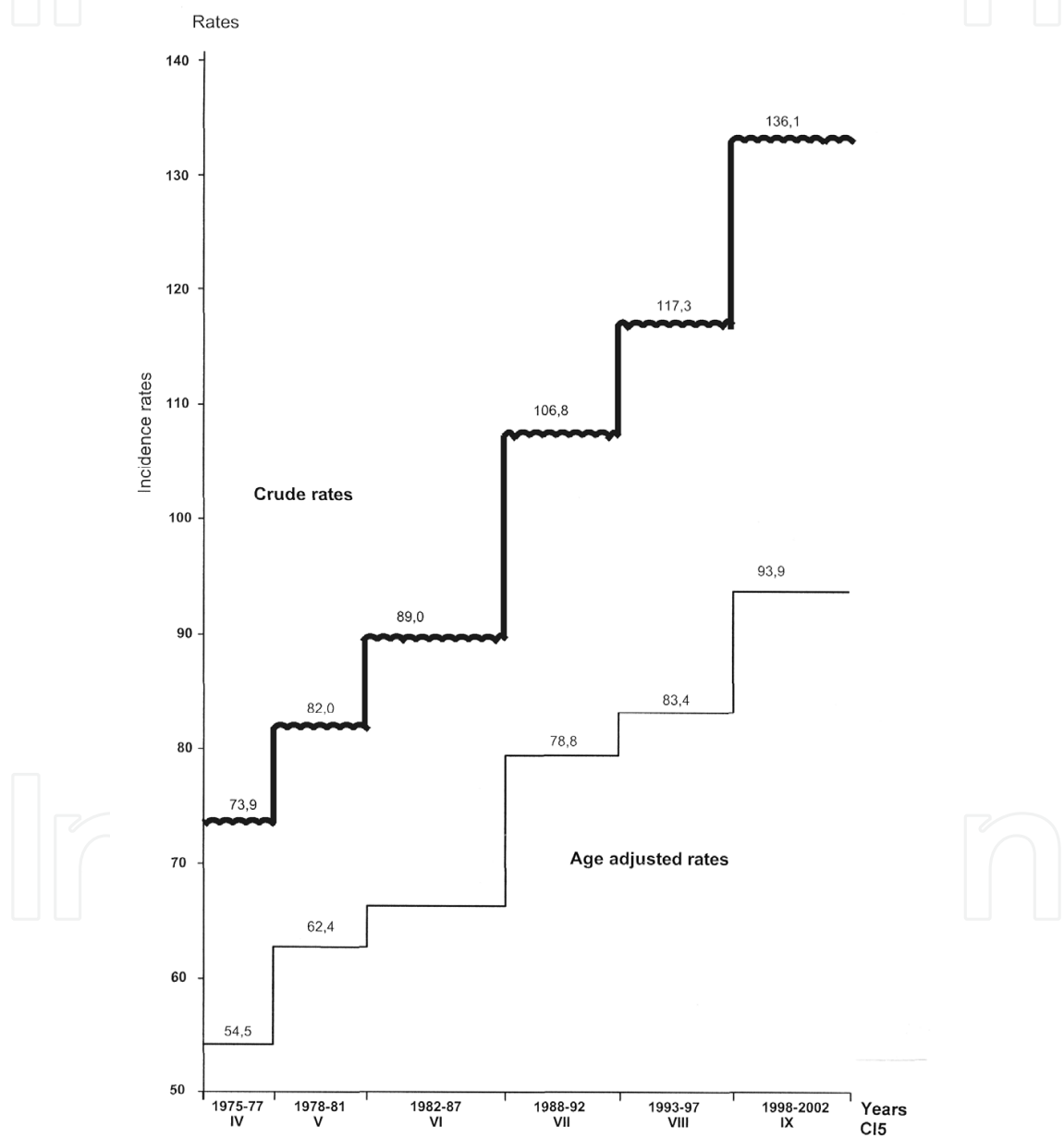


Fig. 6. Breast cancer in Bas-Rhin, France, 1975-2002. Crude and age-adjusted incidence rates, per 100,000

Sweden has always been a lead-country of high breast cancer incidence (**Figure 7**). The country has an interesting epidemiology of the disease, since the current, global breast cancer epidemic seems to have started much earlier there, during the decade of the 1970s, ten years before the epidemic was first recorded in the U.S. in the 1980s. Part of the puzzle lies in the information that condomization (“for non-contraceptive use”) was first introduced in Sweden (Hinman, 1978; Valdiserri, 1988), in the 1970s decade, before campaigns of condomization were carried out in the rest of the world.

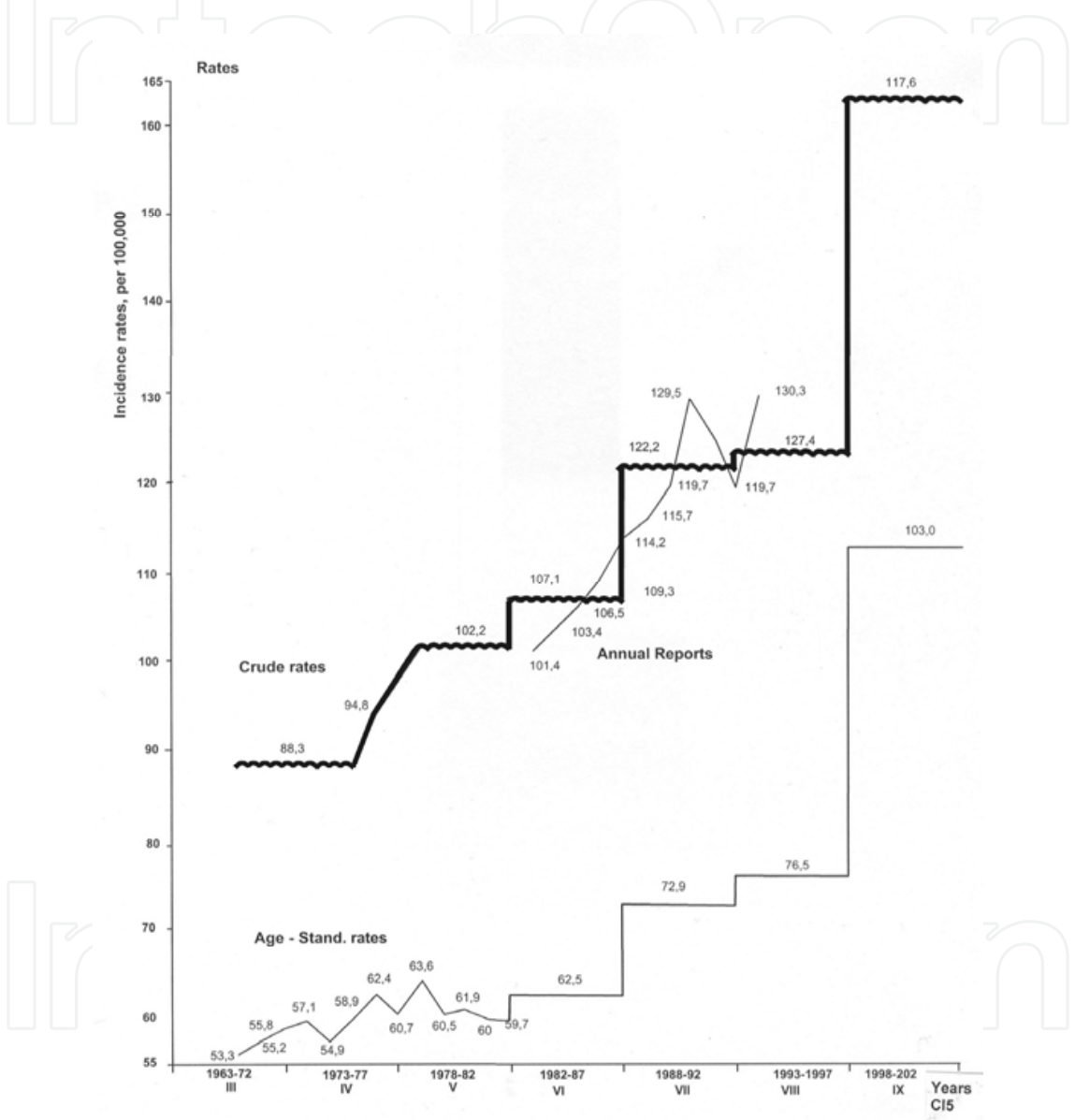


Fig. 7. Breast cancer in Sweden, 1971-2002. Crude and age-adjusted incidence rates, per 100,000

On the other side of the globe, in Australia, the rise of the breast cancer epidemic in the **New South Wales** showed the familiar European model of advent (**Figure 8**). According to the separate Annual Reports of the Cancer Registry of the Province NSW, the rise of breast cancer was apparently steeper than presented by the presentation in 5-year periods of the WHO-IARC CI5 reports.

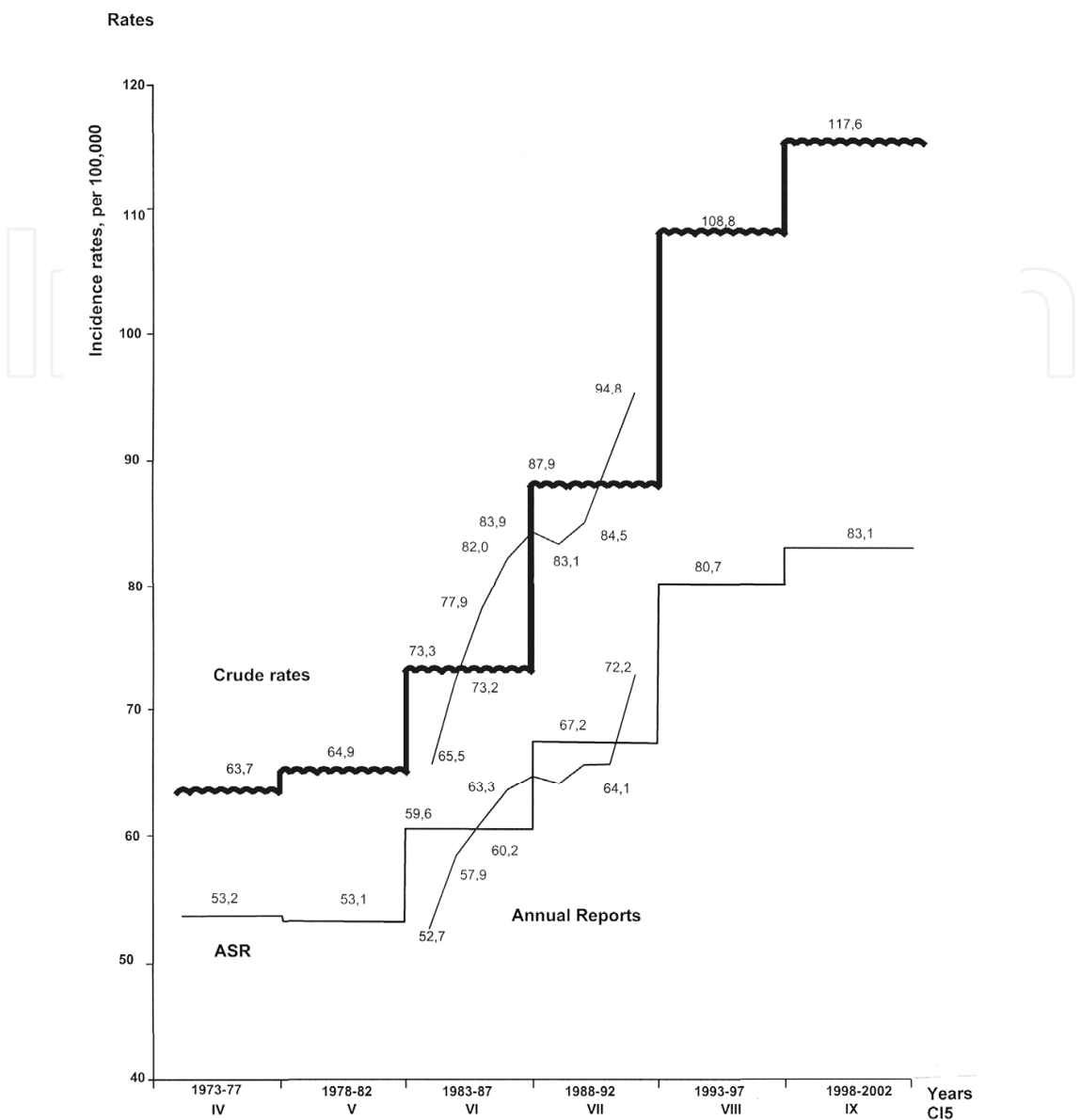


Fig. 8. Breast cancer in New South Wales, Australia, 1973-2002. Crude and age-adjusted incidence rates, per 100,000

In Asia, the experience of **Kuwait (Figure 9)** of the breast cancer epidemic rise was somewhat peculiar. First, Kuwait long enjoyed the distinction to be listed as a country with the lowest rate of breast cancer in the world. I worked and as Director of the National Cancer Registry at the Kuwait Cancer Control Centre for a long while, was able to observe the situation and the ensuing profound changes with regard breast cancer. (Gjorgov, 1986). Second, the breast cancer onslaught happened fast and affected very young, married multipara-women (not less than 4 pregnancies), between 23 to 35 years of age. The surgeons from Europe, worked in the local hospitals, were the first to voice alarm of the unusual in their practice pattern of performing mastectomies to such a young-age group of patients. Third, contrary to the American and European experience, the Non-Kuwaiti, immigrant women, had persistently had a higher incidence rate of breast cancer than the Kuwaiti

women. During the past three decades, the increase of breast cancer in Kuwaiti women did not reach the higher incidence of the immigrant, Non-Kuwaiti women in the country.

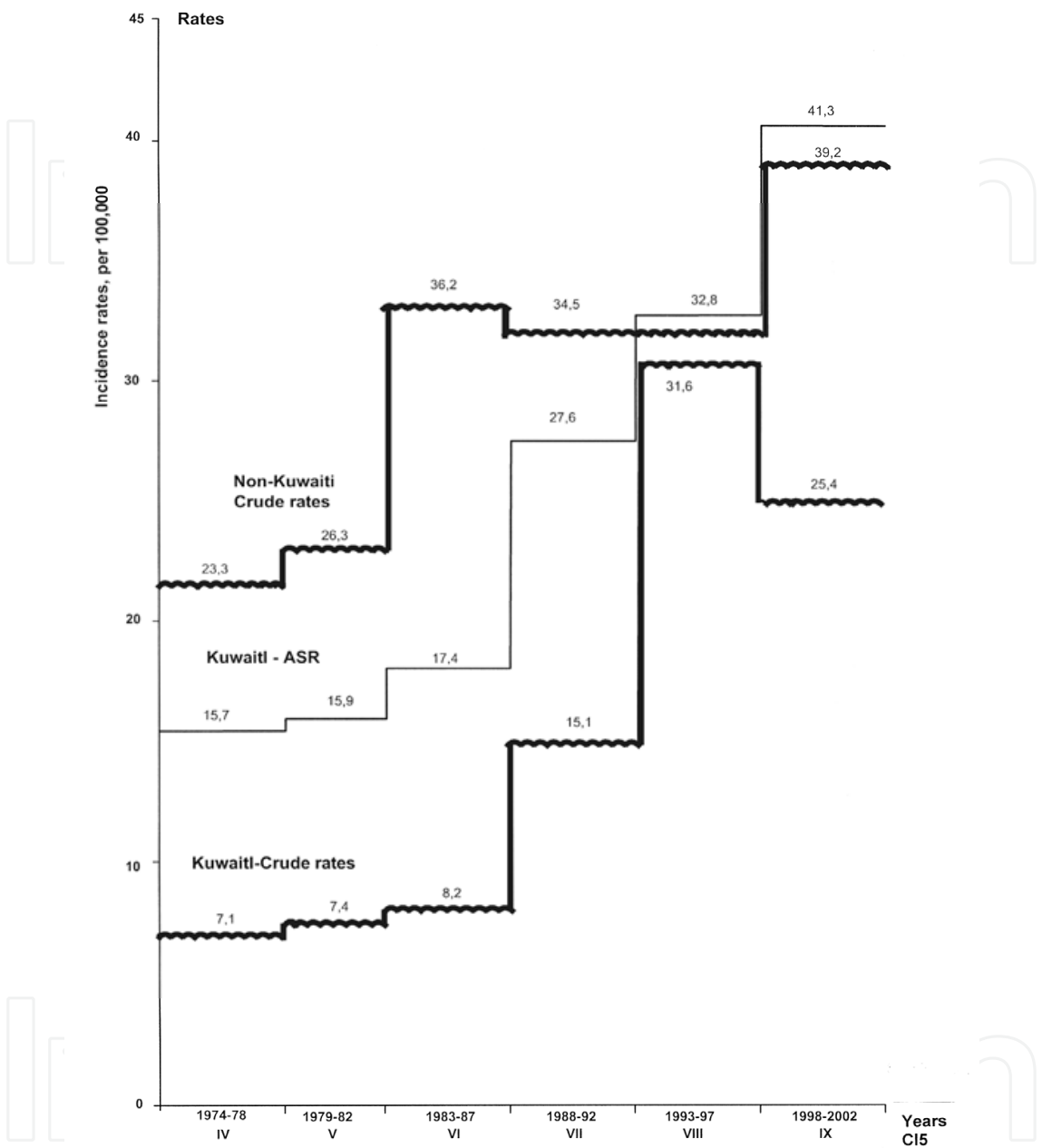


Fig. 9. Breast cancer in Kuwait, 1974-2002, by Kuwaiti and Non-Kuwaiti women. Crude and age-adjusted incidence rates, per 100,000

The other regions and countries of the world followed suit. In Miyagi, Japan, the Figure 10 shows a steadily but moderately increasing breast cancer incidence rates. Nevertheless, the slow-moving breast cancer epidemic revealed an extraordinary evidence / proof of the peculiar characteristics of the breast cancer epidemic, the increase of the incidence in the younger women, most notably in the reproductive age-span of women (Figure 11).

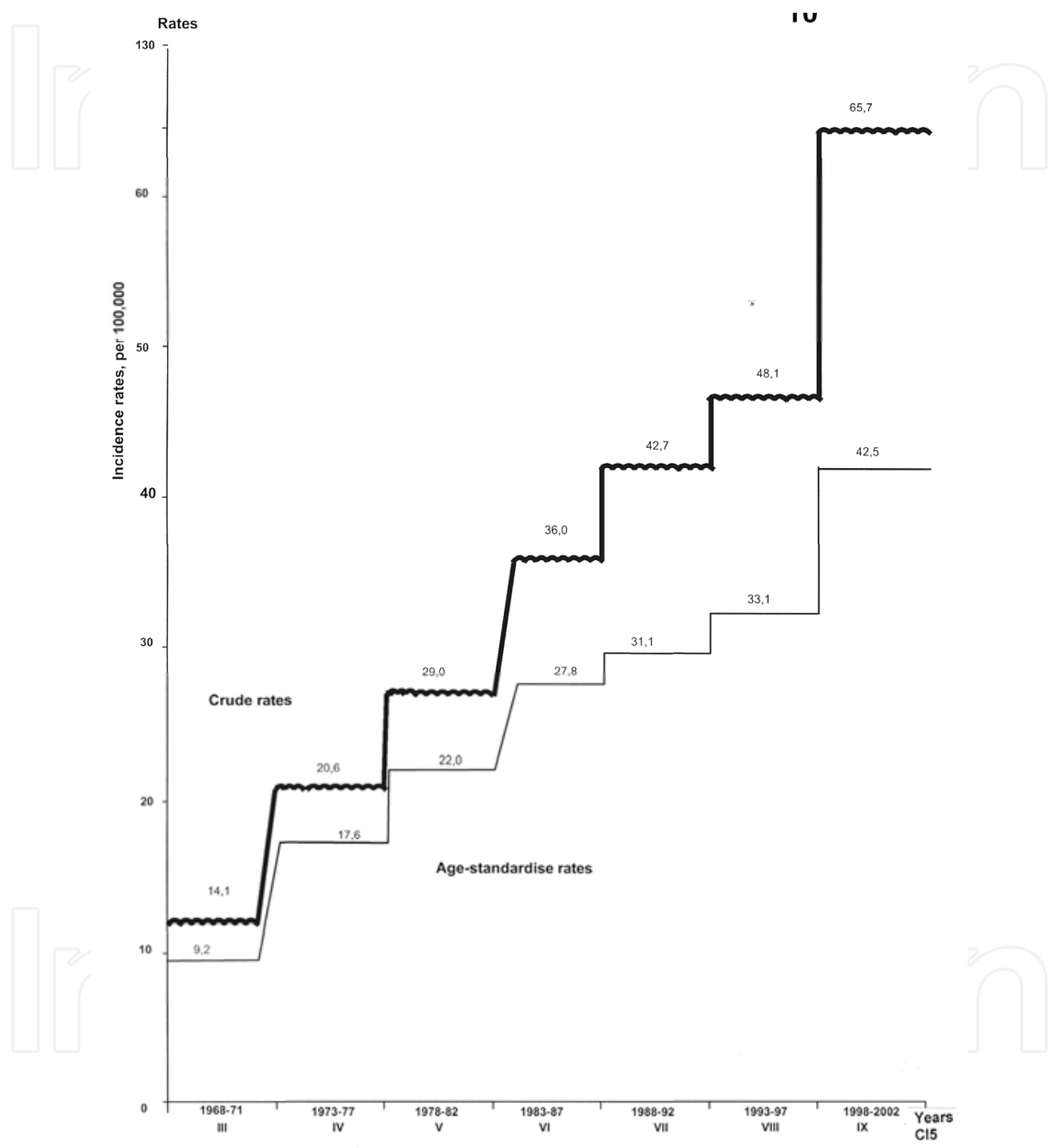


Fig. 10. Breast cancer in Miyagi, Japan, 1968-2002. Crude and age-adjusted incidence rates, per 100,000

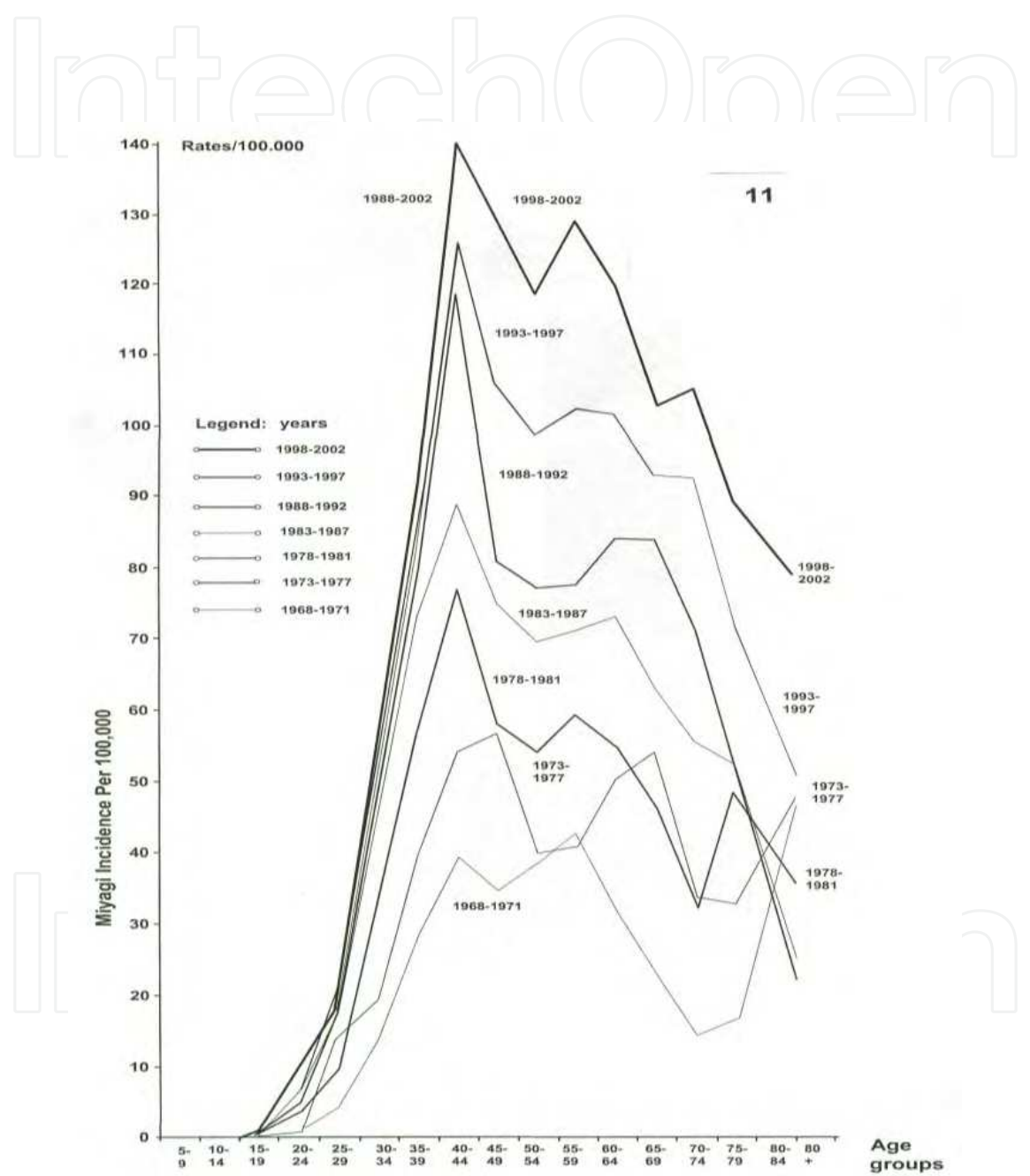


Fig. 11. Breast cancer Age-specific incidence rates in Miyagi, Japan, 1968-2002, by five-year periods, per 100,000

The conventional view that breast cancer is a “disease of affluence” had to be changed in the meantime by the epidemiology and empirical research of the disease in Afro-American women in the U.S., as well as in less industrialized (Krieger, 2002) and other “poor” countries. Three more situations could demonstrate the sudden changes in the trends of breast cancer developments (in %) in a number of centers in the **United States (Figure 12)** and in **Europe (Figure 13)**, from negative-decreasing to positive-increasing breast cancer trends.

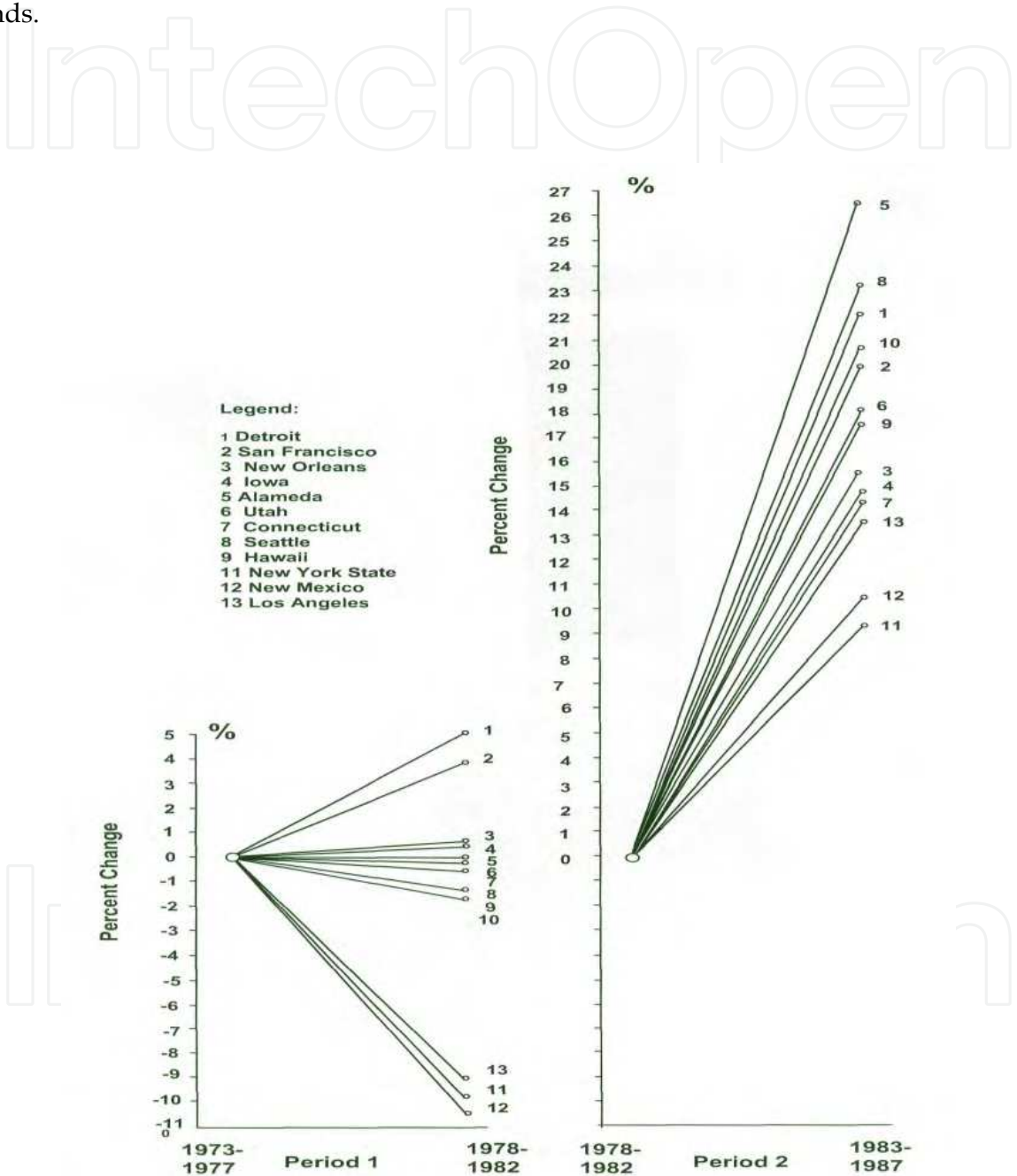


Fig. 12. Shift of breast cancer trends in the United States, 1983-1987, by time periods and regions. Changes of age-adjusted incidence rates, in percentages.

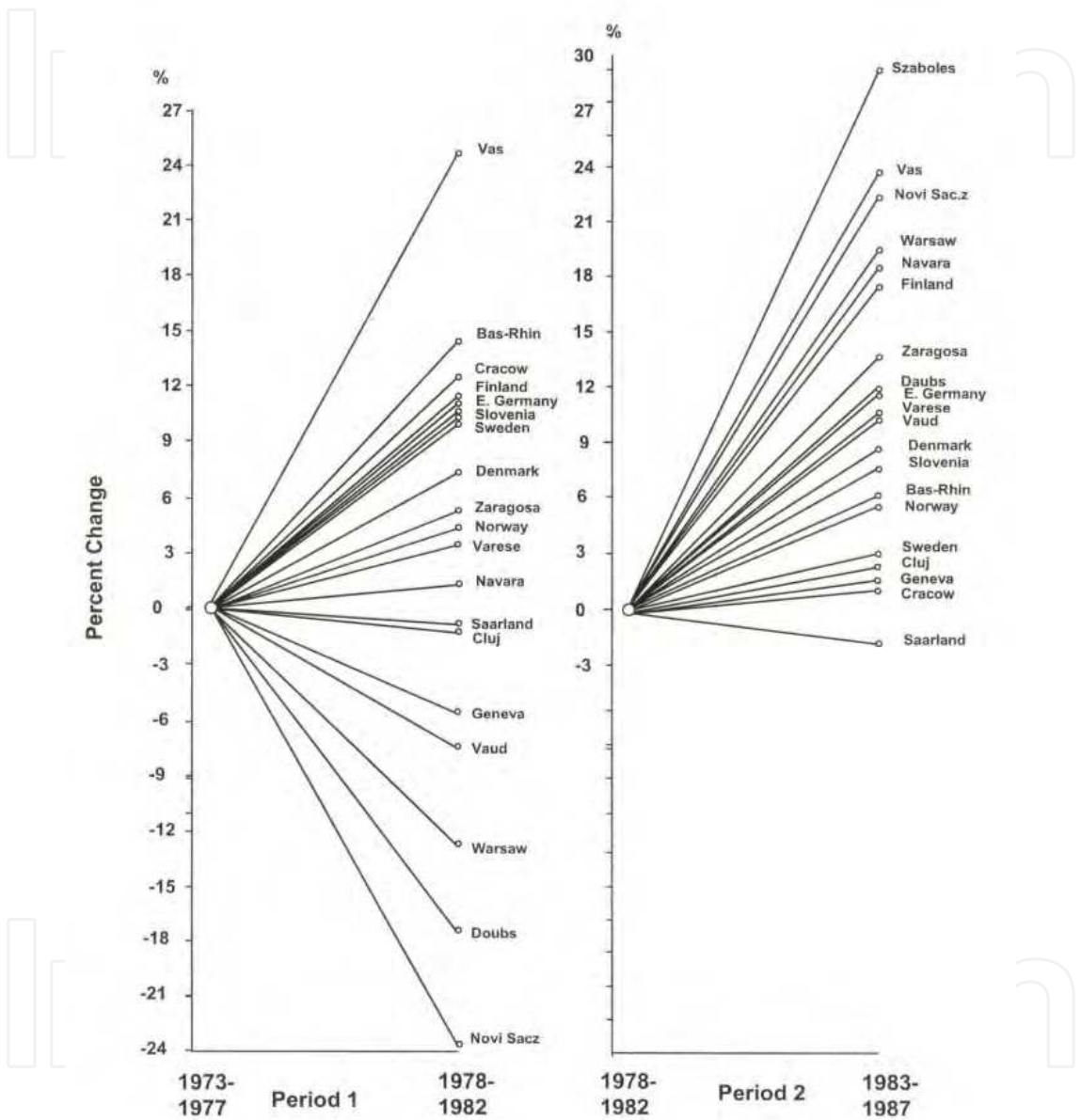


Fig. 13. Shift of breast cancer trends in Europe, 1983-1987, by time periods and countries. Changes of age-adjusted incidence rates, in percentages.

4.3 Inner developments of the breast cancer epidemic

The distribution of the age-specific incidence rates among young women, bellow 45 years of age, during the seven period of five-year intervals (35 years duration), between 1968 and 2002, clearly demonstrates the shift of the breast cancer epidemic towards younger, reproductive-age groups, ostensibly most frequently exposed to the purported risk factor of condomization. In addition to the situation in **Miyagi** (**Figure 11**), an extraordinary evidence of breast cancer descending in young women is evident in **Shanghai, China** (**Figure 14**). Perhaps a foreboding development of the disease in the country, the extraordinary shift of breast cancer incidence towards younger women was recorded in Shanghai in just a single five-year period, 1973-1978. In 2008, an alarming among many other studies appeared that rightly claimed that “China is on the point end of a breast cancer epidemic” (Linoss et al. 2008). However, the solution in averting the predicted, impending breast cancer epidemic was seen and recommended in reductions of “modifiable risk factors,” such as, alcohol intake, parity, hormone use, and adult weight gain... Condomization as a means for the restrictive reproductive policy was neither investigated nor mentioned in the study.

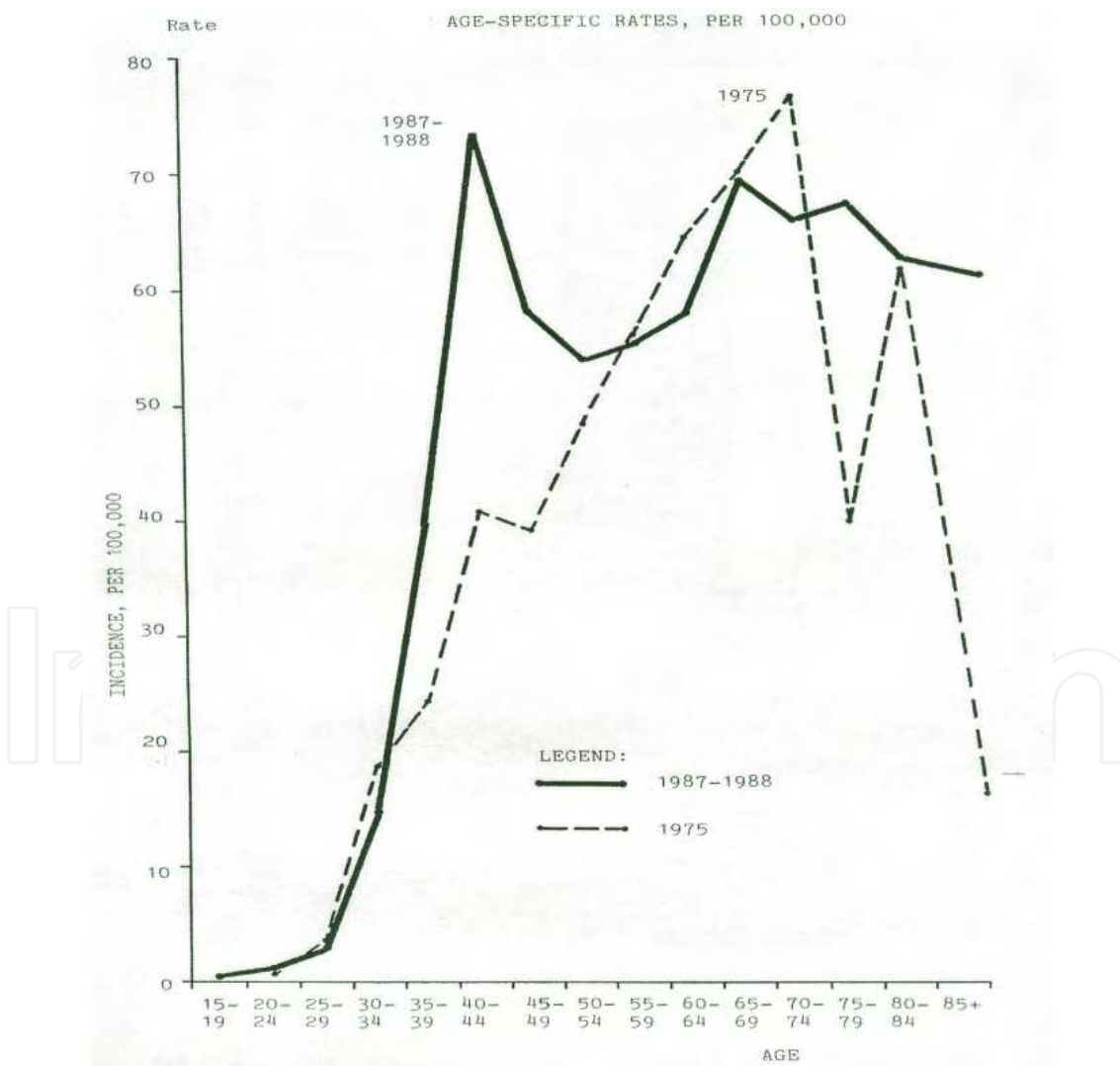


Fig. 14. Breast Cancer in Shanghai, China, 1975 and 1987-1988: “Debut” peak. Age-specific incidence rates, per 100,000

The unexpected shift towards young women was manifested in a remarkable peak of the disease in the of 35-39 year age-group, as a “debut” phenomenon, assuming that condomization was the first and perhaps the main mode of fertility control and family planning. Almost exactly the same situation was observed in Warsaw City (Poland), with the “debut” peak in 1987, compared with the age-specific distribution before the condom-use campaigns, in the period 1968-1972. (Figure not shown.) In the Volume VII of the CI5 (Parkin et al., 1997), and to a lesser degree in the Volumes VIII (Parkin, 2002) and IX (Cirado, 2007), there were more than 60 cases of age-specific distribution in which the first highest incidence of breast cancer was located in younger age groups, bellow 50, and even below 40 years of age. The “debut” phenomenon was mainly seen in countries with low baseline breast cancer incidence and where the breast cancer epidemic has been developing at a faster pace afterwards, such as, for instance, Italy.

The debut peaks showed that they are not static phenomena and not a rare situation. Data from the Malta National Cancer Registry (2010) showed that “debut” peaks popped up in the past decades in almost every year in a ten-year decade, and continued to be still present in subsequent cohorts of women (**Table 3**). Not less than 50-60 breast cancer age-specific distributions in the 1988-1992 period (CI5-VII) showed the highest peaks in younger women. The pattern of “debut” peaks is reminiscent to the epidemiological pattern of breast cancer age-specific incidence in Europe before and immediately after the WWII, with the so-called ‘Clemmesen’s hook’ (Storm, 2011), similar but not equal with the “debut” phenomenon, because it happens to young women, in the prime of their reproductive sexuality, rather than at the end of the reproduction life time of menopause.

Age groups	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
15-19	0	0	0.07	0	0	0	0	0	0	0
20-24	0	0	0.07	0	0	0	0	0	0	0
25-29	0	0.08	0	0	0	0	0	0	0	0
30-34	0.17	0.18	0.09	0.60	0.33	0.24	0.08	0.07	0.15	0.35
35-39	0.36	0.29	0.37	0.30	0.79	0.40	0.41	0.58	0.33	0.41
40-44	1.13	1.68	0.75	0.60	0.87	1.09	1.39	1.44	1.27	1.48
45-49	1.76	1.43	1.57	1.68	0.97	1.02	0.80	2.05	1.32	1.40
50-54	2.47	1.60	1.91	2.22	2.19	1.77	2.14	1.53	1.80	1.92
55-59	2.29	2.26	2.29	2.18	2.07	2.68	2.33	2.00	2.52	2.04
60-64	1.50	2.56	2.62	1.59	2.89	3.59	2.61	3.76	3.20	3.00
65-69	3.23	3.27	3.09	2.34	1.64	2.28	2.13	3.50	3.30	3.65
70-74	4.12	2.28	3.21	2.56	3.15	1.27	3.58	2.19	3.62	3.44
75-79	2.09	4.71	3.83	3.07	2.50	4.26	2.95	4.53	4.41	3.82
80-84	4.12	3.75	6.34	3.43	2.36	3.48	2.86	4.39	2.87	3.85
85+	3.60	3.95	1.55	4.10	3.02	3.72	4.63	3.65	2.90	4.22
Crude rates	106.75	110.34	110.44	100.75	99.57	108.40	109.67	128.81	127.50	131.74
Age-adj. rates	72.61	72.30	70.55	64.35	64.99	67.70	66.84	79.56	75.82	77.78

Table 3. Cancer of the breast: Maltese Islands-Trends in Incidence 1998-2007. Incidence rates, by age and year of cancer registration (February 2010)

Most likely, the “debut” phenomenon is closely related with another puzzling issue of the breast cancer epidemic, the growing cases of ductal carcinoma in-situ (DCIS), or simply in-situ breast cancer, whose incidence, has gone up exponentially, up to 30 percent of the annual number of registered breast cancer cases, since the 1980s (National Cancer Institute, 2001). The in-situ (DCIS) cases in fact, testify of the evolving nature and lack of understanding of the global breast cancer epidemic. The in-situ breast cancer epitomizes also the conceptual vacuum in professional dealing with the breast cancer epidemic, because of misconception of DCIS as a random event in lives of women; not reporting of DCIS in the annual reports of incidence rate of breast cancer; exaggerated and not true claims of excellent (“nearly 100%”) survival rate; unduly and unreasonably defined in-situ cases as non-breast cancer (0-zero stage); the systemic background of the in-situ cases is ignored and treatment is as a local disease. The early-detection screening, for finding most and more of the DCIS cases, has always been mired with uncertainty of further course of the in-situ finding into aggressive and metastatic breast cancer, the extent of treatment, and the dilemma about the usefulness of the early detection as the basic tenet of the breast cancer strategy.

4.4 Reproductive age and breast cancer

Age of women as such has almost invariably been defined among the strongest risk factor of breast cancer. The assertion of randomness has frequently accompanied the age factor. The international experience, however, points out to the long held observation that this assessment is not universally correct and that is in principle wrong. **Figure 15** shows that breast cancer in **Korea** is confined to middle-aged women, to the reproductive-age span women, with declining incidence after the peri-menopausal age of 50. In most of Asian populations (Japan, Malaysia, India), the breast cancer profiles exhibit the same pattern.

The pattern of breast cancer age distribution in Korea was similar to those in many European countries, which could still be seen in Porto, Portugal, evocative to the old rather than new European models. (Figure not presented)

Hidden behind the common reference of “cancer incidence increase” lies the fact that the increase is created to a high extent by the rise of breast cancer, while the category of “the rest of cancers” is actually decreasing. [The categories of breast cancer and “all cancers without skin cancer (C44)” are given as such and, for the purposes of this study, is computed a new category of “rest of cancers,” meaning ‘all cancers’ minus breast cancer)]. The data of the **SEER** (Surveillance, Epidemiology, and End Results) program, containing nine registration centers in the U.S. and, since it stands for about 10 percent of the U.S. population, considered representative sample of the country, showed that the number of breast cancer rose by 11.6 percent, while the “rest” of cancers increased by 8.7 percent, between the two consecutive periods of 1993-97 and 1998-2002. The **Figure 16** presents data of increasing breast cancer age-adjusted incidence rates (16.8%) compared to the decreasing “rest” of cancer (-7.5%) in Afro-American women during the aforementioned two 5-year periods. There was exactly the same reciprocal increase of breast cancer (7.7%) and decrease (-4.3%) of the ‘rest of cancers’ in Afro-American women in Connecticut, and unexpected decrease (of -4.9%) of the ‘rest’ of cancers (age-adjusted incidence rates), and increase (1.2%) in white women in the San Francisco Bay Area, CA.

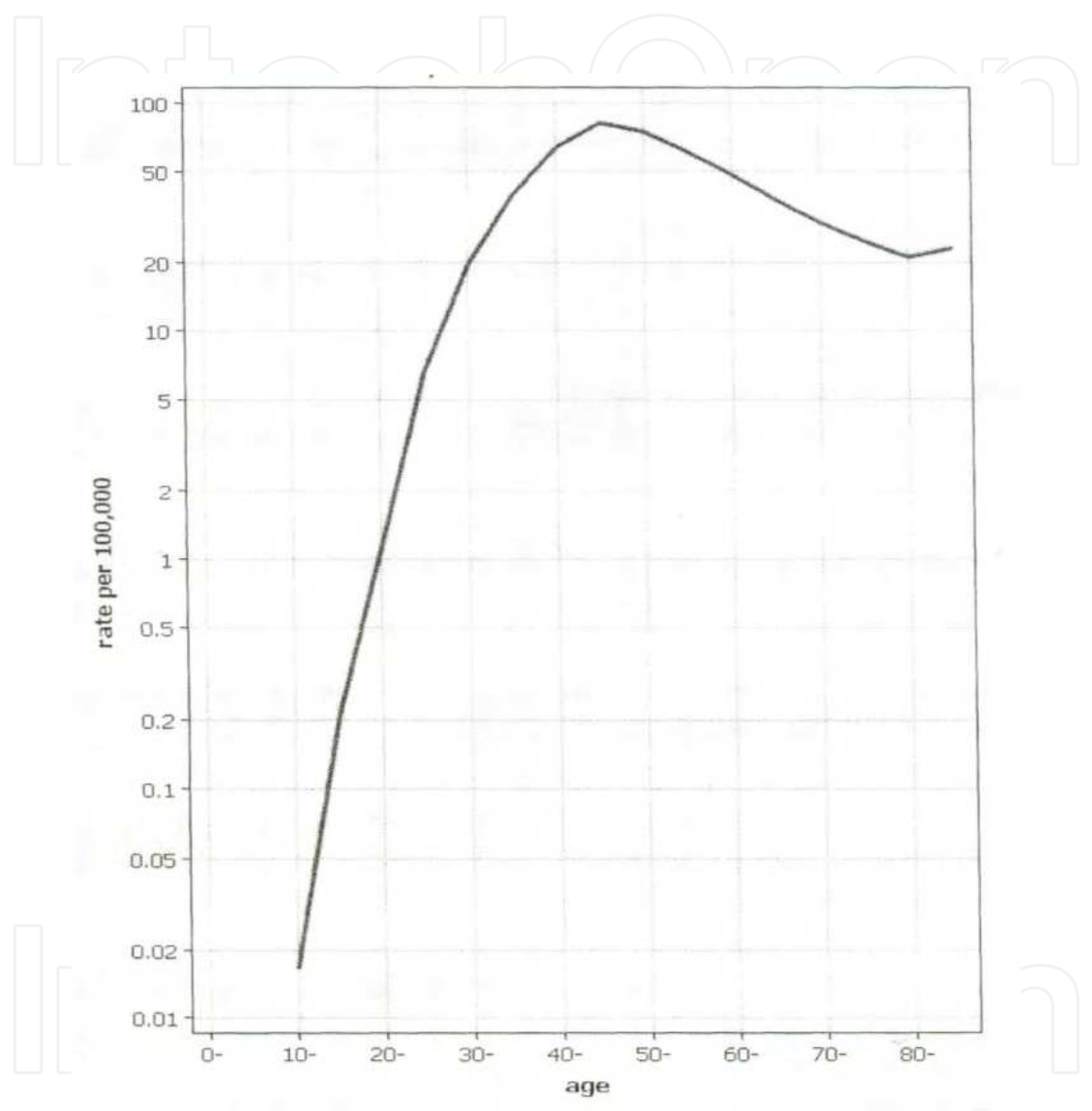


Fig. 15. Breast Cancer in Korea, 1988-2002. Age-specific incidence rates, per 100,000

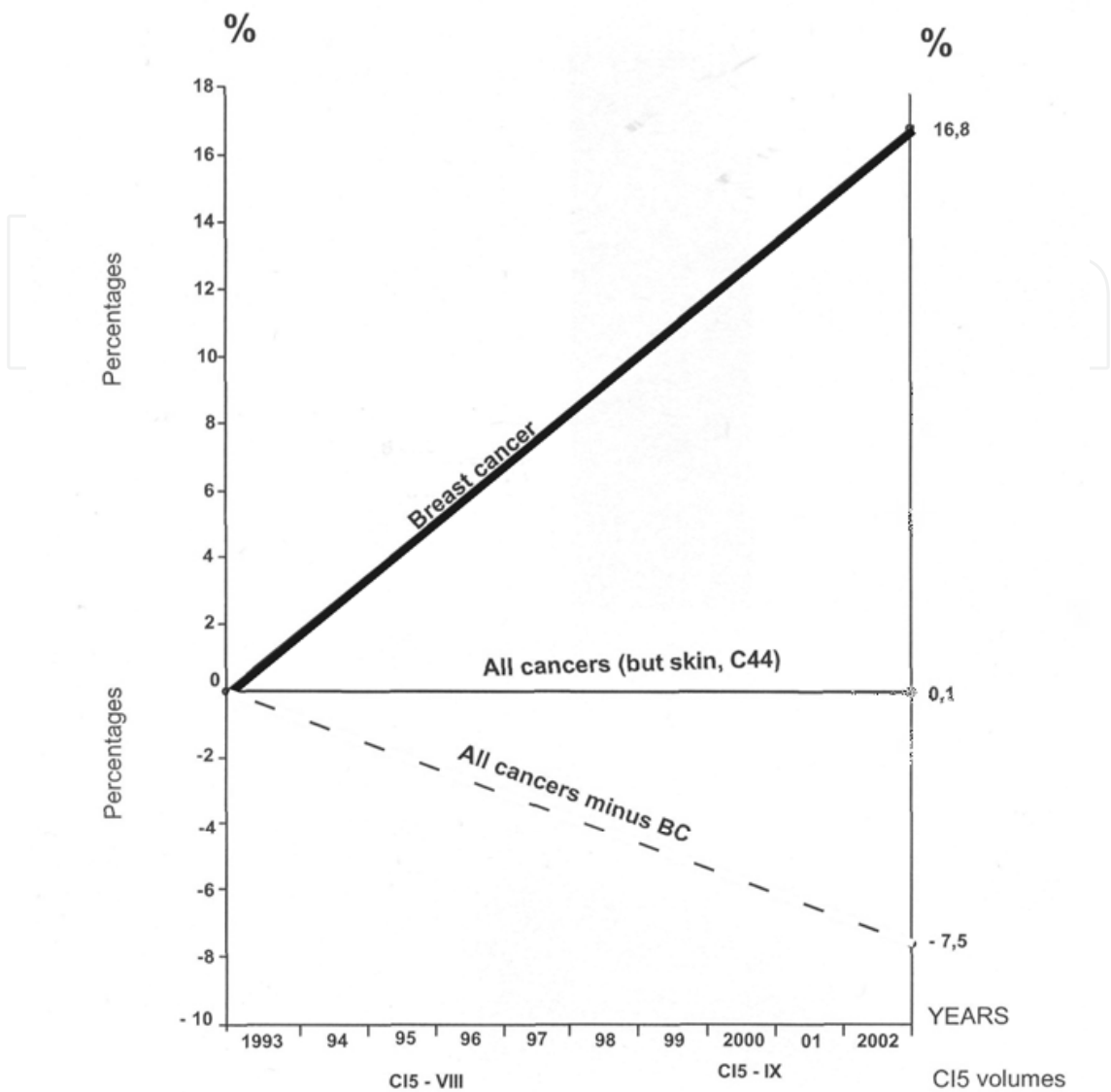


Fig. 16. Diverging trends of increase of breast cancer, and decrease of the ‘rest’ of all cancers in Afro-American women, 1993-2002, SEER - 9 regions. Age-standardized incidence rates, per 100,000

The differences in incidence rates and the diverging, comparative trends of increase and decrease of breast cancer and the ‘rest’ of cancers in women of both races (white and Afro-American), living in a reasonably same environment, gives credence to the evidence that the environmental chemicals/toxins, and of the women’s nature culprit estrogen theory, are not the likely risk factors of the disease. The root cause of the modern-time women’s suffering (breast cancer), is in certain other areas, such as, the “inverse” etiological risk factor at play at personal, intimate (sexual) and familial levels, as postulated.

Exactly the same pattern of diverging trends of rising breast cancer incidence rates as contrasted to decreasing incidence all other forms of cancer (“rest” of cancers) has been determined in Sweden in the past, Poland (Warsaw City) at the recent past and other centers in the world, according to the latest CI5 data (1998-2002). The same source shows that breast cancer incidence rates increased for 14.1% in Hong Kong, while the “rest” of cancer

declined for minus 6.7% between decades 1993-97 and 1998-2002. The Shanghai City, a fast developing urban conglomerate, and similar to Hong Kong in population and number of breast cancer cases, showed the same trends of increase, of 29.8%, of breast cancer (age-adjusted incidence rates), and increase of 9.7% of the “rest” of cancers. Once again, the differing end-results of breast cancer between the two Chinese metropolises may corroborate the evidence that increase of the disease in Hong Kong, along with the decrease of the “rest” of cancers, is more related to other than poisonous risk factors in the environment, than the (fast) increase of breast cancer in Shanghai (together with the “rest” of cancers), which might be related to ecological pollution of presumed exposures to noxious workplace environments. The notion of better controlled environment-related cancers, defined as “rest” of cancers and excluding breast cancer, might be seen in the following examples for the two periods between 1993-97 and 1998-2002: Higher breast cancer rise and trailing rise of the “rest” of cancers is observed in Sweden, at country level again, with 3.3% breast cancer rise and -1.6% decline of the “rest” of cancers), Geneva (Switzerland, with a 6.2% breast cancer rise and -3.0% decline of the “rest” of cancers), Tyrol (Austria, with 4.9% breast cancer rise, and a practically stalled rise of “rest” of cancers, of 0.3%). Virtually, almost all centers of cancer registration in the world, for the two aforementioned periods, showed much higher percentages of breast cancer rises as compared with the increase of the “rest” of cancers.

The intermediate figures and other tabulated data which are to be presented, will try to corroborate once again the underlying tested theory (hypothesis) of the exposure forces of the misconceived barrier contraception as the main risk factor, attributed as the root cause of the epidemic of the gender-specific diseases. Almost no other known alteration in the inter-human environment or corruption of the intimate (sexual) woman-man ecosystem has taken place in the population(s), but the misconceived ubiquitous mass condomization, making this overlooked fallacy an exceedingly hazardous “minefield” to the health, lives and happiness of women and girls in the modern world. In contemporary dictionary of profit-driven healthcare system, the biological risk factors and exposure to ever-rising breast cancer and other epidemic diseases in women are considered as “keeping the healthy people in the risk pool” and “death spiral.” From the deliberately maintaining the “risk pool” leading to scare, anxiety and “death spiral” of cost and uncertainties, new health-care dynamics are created, by which the insurance companies recruit eternal number of cases of breast-cancer affected women for “downstream” clinical activities, deceptively defined and disguised as “preventive health care for women,” and which include “preventive screening,” “preventive mammography programs” for “early detection,” and clinical treatments (surgery and chemotherapy). (The failed, previously carried out community “chemo-prevention” trials on healthy women with *tamoxifen* against breast cancer, in a number of European and North American regions, in the 1990s, is not an active option anymore.)

Most of the results and data evaluated in the study would stay open-ended, to monitor the further developments of the increasing trends of the breast cancer epidemic, until after the decision and public option for intervention is implemented for practical elimination of the breast cancer epidemic and the accompanied diseases-tumors of female reproductive system. (Practical elimination of the excess breast cancer epidemic worldwide might be defined as is a virtual ‘eradication’ of the disease(s) to low incidence rates of sporadic cases the disease(s) at individual, familial and community levels.)

4.5 Ovarian cancer

Besides breast cancer, an integral part of the comprehensive research of the reproductive health of women is the ovarian and endometrial cancers. In this regard, observations and results in joint breast-ovarian cancer research experience are presented. The following commentary to highly publicized results in prevention of ovarian cancer by oral contraceptive pills is presented: Adjacent to cancer of the ovary are considered the polycystic syndrome, menstrual irregularities, endometriosis, female sexual dysfunction, low pelvic pain, craps, bloating.

The following critical comment was communicated to Prof. Valerie Beral, the Director of the **Cancer Research UK** and the lead author of the “Study: the Pill Protects against Ovarian Cancer,” as reported by Washington Post Online, January 25, 2008 (Fragments):

“The Oxford study reported only a partial truth about the prevention / protection against ovarian cancer in the United Kingdom and elsewhere. Yet, the research of the root cause of the epidemic extent of ovarian cancer has NOT been done.

Despite the brief, but interrupted, heated exchange with the author and other presiding colleagues 14 years ago, at the ‘Lancet International Breast Cancer Challenge Conference’ (Brugge, Belgium, April 1994), about the tested evidence... that the CONDOMIZATION of women’s sexuality, as the main root cause of the rising epidemics of epidemic breast cancer and other malignancies (ovarian and endometrial cancers), has been ignored and circumvented time and again, and not investigated to date...

It is a real wonder that there were such women who used oral contraceptive pills during the long era of indiscriminate promotion of ‘condom culture;’ a minority of ‘non-politically correct’ women and couples who rejected, even periodically the use of condoms, perhaps by listening to their inner sense of impaired sexuality and health consequences. For, many millions of women suffered and died mainly in the Western world, including the UK, during the twin breast and ovarian epidemics. The deadly, false belief of the exposure to (use of) condoms as a “safe” device for fertility-control and family-planning purposes has apparently taken a heavy human toll, and puts many more lives in jeopardy.

Despite the controversial assertion (that OC pills ‘increase’ breast cancer while decreasing ovarian cancer), the fact remains that the OC pills (with prevalent use during the 1970s), did not create the breast cancer epidemic, but the condomization of female sexuality (since the beginning of the 1980s), has predictably precipitated the unprecedented natural experiment of rapid breast cancer rise as an epidemic disease, or has ‘coincided’ with the emergence of the current, unabated breast / ovarian / gynecological cancer epidemics. According to previous evidence, the preventive effect is recognized not because of the OC-pill chemical content, i.e., “the first medication...(which) cuts ovarian cancer,” as claimed by the authors of the aforementioned statistical study, but rather because of the non-use or abandoned barriers contraceptive methods (mainly condoms), associated with the observed protection of ovarian / breast cancer.

The OC-pill claim as protective factor also contradicted the added statement by the authors of ‘other protective measures’ against ovarian cancer which included ‘advice’ for “having children or getting tubes tied.” Those two human conditions (pregnancies or tubal ligation) oppose the presumed OC-pill preventive effects, for they contain neither exogenous, OC pill’s estrogens nor any other medication. Consequently, the role of the

OC pills as a presumed preventive measure against cancer in women should be questioned and rejected as an interpretation of its effects, as highlighted previously in a discussion about ‘Tubal ligation and risk of ovarian cancer’ in the same journal, *Lancet* 2001; 358: 1467-70 (pp. 843-44).

Women may change the contraceptive methods during their reproductive lifetimes, and may frequently, even sporadically still use condoms, because of planned ignorance of its carcinogenic effects. It is anticipated that the termination of the main and perhaps the sole risk factor of breast / ovarian cancers, the universal condomization of women’s sexuality, will bring about immediate health gain in the community. A practical ‘eradication’ of the diseases to levels of sporadic cases, is expected to be reached in a speedy decline of the current, excess epidemics of breast and ovarian cancers, in a mirror image of the rapid rise of the sex- (gender-) specific malignant epidemics as they entered the human race more than two-and-a-half decades ago. What might help in defining and providing primary prevention of ovarian and breast cancer epidemics in the advanced countries of the West, including the UK, is the empowerment of the British and other women with the “Right to Know” legislation about life and death matters.”

4.6 Thyroid cancer

An initial hypothesis-testing study, in the mid-1970s, showed evidence of a significant association between the exposure to condom use and the breast cancer development in American and other married women. During the mid-1980s, another field study corroborated the evidence of a postulated association between condom use and thyroid cancer in women as well. The study also confirmed the close relationship between these two female “sex- (gender-) specific” diseases of the breast and thyroid glands along with other accompanying diseases, tumors and cancers of female reproductive tract (Gjorgov, 1999). A feedback was communicated to the *New York Times*, entitled: “Pseudo Answers to the Thyroid Cancer Contingency: Times Essentials” - “The Rising Incidence of Thyroid cancer,” by **Carolyn Sayre** (*NY Times*, Oct. 15, 2010), as follows:

“The thyroid disorders and tumors, along with the other epidemic diseases that afflict women, such as breast cancer, showed to have the same etiologic root cause: the CONDOMIZATION of women’s sexuality. I have investigated in the field of thyroid cancer and I strongly believe that the aforementioned Times essentials of thyroid cancer are incomplete and out of reality.

Firstly, the information in the article should have provided separate data of women (i.e., for the so-named in the article “certain groups”?) and should not be referred to “people” rather than women throughout the article. The existing evidence suggests that the female thyroid cancer may etiologically differ from that in males. Besides the assumed environmental causes, the reproductive causes apparently play a major, additional causative role in the development of thyroid cancer in women. The female-male difference of the root causes of thyroid cancer in the past three decades (since the beginning of 1980s) may confirm or provide further evidence of the potential of primary (non-chemical) prevention of the disease in women to a great extent. The existing epidemiological evidence points out to a situation that thyroid cancer falls into the same category of the female sex- (gender-) specific diseases, along with breast cancer. While the ratio of breast cancer is about 100 in women to 1 in men, the ratio of thyroid cancer in

women is unanimously around or greater than three times of that of men.

Perhaps no one should be so mystified about the emerging, epidemic thyroid diseases nowadays, including the erratic thyroid cancer. Along with the other epidemic diseases which afflict women, such as breast cancer and the thyroid disorders have, almost certainly, the same etiologic root cause: the condomization of women’s sexuality.

Inferring from the NYT article, it could be assumed that out the 45,000 thyroid cancer cases in the U.S. there were at least 1,125,000 thyroid-nodule biopsies, out of which about 843,750 thyroid-nodule biopsies were performed to about 33,750 women a year. It may confirm the assessment that the magnitude of the number of biopsies and other diagnostic procedures equal the scale of clinical diagnostic activities conducted to the epidemic of breast cancer.

It is anticipated that both widespread, epidemic diseases in women, breast cancer and thyroid disorders / nodules, could practically be eliminated (‘eradicated’ to sporadic cases), by a still pending, primary (non-chemical) prevention of the current breast cancer epidemic..”

(The comment was first communicated to the ‘mystifying emergence’ of Oprah’s Thyroid Club almost three years earlier, on October 25, 2007),

The idea of similarity of risk factors of breast and thyroid cancers along with other female specific cancers, diseases and other phenomena was not widely known. The availability of the exceptionally rich cancer data in the WHO-IARC editions of the ‘Cancer Incidence in Five Continents’ (in last six editions) offered an opportunity to test the association, on global as well as regional scale (North America, South America, Europe, Asia, Australia, Africa), in addition to race (white, Afro-American), and developmental stage (developed and developing countries). The following **Table 4** presents the correlation coefficients and significance levels, of world data.

Country / Population	Vol. III: 1968-1972	Vol. IV: 1973-1977	Vol. V: 1878-1982	Vol. VI: 1983-1987	Vol. VII: 1988-1992	Vol. VIII: 1993-1997	Vol. IX: 1998-2002
# of places	80	104	159	166	183	211	300
Breast Ca.	.212*	.265*	.205*	.323*	.166*	.284**	.225**
Cervix Ca.	-.027	-.142	.041	-.060	-.118	-.208**	-.084
Uterus Ca.	.400**	.232**	.274**	.205**	.230**	.322**	.271**
Ovary Ca.	.078*	.080	.294**	.158*	.029	.224**	.538**

Legend:

+Age-adjusted according to World Standard Population (WSP), *Statistical significance p<.05

**Statistical significance p<.01 or p<.001

Table 4. Thyroid Cancer: Correlation coefficients with Breast cancer and other Cancers of reproductive system in women, World data: 1968-2002. Age-adjusted incidence rates, per 100,000.female population.

The results showed positive associations for breast, ovarian and endometrial cancer on global scale, and negative association with the cancer of the cervix uteri. The results are in accord with the postulated condomization exposure of women. The correlations coefficients

controlling for regional, especially on American and European variables and other developmental and racial variables reiterated the conclusion of a common root cause of breast and thyroid cancers. A series of dietary factors investigated in the study showed no significant results. The study was published in the journal “*Libri Oncologici*” in Zagreb, Croatia. A brief summary of the “(Gjorgov, 1998a), is presented below:

Risk Factors Of Female Thyroid Cancer In Kuwait: A Retrospective Study (Summary)

Background. A case-control study was conducted in Kuwait during 1984-1985, in order to ascertain the reproductive characteristics, contraceptive practice, and dietary habits of 101 women with primary thyroid cancer (TC), aged 19-65 years, and a comparative group of 98 control women, free of the disease, and matched by age and nationality status. Information was obtained by personal interview with a questionnaire. **Objectives.** The study investigated the relationship between the risk factors in the domain of fertility control, known or postulated to be related to breast cancer, and the risk of TC in women. **Results.** The study showed that both groups of cases and controls were homogeneous and comparable in almost all studied factors. Differences at statistically significant levels were observed, however, in two contraceptive exposures: the TC patients reported more frequent and more extended use of condoms than the controls ($P<.05$), whereas the controls reported more extended exposure to oral contraceptives than the TC cases ($P<.01$). The highest relative risk (odds ratio) to the disease, $OR = 4.3$ (95%CI: 0.5--39.2), and adjusted $OR = 7.1$ (95%CI: 0.6--78.9), was observed for women with condom use of more than two years. In regard to the dietary factors, no appreciative differences were found for most of the investigated food items, except a difference of borderline significance of higher consumption of sugared products among the TC cases, and a significant difference of a higher consumption of sugared drinks among the controls. **Conclusions.** The findings of barrier contraceptive risk factors (condoms) in this study may help explain the similarity and analogy of the epidemiology of these predominantly female sex-specific neoplasms, cancer of the thyroid and cancer of the breast. **Key words:** Reproduction, Contraception, Barrier methods, Condom, Non-barrier methods, Oral contraceptive, Diet

4.7 Other reproductive-health adverse effects

4.7.1 Adverse effects of condomization on female sexual dysfunction

Besides the new investigations into some new phenomena falling under a diagnosis of “FSDs” (female sexual dysfunctions), as further collateral, potential side effects of changed inter-human (woman-man) micro-environment could also come under consideration for investigation both the increased frequencies of divorce, and the more frequent reports of women’s unhappiness. The assumption of condomization being associated with allegedly newly defined condition ‘FSD’ – Female sexual dysfunction – and the ensuing discussion in the **British Medical Journal-Online**, 2003, is presented in the following rapid response (Gjorgov, 2003):

Condomization of female sexuality - the cause of the FSD (Female Sexual Dysfunction) (Gjorgov, 2003)

“In the recent article about the female sexual dysfunction (FSD) (Moynihan, 2003) and in the ensuing rapid reactions and debate about the subject matter, the keystone factor of the

female sexuality is amazingly missing across the board: the factor MAN. This background of culturally conditioned deficit convinced me that the research on FSD is being taken out of context. In addition, it seems that the FSD is not a static condition, developing by random choice and aimless. As emphasized in the article and the comments, the FSD has certainly a poorly understood etiology, but it might be evolving into some realms of unknown end-result(s).

More than 25 years ago, a hypothesis-testing study² on primary breast cancer prevention and etiology was completed jointly at the University of North Carolina School of Public Health, at Chapel Hill, NC, and at the University of Pennsylvania School of Medicine and Hospital, in Philadelphia, PA, USA, during the mid-1970s. The study has tested and corroborated an a priori hypothesis on "semen factors" (deficiency) that an extended exposure to (use of) barrier contraception, specifically, the long-term condom use, and/or withdrawal practice, is significantly associated with the development of breast cancer in married American and other women, including the British women. Besides defining a new approach to the etiology of and the potential for a primary (non-chemical) prevention of breast cancer, another main contribution, I believe, of my cancer research has been the evidence-based inference that SEX along with marriage and love is a fundamental PHYSIOLOGICAL unit, above and beyond the psychological, social, economic, reproductive and legal linkage. The final report of the study, entitled, "BARRIER CONTRACEPTION AND BREAST CANCER" (Gjorgov, 1980) was published as a monograph by S. Karger Med. Publ., Basel-New York, in the distant 1980. (Since the book has been effectively banned from the public view and professional information, the breast cancer research was first published in the dissertation format, in 1979, by the University of Michigan Dissertation International, Ann Arbor, MI 48106; UMI publication # 79-14352.)

It was further indicated in the study that breast cancer is a systemic disease and not a random event, and that the breast carcinogenesis is most likely passing through nonspecific and unrecognized phases, manifesting itself in a number of trivial or undistinguishable symptoms in women's lives (Gjorgov, 1995), presumably such as the FSD, and eventually reaching a definite stage of overt breast cancer and other accompanying disease end-results, as predicted (Gjorgov, 1993, 1994a; Gjorgov, 1994b). An experimental trial (Gjorgov, 1999) of sterile mating on a colony of small laboratory animals corroborated the preventive efficacy of the semen factors (the prostaglandins) on mammary neoplastic tumors, and on the general impact on animal-female lives and health. The condom use introduces technical effects of absolute male sterility in marriages, placing an impregnable wall between the protective biology of man and woman, and converting their marriages into infertile male partners. It is quite conceivable that many a woman may feel the ill-effects ("female sex problems") because of the persistent and un-physiological condom use, and that the woman is reflexively trying to protect herself by escape, distancing, separation or reluctance against the unwittingly afflicting insults (!) upon her done by her technically sterile husband. It seems quite evident and certain that during the long evolution, Nature has not adjusted the species to sterile mating, including the humans.

Within the framework of the tested "semen-factor" (condom) hypothesis in breast cancer, partial comments, opinion and paraphrases on the FSD debate: - Perhaps "Body-mind" rather than "Mind-body" relationships is a better model than the psychiatric and social

understanding of the FSD; - Contrary to what was mentioned, sex is NOT "Like Dancing": Sex is a physiological impact; - There is evidence that the continuing promotion of condoms use as a "normal sexual behavior" and/or (PC) contraceptive practice is lethal (breast cancer); - "Sexual functioning is an integral part of our lives" and perhaps of (gender) physical survival; - The feminist nonsense as a recipe for producing FSD: "masturbation" in females; - The "Conspiracy of Silence" for FSD is even more so for the unabated breast cancer epidemic; - The FSD, "as potentially epidemic condition" could and should be better handled in the services and domain of the Gynecologists-Obstetricians rather than the Urologists. - The "environmental intervention" in FSD, like in the breast cancer epidemic: Eradication of the "INVERSE" environmental factor, the barrier of the condom use that is eliminating, reducing or making absence the protective biological mechanisms in the intimate and subtle, inter-human (sexual) environment and ecosystem.

No wonder that the FSD is so prevalent in British and American women (reportedly, about 43%), for both are "high-risk" populations of breast cancer and are among the leading breast-cancer epidemic countries, with the highest breast cancer incidence and death rates in the world. Since the CONDOMIZATION of human sexuality seems to be the singular most important factor in the women's sexual dysfunction, my humble and evidence-based suggestion is simple and brief:

ABOLISH THE USE OF CONDOMS FOR CONTRACEPTIVE, FERTILITY-CONTROL AND FAMILY-PLANNING PURPOSES in the British marriages and couples, and make an urgent shift to the "non-barrier" methods of contraception (Gjorgov & Narod, 2001a). It is long overdue to make the British and other women happy."

4.7.2 Condomization, abortions, ‘missed abortions,’ and pseudopregnancy

The following letter to the **Editor of the New York Times**, referring to the editorial “Abortion, Condoms and Bush,” by **Nicholas D. Kristof**, NYT November 5, 2006, tackles the issue of condoms, “missed abortion,” and breast cancer:

Condoms, Condoms, Condoms...and Abortions. A critical reply

“Mr. Kristof seems biased and medically ill-informed by discussing a biological issue like abortions and condoms. What kind of abortion “rise” and “fall” throughout the past (three) decades and during (six) presidential periods? Discussion of temporal changes of all (i) the artificial, (ii) spontaneous, and (iii) so-called “missed” abortions? And, on top of this professional mix-up and mystery of abortions, a cause-and-effect link is added to the (predominant) use of condoms?

The (i) artificial abortions are carried out by demands, and reflect a fertility capacity of at least the woman. The artificial abortions burden the soul of the women in tremendous psychological pain, are reluctantly performed, and socially have always been quite controversial.

The (ii) spontaneous abortions reflect an infertility / sub-fertility status of both partners, usually married, and may indicate a hidden plight in building the family. The infertility condition is an acknowledged risk factor of development of breast cancer and other women’s ill health.

The (iii) “missed abortion” is an utterance of professional, clinical perplexity. As a

pastime term it could only be found in older editions of gynecology textbooks. The contemporary professionals try hard to avoid diagnosis of “missed abortion,” for its occurrence is not understood, and indicates a situation of false pregnancy. The condition is connected with the use of condoms. The ‘failure-rate’ of the use of condoms as contraceptive device is (uncritically) estimated to be around 9 percent. In fact, the use of condoms is induction of technical effects of absolute male sterility in the intimate (sexual) relations. (The prolonged or repetitious condition of false pregnancy is presumed as the initial, still reversible stage of breast cancer and other sex- (gender-) specific diseases in women of all ages.)

In my informed view, the reported, intermittent phrasing of “sharp rise,” “tiny increase” and/or “tiny fall” of abortions throughout time are misleading, inaccurate and incomplete. Actually, who knows whether the reports of abortions could ever be better exact?

On the other hand, the sharp rise and spiraling advent of the breast cancer epidemic in the country, in the last two-and-a-half decades (since the beginning of 1980s), the unending epidemic of malignant disease associated with the persistent condom use, is strangely overlooked in the column assessment.

The professional misjudgment and incompetence seem to be manifested in the confusion and equation of the use of condoms as a general category of family planning. The euphemism of “comprehensive sex education” practically means condom promotion / distribution in the schools, with condomization of the nascent sexuality of the schoolgirls, the youngest generation(s) of the American population, with unknown grave consequences / sequels.

As a young congressman, George H.W. Bush may have sponsored the 1970 public health program of family planning services which, almost certainly, may have included condoms, but, as President, he is recorded at a series on ABC television stations, in 1990, as rejecting distribution of condoms: “Not for me and not for the federal government... I don’t think that just passing out condoms, giving up on lifestyle, giving up on family and fundamental values is correct... In terms of just national passing out of condoms to people, I am not in favor of that.” So, President George W. Bush seems to be actually continuing the family roots. His energetic condom-paradigm shift and the potential of curbing the current breast cancer epidemic with the new anti-condom reproductive policy are anticipated to achieve an impending ‘eradication’ of the dreaded epidemic disease to the levels of sporadic cases in the country and far beyond.”

NOTE: In less than a month, on Dec. 5, 2006, the New York Times run an article entitled; “All the signs of pregnancy except one: A baby,” by Elizabeth Svoboda (Svoboda, 2006). Apparently, the NYT editors have investigated the above critique, confirming the information of false pregnancy which was repeatedly termed by its ancient Greek name, *pseudocyesis*. By quoting certain medical authorities, a skepticism was underlined that “human pseudocyesis will never be completely scientifically understood,” and another assertion that it is “one of the classic examples how the mind affects the rest of the body.” In fact, the condomization of female sexuality (pseudocyesis) may prove to be one of the classic examples of how the injured body affects the mind, rather than the way around. The issue of false pregnancy is associated with the condom-related “reproductive freedom” fallacy (Gjorgov, 1980, 1996a).

4.8 Anorexia-bulimia (‘eating’) disorders

The literature of Anorexia-Bulimia (conveniently called “eating”) disorders match only that of breast cancer. The number of new cases of anorexia and bulimia disorders rose rapidly worldwide in the past three decades, 1980s, 1990s, and 2000s, the rampant condition is rising ever since, continuing its rise in the 2000s, especially in the developed West, such as, the U.S. and the E.U.

A descriptive study was conducted in young female patients in mid-200s, at the Psychiatric outpatient clinic at the Faculty of Medicine of the University Sts. Cyril and Methodius, in Skopje, Macedonia, in order to assess the sub-hypothesis that (illicit) barrier contraception (condom use and withdrawal practice) is a risk factor of anorexia-bulimia disorders in schoolgirls, college female students, and other young women and brides (Gjorgov, 2009a). The main results indicated of the study indicated that the anorexia-bulimia patients [with mean age of 23.3 years (sd= 3.1)] used overwhelmingly condom device and equally practiced withdrawal technique for contraceptive purposes, during most of their young sexual experience and initial reproductive lives, as opposed to negligible use of OC pills.

On the basis of the prior observation (the sub-hypothesis), a confident communication along with a suggestion was forwarded almost 14 years ago to the **Swedish Royal Family**, concerning the announcement of the worrisome ‘eating’ disorder condition in the future Queen of the country, as follows:

M-me Elisabeth Tarras-Wahlberg, Spokeswoman, Skopje, December 10, 1997
The Royal Palace, Stockholm, Sweden

Dear Madam,

This is a humble attempt to try to address, as a physician and researcher, the reported news in the media of a heavy body-weight loss of Her Royal Highness Princess Victoria and to try to suggest a new possible approach in the efforts for solving this worrisome situation.

In my opinion, the heavy body-weight loss, so called *Anorexia nervosa*, is secondarily related to the problems of nutrition and diet. Rather, there is circumstantial evidence, that the life-threatening condition of *Anorexia nervosa* is perhaps causally related to the demands of reproductive and intimate life and to its applied technical barriers. The alternative hypothesis about the nature of *Anorexia nervosa* was deducted from a “byproduct” observation in my long research of the developmental processes in the field of breast cancer. Furthermore, the frequent condition of a prior excess body loss (and gain) in the affected, young, reproductive-aged women with breast cancer was controlled for and partially tested as a sub-hypothesis in my hypothesis-testing study of barrier contraception (the condom use and withdrawal practice) as an etiological risk factor associated to breast cancer in married American women.

During my field and ecological studies of breast cancer, it became obvious that the condom use in your country has been quite prevalent, with all the postulated subsequent consequences of the widespread misconception that “the use of condom has no side effects.” On the other hand, breast cancer in Sweden has been reported and registered as one of the highest in the world, and still raising, mainly because of

the widespread and long-term condom use in the general population, as postulated. In my separate study of the epidemiology and rising trends of breast cancer in Sweden, in 1992, the potential for prevention and control of the current breast cancer epidemic in the country was elaborated and suggested. Because the study could not be published, copies of it were sent from Kuwait University to a number of health and political authorities and institutions in Sweden, as a personal communication.

Based on my research experience, I do believe that the exposure to the condom use (i.e., to technically induced sterile stimulation) induces some devastating effects to a normal, young, vivacious, healthy woman, among which the life-threatening response of *Anorexia nervosa* seems to be one of the most frequent condition in the advanced countries, such as Sweden. The assessment of H.H. the Princess' condition is done on incomplete information and on certain assumptions, which might not be correct. Nevertheless, the possible way out of the anorectic danger for such a lady, in my opinion, would be the absolute elimination of the condom as a fertility-control device, by reverting to any of the non-barrier contraceptive methods (the pills, diaphragm, rhythm, IUDs, creams-jellies), in order to be able to preserve the healthy reproductive and inter-human life, and to prevent neoplastic phenomena.

Enclosure: Clipping from the daily newspaper. Respectfully submitted, ...

(The letter was acknowledged with thanks for the 'wish to help'.)

A similar communication was submitted recently to the Chairwoman of the **White House Council on Women and Girls** and Special Advisor the President, on December 10, 2010, concerning the rampant "eating" disorders cases in the U.S. and other developed countries of the West, as follows:

Dear Madam Special Advisor: Re: Eating Disorders Prevention

"Along with the Best wishes to Rep. Alcee L. Hastings and Patrick J. Kennedy and 34 Members of the Congress for their initiative to incorporate the global eating-disorders issue into the First Lady Michelle Obama "Let's Move Campaign" and the "Federal Response to Elimination of Eating Disorders (FREED) Act 2010."

Just to reiterate that there are no greater "strong environmental, cultural, and social factors" associated to or causing eating disorders, as mentioned in the letter to the First Lady (July 21, 2010), but the condomization of the nascent sexuality of schoolgirls, college and other women in the population. An all-inclusive approach to women's health and the new research of both the breast cancer epidemic and the rampant anorexia-bulimia disorders has identified as the main root cause of the specific sex- (gender-) diseases in women the misconceived and deadly, false belief of condom as a "safe" device for fertility-control and family-planning use.

My concern is, yet, that the blackout history of the past three decades may repeat itself, to continue stocking the unabated breast cancer epidemic in middle-age women (mothers), and extending the ill effects to the helpless anorexia-bulimia bewildered young women (daughters). The strongly reinforced, misleading, renewed condom-use offensive, oblivious of the greatest ill-health consequences to the half of the population, is poised to persist with the discrimination against women, girls and couples, by withholding the potentially life-saving information of a primary (non-chemical, non-profit) prevention / protection against the grave female-specific diseases at personal, familial and community levels. "

4.9 Osteoporosis

Osteoporosis far exceeds in frequency (incidence and prevalence) all other conditions in the female populations. During the past decades, since the early 1980s, osteoporosis and its sequels rapidly rose and continued its unabated rise, reaching excess epidemic proportions. As a “silent epidemic,” osteoporosis has become highly prevalent as a great clinical and societal burden, and a heavy public health problem of highest priority, especially in the affluent North American, European and other communities. A systemic disease, affecting 7.8 million women in the U.S. and worldwide, osteoporosis is diagnosed by low bone mass than average and steadily deteriorating bone tissues, leading to bone fragility and increased fracture risk. In the U.S. and Europe, 1 in 3 or even 2 women over 50 years of age will develop the disease, and more and more affecting premenopausal women. Presently, there is a gap in the efforts to control, treat and prevent the osteoporosis. The predominant theories of diet, calcium and vitamin D deficiency, and other macro-environmental factors have advanced no progress in the etiology, treatment and prevention of the osteoporosis in women. The traditional and doctrinaire approaches have neither identified the etiological causes of the osteoporosis epidemic nor defined the ways of preventing the disease in the community and at individual and family levels. Within the framework of the Bone and Joint Decade 2000-2010, an attempt was made by submitting a project proposal to test a new hypothesis of an etiological relationship between the barrier contraception and the risk of osteoporosis development in women. The proposed hypothesis of the etiology of osteoporosis (and osteopenia) and of the potential of primary prevention of the condition in women postulates that the osteoporosis is a late, delayed and/or a prolonged consequence of the marital exposure to (use of) barrier forms of contraception (specifically, condoms and/or withdrawal, and male/family infertility) during the reproductive, pre-menopausal age span of women (Gjorgov, 2006).

Once again, various manifestations of affected bone health, such as the low back pain, showed distinct increase in prevalence the U.S., after the 1980s, the same alleged time period during all other ill-health developments occurred in women (**Figure 17**).

Osteoporosis, and its initial stage, osteopenia, are perplexed with misinformation and misconceptions. First, the proportion of women with osteoporosis over men with osteoporosis is almost nine times greater in women than in men, which fact is not always underlined for further considerations; Second, the condition fall into the setting of so called sex- (gender-) specific diseases in women (like breast cancer, in proportion 100:1 females to males; Third, the grave condition do not ‘naturally’ come with age (look at the Sybille figures of the Michelangelo frescoes); Fourth, not all women carry the same risk of osteoporosis; Fifth, the (mystified) “FRAX” osteoporosis / osteopenia risk assessment tool from the osteoporosis associations, consists of majority of the same spurious and secondary risk factors of breast cancer; Sixth, a primary (natural) prevention of the conditions has neither been mentioned nor considered. Since the idea of potential breast cancer prevention is that it should start long before the malignant tumors are diagnosed, it could be safe to suppose that the “natural” (non-chemical) prevention of the crippling conditions of osteoporosis/osteopenia should be attempted at the same time along with the prevention of the other gynecological lesions, or even earlier, during the peak of the reproductive lives of women. Information for prevention seems far superior to pharmaceutical marketing concerning the chemical control and ‘treatment’ of osteoporosis and osteopenia in women.

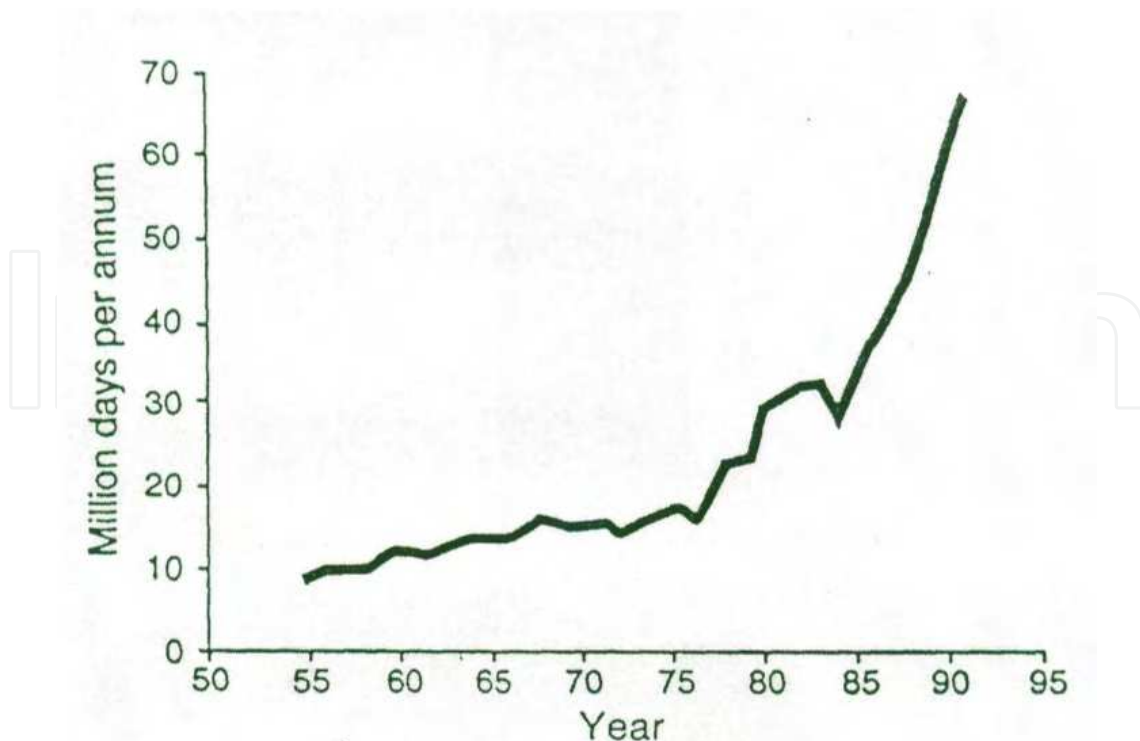


Fig. 17. Low back pain increasing trend in the U.S., 1955-1995.

5. Social and demographic consequences

5.1 Condomization adverse effects in marriage and divorce

The issues of contraception, marriage and divorces have been speculated upon frequently, mainly in the denominational quarters, in the U.S and elsewhere, under the sign of “controversial” issues and in some instance under feministic tendencies of interpretation. In the numerous judicial and social literature of the causes of divorce, some findings seem novel, such as the information that more women seek divorce than men nowadays (Ambekar, 2009) that divorces take husbands by surprise (Peatling, 2005), that sex is a reason for divorce and that “dissatisfied women are less likely to have sex” (Kimbal, 2010). Some older sources of religious discussion were practically out of reach (Peters, 1998). It was early warning that the divorce rates have much risen recently. Hardly any of the recent studies in marriage, divorce and sexuality ever considered condoms as an impediment to marital relations.

Other recent reports confirmed the rapidly increasing divorce rates in the U.S., with a distinct jump at the end of the 1970s and the beginning of the 1980s, greatly surpassing any divorce rates in the U.S. over the recorded past 150 years (Stevenson & Wolfers, 2007a, 2007b; Wolfers, 2010). The surprising rise of the divorce rate, greater than that recorded after WWII, and subsequently fluctuating and slowly declining trend was presented in the first figure in the text. The explanation of the truly distinct changes of the divorce rates, with the mass and still high jump in divorce rates was not fully explained in the report. (**Figure 18**). The presumed ‘driving forces’ of divorce talked about a variety of conventional causes, such as, importance of marriage has changed, rising age at first marriage, high remarriage rates, rise of cohabitation, rise of out-of-wedlock fertility, and other social and economic reasons.

In a response to the authors, Betsey Stevenson and Justin Wolfers, a critical commentary of the missing biological dimension in their scholarly analysis of national data of divorce and marriage, underlying the following points:

"It seems we could not really know about the break-up of marriages, "long" or "new," if only the "broader economic and social consequences" are being considered, by forgetting the simple biological causes of the events.

By looking into the primary source of the news ("*Marriage and Divorce: Changes and their Driving Forces*," by B. Stevenson & J. Wolfers, 2007 & 2009; Brining & Allen, 2000), besides the scholarly done review and presentation of official registry, raw data, the way of thinking, heavily influenced by the old-time feminism, seems very one-sided and insufficiently interpreted. The woman is analyzed mainly as a technological, social, economy- and business- oriented personality, with no reference whatsoever to her (their) biological individuality.

It was rightly emphasized in the study that marriage and divorce laws and regulations along with technical changes in the family do not explain the rise of divorces over the past few decades. And yet, the women "who suffer" are those who in majority file for divorce. The figure 1 in the aforementioned study, presenting the rates of marriages and divorces (per 1000 American people), stretching for 145 years (1860-2005) is truly revealing. It seems to explain to a great extent the missing references to the most critical period of rapidly rising and still on-going period of exceptionally high-divorce rates in the country in the decades of 1980s, 1990s, and first part of the 2000s: the mass CONDOMIZATION of female sexuality. While the contraceptive pills and their impact upon the society have been studiously explained, the destructive impact of the promoted use of condoms over the past three decades has been strangely overlooked, with an utter oblivion to the current, excess breast cancer epidemic, the greatest scare, dread and real risk of women, along with the widespread gynecological tumors and other afflictions.

Given the corroborated evidence that the condom use is significantly associated with the breast cancer development in American and other married women, it is not a wonder that many a woman is filing for divorce and, supposedly looking for a "new partner." Intimate condomized relations induce technical effects of absolute sterile husband in the marriage, perhaps worse stressor than other ones mentioned in the debate blog, such as "poor health, poverty, and unemployment." If in the biological struggle the wife is not supported (by a fertile husband), it is a general belief / observation, and she is turning against him. (The racial differences in rates of divorce are also consistent with the differences in breast cancer incidence and prevalence rates, the levels of condom-use acculturation.)

The figure 1 in the study seems circumvented in the analysis of the causes of the sudden bulge of skyrocketed rates of divorces ever since the end of 1970s and still on-going (in 2005). (The condomization started with rumors at the end of the 1970s.) It may be safe to assume that it is the most likely a response of women "who suffer" and try to escape (mainly by divorce) from the unknown but felt devastating and carcinogenic effects of sterile mating, and the incremental bodily and breast-cancer changes. Since the figure 1 with unusual trends of divorce trends is rarely seen in the literature, it may be worth following up the trend data, to witness the probable rapid fall of the divorce rates along with the information of the root cause(s) for and elimination (fall) of the epidemic breast cancer incidence rates and the main risk factor, the condom-control of women, perhaps at the earliest anticipated date, after the year 2010."

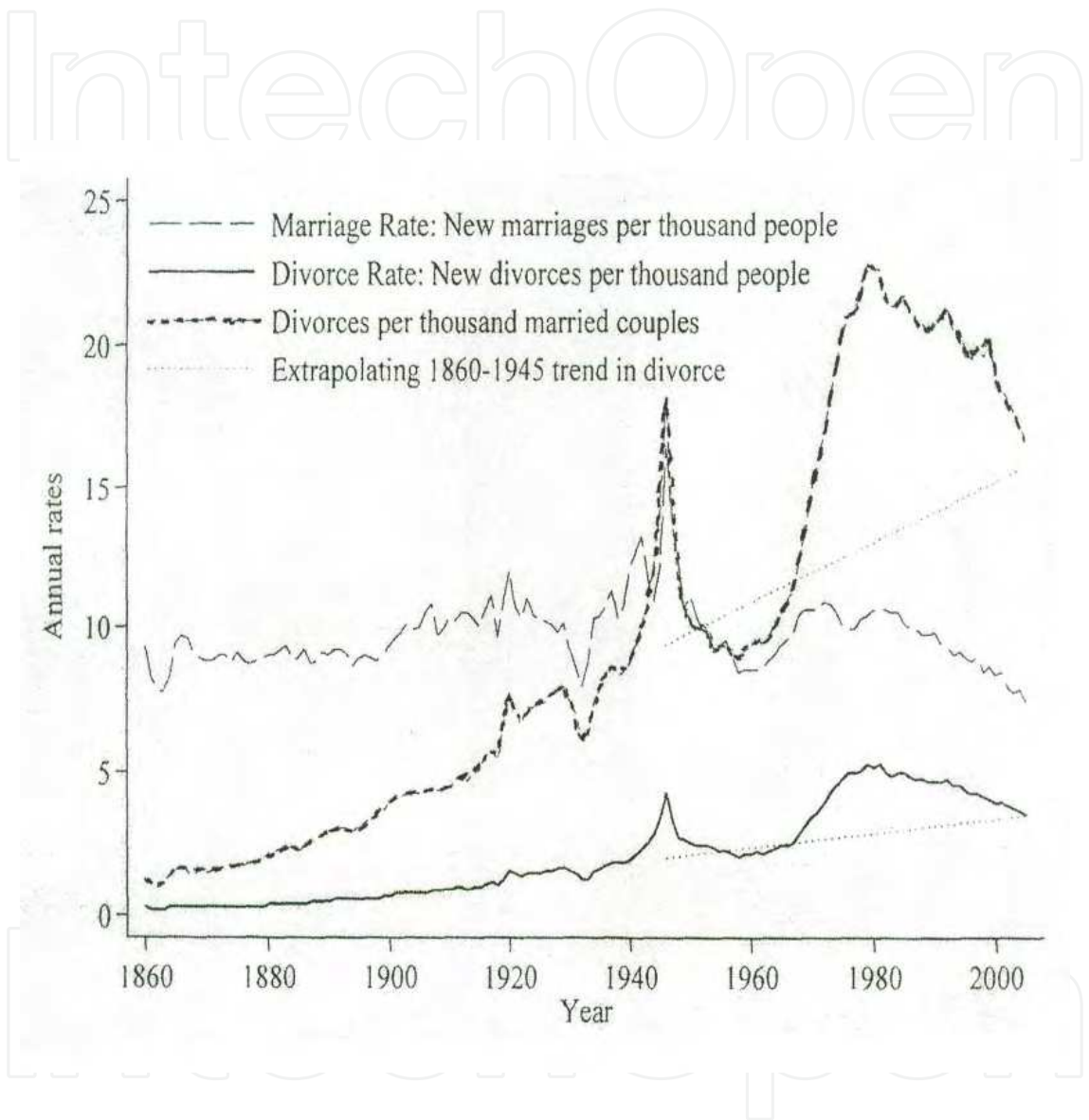


Fig. 18. Marriage and divorce rates in the United States, 1860-2000.

The unexplained changes in divorce rates reflected in other parts of the developed and affluent world. In **Australia**, a highly dramatic upsurge of divorce rates was recorded around 1978-1979, with a subsequent sharp decline and fluctuating changes afterwards (**Figure 19**) (Australian Historical Statistics, 2001). In the **UK**, the sudden almost threefold rise of the number of divorces was recoded somewhat earlier, in the mid-1978, and did not show appreciable decline for the next several years, until 2000 (**Figure 20**) (Office on National Statistics UK, 2004)...

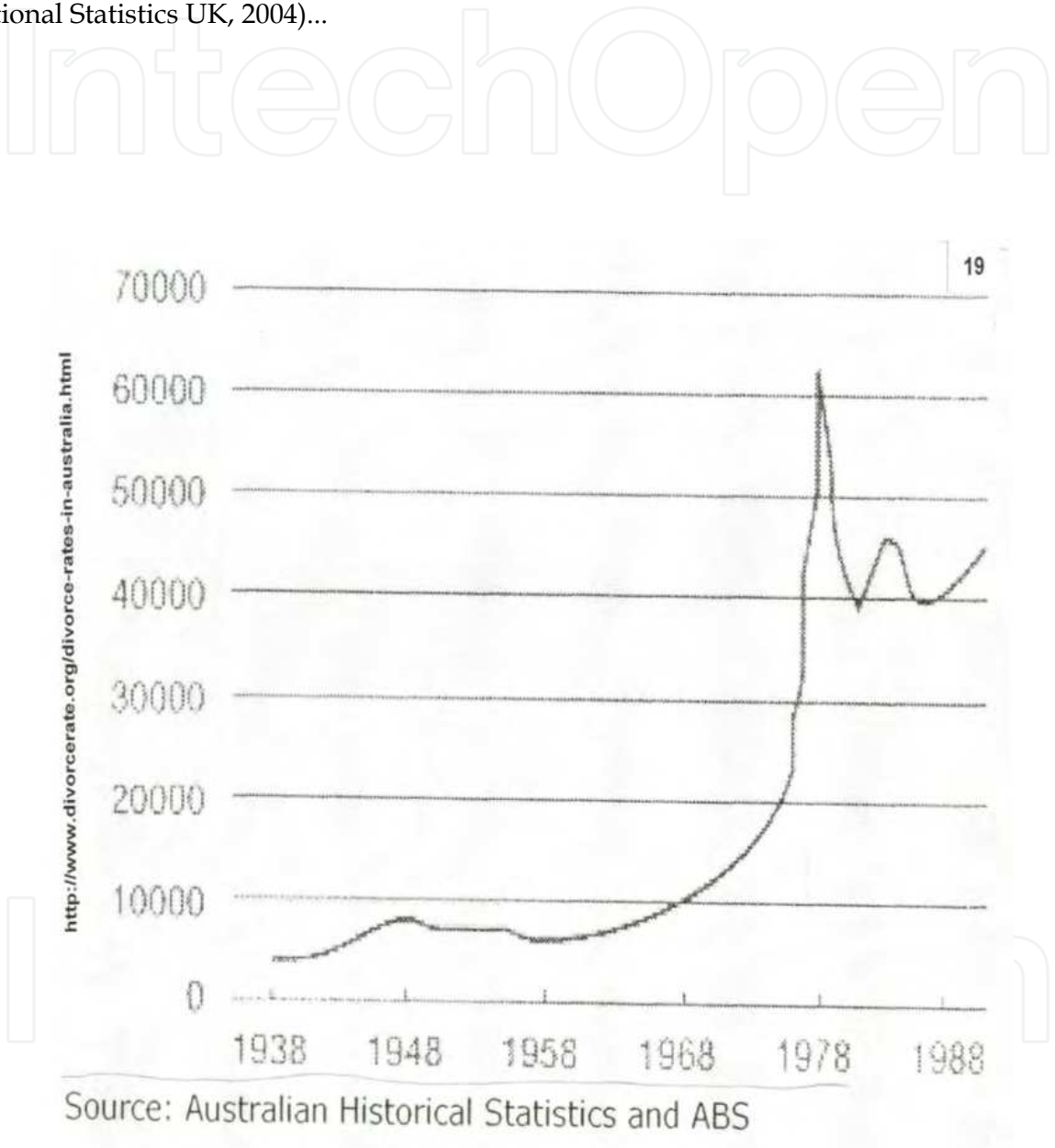


Fig. 19. Number of divorces in Australia, 1938-1991.

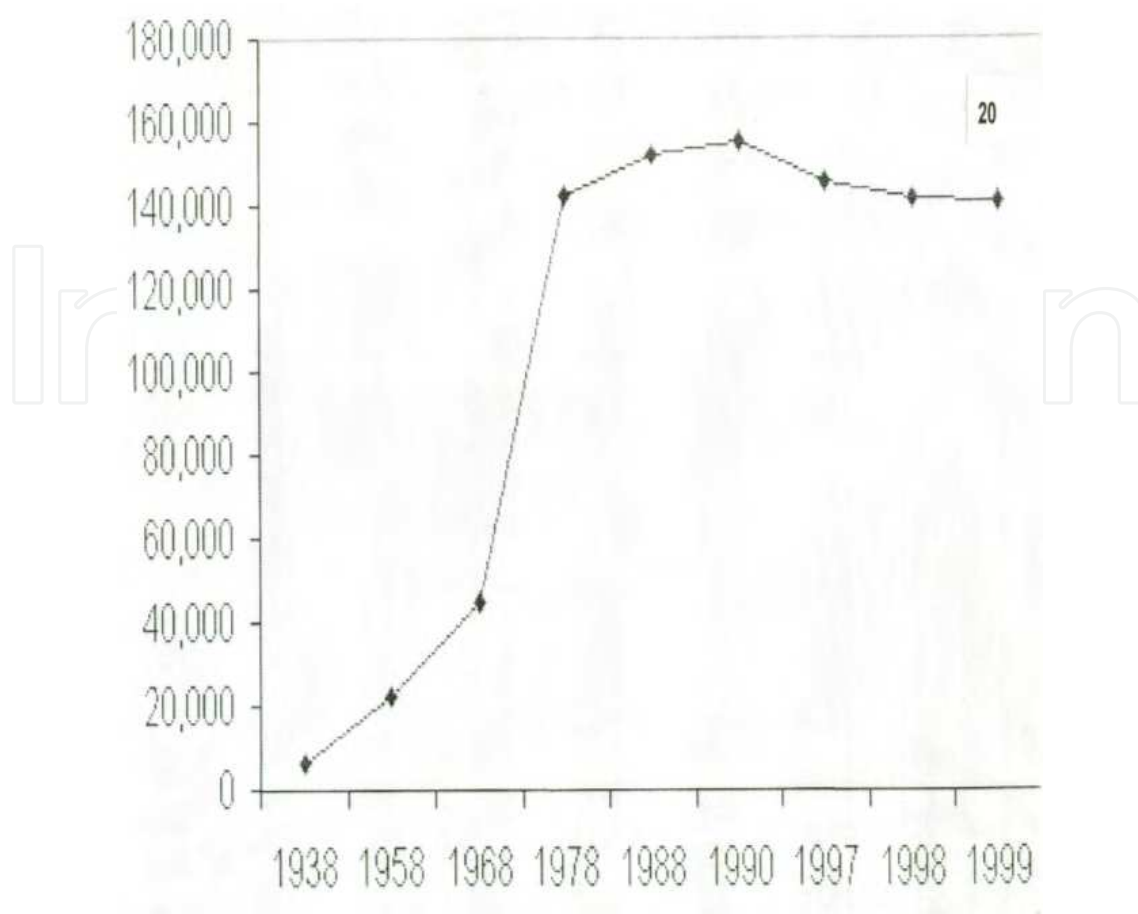


Fig. 20. Divorce rates in the UK, from 1938 to 1999.

In **Japan** there was also a wave of increased divorces as well (**Figure 21**) (Japanese Ministry of Health, 2002). However, the increase of the divorce rate in Japan showed at least three different demographic features: the increase was incremental and relatively lower, less than two rates (per 1000 population), against the increase in the U.S. (reaching more than 5.5 rate); and the peak of the divorce rates occurred about five years later than in the U.S. It is assumed that the changes in the divorce incidence rates may have the same driving force, stretching within a time period of several years, at the beginning of the 1980s.

The attempt for explanation of the observed social phenomena of high divorce outbreak did not reach considerations of condomization as a possible root cause of the observable fact. An attempt was made to address the issue of condoms as newly introduced environmental pollution in the inter-human intimate relations, in a comment to the article "Contraception and Divorce: Insight from American Annulment Cases," of 1998, by Dr. Edwards N. Peters, Edmund Card. Szoka Chair in Faculty Development, Canon of the Law Blog, Christmas 2010

"What prompted me to (belatedly) comment your article of 12 years ago is the ongoing routine of addressing condom as "contraception." In the mid-1970s, I conducted a hypothesis-testing study (jointly at two American universities) of the barrier contraception (condom use and withdrawal practice) and the development of breast cancer in American (and other) married women. The results corroborated the hypothesis and showed evidence of a significant condom and breast cancer association, together with the defined potential of primary (non-chemical) prevention of breast cancer as an epidemic disease. One of the main

inferences was that marriage along with sexuality, love and family is a profound biological union between woman and man, along with the conventional definition of marriage as a social, economic, psychological, and legal unit.

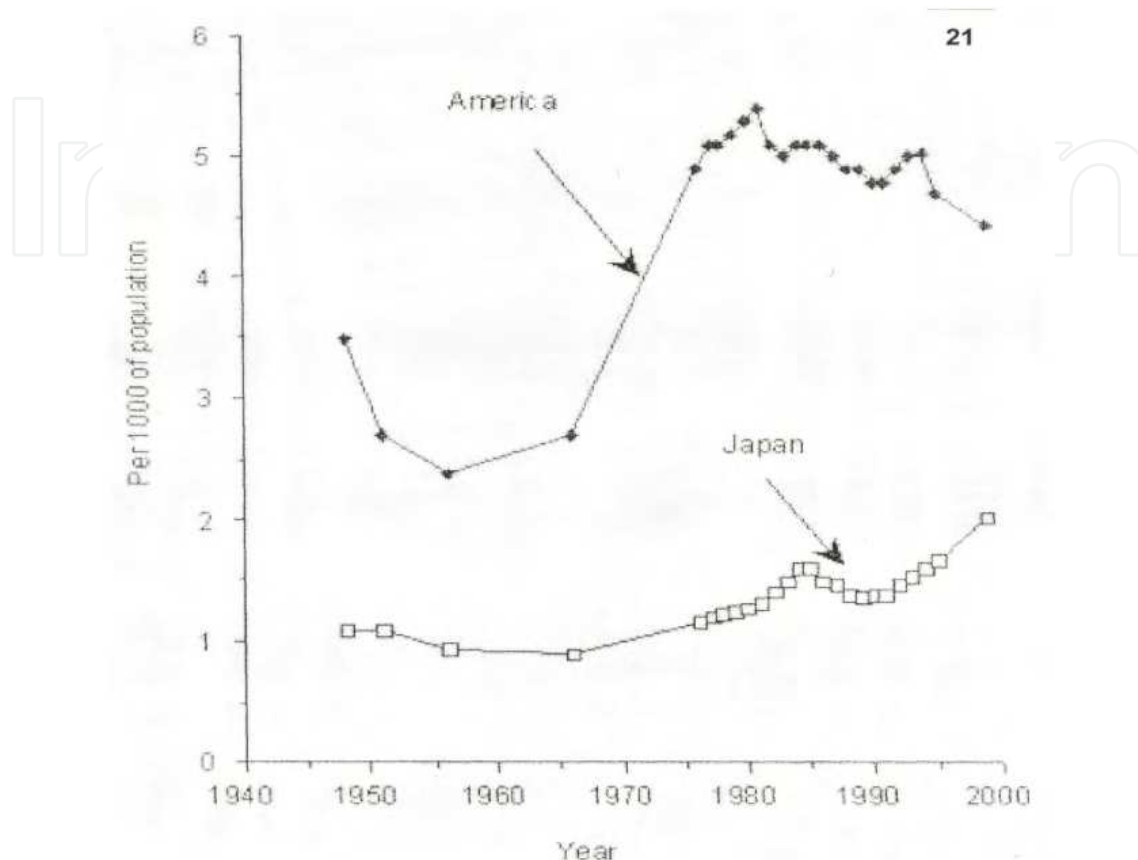


Fig. 21. American and Japanese divorce rates, from 1940 to 2000.

In a nutshell, condom is not a contraceptive method. This old/new (high-tech) barrier-device is literally a marriage-killer (divorce and a variety of psychosomatic phenomena and unhappiness) and woman-killer (breast cancer in mothers, and anorexia-bulimia disorders in young daughters). Condomization of female sexuality has been defined as the main and perhaps sole root cause of the unabated, excess breast cancer epidemic and other accompanying disorders of women and girls in the modern world. No other method of 'contraception' has been linked with the apparent natural experiment of the current breast cancer epidemic, or has shown the distinction to induce carcinogenic consequences on women on unprecedented scale in the country and societies globally. It seems that the study provided a basis of new understanding of contraception, and an attempt to use some of the (non-barrier) methods in preventive/therapeutical ways. In my view, the condomized control of women, rather the 'contraception' is the main causal factor for divorce, by which women supposedly try to escape from the deeply felt cancer-initiation process.

A real concern may present, time and again, the newly reinitiated, so-called "Rubber Revolution," the renewed, forceful and reckless condom promotion, entirely oblivious to the unabated, excess breast cancer epidemic, worldwide, and insensitive to the plight of the half of population, exposed to the highest risk of developing and suffering of the malignant epidemic disease(s) and other morbid phenomena."

The so-called Marriage calculator- divorce360 (Stevenson, 2010) could hardly fulfill its intended predictive purpose, since the analysis was based mainly on the educational levels and other social profiles of the spouses, and the failure (bias?) to consider the biological (sexual) dimension of marriage. Besides the calculator seems incomplete, because it lacks the necessary putative external risk factor quantified exposure, in order to serve as a Bayes' probability theorem requirements (Gjorgov, 2009b, 2010).

The dilemma of the official, but mistaken emphasis on strict promotion of use of condoms (in all sexual relations) in the U.S. House of Representatives (Lincoln, 1979) is given in the following personal communication to the **Honorable James H. Scheuer**, Chairman of the House Select Committee on Population, on May 29, 1979, in Philadelphia, PA:

"In reference to the conclusions of your Committee on Population concerning family planning policy, as reported by Richard Lincoln in *Family Planning Perspectives*, March/April 1979, the promotion of the "barrier" methods of contraception become an objective of first priority in the contraceptive research "of methods that are not known to be associated with hazardous side effects." No definition of "barrier" methods was presented in the journal's report (Lincoln, 1979) of the conclusions of your Committee. This is to inform you and your Committee that there are indications that some forms of barrier contraceptive methods are perhaps the most inadequate and hazardous methods for fertility regulation. This is also to present to you the available evidence of a recently completed study, indicating an association between the use of barrier contraceptive techniques and long-term health hazards in women. A barrier contraceptive, as defined in the study, is one which obstructs the passage and resorption of seminal content during sexual contact, such as the condom and withdrawal. The results of the tested hypothesis of the study corroborated the evidence that there is a significant relationship between barrier contraceptive practice and the development of breast cancer in women. The final findings corroborated the research hypothesis and the preliminary results of the study that women who used barrier contraceptive methods for extended periods of time in their marriages have a risk of developing breast cancer that is 4.6 – 5.2 times the risk of women who used other forms of fertility control. The results of the research also indicate that there is a potential for preventive action against the disease for a sizeable proportion of women in the population. It is estimated that by eliminating barrier contraceptive techniques, specifically the condom, and the incidence of breast cancer among married women in the United States could be reduced by as much as 50 percent. The results of the study consistently showed that the effects of a number of other reproductive and biological factors, such as age at first birth, parity, menarche, and others, had non-causal associations with the disease; The carcinogenic effect of the barrier contraceptive use was operative within a five-year exposure to condom use in marriage, with a cumulative effect; The study helps explain the increasing incidence of breast cancer, the international variation of the disease, and most of the reproduction-related risk indicators.

The final report, which is my dissertation, along with some other documents and material of the study would be gladly submitted to you and your Select Committee, if necessary. It is my belief that until further work in this field is done and confirmatory studies are conducted that this information of the devastating effects of condom use on woman's health should be made available to the users in community without unnecessary delay."

The recent report of the "Use of Contraception in the United States: 1982-2008" (Mosher and Jones, 2010) provided an abundance of data offering the opportunity to interpret the contraception figures, rates and trends in another way. There are a number of important findings which may shed a different light on the current discussion of the adverse impact of condomization upon society, and could be underlined, as such.

- It was stated in the Report that "in 2006-2008, 93 percent had ever had 'a partner' who used the male condom; 82 percent had ever used the oral contraceptive pill; and 59 percent had ever had 'a partner' who used withdrawal."
- The greatest increase of contraceptive methods recorded between 1982 and 1995 was for condoms, 79.5 percent of those who ever used the device, in comparison to OC pill, of only 7.9 percent increase. The increase of the condom 'ever used' prevalence in 1982 was 51.8 percent, and in 1995 82.0 percent, while the OC pill use remained virtually at a plateau, from ever-used prevalence of 94.5 percent in 1982 to 96.2 percent in 1995. For the next 13 years, until 2008, the increase of partners who have ever used condom was 93.0 percent (with 79.5 percent increase from 1982), while the OC pills ever used 82.3 percent (with 7.9 percent increase). The data may indicate that a combined (dual) use of condoms and OC pills might have been practiced, or an intermittent, non-consistent condom use.
- Changes in use of condom, pill and other contraceptive methods between 1982 and the subsequent years until 2008 clearly showed higher increases of all methods in certain ethnic groups in the U.S., corroborating the notion of condom acculturation as well. Thus, condom use by Hispanics at first sexual intercourse rose for 70.9 percent, for Afro-Americans 65.2 percent, and for whites 26.9 percent. OC pill dropped by -44.5 % for the Afro-American women, and withdrawal technique dropped by -17.3% for whites and -52.3% for Afro-Americans, but not for the Hispanics (which was low). The condom-use campaigns were not mentioned in taking place during the intervening years.
- Condom use by women aged 15-44 showed a declining trend after 1995, when the number of users (in thousands) declined from 13.1 to 11.1 in 2002, and to 10.0 in 2006-2008. The qualification of "persistent" condom use, which is considered practically impossible, because of the early adverse effects, use was not mentioned in the report.
- Prevalence of contraception use, both condoms and OC pills, was higher in younger groups up to age 30-34 than in the older groups 35-44, what is to be expected. The data of use of condom has obviously shifted to women of younger age which helps explain the "debut" breast cancer age-specific incidence peaks. The pill was used almost twice as much than condoms by women aged 20-24 (26.2 versus 13.4 by age, respectively); the condom was used in average of 10.0% by young women, and between 8.4 and 6.8 percent in older age groups 35-39 and 40-44. It looks like the ancient Roman "decimation" penal code is still powerful enough to make a strong impact on the community.
- Female sterilization was assessed at 27.1% in the 2006-2008 periods. There was age gradient of increase, showing a prevalence rate of 50.3% in the 40-44 age group. However, the unexpected high rate of "female sterilization" was not specified, in terms of proportion of elective tubal ligation and non-elective sterilizing surgical procedures. Tubal ligation is an established contraceptive method, but the hysterectomies and/or oophorectomies (one- or double-sided), are salvage surgical procedures carried out for

survival in many cases of breast, ovarian and other gynecological cancers. The blurred category of “female sterilization” showed a gradual increase of rates by parity, to highest proportion, of 58.7%, in women with three or more children. Once again, the purpose of the “sterilization” has not been specified, but helps explain the increasing survival rates of breast cancer in younger patients. (The male sterilization, vasectomy, assessed at 9.9% in the studied population sample, in 2006-2008, is still considered too controversial a method of contraception for pertinent comments.)

- Reasons for discontinuation of ever used contraceptive method, included prominent concern for the OC pill. To the question of “You had side effects,” the pill users responded positively in 63.7 percent, while only 12.0 percent of condom users responded positively; to the question “Did not like changes to menstrual cycle,” positive answer provided 10.6 percent of the pill-users, and none (zero percent) of the condom users. There was no side effect either recorded for condom use, even after more than 30 years of the condom - breast cancer link evidence first published.

The Scriptures and other classic literature throughout history seem to give ground for validity of the debates on the perennial issues of sexual relations, marriage, woman, love, conception, human seed, the “sin against nature” of sterile acts (coitus interruptus), prostitution, adultery and other human matters. A consensus in the polemic seems to be the belief that “husbands are the chief persons responsible for dissipation of their wives” (Flandrin, 1975; Gjorgov, 1977/1998). Many writers (Leo Tolstoy, Honoré de Balsac, Stefan Zweig, and many others), and other artists seem to have been ahead of the contemporary medical experts in assessing the natural forces of human intimate (sexual) relations. The Gustav Klimt’s artistic vision of “Medicine” was unfairly discarded by the professors of the famous Faculty of Medicine of Vienna at the beginning of the 20th Century. The apotheosis of “Medicine” was angrily discarded by the professors, most likely because the artist portrayed superiority of nature (physical love) over medicine, and depicted his idea of the role of man as a biological complement and the key to functioning of (impact on) the captured woman's life, health, reproductive processes, fate, and exquisite beauty (Gjorgov, 2003b). (Remember the strange slay of Biblical Onan because of his ‘mortal sin’ of spilling the seed on the ground in sexual relations with his “dissatisfied” second wife?). No wonder that there were confounding ‘clusters’ of breast cancer in various public institutions around the world (Australia, the U.S.), given the multitude of fashionable, politically correct, condom-promoting zealots.

One of the major conclusions from the studies on marriage and divorce could be inferred that condomization has been implemented long before the AIDS epidemic emerged, during the second half of the decade of 1970s. That was the time of ascendance of feminism, with its primary anti-marriage mission. The promotion of condoms seemed as an “ideal” technical device for the “Our Bodies Ourselves” health-promotion movement. Although condom-promotion started with whispers and rumors, it was quite fervent, distributing condoms at the entries / exits of some of the hospitals, in a somewhat confidential way. The semi-secretive distribution extended for several year until the solemnization of the mass condomization in the summer of 1986 (Koop, 1986).

The popular belief of the sexual relations exerting biological impact and health gain between woman and man, and for the woman in particular, is strongly imbedded in the minds of the people in the Mediterranean and Balkan regions, especially among the isolated Macedonian rural, mountainous, population (Gjorgov, 2001). It seems that the popular belief of

physiological marital inter-dependence on woman reflects possibly the remnants of the classical Hippocratic teaching on seed. The dramatic developments of the contemporary, ever-rising breast cancer epidemic and reproductive health and nature of women and girls may incite a renewed philosophical debate for better understanding as to what is in having sex for a woman, whether women need (drive for) sex for a different biological 'purpose' than men do, and to eventually reconsider the unanswered persistent question "What the women want?" which Freud failed to answer.

It should be mentioned here that in the meantime a fleeting attempt was made by the Israel Health Minister in the 1990s to ban AIDS campaign promoting condom as a prophylactic against the HIV infection, recommending divorce instead for the healthy wife, rather than use of condoms (Siegel-Itzkovich, 1999). More importantly, on December 19, 2002, the U.S. agency CDC (Centers for Diseases control and Prevention) in Atlanta, GA, proclaimed official news, entitled: **"CDC Fact Sheet Not Promoting Condom Use Anymore"** (Meckler, 2002), which was enforced by the American President, who acted on extra information about the ill-effects of condom use. The CDC declaration seems to have had an immediate but short-lived impact on decline of the breast cancer epidemic in the U.S. in the 2003-2004 time period.

5.2 The hidden impact of condomization on life expectancy of women

A few years ago a series of reports appeared simultaneously indicating an unexpected decline in the life expectancy of American people (Ezzati et al., 2008; Brown, 2008; Danaei et al., 2010). The main point in these and other reports was that after a long while a shift in the in U.S. demography has happen, from the customary decrease to sudden increase of mortality. The 'reversal of fortunes' as the shift was termed of the increasing mortality has happened in the last three decades, exactly after 1983. The fall of women's life expectancy was more pronounced than in men – of "one in five women" now experiencing lesser longevity and dying younger than before the beginning of 1980s. Although admitting that that the root causes for the downward trend is "impossible to know exactly," the search for causes was directed primarily on "modifiable behaviors and exposures," such as smoking, diet, and lack of exercise, along with the mortality of certain conditions of both sexes. "This is a story about smoking, blood pressure and obesity," was one of the over-confident statement of one of the Harvard researchers (Ezzati, 2008). Besides, the investigation included also diabetes, obesity and AIDS as possible causes of the fall in the life expectancy. The AIDS mortality, while insignificantly linked with the male life expectancy decline, did not relate to that of women.

A more recent background source, 'Explaining Divergent Levels of Longevity in High-Income Countries' review (Crimmins et al, 2011), offers more detailed information on the subject matter of declining life expectancy in the country, and in other comparative countries as well. The evidence in the review, indicated that: (1) the life expectancy is falling in the U.S., (2) the observable fact of falling life expectancy is particularly pronounced among women, (3) the new phenomenon of falling longevity occurred in the last 25 years (during the period 1980-2005), and (4) no risk factors, disease, or any other reason for the falling life expectancy in the U.S. and elsewhere has been determined for the evident, unexpected decline in life expectancy, especially in women (Figure 22).

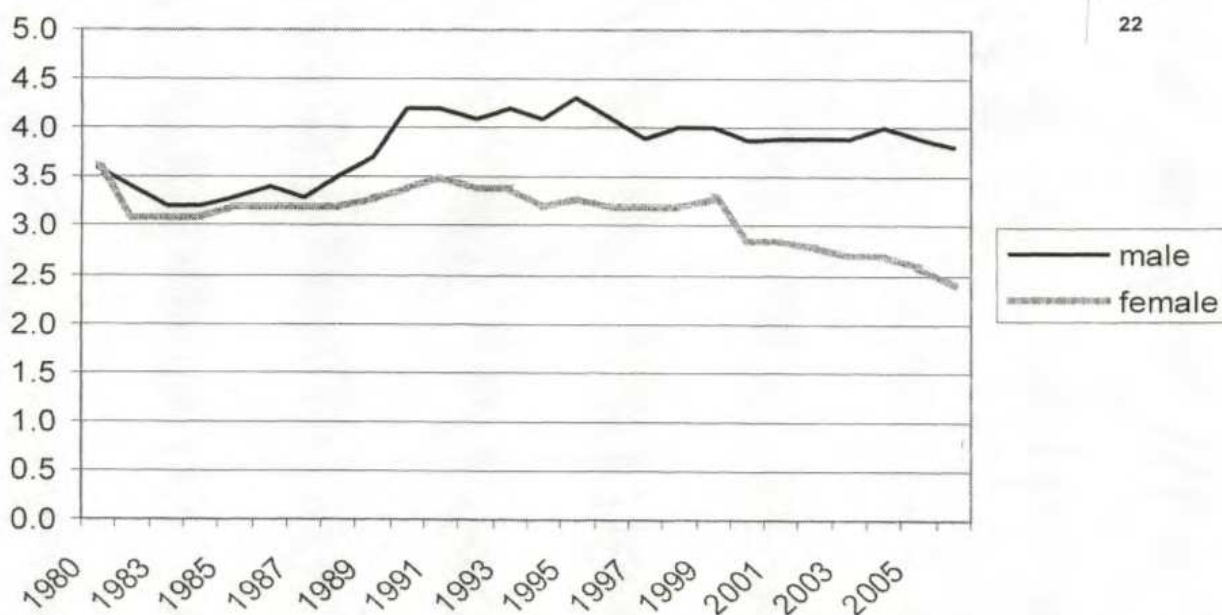


Fig. 22. Gender differences in declining life expectancy at age 50 for U.S. men and women, 1980-2006.

There must be some better way than unconvincing explanation of the confounding smoking and obesity factors, imparting them as the main culprit factors for the slashed longevity of American (and other) women. Missing factors in the review seem to be the unspoken breast cancer epidemic and the mass condomization of female sexuality. Breast cancer is generally treated in the analysis as a passing reference throughout the review. Conspicuously, the unabated and excess epidemic disease of breast cancer is hardly mentioned in the analysis. In the Chapter 8 of the review, entitled Hormone Therapy (in women), the main point of considerations was given on Coronary heart disease and Stroke, and Lung cancer, rather than on Breast cancer. Instead, Lung cancer was sited uncritically as a mortality factor for the decline of longevity even of men and women, because of neglected information that metastases of breast cancer to lungs account for more than 21 to 25 percent. The transmission of HIV/AIDS virus has not been found in the review as a risk factor for the enduring, 25-year decline of women's life expectancy.

The condomization of women's sexuality has been defined as a root cause of the current breast cancer epidemic along with the widespread, accompanying gynecological diseases, tumors and lesions of the organs of reproductive system and other phenomena in American women. The consequences, however, of the general condomization of women's and girls' sexuality in the mainstream population, in a misconceived attempt to stem the emergent AIDS epidemic by barrier birth-control device, has changed the demography of the American society, perhaps the most in the world. The never before experienced change of decline in longevity in of the people has been achieved by a profound corruption of the nature of the intimate (sexual) ecosystem of people, due to elimination of the biologically protective, primordial physiological impact of mutual woman-man relations. That is the change has been achieved by inducing technical effects of absolute male sterility in the marital and inter-gender micro-environment. Namely, the evidence of a significant association between condom use and breast cancer development in the population at large,

rather than the transmission of HIV/AIDS virus in any high-risk group, or hormone therapy (for breast cancer) for that matter, may better explain the decline of longevity of American women. It is almost certain that the extent of condom promotion / distribution in the U.S. has been more persistent and more indiscriminate than in the other high-income, comparable countries.

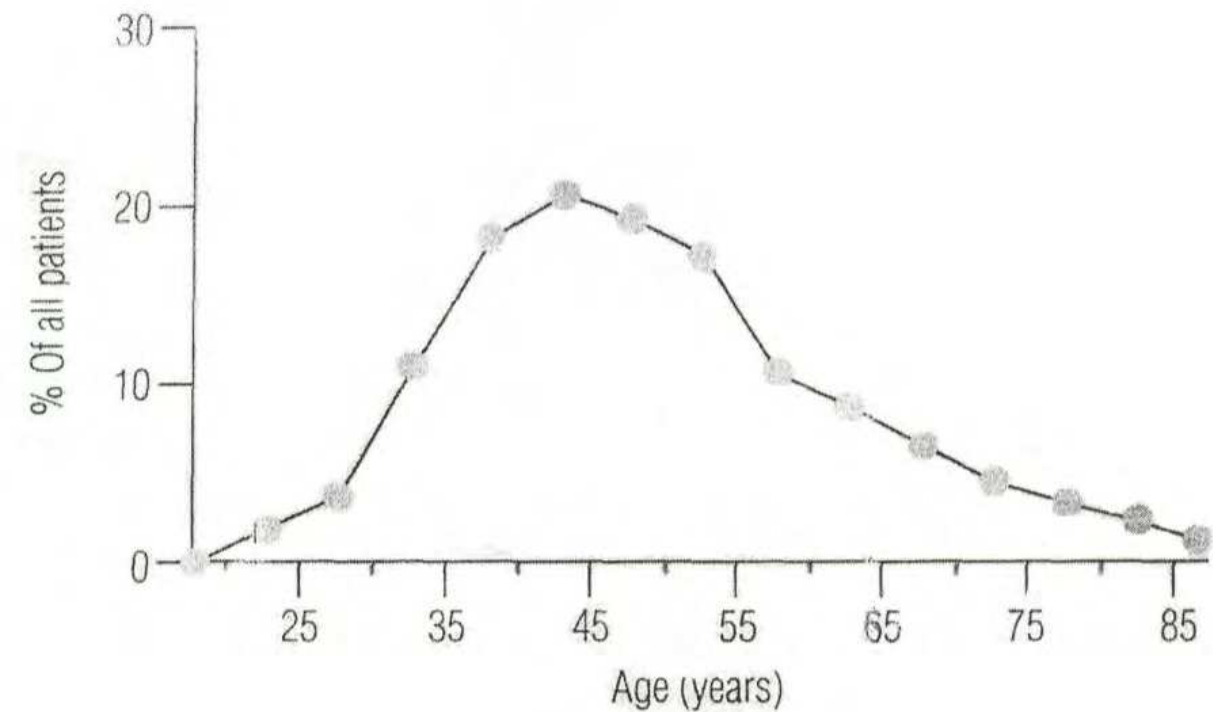


Fig. 23. Percentage of all deaths in women attributable to breast cancer (in 1990s).

The breast cancer epidemiology in the **U.K.**, in the mid-1990s (McPherson et al, 2000), included mortality figures of percentage of all deaths in women attributable to breast cancer (**Figure 23**). The proportion of breast cancer deaths was more than 20 percent in young women aged 40-45, and around 20% in the adjacent age groups 35-39 and 45-49.

In fact, the remarkable, long-term decline of life expectancy in American women may become a unique proof and testimony for both the medical, and perhaps political, misconception of social benefit of the indiscriminate, mass condomization, associated with the breast cancer epidemic, and the wrong-for-long misleading, deadly false belief of condom use as a “safe” hi-tech device for fertility-control and family-planning purposes. [The data of parallel decline on a lesser scale of male longevity might indicate that the devastating and carcinogenic effects of condomization on women’s health and lives, resulting in epidemics of breast-ovarian-gynecological cancers, might exert some reciprocal, unknown social or any other biological effect on men as well.] The hope remains, however, that the elimination (practical ‘eradication’ to levels of rare, sporadic cases) of epidemic breast cancer, by elimination of the sole breast-cancer risk of condomized control of women’s sexuality, to reflect rapidly on both decline of the breast cancer epidemic, and restoration of rising women’s life expectancy, in a fast manner as the disease entered human race, after the point of departure of all events at the beginning of the 1980s.

6. The future: Prevention of the breast cancer epidemic

In the perspective of breast cancer, the future is present. The answer is the primary, non-chemical prevention of the breast cancer epidemic, although the idea about prevention seems lost and no-existent in the West (Ferlay et al, 2010; EuropaDonna, 2010). Based on 2002 to 2006 trend of increase, the projected future trend of breast cancer increase was estimated at 53% by 2030. Similar disturbing forecast of breast cancer increase of 66.3% in the England and Wales by 2025 has been computed by using a mathematical model based on abortion prevalence rates and several other secondary reproductive factors; the predicted increase being from 39,229 in 2004 to 65,252 in 2025 (Carroll, 2007). Other projected/predicted increase of breast cancer of 32.9% in the U.K., from 2005 till 2024, the present number of 41,900 new cases annually to 55,700 new breast cancer cases in 2024 was assessed by Cancer Research UK (2007). The basic assumption being that the present, sad situation of the breast cancer epidemic in the country will stretch helplessly in the next 20 years, and beyond, into infinity.

To the contrary, the breast cancer epidemic could change by a dramatic decline in the UK, by not less than -80%, from both the forecasted by Carrol excess number of 65,252 cases to eventually 13,050 in 2024, and the forecasted by the Cancer Research UK organization (2007) also excess number of 55,700 cases to 11,140 or less, by 2024, provided primary prevention is implemented in the meantime. The mentioned number of in-situ (DCIS) cases, defined as non-breast cancer (0-zero stage), is expected to decline to a level of one-third (1276 in-situ cases) or less, of the 3,827 cases in England & Wales in 2004 (Carroll, 2007), provided, again, primary prevention is initiated. This is just for laying the groundwork for testing *in vivo* the two opposite theories of breast cancer preventability in the near future.

The following comment was conveyed to **Nicholas D. Kristof**, the New York Columnist as a reply to his article "The secret war on condoms," NYT, Jan. 12, 2003:

"The War On Condoms Is The War Against Breast Cancer

With reference to your article, "The Secret War on Condoms" (NYT, January 10, 2003), your bitter denigration of the efforts and the politics of the U.S. President, George W. Bush, for dismissal of the condom use as a device for contraceptive, fertility-control and family-planning purposes is misplaced, one-sided and seemingly rational. Apparently, Mr. Bush is in command of extra information of the devastating, adverse and carcinogenic effects of the consistent condom use in married American and other women. It is not your fault, of course, that you might have been ignorant of a hypothesis-testing study, which defined and corroborated the true etiology of breast cancer in the country, determined a potential of a primary (non-chemical) prevention of the breast cancer epidemic in the community, predicted the imminent epidemic rise of the malignant disease and, I believe, provided ANSWER for solution and creation of a public health policy in the field of breast cancer and other accompanying diseases. The study was initiated, supported and completed during the mid-1970s, at the University of North Carolina School of Public Health, at Chapel Hill, NC, and at the University of Pennsylvania School of Medicine and Hospital, in Philadelphia, PA. The final report of the aforementioned study was published in the distant 1980, as well as in 1979 by the Michigan University Dissertation International, Ann Arbor, MI.

However, there are strong indications that the research study has been concealed and secretly suppressed by the previous ("liberal") administrations, dealing with researchers

discovering other approaches with unemployment, academic and professional uprooting and deportation; very soon afterwards, the breast cancer epidemic suddenly and sharply rose and unabated continued its ever-rising increase. The estimate of the U.S. Senate has been that about 2,000,000 women became breast cancer victims during the decade of the 1990s, with 500,000 deaths of the disease. Nowadays, it has been reported that one million of new American breast cancer cases (most of them affluent victims) are registered in four years (rather than in five years, like in the 1990s). The incidence of breast cancer in the United States (as well as in Europe) has been at least seven times higher than the spread of AIDS, the deadly twin epidemic disease. Based on the available WHO data, during the two-decade period, 1981 till 2000, in the U.S have been registered 500,000 (accumulated) cases of AIDS, with about 150,000 deaths (and not less than four million women afflicted with breast cancer, including in-situ cases, with mote than a quarter of the affected women perished).

Apparently, by this backdrop of massacre of women, shattered families, widespread fear, real threat and tragedy in the Country and worldwide, the promotion of the indiscriminate, absolutistic and persistent exposure to (use of) condom in the mainstream population had to be reassessed and amended. The previous administration (at the highest possible levels), regretfully, missed the opportunity to properly address and entirely eliminate the breast cancer epidemic in the country and beyond, and to make the American women happy. With the resolute campaign of President George W. Bush against condom education among the teenagers in the schools, the ultimate objective of condomization of the society has been terminated and the cornerstone of a condom culture has been removed, I hope. In addition, I wonder as to whether a solution of the present gloomy breast cancer emergency or a sustainable prevention of breast cancer could be reached in the Country or elsewhere as long as an American study in primary breast cancer prevention and etiology, such as my monograph "*Barrier Contraception and Breast Cancer*" (1980), is effectively banned from public view, professional scrutiny and clinical assessment for a possible basis of a new breast cancer policy and efficient public health action in the field.

cc: Dr. Andrew C. von Achenbach, Director of the National Cancer Institute, January 12, 2003

cc: The Editors of the New York Times, February 12, 2003

The breast cancer epidemic has remained a perplexing epidemic, and is the case in point of a gender-specific, malignant disease, replacing the routine models of traditional epidemics of contagious, infectious diseases in the general population of both genders and all age groups. The traditionally known in the human history epidemics of infectious diseases have had defined source(s) of the contagious agent, are known to take a course of three main phases (slow or explosive beginning, reaching acme (the peak), and a protracted self-decline ('tail') of the natural end of the epidemics. It seems that the incidence, new HIV/AIDS cases, globally, have reached the peak at the beginning of the 1990s, and are presently showing sings of gradual, protracted, steady decline ever since (McNeil, 2010; USAIDS, 2010). Contrary to the medical experience, the breast cancer epidemic emerged fast, continued its unabated rise, never reached its culmination (acme), and never subsided in expected, tailed decline in the last three decades, since the beginning of 1980s. To the contrary, the new epidemic of breast cancer and other malignant disease(s) in women is not expected to vanish 'naturally,' by its own. Almost certainly, the current breast cancer epidemic is to be

terminated by deliberate and conscious human intervention only. The data indicate that the increase of the 'cancer' epidemic in the West, and in other parts of the world, is fueled up mainly by the cancer of the breast and its steady epidemic increase. Apparently, to try to eliminate the current, unabated and excess breast cancer epidemic, a new way of thinking may be needed. The misconception about the breast cancer etiology and community burden hinders the efforts to understand, prevent and control the epidemic malignant breast disease. "What is of concern...is the way the medical-industrial complex uses the research. They would have us believe that because of various findings, such as cancer genes, the cure lies just around the corner. The truth is, however, it doesn't make much difference if a cure ever emerges. The search is a splendid money generator," by quoting other authors, declared the unheeded UK Working Group on the Primary Prevention of Breast Cancer (2007) and, in addition stated, that "there is no sign of leadership from government regarding... (prioritizing).. primary prevention" of breast cancer.

In the last three decades, breast cancer epidemic has spread to other, developing countries of Africa, South Asia, Latin America and elsewhere, as expected. The emerging breast cancer epidemic in the "poor" countries is attracting increasing attention in western countries, with projects and programs relied on old science, and the failing strategy of "palliative care" and "no cure" attitude to continue to be applied against the epidemic disease(s) everywhere. Practically, the inner nature and hormonal balance of woman is still considered to be at fault, which should and could be 'corrected' by chemical agents and human interventions.

The basic strategy of a breast cancer prevention is chemoprevention, particularly with the obsolete *tamoxifen* and other 'selective estrogen modulators,' conducting "downstream" clinical activities of early detection with mammographic screening, so-called 'preventive' mastectomies and oophorectomies, and ineffective counsels for "lessening" spurious risk factors of breast cancer, among which the condom use as a contraceptive method is never considered and maybe still suppressed (Mills, 1987; Bray et al., 2004; National Cancer Policy Board, 2005; Anderson, 2008; WHO-PAHO, 2008; Frenk, 2009; Lancet Editorial, 2009; Meriman, 2010; .Miller, 2010; European Breast Cancer Network, 2010).

Several years earlier, a communication was directed to **Dr. Mitra Roses Periago**, Director of the Pan-American Health Organization-PAHO, Washington, DC, February 14, 2006, regarding the "*Guidelines for International Breast Health and Cancer Control*," *Breast Journal* Suppl., January-February 2006, conveying the following critical comments (fragments):

"First and foremost, NO PREVENTION of breast cancer was ever mentioned in the PAHO Guidelines. The long-standing, tested evidence (Barrier Contraception and Breast Cancer," 1980), strongly indicating a potential of primary (non-chemical) prevention of breast cancer in American married women, was not taken under consideration in the Guidelines. The evidence, neither disputed nor rejected, showed that breast cancer is a preventable epidemic disease.

The PAHO Guidelines documented the fact that the expected epidemic wave of breast cancer, expanding from the affluent and prosperous Western World (North America and Europe, and others), has already reached the shores and lands of the developing world of Latin America, Africa, and Asia. The Guidelines displayed the growing rates of breast cancer in 'low-resource countries' as an equally serious, rapidly emerging political crisis and a grave public health issue and burden in both developed and developing world. The PAHO Guidelines for breast cancer control in developing countries, however, have relied

heavily on the efforts and experience of the inefficient and fruitless breast cancer control measures in stopping breast cancer before it starts in the developed countries of the West and the WHO. The added rhetoric and new terminology in the Guidelines about the new approaches, innovative research, stratification of the levels of needs, community-based programs, social support, and other envisioned activities against the epidemic of the cancer of the breast, may only replicate the conceptual vacuum and futility in understanding of the etiology and prevention of breast cancer (along with other tumors of the reproductive organs and ill-health phenomena in women) in new settings around the world...

The recent, dramatic “condom paradigm shift” entailed by the U.S. Government (2002) in favor of an “anti-condom” reproductive policy was, most probably, imposed by no accident... Informed observations seem to indicate that race might play a more lethal outcome to married ‘non-white’ women (Afro-American, Hispanics, Asian-American), exposed to absolute-sterile mating (condom use), than to ‘white’ women, in terms of breast cancer development, earlier death, shorter survival and physical devastation. If anything, empowerment of women and their husbands / partners with information of the real breast cancer risk would prove to be more useful in preventing the disease at individual, familial and community levels, than the planned regulations and guidelines...”

The following **Table 5** is an attempt to define and elaborate the proposal of the hypothesis 1978 (Gjorgov, 1978a,b, 1979, 1980) of the etiology of breast cancer, and a likely shift of the conceptual framework of the epidemic disease:

Old Paradigm	New Paradigm
1. No Prevention of Breast Cancer (BC)	1. Yes, Primary (non-chemical) Prevention of Breast Cancer
2. Public-health emphasis on mammography screening and early BC detection; Epidemiologically: (unreported) <i>in-situ</i> cases	2. Public-health emphasis on primary prevention; Instead of exposure to the BC risks; the <i>in-situ</i> cases counted as BC cases;
3. The risk factors of BC are not amenable	3. The main risk factor readily amenable; BC is preventable
4. Treatment and chemical prevention of the BC epidemic	4. Primary (non-chemical) prevention of BC as epidemic disease
5. Nutritional presumed causes (fat, alcohol, smoking, diet, environmental chemicals, toxins, etc), and Reproductive causes: Early menarche, Late births (>30 yrs), Family history, Low parity, No breast-feeding, OC pill use, Late menopause, Lack of exercise, ‘Marital’ Infertility issue, and other risk factors; Genes and mutations	5. Semen-factor deficiency tested hypothesis: The main etiological cause: the widespread use of Barrier methods: of contraception: Condom devices, Withdrawal practice and male sterility/infertility in marriages. Condom-use technical effects of absolute male sterility: condomization of female sexuality due to Sterile mating
6. Environmental toxic substances & Industrial waste as BC causes, Polluted living settings (home, food, water, working place, streets); Radiation; Gene mutations	6. Inverse environmental factor of BC: absence or elimination of putative protective factors in the intimate (sexual) ecosystem and inter-human micro-environment

Old Paradigm	New Paradigm
7. Toxic environmental waste as direct cause of BC	7. Toxic waste: Indirect cause of BC <i>via</i> male infertility
8. Estrogen-Progestin model; 'Toxic-loaded' bodies, HRT, Ignored carcinogenic effects of external steroids, 'Endocrine disrupters' as causes of the current BC epidemic	8. 'Deficiency' of Prostaglandins, seminal fluid; Inner endocrine imbalance in women-related to causes of BC; Foretold BC carcinogenicity of "exogenous hormones" (HRT)
9. Marriage as a social, psychological, economic & legal unit only. Biological independence of spouses-genders	9. Marriage (along sex & love): a biological union w/ profound physiological impact; Sex (gender) inter-dependence
10. BC: poorly known, 'random' disease; local treatment	10. BC a systemic disease, No known cure
11. Hopes & trials in BC chemoprevention (<i>Tamoxifen</i>)	11. High-tech devices (condoms, HRTs) gone wrong
12. BC: poorly understood disease, treated as a local one	12. BC: Systemic disease with no known cure
13. Focus on selected BC figures & emphasis to find cure	13. Research-based, hypothesis-tested evidence & data
14. 'Heroic' treatment procedures, endurance of women, learned helplessness and ignorance for self-protection against BC; Decisions of BC 'reduction' at the top, governmental levels	14. Empowerment of women and couples with information of the root cause & BC prevention; Cause-effectiveness assessment for protection made 'at the bottom,' personal and family levels
15. BC as a political crisis, because of progressively rising epidemic spread of the malignant disease in the society	15. Solution/answer to the current, excess BC epidemic, subject to the will and commitment of highest political level
16. The risk of BC unknown; Early detection & treatments as secondary prevention of early death, longer survival	16. Evidence-based definition of the main BC risk: Marital and persistent (long-term) exposure to (use of) condoms
17. Focus on selected BC figures and prejudiced data	17. Evidence-based and hypothesis-tested results / data
18. Long latent period of BC: between 10-20 years or, starting even "in the womb" (both unsubstantiated)	18. Short BC latent period: between 2½ to five years; Evidence confirmed / verified by forecasted BC natural experiment
19. No comprehensive theory (conceptual vacuum) of BC & women's ill health and associated BC equivalents of tumors of the reproductive system; BC linked to ovarian cancer mainly	19. Comprehensive approach to women's health: BC, Ovarian cancer / cysts, uterine cancer/lesions, thyroid cancer / nodules. Anorexia disorders; female osteoporosis; Body-mind phenomena
20. BC prevalent in older, postmenopausal women (>50)	20. Shift to young women (<50); debut peak condom users
21. Current BC epidemic-rapid rise: Denial / artifact claims	21. Rise of the BC epidemic predicted; Verified by events
22. Officially, not recognized & nonexistent BC epidemic	22. Evidence of rapid, unabated & ever-rising BC epidemic

Old Paradigm	New Paradigm
23. 'Second' most common malignant disease in women	23. BC - the commonest malignant disease in women
24. Competing high rates of Lung Cancer in women	24. Fueled by >20% BC metastases to the lungs
25. Higher BC incidence rates in white women	25. Higher BC rates in women of higher living standards
26. Ostensibly, BC mortality decline due to early detection and BC screening programs; (Consensus: <i>in-situ</i> cases not to be included in the total annual number of BC figure)	26. If there is a BC mortality decline, then probably due to therapy and surgical modalities, particularly hysterectomy, (with or without one-sided or two-sided oophorectomy)
27. Promotion of condoms as "safe" device for fertility-control and family-planning method	27. Elimination of condoms for contraceptive purposes in population as the main etiological risk of the BC epidemic
28. Priority: 'downstream' activities: screening for more cases & clinical salvage of BC affected women;	28. Priority: Prevention of the risks & cause(s) of current BC epidemic: shift to non-barrier birth-control methods
29. No definition of female response to sterile mating	29. Inner imbalance (Pseudopregnancy), Missed abortion
30. Primary (non-chemical) prevention of the BC epidemic not considered, despite the failed chemoprevention trials	30. Primary prevention ('eradication'), w/ estimated >80% reduction at individual, family and community levels
31. Chemo-prevention of BC: assuming "wrong" female nature to be corrected by Tamoxifen / Raloxifene & drugs	31. Nothing wrong with women's nature subject to chemical correction: Misconceived toxic-substance prevention of BC
32. Ovarian, endometrial and thyroid cancers and other gynecological diseases as unrelated to BC entities	32. Ovarian, endometrial, thyroid & gynecological cancers, lesions of same etiology, condomization of women all ages
33. Silence and suppression of the information of the potential for prevention of the current BC epidemic	33. Decision (pending?) for non-mutually exclusive primary prevention against the twin epidemics of BC and AIDS
34. Plan for action: Search for cure, better therapy, and new drugs and 'better armamentarium' for BC screening	34. Needed plan for action for BC prevention: Elimination of condom use for contraceptive purposes.
35. Overlooked impact of condomization upon issues of marriage, divorce, and women's mortality and life expectancy	35. Considerable protective impact upon social issues of marriage, divorce, and women's mortality and life expectancy

Table 5. Breast cancer hypothesis 1978 and shift of the conceptual framework. (Updated: March 2011)

In the strategy for the global Millennium Development Goals 2015 (MDGs) decisions, a similar situation presented itself regarding condomization of women in less-developed regions. In a letter to the United Nations Secretary-General, the **Hon. Ban Ki-moon**, on September 25, 2010, the following message about the harmful effects of condom-use programs was conveyed:

“As a former United Nations Fellow, Fulbright Scholar, physician and researcher, I like to take the liberty of trying to draw your attention to the grave consequences on women’s and girls’ reproductive health and lives of continuation of the fallacious condom policy in pursuing the future global Millennium Development Goals 2015 (MDGs).

The condomization of female sexuality, defined long ago as the root cause of the current breast cancer epidemic worldwide, is going to be perpetuated by the UN global MDG Plan for Action. The Plan is apparently oblivious to the global twin epidemic of breast cancer along with AIDS, and is projecting the mass condomization as the main critical plan for action for the Goal 5 and Goal 6 in particular. The breast cancer epidemic has been superseding manifold the HIV/AIDS epidemic in the developed, affluent world of the West, including the U.S., UK, and other EU countries, from the outset, in the early 1980s.

From the affluent, rich western world, the breast cancer epidemic is rapidly spreading to the so-called developing, ‘poor’ world of Africa and Asia, as anticipated. The typically affected by the disease young / younger women (the main condom users), testify in favor of the defined etiology of the rising breast cancer crisis in the developing regions of the world... Besides breast cancer, there is a myriad of accompanying gynecological tumors and diseases increasingly afflicting women of all races and age-cohorts during their reproductive life-span. It is anticipated that another, more fatal category of female suffering may soon appear, of women affected by both HIV/AIDS and breast cancer diseases combined.

The main culprit of the on-going global breast cancer crisis is the deadly false belief of the use of condom is a “safe” device for fertility-control and family-planning purposes. (By this token, let me mention some official data of the Korean women in the U.S. who have been and still are with the lowest recorded breast cancer incidence rates, which, in my experience, could be attributed to a traditionally low prevalence of condom use and, accordingly, to the assumed lowest condom acculturation in the new/old country.) Almost certainly, it was not by accident that the former President, George W. Bush, acting most likely on extra information, imposed a bold ‘condom-paradigm shift,’ in favor of an anti-condom reproductive policy, followed by a global ban on condom promotion and distribution, and termination of the unlimited condom funds to global agencies at home and abroad (including WHO, UNFPA, UNAIDS, World Bank and others)... At the present, I believe, the signs may seem encouraging that President Barack Obama would proceed with the same policy of non-condomization of the mainstream population, which policy is expected to prove to be extremely beneficial for elimination, i.e., for primary prevention (non-chemical, non-profit) of the current breast cancer epidemic, and for a better control of the other gender- (sex-) specific diseases in women of all ages. What seem to be happening now, instead, is that the United Nations and its agencies continue to sponsor / promote the relentless push of condoms, disguised as family planning methods, with lingering ill-effects and inevitably up-dating and transferring the current, breast cancer epidemic and other harmful experience of the West into poor world regions...

It is my belief that your post of UN Secretary-General embodies a unique opportunity to be able to try to help reassess the new scientific evidence about the epidemiological and social consequences of the never openly debated, arbitrary silenced issue of condomized control of women’s and girls’ sexuality, a deceptive protection of their reproductive health in the UN sponsored MDGs 5 & 6.”

E-mailed and AIRMAILED

7. Conclusion

The perplexing worldwide breast cancer epidemic, defined as unintended consequence of widespread condomization of women's sexuality, carried out in fervent campaigns for both contraceptive and prophylactic (anti-HIV/AIDS) purposes continue to reign supreme, globally. It is the quintessence of a deadly female sex- (gender-) specific, malignant disease. The data indicate that the increase of the 'cancer' epidemic in the West, and in other parts of the world, is fueled up almost entirely by the breast cancer epidemic and its steady increase. The breast cancer epidemic is thriving mainly because of lack of commitment to eliminate the disease(s) to rare, sporadic cases, at personal, familial and community levels. The condomization of women's and girls' sexuality is directly related to multitude aspects of female ill health, disturbed functions, specific and accompanying diseases, life, death, marital malfunctions, and reduced longevity.

Most of the researchers in the field of cancer research and birth control seem to refer to a "recreational" value of sex, by searching only for technical aspects ("frequency") of intimate encounters and utterly ignoring the biological aspects and barriers to the primordial 'gender' communication, sexual relations. It is amazing that the authors have consistently missed the opportunity to consider barriers to sex as a part of life, particularly of women. The new epidemic of breast cancer and other malignant disease(s) in women is not expected to vanish 'naturally,' by its own. The data indicate that the increase of the breast cancer epidemic in the West, and in other parts of the world, is fueled up mainly by the deceptive condomization of female sexuality in mainstream populations. Almost certainly, the current breast cancer epidemic is to be terminated by deliberate and conscious human intervention only. To try to eliminate the current, unabated and excess breast cancer epidemic, a new way of thinking may be needed.

The answer to the current breast cancer contingency is to undertake a primary, non-chemical, no-profit, prevention of the epidemic. Since information in public health actions is superior to legislation, it seems better to take the first steps with subtle, nonjudgmental attitude. Perhaps the true information of the devastating and carcinogenic effects of condom use should be communicated to the consumers and displayed on the commercial product.

The information (warning) of the breast cancers risk being included in condom labeling. No doubt that women and couples, empowered with preventative, potentially life-saving information, will be able to make correct assessment of the risks and benefits values on matters of life and death, at a bottom, personal and familial, rather than at the detached at the top decision-making level.

8. Acknowledgments

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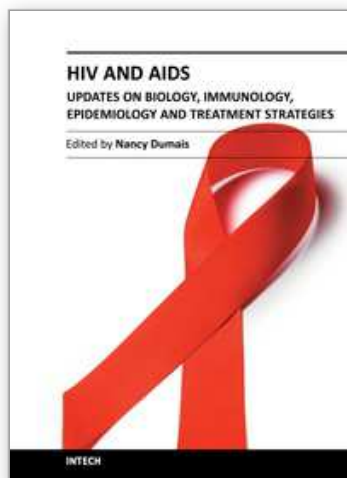
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