

Dear Sir/Madam,

Australia, in the context of the Covid pandemic, is in the enviable position of being able to observe what is happening around the world, and formulate a response capable of protecting our people, so that we are adequately armed in order to return us to health physically, socially, mentally and economically.

The Covid (Covid-19 or SARS-CoV-2) narrative presented in the Media presents vaccines as the way out of daily frightening case counts, lockdowns, loss of social freedoms and disruption of the economy. Drugs are not presented as an immediate or generally effective or widely available solution.

The possibility of Covid infections and subsequent disease and death¹ remains, even in countries with high vaccination cover². Therefore, development of accessible, affordable, even population-wide drug treatments should be a priority.

The most urgent considerations are:

- Public Health interventions encouraging **therapies which strengthen the immune system** and decrease the likelihood of severe disease.
- to make available **effective, easily accessible, early, even pre-emptive (before positive test is verified) and prophylactic treatment** for COVID-19, for all stages of disease.
- use of **safe vaccines** which have a *risk:benefit ratio* which warrants their use in the *context of effective early treatment*,
- **aiding poorly resourced nations** in an orderly *provision of safe treatments and protecting them from experimentation and exploitation*,
- to understand that the Nation's health is at risk, it is still important that we have the best **information available** for doctors and patients alike to allow informed medical management decisions and appropriate informed consent to therapies and vaccines.
- to **avoid the draconian control measures** required when there are no available treatment options (see Addendum on Lockdowns)
- **stop possible hospital overload** with a decrease in quality of medical care for the community in general and staff not being able to cope. Konstantin S. Sharov offers an interesting insight into the role of distorted Information in feeding into a stressed Healthcare System.³
- **decrease fear in community** due to reasonable treatment options being available.
- **Allow return of social and political freedoms** (removal of State of Emergency provisions in Victoria, for example).
- **allow immunity to SARS-CoV-2 to increase** in the community relatively **safely** and **decrease viral transmission** through effective early treatment preventing more complex, later disease quickly and reducing viral load . Doctors using early outpatient treatment in SARS-CoV-2 outbreaks have had 99.9% success rate even with elderly patients^{4 5}.

Part 1: Therapy

The National COVID19 Clinical Evidence Taskforce have been carefully researching and recommending therapies suitable to treat or ameliorate mild to severe Covid disease.⁶

There are **no Public Health recommendations** to fortify the population against Sars-CoV-2. In fact, the use of Vitamin C, D and Zinc in COVID-19 are relegated to Clinical Trials, unless indicated for some other reason.

There are, however, **no prophylactic therapies** recommended despite quarantine personnel being a major source of new community infections in Australia. Ivermectin is currently being reviewed by the panel for prophylaxis at this time.

There are **no therapies recommended for Outpatient treatment** to prevent progression of disease (a major emphasis in clinical management in countries where Covid disease is more prevalent)⁷ although Monoclonal antibodies (Bamlanivab plus Etesivimab) may be used in an approved trial for mild or asymptomatic patients. Therapies such as Hydroxychloroquine and Azathioprine are recommended against as they are not efficacious as stand-alone therapies, despite the fact that clinical experience overseas notes their synergistic actions together and with Zinc in multi-drug therapy, whereas Ivermectin, Ivermectin and Doxycycline, Budesonide various Interferons and Fluvoxamine are not recommended except in research trials.

All recommended therapies are for Moderate to Severe disease in hospitalised patients. The only firm recommendation is for Dexamethasone in hospitalised patients requiring oxygen. Conditional recommendations for patients with moderate to severe disease include Baricitinib(JAK inhibitor, anti-inflammatory), Sarulimub(monoclonal antibody), Tocilizimub(biological, inhibits IL-6, anti-inflammatory), and Remdesivir (an anti-viral).

Remdesivir, conditionally approved for moderate to severe Covid, has not shown any effect on death rate and has been used preferentially in Tamil Nadu State, India, where it has made no impression on the rocketing death rate there. In contrast, Ivermectin in multi-drug regimes has been recently taken up by other States of India with a rapidly decreasing death-rate from peak levels in less than ten days.

There follows a review of some therapies that have a pathophysiological/therapeutic rationale and evidence for efficacy in patient care, as testified by doctors involved in the care of countless COVID-19 patients integrated with research.

1. General Prophylactic Therapies

Vitamin D3, Zinc, Vitamin C and Quercetin

Vitamin D³⁹ is of importance in ameliorating the severity of COVID 19⁸. Vitamin D3 Deficiency leads to the increased production of ACE2 receptors in the lungs and other sites in the body, thereby increasing Covid infectivity¹⁰. A patient is 77% more likely to be hospitalised with Covid if they were Vitamin D deficient. A recent Israeli study confirms these findings¹¹. In combination with Zinc⁸ which has antiviral action intracellularly, and Vitamin C⁸ (which acts as an anti-oxidant reducing the damage from free radicals released by an overactive immune response to the virus) the severity of Covid and hospitalisation can be reduced by 95%¹². This would be a very relevant and low-cost public health intervention here, but also for our Pacific neighbours, like Papua New Guinea and Timor L'Este. Quercetin¹³ is a potent plant-based antiviral which is quite effective against SARS-CoV-2⁸. A Review by Saeedi-Boroujeni et al¹⁴ demonstrates multiple effective therapeutic actions of Quercetin to counteract the inflammatory responses of even severe Covid-19.

It would seem that a sensible public health initiative would be to encourage more time in sunshine and fresh air and widespread prophylaxis with Vitamin D3, Vitamin C, Quercetin and Zinc daily if there are no contra-indications or interactions with other drugs in the more complex patient.

2. Effective Pre-emptive, Early Outpatient and Inpatient Therapy.

High infectivity and breakthrough infections even in vaccinated communities¹⁵ necessitates rapid uptake of safe, effective treatment options to quickly decrease transmission rates as a first priority. The initial approach of waiting in isolation at home for respiratory symptoms necessitating hospitalisation, without instituting early outpatient therapy was probably responsible for 85% of deaths in US according to Peter McCullough¹⁶. The insistence by Physicians to try to treat Patients even before a positive Covid test was probably responsible for keeping deaths to around 600,000 instead of the projected 2.1 million deaths in US.

Various effective treatment regimes have been developed by clinicians in response to the pathophysiology of SARS-CoV-2 infection, making use also of useful synergistic actions between known drugs. Rapid response to a pandemic requires an informed empiric approach on the part of the Physician, which then evolve with further therapeutic trials evidence and more insight into the pathophysiology of Covid-19¹⁷.

Hence, most drug protocols use a **multi-drug approach**⁷ to achieve **1) combination antiviral therapy**(for example, Ivermectin¹⁸, Zinc⁷, Hydroxychloroquine, Doxycycline and/or Azathioprine), anti-testosterone agents such as Dutasteride and Proxalutamide in men decrease spike protein-cell fusion, **2) Immunomodulation** (for example, corticosteroids from the onset of respiratory symptoms, Colchicine, Ivermectin¹⁸, Fluvoxamine and other drugs), **3) Anti-platelet action and antithrombotics**(for example, Aspirin⁷, sub-cutaneous Heparin, Cyproheptadine-actually an anti-serotonin agent which decreases platelet activation). Together with physical measures of self-isolation, hand hygiene, sterilising surfaces to **reduce spread of disease, reduction of self-**

inoculation(and therefore viral load) by allowing fresh air(open windows, good airflow, time outside away from others) without rebreathing viral bioaerosol⁷.

Ivermectin^{19 20}in combination therapy

Ivermectin was first supported by Professor Thomas Borody²¹, Medical Director of **Australia's** Centre for Digestive Disease, in combination **with Doxycycline and Zinc**. He proposed this triple therapy for safe prophylaxis for elderly residents living in Nursing Homes and for the treatment of those who had proven COVID infection and close contacts at a time of outbreak in Victoria, Australia. It has been shown to be useful across the whole range of Covid-19 from Prophylaxis to Critically ill Hospital patients, also showing 97% efficacy in treating post-COVID syndrome, and for mass treatment and decreased viral transmission across a population¹⁸.

Safety

It is one of the safest drugs known. It is on the WHO's list of essential medicines, has been given 3.7 billion times around the globe, and has won the Nobel prize for its global and historic impacts in eradicating endemic parasitic infections in many parts of the world²².

It has become quite a contentious drug in medical/scientific circles^{23 24} and it seems that its reputation has gone before it as a powerful Covid cure. In truth, Ivermectin has been found to be effective, but in the context of carefully balanced combination therapy²⁵ prescribed by an appropriate physician.

A review of 350 articles by a toxicologist at Medincell concluded that there were no safety concerns "that would prevent health authorities from assessing the use of Ivermectin against COVID-19." Current research shows no evidence of danger for pregnant women or their offspring, no hepatotoxicity and no neurotoxicity, even in the elderly. <http://www.medincell.com/ivermectin>

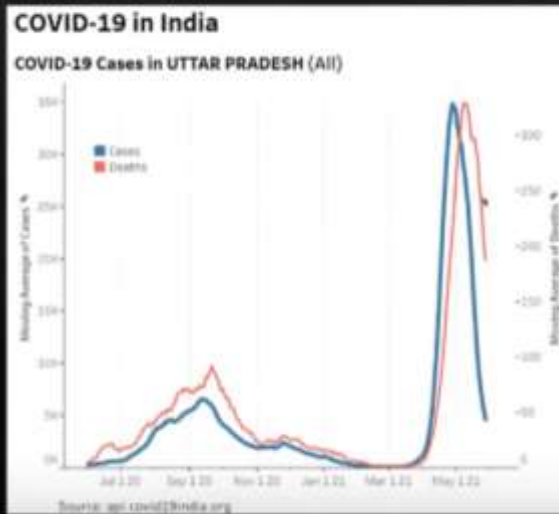
Inappropriate self-medication²⁶ in some countries and in drug combinations²⁷ (including Chloroquine, a more toxic cousin of Hydroxychloroquine) which have not been recommended have muddied the waters somewhat. Vermifuge Ivermectin from China has been implicated in liver toxicity in Brazil (perhaps a need for independent quality analysis for this brand²⁷).

Real World Efficacy

India

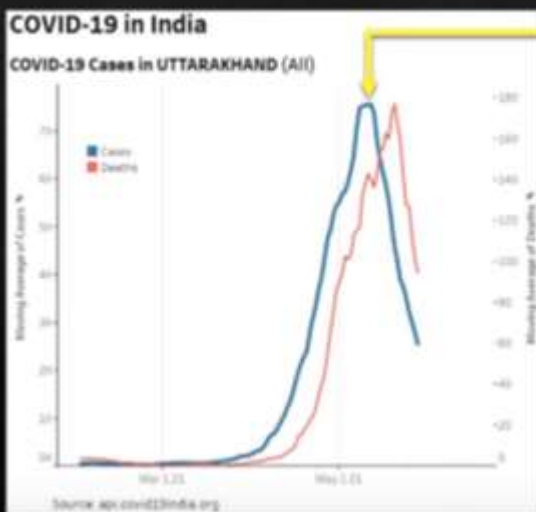
Ivermectin was quickly taken up by some states in **India**²⁸. It had proved useful in India to keep deaths quite low for population²⁹ until the most recent surge. Juan Chamie³⁰, a data analyst studying Covid-19 trends throughout the world, has recently analysed India's Covid data, which he asserts is reliable³¹, to determine the source of the latest surge(E484K mutation, an escape mutation, which evades immune defenses and is highly transmissible), means of spread(migrant workers leaving Mumbai and Delhi for Uttah Pradesh and elsewhere to escape lockdowns) and the effect of the control measures for Covid in India³². He shows unequivocally, through graphs that Ivermectin implemented population-wide brings the caseload and death rate down within ten days of institution³¹.

Uttar Pradesh - Unbeatable



Covid Tracking India @CovidTrackingIn
#UttarPradesh's second wave charts are nothing short of spectacular. Cases & positivity reducing at astronomical speed with tests increasing.

Uttarakhand – Prevention



Ivermectin tablets to be distributed among Uttarakhand residents to prevent Covid, says state govt

The Uttarakhand government has announced that Ivermectin tablets will be distributed among the citizens of the state to prevent the spread of Covid-19.

PTI
New Delhi
Ivermectin tablets to be distributed among Uttarakhand residents to prevent Covid, says state govt
May 12, 2021, 12:00 PM

Test positivity ratio

May 12: 22.2% (35K tests)

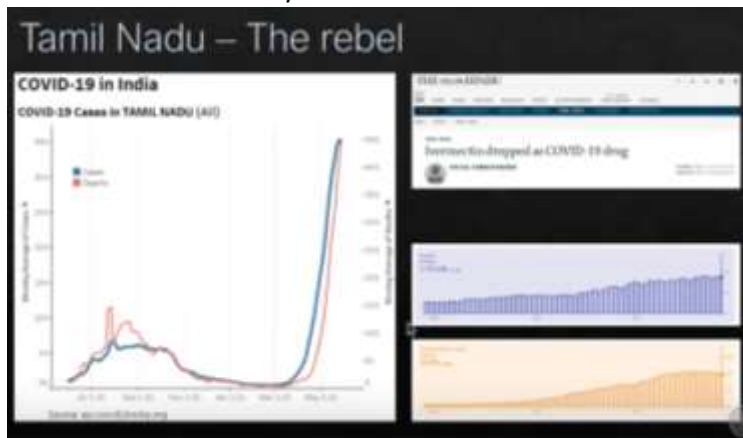
May 28: 5.8% (37K tests)

Uttar Pradesh was the destination of at least a million Migrant workers from Mumbai. The management was to continue using Multi-drug therapy with Ivermectin to quell the new source of infection. The immunisation rate in Uttah Pradesh is less than 6%.³¹

³¹Ivermectin was also used in a population-wide prophylaxis/treatment in Uttarakhand, India.

Shashikanth Manikappa , a specialist cardiac anaesthetist from Monash Health, is currently working in India and has been successfully using combination therapy (**Ivermectin, Doxycycline, Vitamin D3, and zinc**) in a trial there³³. He has noted the evident efficacy of both Ivermectin and Hydroxychloroquine. Dr Manikappa commented, "Unfortunately, the American NIH does not recommend either of these medicines to treat COVID-19, instead suggesting Remdesivir by Gilead."³³ And further, " This is a puzzling recommendation and might have something to do with 19/40 people on the NIH board reporting conflicts of interest and 10/40 of them being sponsored by Remdesivir's pharmaceutical giant, Gilead. If this is not the reason for this recommendation, none other is obvious or apparent."

Remdesivir, a drug gaining traction in India, and also Australia, did nothing to change the trajectory of accelerating deaths and infections in Tamil Nadu, the state which chose Remdesivir over Ivermectin as their early treatment Protocol.



To look at today's data from sites like 'Worldometer' it would appear that the Covid-19 crisis is over for Tamil Nadu as for other states of India, but the picture on the ground is very different. Whereas Uttah Pradesh³⁴ is returning to normal, reducing restrictions, Tamil Nadu is plagued by a lack of supply of treatment options, masses of people trying to fill scripts for Remdesevir for relatives, waiting in lines for hours and turning away empty-handed³⁵. Given that Remdesivir is effective in a very small window of viral multiplication, Tamil Nadu is left utterly defenceless. An NGO³⁶ in Tamil Nadu also calculated that the death toll was up to 13.5 times the reported Government figures for April and May 2021.

India, however, has shown something of Ivermectin's Real-World efficacy and The Indian Bar Association has served a Notice on Dr Soumya Swaminathan, Chief Scientist at the World Health Organisation, for spreading misinformation about Ivermectin and misguiding the people of India³⁷. However, India's Directorate General of Health Services (DGHS) has, despite the evident success of the multi-drug therapy, recently (late May 2021) changed their policy guidelines for Outpatient treatment, removing all repurposed drugs and vitamins from the protocol. The results for India's death rate may depend on Indian doctors and other influential Indian Medical Authorities.

Africa

Many **Sub-Saharan African countries** have the advantage of prophylactic use of Ivermectin for Endemic parasites and Hydroxychloroquine (HCQ) for Malaria, show a low Death rate from Covid, 1-10% of USA,¹² for example, despite the inherent difficulties of Sub-Saharan African life.³⁸ Paradoxically, African Americans are particularly susceptible to severe Covid19 disease³⁹. Another factor could be the lower age of the population in comparison to more affluent regions.

USA

Dr Pierre Kory and other Critical Care Specialists have been championing Ivermectin's use in **USA**⁴⁰ whilst the BIRD (British Ivermectin Recommendation Development) group are supporting

Ivermectin⁴¹ in Britain and internationally. A review and meta-analysis of 27 randomised controlled trials⁴² supports their approach.

In these trials, **Ivermectin** has been shown to **reduce the risk of death** from COVID-19 by **65-92%** and was **88% effective as prophylaxis** against infection in Medical Workers. Dr Kory recommends **Ivermectin in conjunction with Vitamin C, Vitamin D3, Quercetin, Zinc and Melatonin** in Outpatient settings with the addition of other treatment modalities in response to hospitalised patient's needs. Ivermectin has anti-inflammatory effects in Covid19 making it useful in hospitalised patients also (see the **Complete Care of the Covid Patient**⁴³). Dr Pierre Kory et al have presented the latest epidemiological data in a recent review article¹⁸ and Webinar⁴⁴. The meta-analysis of several well-conducted clinical trials is the gold standard for assessing efficacy of treatment but WHO knows about it?⁴⁵

The suppression of Ivermectin

For a reasonable, yet disturbing perspective of the international suppression of Ivermectin Dr Richard Eggleston provides an insightful look at the role of international health authorities, private business interests and huge pharmaceutical interests⁴⁶, some Universities and some Medical journals. For a more detailed analysis of the conflicts of interest of some within WHO and the Gates Foundation and the negation of Ivermectin clinical evidence, Andrew Bannister's article⁴⁷ makes discomfoting reading.

The Australian Situation

An analysis of evidence from **an Australian review** was still uncertain in December 2020 of the efficacy of **Ivermectin**⁴⁸. The National COVID19 Clinical Evidence Taskforce in Australia is currently investigating the use of **Ivermectin with Doxycycline** in Australia and it is available in ethical randomised trials, but this is still not looking at the clinical evidence already available which does not recommend this double therapy alone.

It is urgent that governments encourage an increased production of Ivermectin globally as it is an accessible, cheap and highly effective drug used in combination therapies and has a 30 year history of safe use internationally.

Fluvoxamine⁴⁹

Steve Kirsch, a medical philanthropist started Covid-19 Early Treatment Fund to finance research on promising repurposed drugs⁵⁰. One drug, **Fluvoxamine**, a Selective Serotonin-Reuptake Inhibitor (SSRI) has had outstanding success in decreasing hospitalisation, preventing severe disease, and has some effectiveness in treating Covid long-hauler syndrome in two small peer-reviewed and published trials^{51 52}. It is the most efficacious drug in early treatment⁵³ through its anti-inflammatory effect. Fluvoxamine is not yet acknowledged by WHO⁵⁴ or recommended in the NIH guidelines⁵⁵ although a panel of 30 experts from NIH, CDC and other academic institutions concluded that the

drug should be added to the NIH Guideline in late January 2021⁵⁶. Steve Kirsch has also suggested that it may be a useful drug pre- and post-vaccination to damp down the inflammatory effects of spike protein and lessen severe adverse effects post-vaccination.⁵⁷

In many Western countries, symptomatic treatment with Paracetamol was recommended for symptomatic Covid-Positive patients unless deterioration occurred, in which case, hospitalisation and supportive measures were given. Paracetamol was dangerous for two reasons. Firstly, it masked symptoms of disease progression and secondly it had no anti-inflammatory effect (no effect on disease progression)⁴. Early treatment is the key in successful treatment of Covid^{7 58} so a 'wait and see' policy misses a window of opportunity to avert serious disease.

Hydroxychloroquine (HCQ) in combination therapy⁵⁹

Pharmacodynamics

It would seem, from studies of Hydroxychloroquine's pharmacodynamics that it would be an ideal drug for early therapy of Covid19. It competes with SARS-CoV-2 for cell-membrane receptor sites. It synergises with Azithromycin (ATM) which competitively binds sites on the spike protein, thus, using both drugs together, they act as competitive inhibitors of SARS-CoV-2 attachment to the host cell membrane, protecting the host cell from viral entry⁶⁰. This mechanism would be useful in very early stages of disease or even prophylaxis. Further, Hydroxychloroquine (HCQ) aids the entry of Zinc (an intracellular viral inhibitor) into cells⁶¹. A retrospective study in New York⁶² compared patient outcomes for hospital inpatients on ATM and HCQ and those on ATM, HCQ and Zinc. The study found that Zinc, added to ATM and HCQ decreased mortality and increased the likelihood of being discharged directly home from the hospital in non-ICU patients. Again, this is a mechanism suited to the earlier, viral stage of the disease. Hydroxychloroquine also has anti-inflammatory effects⁶³ mediated through suppression of cytokine activation and increase in intracellular pH. This could conceivably be useful in the second stage of the disease, which is inflammatory. Hydroxychloroquine also inhibits platelet aggregation⁶³ in a dose-dependent manner which could be useful in the modulation of thrombotic complications of COVID-19 disease.

Safety Concerns

However, it is unclear in early stages of disease who will progress to serious disease so a drug used at this stage must be safe. Herein lies the rub. The FDA(US) withdrew authorisation from HCQ because some major clinical trials showed HCQ to be ineffective in the treatment of Covid19 (see below), some articles highlighted dangerous side-effects from HCQ treatment and the Australian Government Department of Health cites 'risks including cardiac toxicity (potentially leading to heart attacks), irreversible eye damage and severe depletion of blood sugar levels (potentially leading to coma)'⁶⁴ as reasons for limiting use of Hydroxychloroquine to Clinical Trials and limiting prescription rights to appropriate specialists⁶⁵ in Australia.

An article⁶⁶ looking at Adverse drug reactions to HCQ during the COVID-19 pandemic derived from FDA Adverse Event Reporting System concluded there was an increase of severe adverse events from HCQ in 2020. A comment followed the article by Professor SJ Wimalawansa MD, PhD, MBA, DSc (Cardiometabolic and Endocrine Institute) makes interesting reading. After criticising the lack of appropriate information in the article to ascertain which adverse events were linked to Covid-19 treatments rather than HCQ in treatment of other diseases(which prior to Covid-19 comprised 97% of prescriptions⁶⁷), Professor Wimalawansa continued:

'The two clinical studies published in mid-2020 using hydroxychloroquine in persons with COVID syndrome had two significant study design errors. Higher doses of hydroxychloroquine than recommended and use in persons with advanced disease. Therefore, it does not surprise the reporting higher number of adverse clinical outcomes^{68 69} due to the faulty study design that led to the withdrawal of FDA approval for using hydroxychloroquine in persons with COVID. Moreover, when a drug administered to larger groups of people, the number of adverse effects reported will proportionately increase. These not presented in the letter. The mentioned two significant design errors caused increased adverse effects from hydroxychloroquine. Because of the above-mentioned, conclusions are invalid and cannot be relied on.'⁶⁶

He also noted:

'Many recent clinical studies reported significant benefits of using the recommended dose of hydroxychloroquine for prevention and during the early stage of COVID-19 with little adverse effects'.⁶⁶

Further to the Australian Department of Health's concerns about severe adverse events associated with Hydroxychloroquine usage in Covid patients, Okada et al⁷⁰ found that arrhythmias did not occur at therapeutic doses used for Covid19 for Chloroquine, Hydroxychloroquine or when used in combination with Azathioprine. Retinal toxicity is seen in 1% of patients after 5-7 years of chronic use of Hydroxychloroquine⁷¹, whereas the usual dose for Early Outpatient treatment of Covid19 is 1:500 of the cumulative dose in chronic use⁷². Hypoglycaemia is a rare side-effect with Hydroxychloroquine⁷³. One study⁷⁴ showed that 1:200 patients in their HCQ trial for Covid patients developed Hypoglycaemia, although the doses were twice the recommended dose for Covid-19 Treatment and there was consequently a high rate of side-effects(5-1000 times the incidence of side-effects from other studies cited⁷³). The warnings from the Australian Department of Health therefore seem quite extreme.

Efficacy

Hydroxychloroquine's efficacy for Covid19 has been discounted by some trials (including early retracted results from the Solidarity Trial)⁷⁵, and it's safety has been impugned by several trials and even health regulatory agencies(WHO and FDA). Strangely, it does have a huge database of research to support its efficacy and safety in early disease. Although not as efficacious as Ivermectin, Hydroxychloroquine is widely available and considered safe for use in Pregnancy and during Lactation⁷⁶. **A Meta-analysis⁷⁷ of 239 studies found that HCQ was effective in treating Covid-19, especially early disease (90% of prospective studies), and that there was a bias in the literature towards publishing negative results, especially in North America.** Negative conclusions commonly ignore treatment time, often focusing on a subset of late stage studies.⁷⁸ Evidence of the skewing of HCQ trials, including the WHO Solidarity Trial, the UK Recovery trial and the REMAP-Covid Study, has had some success in the affluent nations in dissuading the use of this cheap, easily available drug

where more expensive, patented medicines and vaccines could possibly hope to gain traction.⁷⁹ These multicenter clinical trials⁸⁰ which were supposed to investigate the safety and efficacy of HCQ “administered non-therapeutic, toxic and even lethal doses⁸¹ of HCQ (four times higher than standard doses) to thousands of study participants.” At times, inappropriate moribund patients were included in the trial. The National COVID19 Clinical Evidence Taskforce have referenced the Solidarity, Recovery and Remap-Covid trials in some of their decisions which would contribute to the negative view of Hydroxychloroquine for COVID patients in Australia.⁸²

Harvey Risch, MD, PhD, a Yale Epidemiology Professor, claimed that the maligning of HCQ in the treatment of COVID-19 has contributed to tens of thousands of deaths for reasons unrelated to science.²⁰ Further⁸³, “As of late July, a tally of 65 studies around the world indicated that [100%](#) of the studies that assessed HCQ for COVID-19 pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP) or early use showed “high effectiveness,” as did 61% of the studies examining HCQ use in later stages of illness.”

[Another known anti-malarial is being investigated as a treatment for Covid-19⁸⁴. It is an aromatic herb, Artemisia Annu (Sweet Wormwood) which is widely distributed through temperate and sub-tropical regions of the world, especially, Asia. The study⁸⁵ shows in vitro inhibition of SARS-CoV-2 infection by targeting a post-cell entry step. The anti-viral action is not related to the Artemisinin or flavonoids, but to some other compounds in the dry leaf mass extracted with hot water (essentially, Sweet Wormwood tea). A study of useful anti-inflammatory drugs in lupus nephritis⁸⁶ has shown that low-dose HCQ and Artemisinin reduced inflammation and cytokine activation to the same degree as Prednisolone or high-dose HCQ therapy. It is therefore possible that more than one compound in Artemisia Annu could be helpful in alleviating Covid-19, and both viral and inflammatory stages of the disease could be targeted. It is also possible that Artemisia Annu(antiviral and anti-inflammatory compounds) could be synergistic with Hydroxychloroquine.]

Real World Evidence

Switzerland

Describing a “natural experiment” in Switzerland, Yale’s Dr. Risch has noted:

“On May 27, the Swiss national government banned outpatient use of hydroxychloroquine for COVID-19. Around June 10, COVID-19 deaths increased four-fold and remained elevated. On June 11, the Swiss government revoked the ban, and on June 23 the death rate reverted to what it had been beforehand.”⁸³

India

An article by Desai, Chavan, Gharpure, Bargaje and Bakhle (2021) discussed India’s earlier success in flattening the curve²⁹(prior to the current wave of delta variant) and keeping its death rate relatively low. India was projected to have between 1.2-2 Million deaths from Covid on early modelling, but currently has had just over 335,000 deaths⁸⁷. The authors looked at several theories and proposed that the emphasis on early treatment with HCQ⁸⁸ or Ivermectin with zinc and Doxycycline, available through telehealth consultation, decreased the transmission rate of COVID-19²⁹ in the first wave of Covid. The home Covid Kit called ‘Ziverdo’ cost less than \$2.65 US²⁸. Management of the current covid crisis has already been discussed(see Ivermectin).

USA

Vladimir Zelenko⁵, a Primary Care Physician for a population of 32,000 people in a densely populated area in Brooklyn, US, treated his patients in the General Practice setting using pre-emptive (before positive test was back), patient specific therapies with a 99.99% success rate. The Zelenko protocol uses Hydroxychloroquine, Zinc and Azithromycin.

Italy

A study across 23 of Italy's major Hospitals also showed a significant advantage for the use of HCQ for COVID inpatients.⁸⁹ Use of Hydroxychloroquine with Vitamin D in early SARS-CoV-2 resulted in no deaths in 6000 patients in northern Italy⁴.

Budesonide/Pulmicort^{90 91}

Early use of a common asthma medication **Budesonide/Pulmicort**⁹⁰ in the first 7 days of COVID is the subject of the Oxford-led STOIC trial⁹² (including some Australian Researchers) which showed a 91% reduction in the need for hospitalisation in COVID patients and reduction in persistent symptoms compared to those taking a placebo. Phase 2, open label, randomised controlled Trial results for the STOIC trial have been published late April, 2021⁹³. "Stochastic simulations, in a virtual twin post-hoc study design, showed that the daily odds ratio of reaching the primary outcome (that is, needing emergency care), with budesonide reduced by a significant factor of 30-times"⁹³.

Budesonide's efficacy was shown to be similar to immunisation and is cheap and widely available. It is thought to suppress the cytokine storm, an immune response to SARS-CoV-2 infection.

With accurate testing and prompt Primary Care involvement, all four of the above treatments for early COVID illness (and, in Ivermectin's case, disease in hospitalised patients) are cheap and accessible. Ivermectin and HCQ also reduce transmission quickly, thereby making herd immunity easier to achieve²⁹ and development of mutant strains less likely. If the decreased percentage of immune individuals required for herd Immunity with decreased viral transmission were generally known, it would contribute to a more reasoned debate about management of the pandemic.

Intranasal Interferon

In addition to Ivermectin, HCQ and Budesonide/Pulmicort, the use of **intranasal Interferon**, has demonstrated efficacy as an early Covid treatment. Alibedk and Tskhay (2020)⁹⁴ reviewed studies showing the relation between early Interferon response to COVID infection and subsequent less severe disease, and studies showing intranasal Interferon's efficacy in prophylaxis (100% efficacy in

one study of medical personnel⁹⁵) and treatment of COVID (decreased severity and duration). It is a review well worth reading in its entirety. Auto-antibodies to Type 1 Interferons⁹⁶ were seen in 14% of patients with severe Covid disease and 3.5% of severe Covid patients had a genetic inability to produce Interferon Type 1.⁹⁷ Decreased Interferon1 response is seen in the elderly, diabetics, cancer patients and the obese⁹⁸ all of whom are prone to severe disease. Many proteins in SARS-CoV-2 delay the initiation of Interferon 1 responses, although Spike protein was one of two proteins which actually stimulated IFN response. Kieren Dee⁹⁹ et al found that infection by circulating Rhinovirus triggered an Interferon response which blocked SARS-CoV-2 replication. Modelling suggested that more ubiquitous Rhinoviruses could significantly reduce the prevalence of Covid throughout a given population, but it is also an indication of the importance of initiating an interferon response for the control of Covid-19. Currently, there is a Clinical Trial involving cancer Patients at Peter MacCallum Cancer Center, Melbourne¹⁰⁰, which is looking at IFN-alpha in prophylaxis and post-exposure prophylaxis in cancer patients. It would seem appropriate to have a trial in Quarantine personnel who had no contra-indication, as this seems to be the Achilles' heel of our Covid prevention and a continuing source of societal disruption and economic distress in Victoria (see Postscript on lockdowns).

Conclusion

Because our clinical experience with the treatment of Covid19 in Australia has been limited due to small patient numbers, Australia is not in a position to run extensive drug Trials on Covid Patients. For effective drug combinations which have proven beneficial to patients we need to look to experienced clinicians overseas who have a proven record of successful outcomes with Covid patients in the various stages of disease.^{101 102 7 103 53 104 105}

In many Zero Covid Nations cases are beginning to soar (Thailand, Vietnam, South Korea). This could happen in Australia too. We need to have a range of therapeutic options at every stage of disease.¹⁰⁶
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Peter A. McCullough et al¹⁰⁷ give a very worthwhile summary of the experience of numerous doctors around the world in the successful multi-drug treatment and prevention of Covid.

The FLCCC (a coalition of highly published critical Care Specialists in US)⁴³ have many resources including 'A Guide to the 'Management of the COVID-19' which is backed by extensive experience of treatment in every phase of care, including Intensive Care, based on thousands of research articles.

The British Ivermectin Recommendation Development (BIRD Group)¹⁰² also has treatment protocols used in many countries.⁴¹

Further Thoughts

Why is the use of re-purposed drugs not encouraged?

Despite the evident effectiveness of many cheap, repurposed drugs they remain unavailable in the West. The reason: 'Evidence is inconclusive'. Why?

Dr Robert Malone (inventor of the mRNA vaccine) and Steve Kirsch, entrepreneur and proponent of repurposed drugs, in a recent discussion⁵⁷ noted anomalies in the way Regulatory agencies have responded to the Covid pandemic. Those relevant to some repurposed drugs include:

- requiring expensive Controlled Research trials to prove safety and Efficacy (not financially possible for clinicians)
- rejection by regulatory bodies of Meta-analyses (the gold standard of clinical research) supporting repurposed drugs, as some of the trials included had not been peer-reviewed or published; however...
- Trials of repurposed drugs are not peer-reviewed or published because they are delayed in publishing for months by Journals (which are often sponsored by pharmaceutical companies);
- repurposed drugs which are cheap, out of patent and make no money for the pharmaceutical companies are maligned. The system for authorising drugs or vaccines for emergency use demand that there are no current safe and efficacious treatments available. For drug and vaccine companies who have a portfolio of drugs or vaccines which are vying for emergency use authorisation, it would be important to remove any contenders. This is 'patently' obvious in the case of Merck which disavowed its own drug, Ivermectin (out of patent), in order to bring molnupiravir to the market for Covid treatment, which mimics only one of Ivermectin's therapeutic actions.¹⁰⁸

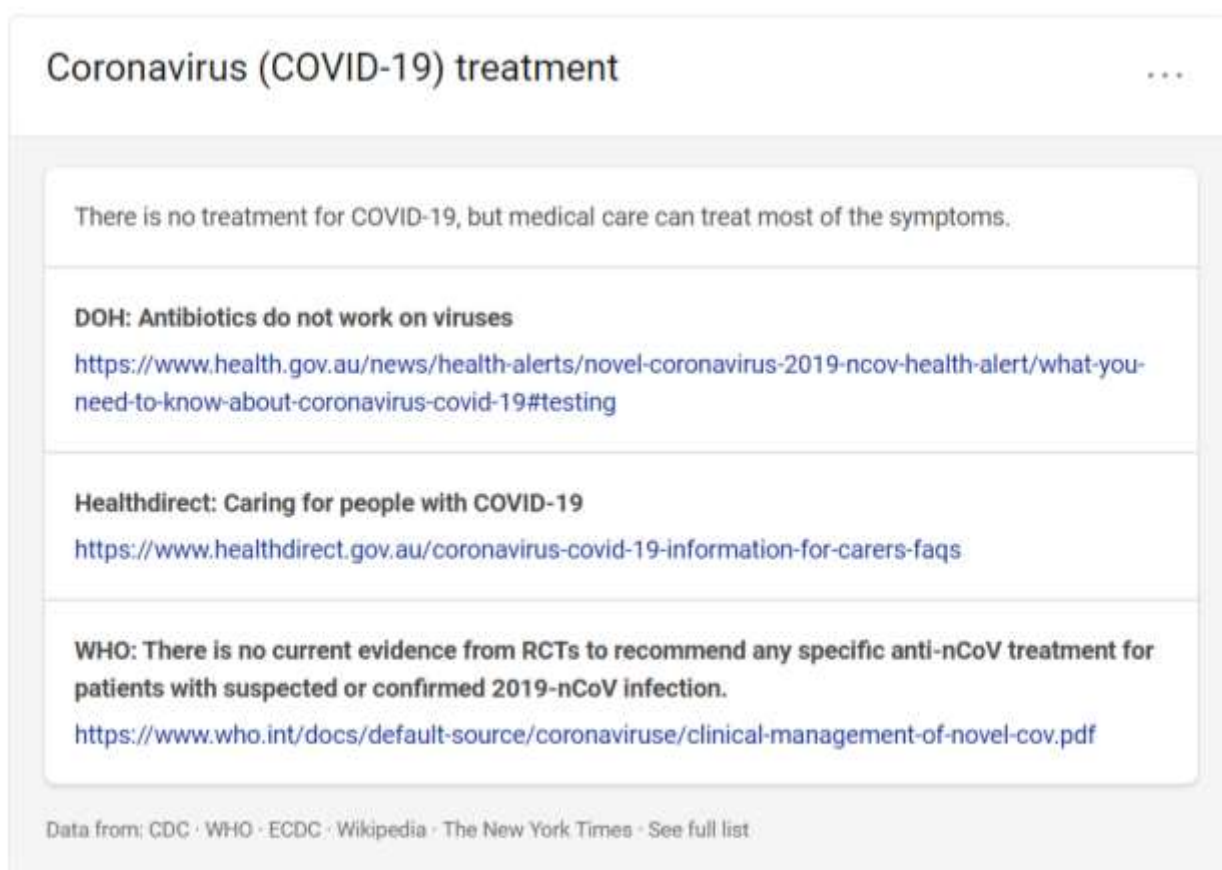
Government or Regulatory Agency insistence on Clinical research trials before any approval of drug or therapy basically means that the only contenders will be new, expensive drugs proffered by Pharmaceutical companies or co-sponsored by Governments⁵⁷, leaving clinically effective combination therapies with repurposed drugs on the shelf⁴⁶ and pandemic response short-changed.

Clinically effective repurposed drugs which have been proven in patient care overseas should be added, after due enquiry, to the National Covid19 treatment guidelines and made available for appropriate patient care. Successful treatment protocols, from doctors experienced in the care of the Covid Patient should also be widely available to doctors once these treatment options are available.

Treatment recommendations and treatment availability in Australia

have already been addressed, with no recommendations for general health measures, prophylaxis or outpatient treatment. Recently, this need has been recognised, especially with regard to the immunocompromised as vaccination may not be protective ¹⁰⁹.

After reviewing the evidence for effective therapies developed by clinicians internationally who are treating thousands of COVID-19 patients at all stages of disease, I was shocked to see the following message on my computer screen when doing a Web search for 'Treatments available in Australia'.



The screenshot shows a search result for "Coronavirus (COVID-19) treatment". The main text states: "There is no treatment for COVID-19, but medical care can treat most of the symptoms." Below this, there are three links from authoritative sources:

- DOH: Antibiotics do not work on viruses**
<https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/what-you-need-to-know-about-coronavirus-covid-19#testing>
- Healthdirect: Caring for people with COVID-19**
<https://www.healthdirect.gov.au/coronavirus-covid-19-information-for-carers-faqs>
- WHO: There is no current evidence from RCTs to recommend any specific anti-nCoV treatment for patients with suspected or confirmed 2019-nCoV infection.**
<https://www.who.int/docs/default-source/coronaviruse/clinical-management-of-novel-cov.pdf>

At the bottom, it says: "Data from: CDC · WHO · ECDC · Wikipedia · The New York Times · See full list"

COVID-19 treatments | Australian Government Department of

Note the first line:

There is no treatment for Covid-19, but medical care can treat most of the symptoms!

(CDC, WHO and The New York Times, amongst others are cited as sources for this pronouncement....)

After immersing myself in the Treatment of COVID-19 for the last 5 months, and researching the positive difference dedicated physicians have made in their patient's disease severity and viral transmission with antiviral, immunomodulatory and anti-thrombotic drugs, this statement seems to come from an alternate reality.

Fortunately, doctors have been busy innovating treatments wherever COVID patients have needed care.

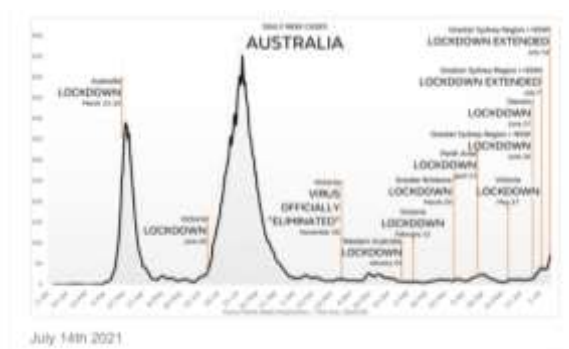
Not only will the Immune-compromised need available treatments¹⁰⁹, but the vaccinated and the unvaccinated will need early therapy to deal with breakthrough infections (like the delta variant, or further variants of concern) and to reduce the pool of mutant Coronavirus that could develop in partially immune people¹¹⁰ (such as vaccinated people with asymptomatic or low-symptom disease due to partial effectiveness of S-specific antibodies against variants)¹¹¹.

I find that we are in a very vulnerable position in Australia. We need to redress the deficiencies in effective, available treatments to ameliorate COVID disease and reduce viral transmission with all the ingenuity, due care and speed that we can muster.

Yours sincerely (and with some concern for our Nation and its people),

Robyn Stephenson MBBS(Mon)

Postscript: Lockdowns



Lockdowns produce their own Morbidity

and Mortality ¹¹².

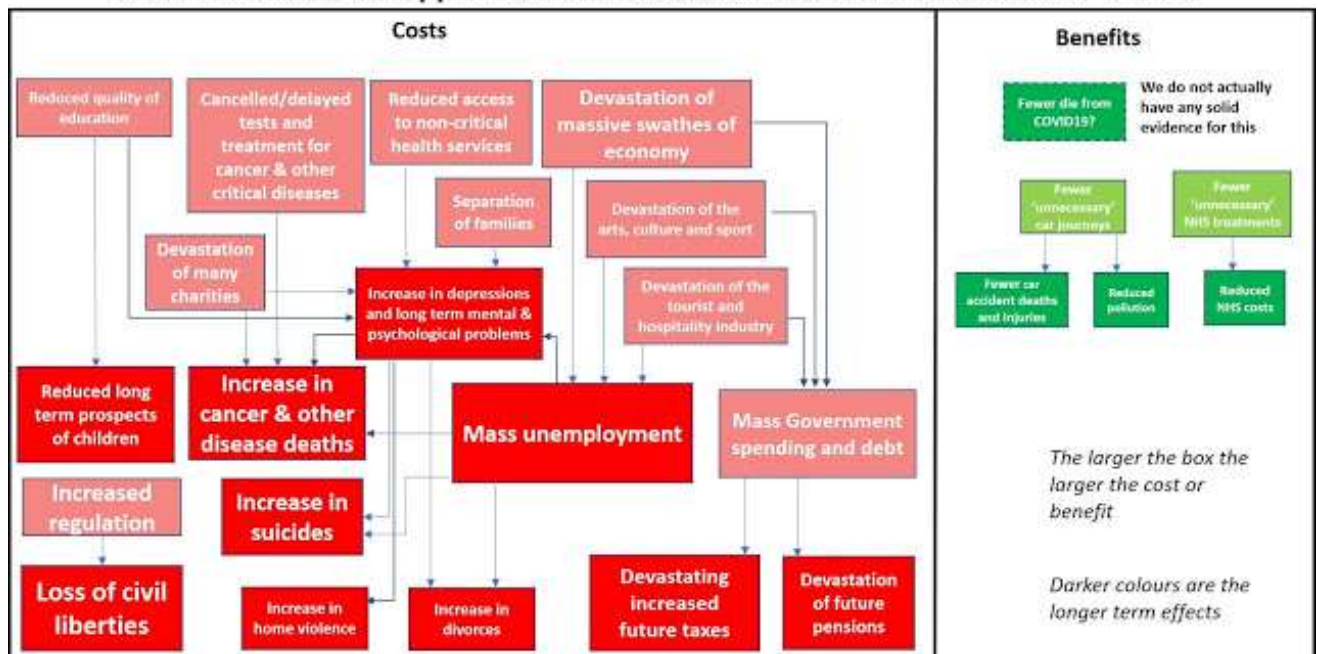
Data analysis¹¹³ raises questions about the basis for lockdowns. The costs of lockdowns are particularly acute for families (increasing domestic violence, mental health issues, suicide,¹¹⁴ health issues, unemployment, bankruptcy) and small businesses in the western world as well

as for National debt. Lockdowns in developing countries have prevented people from being able to continue their subsistence farming, caused famine and have left people without any means of support leading to arduous journeys to homelands, increasing spread of the virus with many falling by the wayside. Our world presents a tragic picture and yet this is the primary means of disease control chosen.¹¹⁵

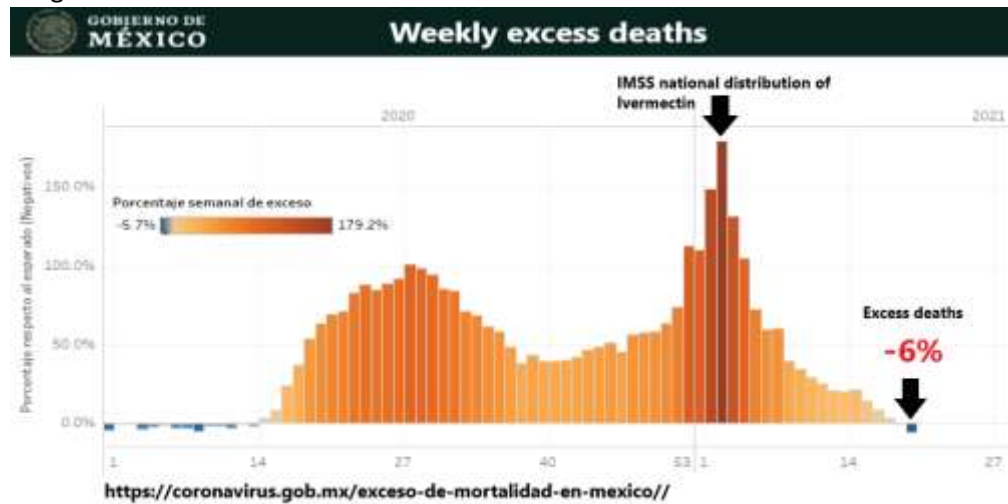
Lockdowns have particular dangers for health as the stringent distancing, masking and isolation lead to an Immunity debt which amongst other things leads to childhood epidemics (for example, RSV outbreaks)^{116 117}. Conceivably, isolation could also lead to Covid Outbreaks as immunity has not built up to the circulating variants. A study¹¹⁸ in December, 2020, examining the practices of 'Zero Covid countries', found that the only effective physical measures against Covid-19 were prompt border closures, isolation and identification of incoming infected people with dedicated isolation facilities. The down-side is that the presence of any SARS-CoV-2 in the community in a Zero Covid country (such as Australia and New Zealand) is countered by Lockdowns and excessive community control in the absence of recognised pre- and post-exposure prophylaxis and easily available Mass Treatment for exposed communities.

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Evidence needed to support COVID-19 lockdowns: do 'benefits' exceed 'costs'?



For an example of managing a Covid Outbreak with Mass Treatment, Mexico City offers an insight¹¹⁹.



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