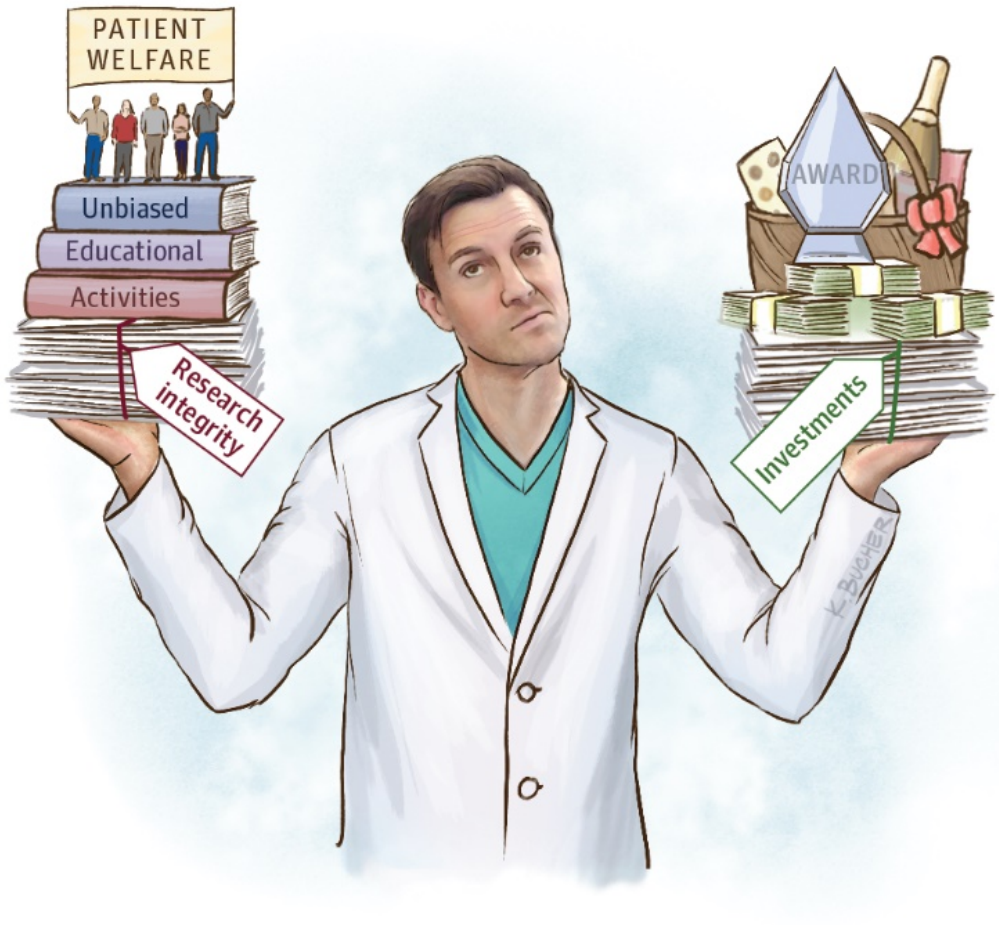
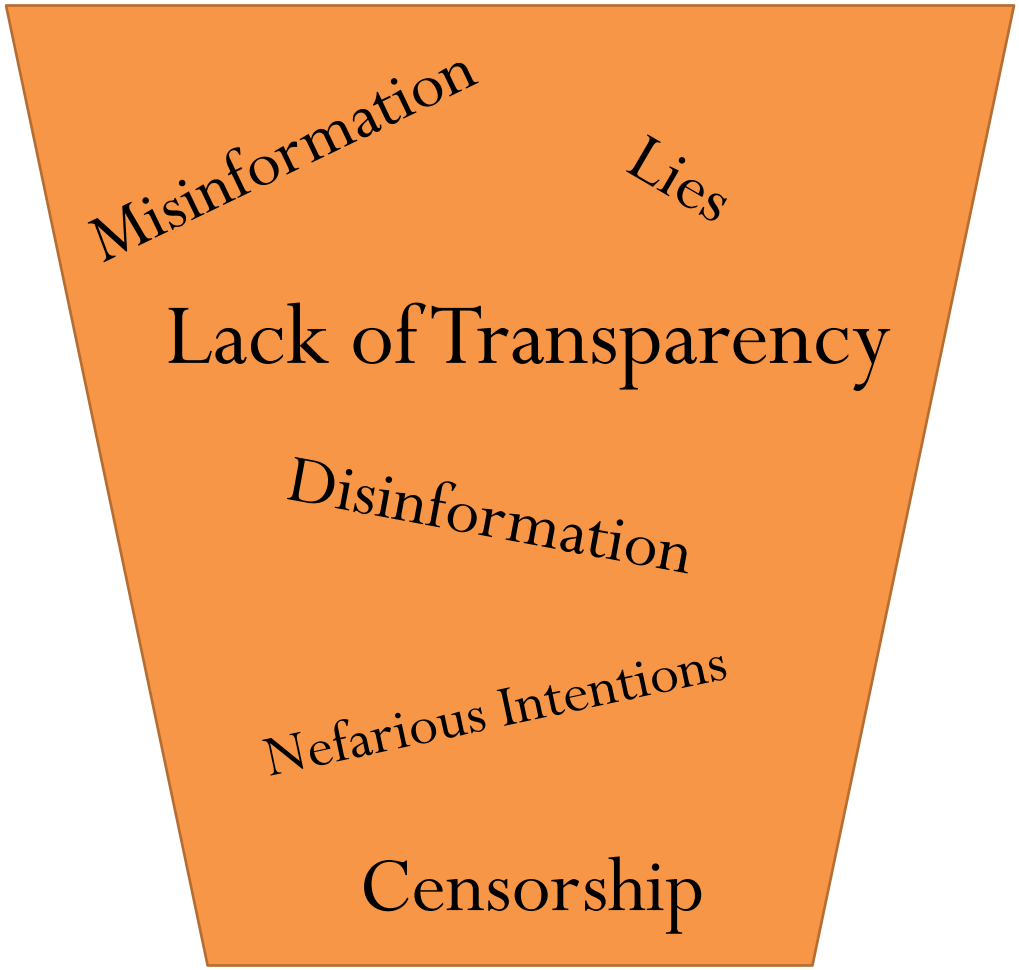
Hospital Treatment of COVID-19: The Intersection of Politics, Money and Science

Paul Marik MD, FCCM,FCCP

Conflicts of Interest



The Vacuum of Truth



The BMJ, London, UK

Correspondence to: P Doshi
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Cite this as: *BMJ* 2022;376:o102
http://dx.doi.org/10.1136/bmj.o102
Published: 19 January 2022

Covid-19 vaccines and treatments: we must have raw data, now

Data should be fully and immediately available for public scrutiny

Peter Doshi, Fiona Godlee, Kamran Abbasi

Conflicts of Interest

Mark McClellan
On the left is the former FDA commissioner in charge of regulating Johnson & Johnson. On the right is a current member of the Board of Directors of Johnson & Johnson.

Scott Gottlieb
On the left is the former FDA commissioner in charge of regulating Pfizer. On the right is a current member of the Board of Directors of Pfizer.

Stephen Hahn
On the left is the former FDA commissioner in charge of regulating Moderna. On the right is the current Chief Medical Officer of Flagship Pioneering - the venture capital firm behind Moderna.

James C. Smith
On the left is the CEO of Reuters in charge of informing people about the COVID-19 vaccines. On the right is a current member of the Board of Directors of Pfizer.

Anthony Fauci
On the left is the NIAID Director under the National Institutes of Health. On the right is the funder of bioweapons research on gain of function bat coronaviruses at the Wuhan Institute of Virology.

CENSORSHIP

Account suspended

Twitter suspends accounts which violate the Twitter Rules. Learn more

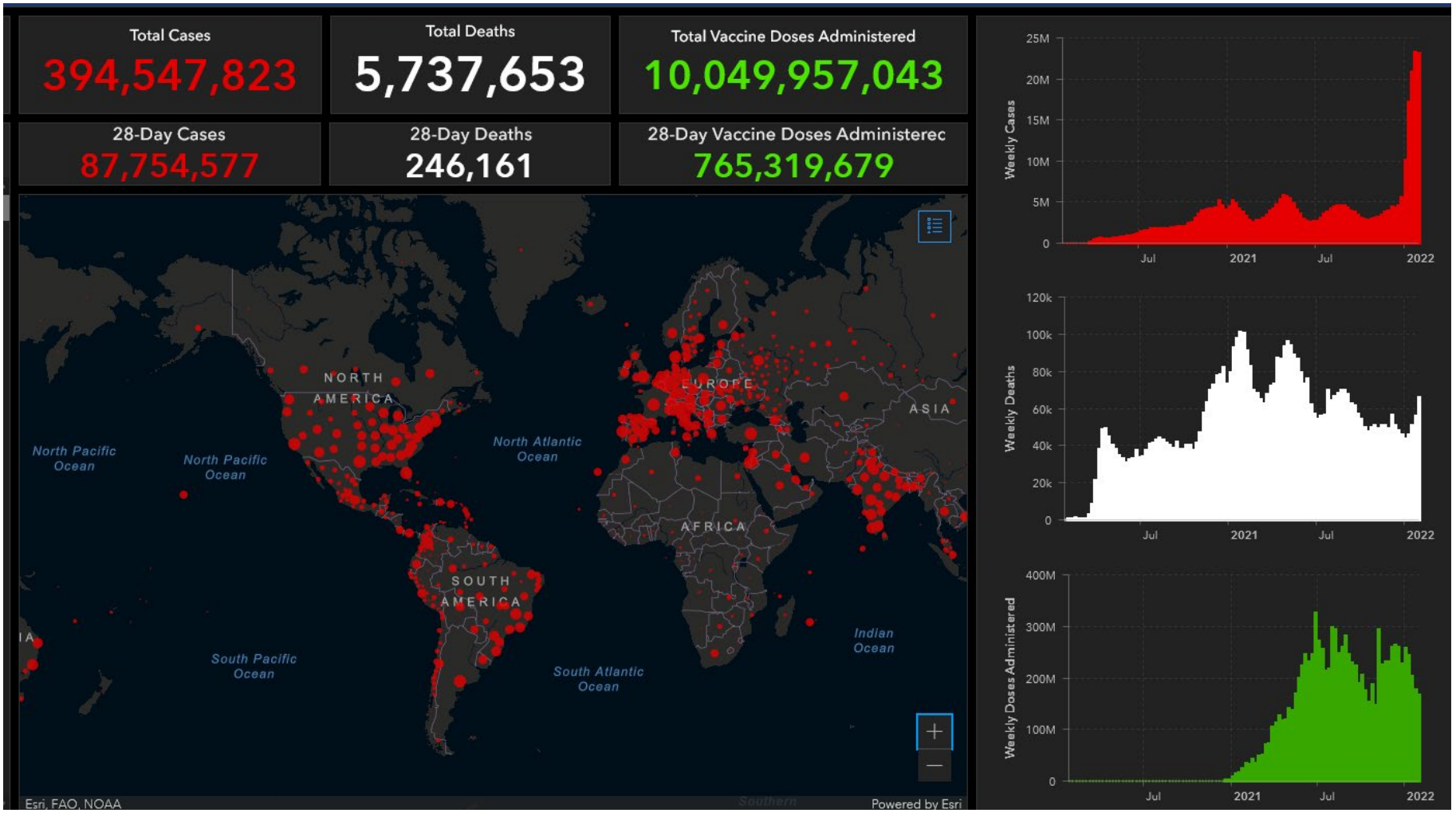
Banned from Twitter (again)

I just got the news today at 7:12pm. All my posts and followers are gone.

Steve Kirsch
Feb 7

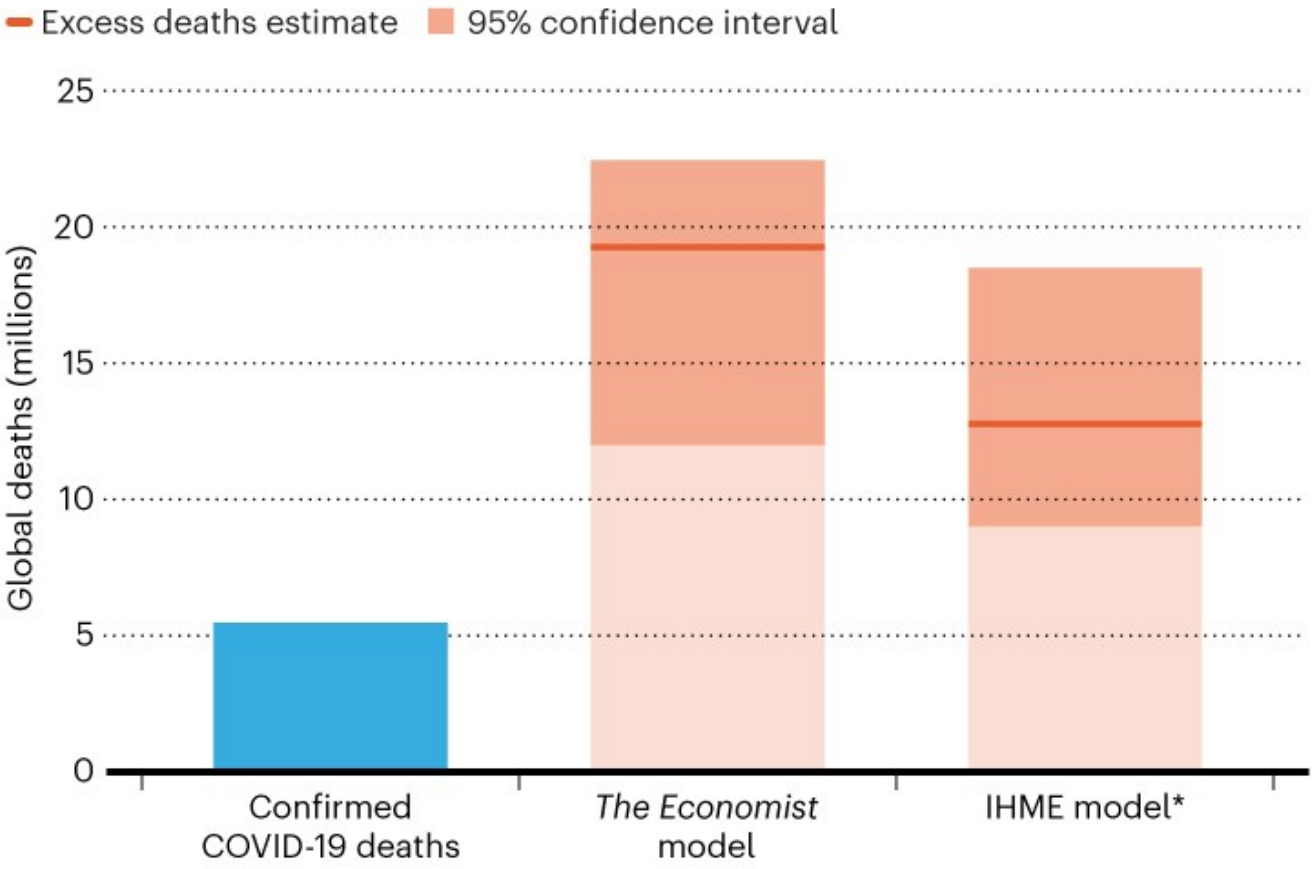
"The phrase medical misinformation about COVID-19 seems to be a euphemism for any statement or scientific evidence that differs from the prevailing narrative of the vaccine and patented drug stakeholders." RJK Jr

A Global Disaster



GLOBAL TOLL

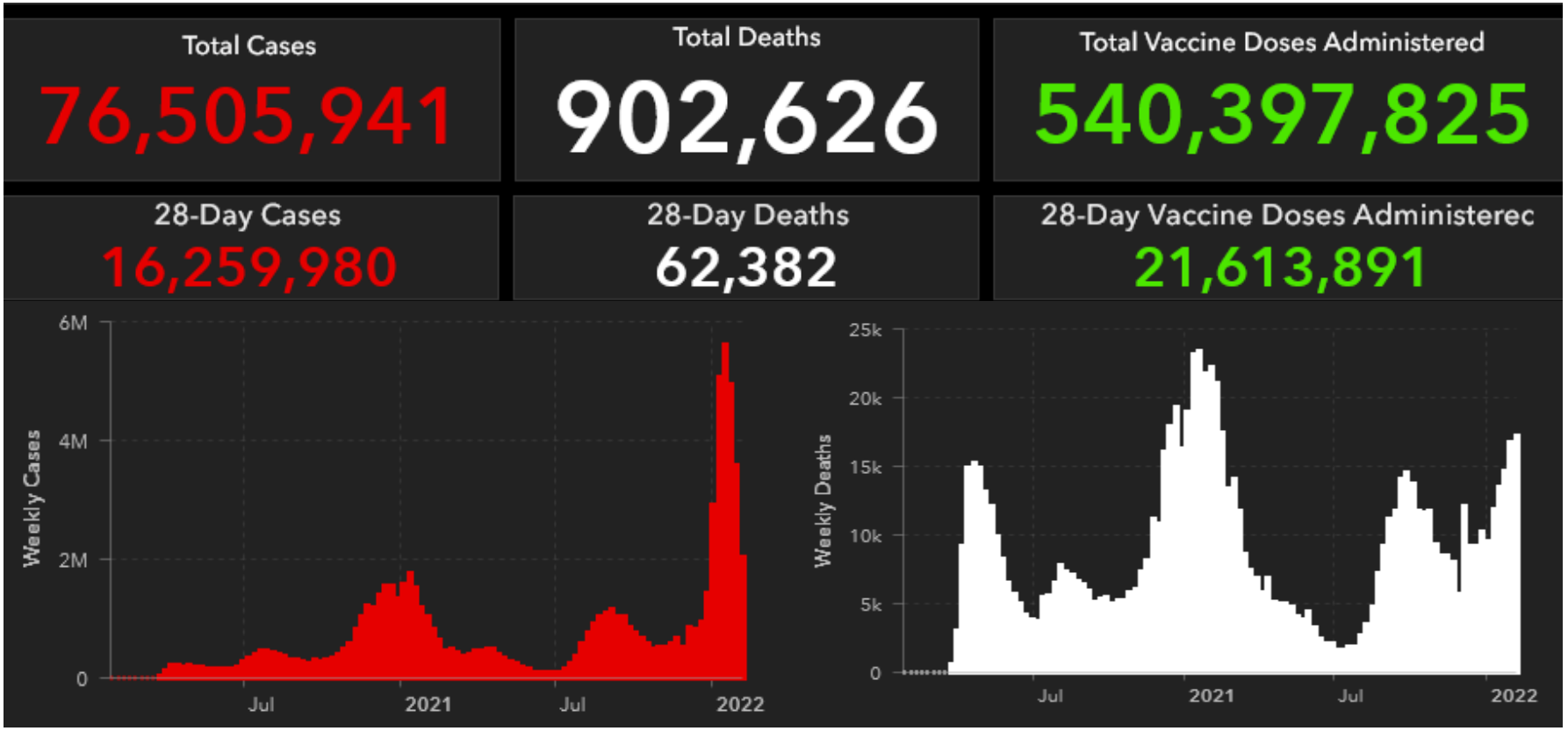
By January 2022, there had been 5.5 million official COVID-19 deaths worldwide in the pandemic. But models estimate that there have been between two and four times that number of excess deaths — that is, mortality above what was expected — since the start of 2020.



*Institute for Health Metrics and Evaluation; Data and models up to 13 January 2022.

Sources: Our World in Data/*The Economist*/IHME

USA: The Highest Death Rate in the World



USA: deaths per million = 2,554

Ethiopia: deaths per million = 63

Despite the Mandates, Lockdowns, Masks and Vaccination we have more cases than ever before… this approach has FAILED. What happened to Herd immunity? STOP THE MADNESS!

The Key to Stopping this PLANDEMIC

Prevention
EARLY TREATMENT

Early Multidrug Treatment of SARS-Cov-2 (COVID-19) and Decreased Case Fatality Rates in Honduras

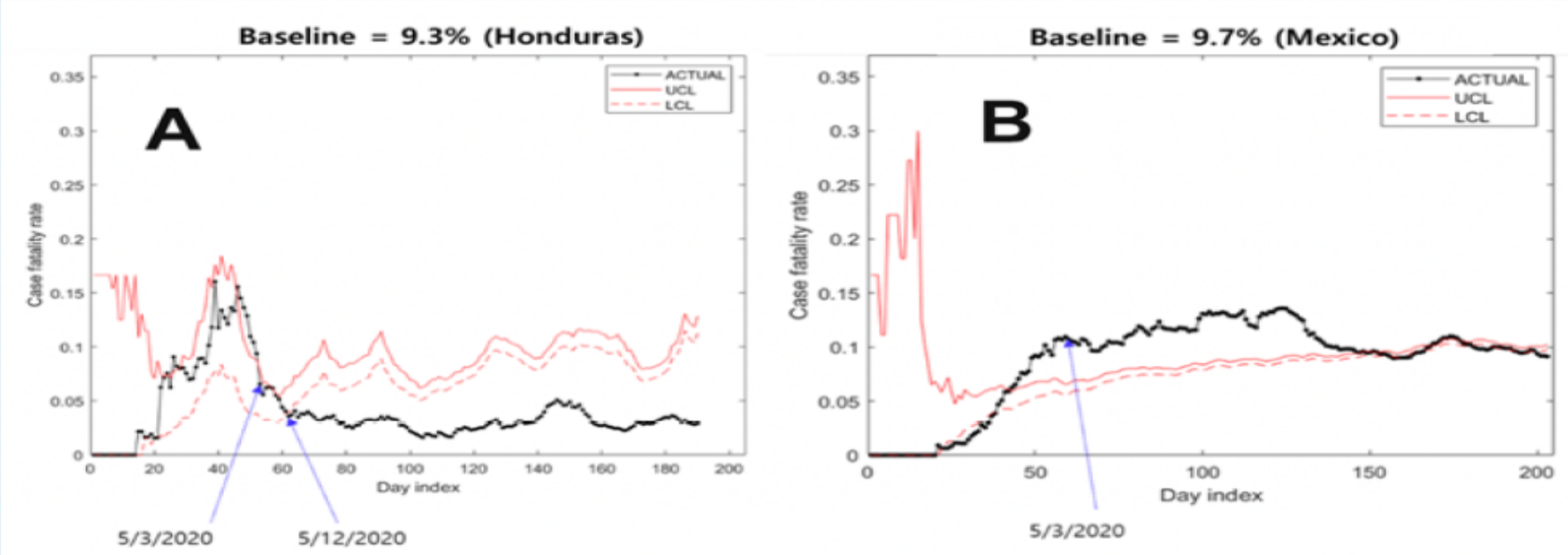


Figure 1A-B: Shewhart control chart upper and lower control limits for 14 day rolling average case fatality rate. Control limits were estimated using a baseline which was the average case fatality as of May 3, 2020 for Honduras (A) and Mexico (B); and as of June 10, 2020 for Honduras (C).

Management of the Hospitalized Patient with COVID-19

Figure 2. Therapeutic Management of Hospitalized Adults With COVID-19 Based on Disease Severity

DISEASE SEVERITY	PANEL'S RECOMMENDATIONS
Hospitalized but Does Not Require Supplemental Oxygen	The Panel **recommends against** the use of **dexamethasone (AIIa)** or **other corticosteroids (AIII)**.[a] There is insufficient evidence to recommend either for or against the routine use of remdesivir. For patients at high risk of disease progression, remdesivir may be appropriate.
Hospitalized and Requires Supplemental Oxygen	Use one of the following options: • **Remdesivir**[b] (e.g., for patients who require minimal supplemental oxygen) **(BIIa)** • **Dexamethasone plus remdesivir**[b] (e.g., for patients who require increasing amounts of supplemental oxygen) **(BIII)** • **Dexamethasone** (when combination with remdesivir cannot be used or is not available) **(BI)**
Hospitalized and Requires Oxygen Delivery Through a High-Flow Device or Noninvasive Ventilation	Use one of the following options: • **Dexamethasone (AI)** • **Dexamethasone plus remdesivir**[b] **(BIII)** For recently hospitalized[c] patients with rapidly increasing oxygen needs and systemic inflammation: • Add either **baricitinib (BIIa)** or **IV tocilizumab (BIIa)** to one of the two options above[d] • If neither baricitinib nor IV tocilizumab is available or feasible to use, **tofacitinib** can be used instead of baricitinib **(BIIa)** or **IV sarilumab** can be used instead of IV tocilizumab **(BIIa)**.
Hospitalized and Requires IMV or ECMO	• **Dexamethasone (AI)** For patients who are within 24 hours of admission to the ICU: • **Dexamethasone plus IV tocilizumab (BIIa)** • If IV tocilizumab is not available or not feasible to use, **IV sarilumab** can be used **(BIIa)**.

Rating of Recommendations: A = Strong; B = Moderate; C = Optional
Rating of Evidence: I = One or more randomized trials without major limitations; IIa = Other randomized trials or subgroup analyses of randomized trials; IIb = Nonrandomized trials or observational cohort studies; III = Expert opinion

THINKING IS HARD

LET'S JUST TRUST THE EXPERTS

KEEP CALM AND FOLLOW THE PLAN

World Health Organization

FDA

NIH National Institutes of Health

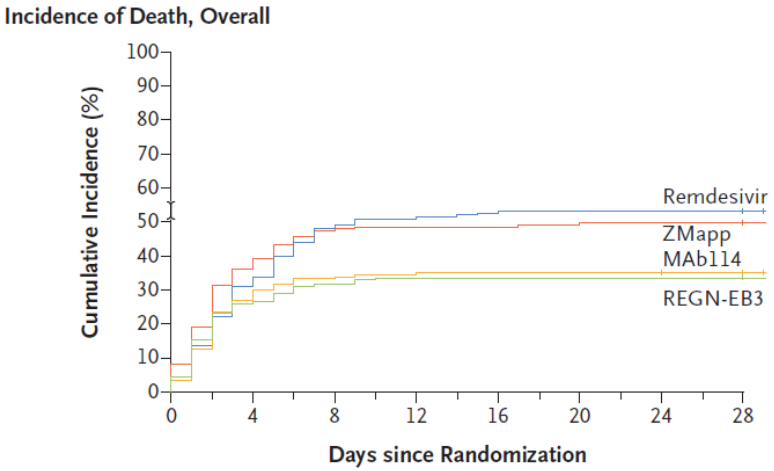
CDC

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 DECEMBER 12, 2019 VOL. 381 NO. 24

A Randomized, Controlled Trial of Ebola Virus Disease Therapeutics

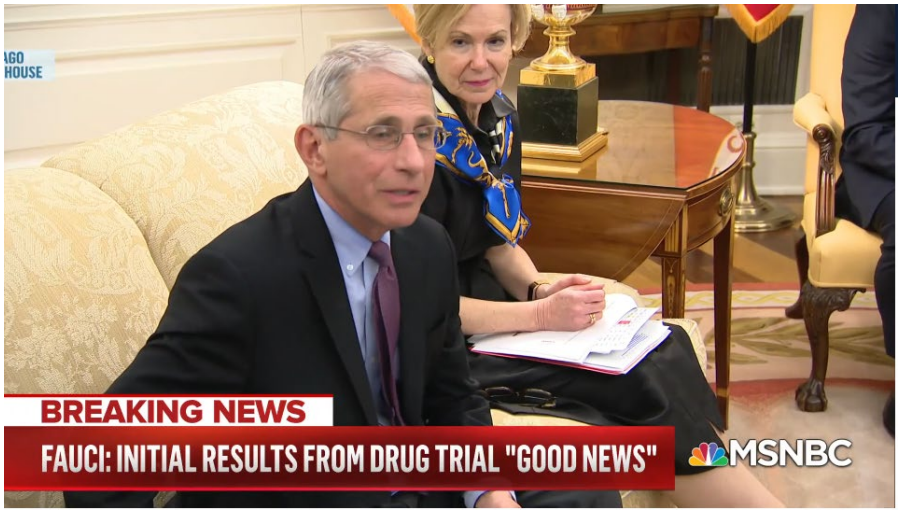
On August 9, 2019, when 681 patients had been enrolled, the data and safety monitoring board conducted an interim analysis on data from 499 patients and, on the basis of two observations, recommended terminating random assignment to ZMapp and remdesivir.

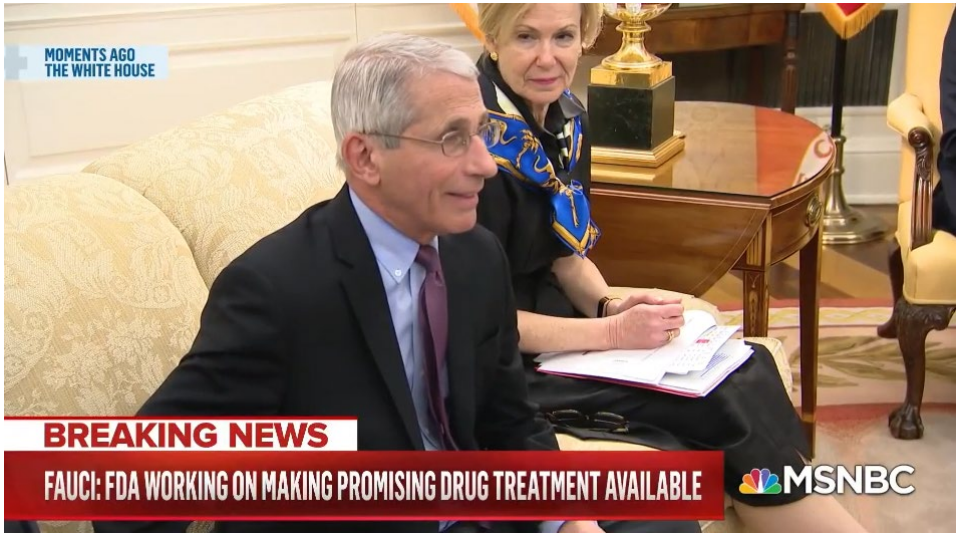


Remdesivir for the Treatment of Covid-19

ACTT-1 Trial Enrollment Feb 21 to April 19th 2020

April 29th 2020 – White House





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The NEW ENGLAND JOURNAL of MEDICINE

Remdesivir for the Treatment of Covid-19 — Preliminary Report

Gilead changed the end-point halfway through study – Scientific Misconduct

Outcome Measures

Primary Outcome Measures:

1. ~~Percentage of subjects reporting each severity rating on an 8-point ordinal scale~~
   ~~The ordinal scale is an assessment of the clinical status at the first assessment of a given study day. The scale is as follows: 1) Death; 2) Hospitalized, on invasive mechanical ventilation or extracorporeal membrane oxygenation (ECMO); 3) Hospitalized, on non-invasive ventilation or high flow oxygen devices; 4) Hospitalized, requiring supplemental oxygen; 5) Hospitalized, not requiring supplemental oxygen - requiring ongoing medical care (COVID-19 related or otherwise); 6) Hospitalized, not requiring supplemental oxygen - no longer requires ongoing medical care; 7) Not hospitalized, limitation on activities and/or requiring home oxygen; 8) Not hospitalized, no limitations on activities.~~

   [Time Frame: ~~Day 15~~]

   Time to recovery
   Day of recovery is defined as the first day on which the subject satisfies one of the following three categories from the ordinal scale: 1) Hospitalized, not requiring supplemental oxygen - no longer requires ongoing medical care; 2) Not hospitalized, limitation on activities and/or requiring home oxygen; 3) Not hospitalized, no limitations on activities.

   [Time Frame: *Day 1 through Day 29*]

Secondary Outcome Measures:

CONCLUSIONS

Our data show that remdesivir was superior to placebo in shortening the time to recovery in adults who were hospitalized with Covid-19 and had evidence of lower respiratory tract infection. (Funded by the National Institute of Allergy and Infectious Diseases and others; ACTT-1 ClinicalTrials.gov number, NCT04280705.)

Preliminary Report - May 22nd, 2020
FDA approval - October 22nd 2020
Final Report – November 5th 2020

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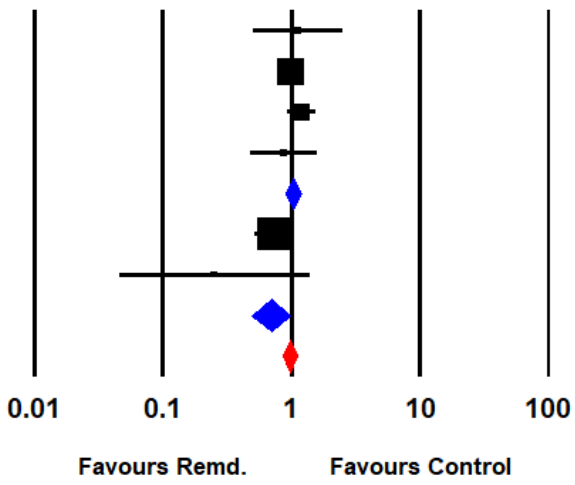
Remdesivir for treatment of COVID-19: Grouped By Pharma Controlled vs Independent

Meta-analysis of Mortality

Group by Pharma/IND	Study name	Odds ratio	Lower limit	Upper limit	Z-Value	p-Value
I	Wang	1.116	0.501	2.488	0.269	0.788
I	SOLIDARITY	0.978	0.826	1.159	-0.254	0.800
I	VA Coperative	1.175	0.910	1.516	1.234	0.217
I	DisCoVery	0.866	0.475	1.581	-0.467	0.640
I		1.027	0.897	1.176	0.391	0.696
P	Beigel	0.724	0.507	1.035	-1.773	0.076
P	Spinner	0.249	0.045	1.370	-1.599	0.110
P		0.692	0.488	0.982	-2.062	0.039
Overall		0.976	0.860	1.107	-0.380	0.704

Statistics for each study



Meta Analysis

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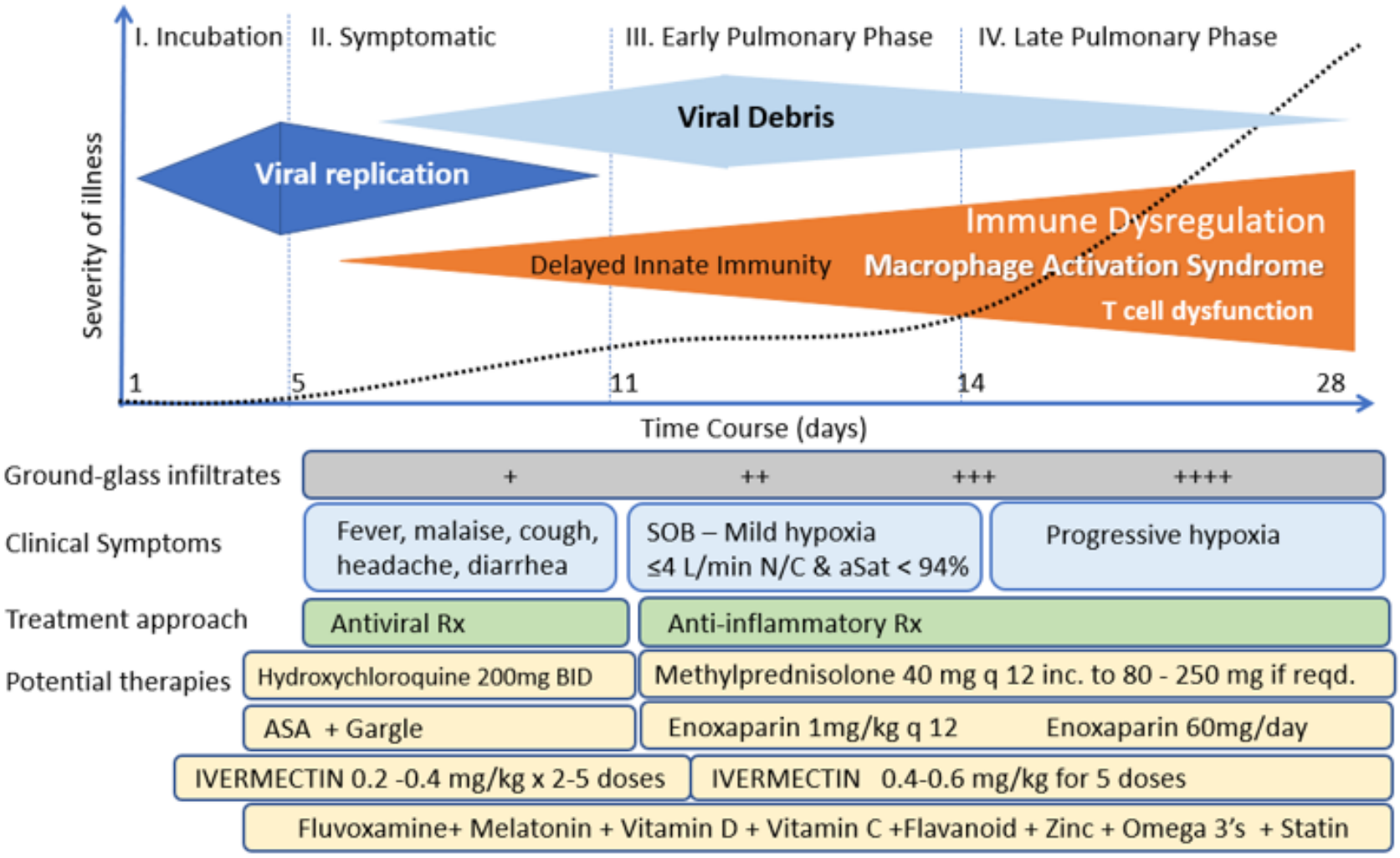
Phase Specific Combination Therapy



Remdesivir (antiviral) has no place in the pulmonary phase

Kidney disorders as serious adverse drug reactions of remdesivir in coronavirus disease 2019: a retrospective case–noncase study

Table 1 | Reporting of kidney disorders in remdesivir users among COVID-19 patients, and their RORs within the WHO global pharmacovigilance database

Type of analysis	Kidney disorder cases[a]	Noncases[b]	ROR (95% CI)
Primary analysis			
Remdesivir users	327	1526	7.2 (5.7–9.0)
Other drug users	107	3572	1 (Reference)
Sensitivity analysis restricted to severe to critical COVID-19 patients			
Remdesivir users	327	1526	3.7 (2.6–5.4)
Dexamethasone, sarilumab, or tocilizumab users	34	591	1 (Reference)
Sensitivity analysis restricted to serious kidney disorders[c]			
Remdesivir users	301	1552	6.9 (5.4–8.7)
Other drug users	101	3578	1 (Reference)
Sensitivity analysis restricted to kidney disorders not including concomitant nephrotoxic drugs[d]			
Remdesivir users	242	1611	6.1 (4.8–7.9)
Other drug users	88	3591	1 (Reference)

Remdesivir increases OR of Acute Kidney Injury: 6.1 -7.2

Kidney International 2021:99:1234-1243

Politics and Economic Greed Define Science

August 21, 2020

Print This Post

Editors of The Lancet and the New England Journal of Medicine: Pharmaceutical Companies are so Financially Powerful They Pressure us to Accept Papers

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Politics and Economic Greed Define Science

August 21, 2020

Print This Post

Editors of The Lancet and the New England Journal of Medicine: Pharmaceutical Companies are so Financially Powerful They Pressure us to Accept Papers

As uncovered by Science Defies Politics: 16 of the panel members selected by NIH to formulate the official COVID-19 Treatment Guidelines – including two of the three co-chairs – were paid by Gilead.

At least 7 (seven) members of the Panel on COVID-19 Treatment Guidelines, including 2 out of 3 Co-Chairs, have not disclosed their financial ties to Gilead Sciences (GILD), the patent owner and manufacturer of *remdesivir*.

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Hospitals' Incentive Payments for COVID-19

AAPS Association of American Physicians and Surgeons

The hospital payments include:

- A "free" *required* PCR test in the Emergency Room or upon admission for every patient, with government-paid fee to hospital.
- Added bonus payment for each positive COVID-19 diagnosis.
- Another bonus for a COVID-19 admission to the hospital.
- A 20 percent "boost" bonus payment from Medicare on the *entire hospital bill* for use of remdesivir instead of medicines such as Ivermectin.
- Another and larger bonus payment to the hospital if a COVID-19 patient is mechanically ventilated.
- More money to the hospital if cause of death is listed as COVID-19, even if patient did not die directly of COVID-19.
- A COVID-19 diagnosis also provides extra payments to coroners.

February 1, 2022
1:46 PM EST
Last Updated 6 days ago

Healthcare & Pharmaceuticals

REUTERS®

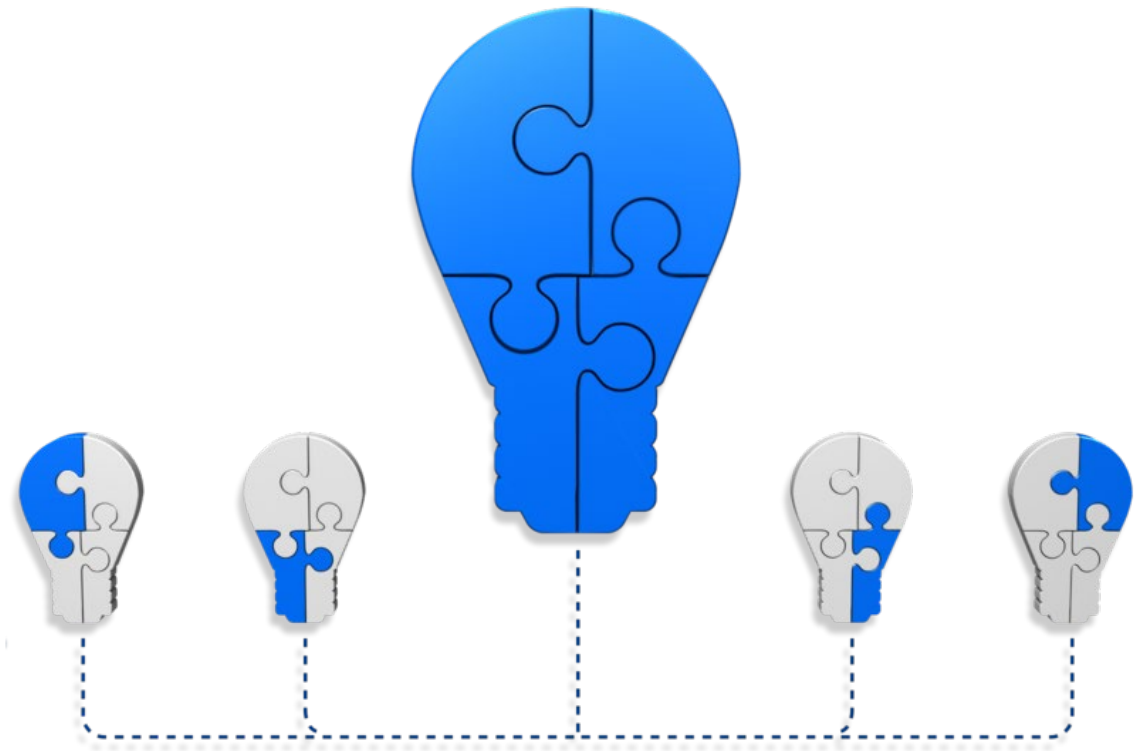
Gilead COVID drug takes top spot for U.S. hospital spending - report

By Deena Beasley

Gilead, which will report quarterly results on Tuesday, posted $4.2 billion in global Veklury sales in the first nine months of 2021.

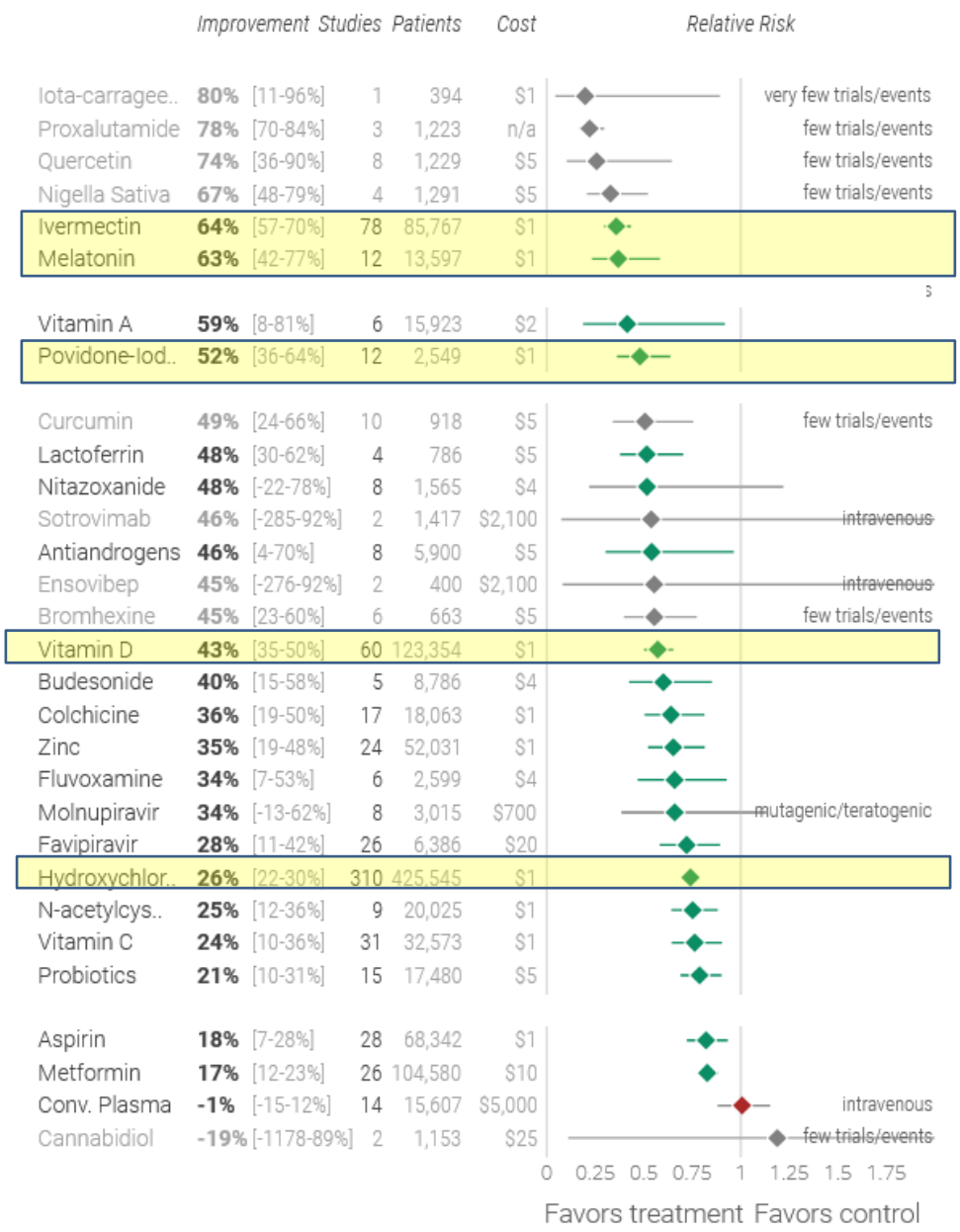
No Single Magic Bullet!

synergy

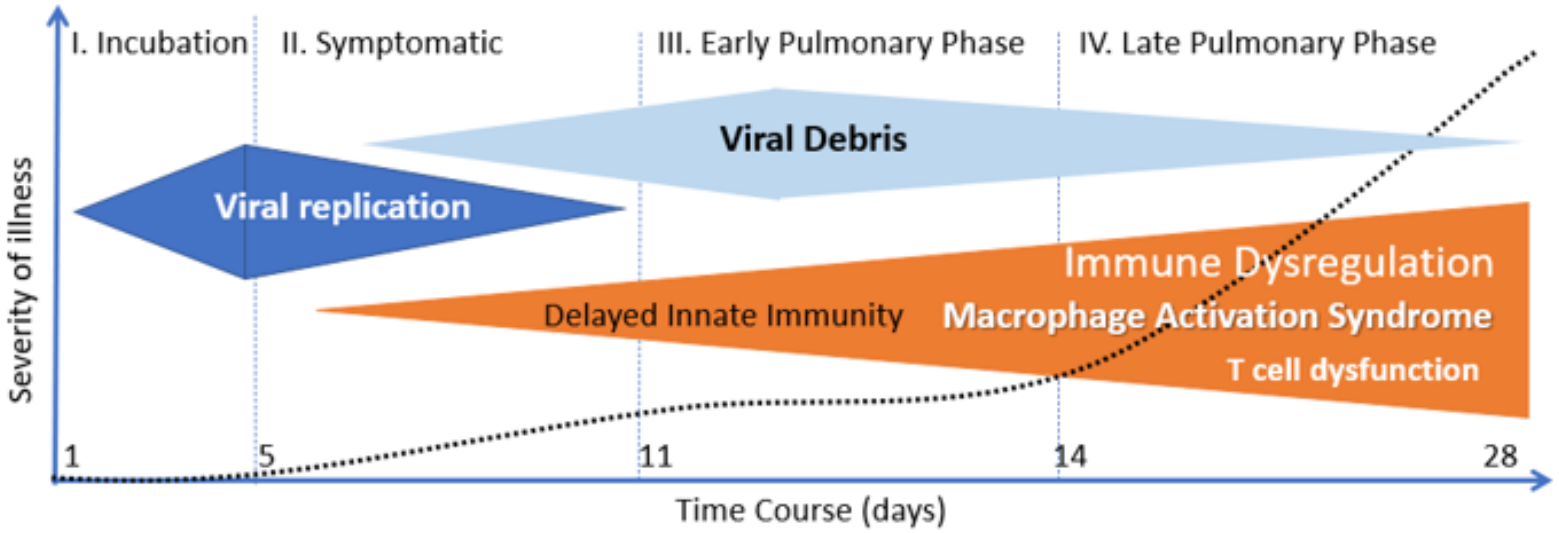


COVID-19 early treatment: real-time analysis of 1,384 studies

All studies combined (pooled effects, all stages) c19early.com Feb 6, 2022



Phase Specific Combination Therapy



Ground-glass infiltrates	+	++	+++ ++++
Clinical Symptoms	Fever, malaise, cough, headache, diarrhea	SOB – Mild hypoxia ≤4 L/min N/C & aSat < 94%	Progressive hypoxia
Treatment approach	Antiviral Rx	Anti-inflammatory Rx	
Potential therapies	Hydroxychloroquine 200mg BID	Methylprednisolone 40 mg q 12 inc. to 80 - 250 mg if reqd.	
	ASA + Gargle	Enoxaparin 1mg/kg q 12	Enoxaparin 60mg/day
	IVERMECTIN 0.2 -0.4 mg/kg x 2-5 doses	IVERMECTIN 0.4-0.6 mg/kg for 5 doses	
	Fluvoxamine+ Melatonin + Vitamin D + Vitamin C +Flavanoid + Zinc + Omega 3's + Statin		

Tweets | Tweets & replies | Media | Likes

Pinned Tweet

U.S. FDA @US_FDA · 9h

You are not a horse. You are not a cow. Seriously, y'all. Stop it.

Why You Should Not Use Ivermectin to Treat or Prevent COVID-19

Using the Drug ivermectin to treat COVID-19 can be dangerous and even lethal. The FDA has not approved the drug for that purpose.

fda.gov

Horowitz: FDA disseminates dangerous and libelous misinformation against lifesaving COVID treatment

DANIEL HOROWITZ | August 23, 2021

Merck Statement on Ivermectin use During the COVID-19 Pandemic

KENILWORTH, N.J., Feb. 4, 2021 – Merck (NYSE: MRK), known as MSD outside the United States and Canada, today affirmed its position regarding use of ivermectin during the COVID-19 pandemic. Company scientists continue to carefully examine the findings of all available and emerging studies of ivermectin for the treatment of COVID-19 for evidence of efficacy and safety. It is important to note that, to-date, our analysis has identified:

- No scientific basis for a potential therapeutic effect against COVID-19 from pre-clinical studies;
- No meaningful evidence for clinical activity or clinical efficacy in patients with COVID-19 disease, and;
- A concerning lack of safety data in the majority of studies.

We do not believe that the data available support the safety and efficacy of ivermectin beyond the doses and populations indicated in the regulatory agency-approved prescribing information.

Ivermectin for COVID-19

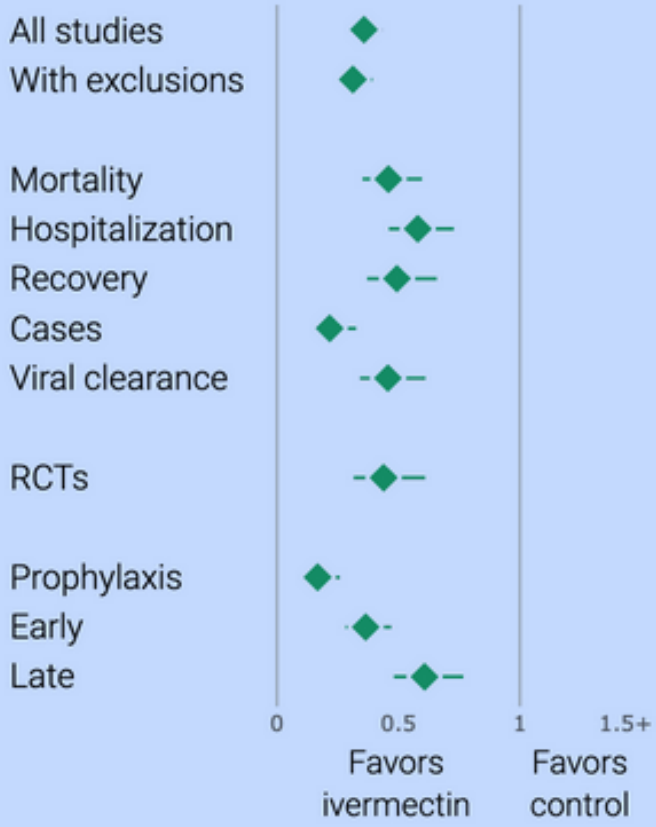
78 studies from 736 scientists
85,767 patients in 27 countries

Statistically significant improvement for **mortality**, **ventilation**, **ICU**, **hospitalization**, **recovery**, **cases**, and **viral clearance**.

83%, 63%, 39% improvement for prophylaxis, early, and late treatment CI [74-89%], [53-72%], [23-52%]

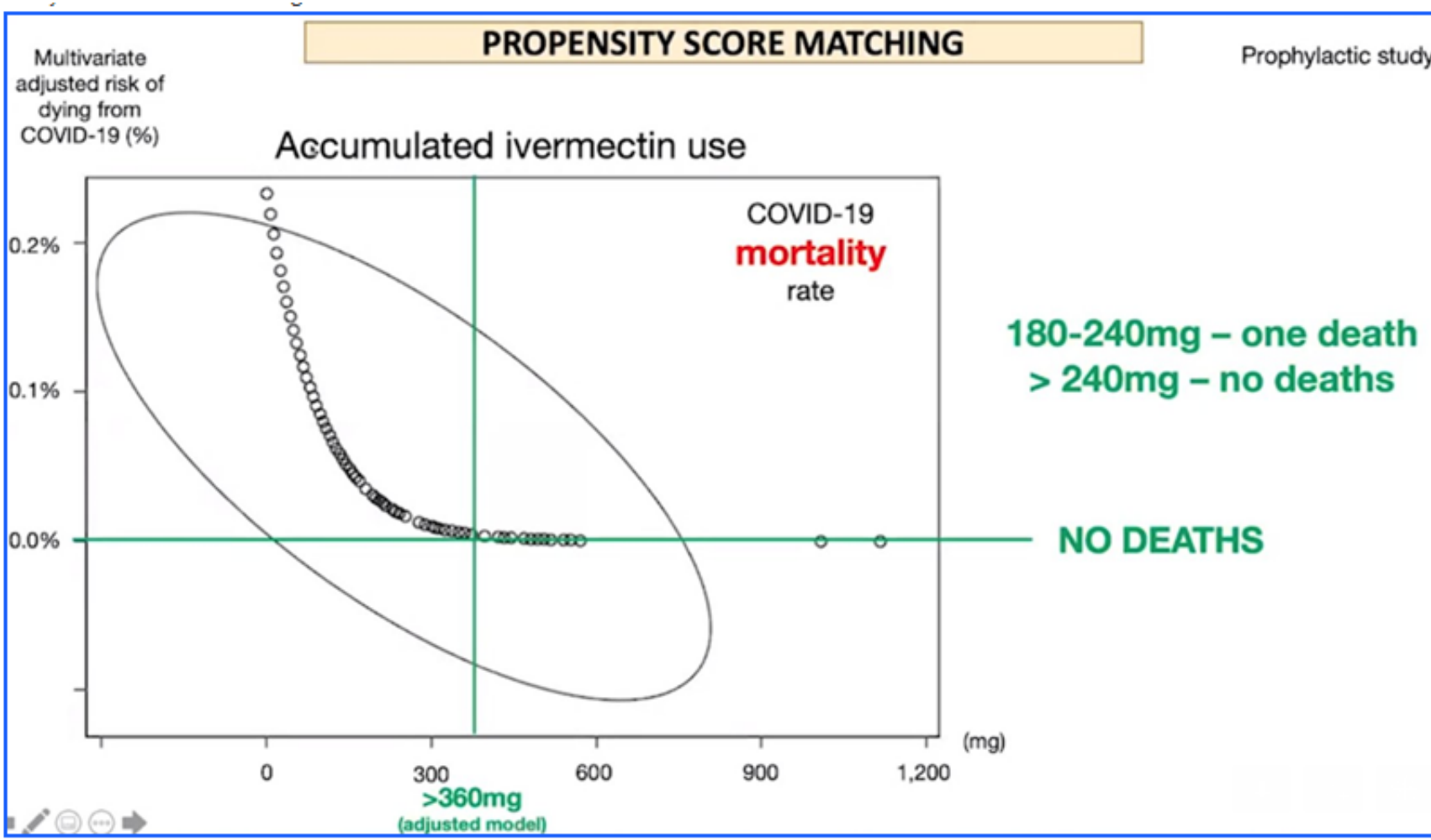
56% improvement in **33 RCTs** CI [39-68%]
54% lower **mortality** from **38** studies CI [40-65%]

COVID-19 IVERMECTIN STUDIES. FEB 7 2022. IVMMETA.COM



PROPENSITY SCORE MATCHING

Prophylactic study



180-240mg – one death
> 240mg – no deaths

NO DEATHS

- **Ivermectin** 1 tab 6 mg

2 : 200 µg/kg/day

2 : 2 tab/day (๑๕ ~ 60 kg)

2 : 2 Day

2 : 2 cents a tab

(WHO Pricing)

VigiAccess™

Uppsala Monitoring Centre

WHO Collaborating Centre for International Drug Monitoring

Medicine	Year started reporting	Deaths	Adverse events
Ivermectin	1992	18	4 669
Remdesivir	2020	579	7 798
Tocilizumab	2005	786	47 345
COVID-19 vaccines	2021	**15 789***	**3 173 622**
Tetanus vaccine	1968	32	14 697
Measles vaccine	1992	35	3 696
Acetaminophen (Tylenol)	1968	3 865	> 146 000

* Underreporting by a factor of a least 20x

World Health Organization

FDA

Pfizer

MERCK


IVERMECTIN
SAFE
IN
COUNTRIES
UNSAFE IN USA?
FLCCC.org
FLCCC
ALLIANCE

FLCCC ALLIANCE

REMDESIVIR VS IVERMECTIN

COMPARISONS	REMDESIVIR	IVERMECTIN
COST	$ 3,000.00	PENNIES
LOWER DEATH RATE IN STUDIES	NO	YES 50% +
SIMPLE ACCESS AT HOME	NO	YES
CAUSES ORGAN DAMAGE	YES	NO
STUDIES NEEDED FOR APPROVAL	1 and approved	60 + and not considered
MAJOR CONFLICTS OF INTEREST	YES	NO
SUPPORT OF FDA AND FAUCI	YES	NO

Why the dishonesty?

If Ivermectin was "approved"
EUA would need to be TERMINATED.

d. No Alternatives

For FDA to issue an EUA, there must be no adequate, approved, and available alternative to the candidate product for diagnosing, preventing, or treating the disease or condition.

U.S. FOOD & DRUG ADMINISTRATION

MATH+

HOSPITAL TREATMENT PROTOCOL FOR COVID-19

Intravenous **M**ethylprednisolone
High Dose Intravenous **A**scorbic Acid (Vitamin C)
Thiamine (Vitamin B1)
Low Molecular Weight **H**eparin
+

IVERMECTIN – Statin – Zinc – Vitamin D – Famotidine – Melatonin

MATH+ HOSPITAL TREATMENT PROTOCOL FOR COVID-19

Version **14**
2021-09-07

MEDICATION	INDICATION/INITIATION	RECOMMENDED DOSING	TITRATION/DURATION
A. CORE MEDICATION			
Methylprednisolone	A. *Upon oxygen requirement or abnormal chest X-ray*	Preferred: 80 mg IV bolus, then 40 mg IV twice daily Alternate: 80 mg / 240 ml normal saline IV infusion at 10 ml/hr Follow COVID-19 Respiratory Failure protocol (see flccc.net/respiratory-support-c19/)	A1. If no improvement in oxygenation in 1–3 days, double dose to 160 mg/daily. A2. Upon need for FIO_2 > 0.6 or ICU, escalate to "Pulse Dose" below (B) A3. Once off IMV, NPPV, or High flow O_2, decrease to 20 mg twice daily. Once off O_2, then taper with 20 mg/day × 5 days then 10 mg/day × 5 days
	B. *Refractory Illness/ Cytokine Storm*	"Pulse" dose with 1 gram daily × 3 days	Continue × 3 days then decrease to 160 mg IV/ daily dose above, taper according to oxygen requirement (A). If no response or CRP/Ferritin high/rising, consider mega-dose IV ascorbic acid and/or "Therapeutic Plasma Exchange" below
Ascorbic Acid	*O_2 < 4 L on hospital ward*	500–1000 mg oral every 6 hours	Until discharge
	O_2 > 4 L or in ICU	50 mg/kg IV every 6 hours	Up to 7 days or until discharge from ICU, then switch to oral dose above
	If in ICU and not improving	Consider mega-doses: 25 grams IV twice daily for 3 days	Completion of 3 days of therapy
Thiamine	*ICU patients*	200 mg IV twice daily	Up to 7 days or until discharge from ICU
Heparin (LMWH)	*If initiated on a hospital ward*	1 mg/kg twice daily — monitor anti-Xa levels, target 0.6–1.1 IU/ml	Until discharge then start DOAC at half dose × 4 weeks
	If initiated in the ICU	0.5 mg/kg twice daily — monitor anti-Xa levels, target 0.2–0.5 IU/ml	

MATH+ HOSPITAL TREATMENT PROTOCOL FOR COVID-19

B. FIRST LINE ADJUNCTIVE THERAPY (use in all hospitalized patients)			
Ivermectin[2]	*Hospitalized patients*	0.6 mg/kg per dose — daily[3] (take with or after a meal)	For 5 days or until recovered
Nitazoxanide	*Hospitalized patients*	500 mg twice daily — (take with or after a meal)	For 5 days or until recovered
Dual Anti-Androgen Therapy	*Hospitalized patients*	1. Spironolactone 100 mg twice daily 2. Dutasteride 2 mg on day 1, followed by 1 mg daily	14 days or until discharge from hospital
	ICU Patients	1. Flutamide 250 mg TID[1] 2. Dutasteride 2 mg on day 1, followed by 1 mg daily	14 days or until discharge from hospital
Vitamin D	*Hospitalized patients*	Calcitriol: 0.5 mcg on day 1, then 0.25 mcg daily	7 days
Melatonin	*Hospitalized patients*	6–12 mg PO at night	Until discharge

MEDICATION	INDICATION/INITIATION	RECOMMENDED DOSING	TITRATION/DURATION
C. SECOND LINE ADJUNCTIVE THERAPY (use in addition to "First Line Adjunctive Therapies" in all ICU patients?)			
Fluvoxamine[4]	*Hospitalized patients*	50 mg PO twice daily — consider fluoxetine 30 mg daily as an alternative (it is often better tolerated)	10–14 days
Cyproheptadine	*If any of: 1) on fluvoxamine, 2) hypoxemic, 3) tachypneic/respiratory distress, 4) oliguric/kidney injury*	8 mg — 3 x daily	until discharge, slow taper once sustained improvements noted
Zinc	*Hospitalized patients*	75–100 mg PO daily	Until discharge
Famotidine	*Hospitalized Patients*	40–80 mg PO twice daily	Until discharge
Atorvastatin	*ICU Patients*	80 mg PO daily	Until discharge
Therapeutic Plasma Exchange	*Patients refractory to pulse dose steroids*	5 sessions, every other day	Completion of 5 exchanges

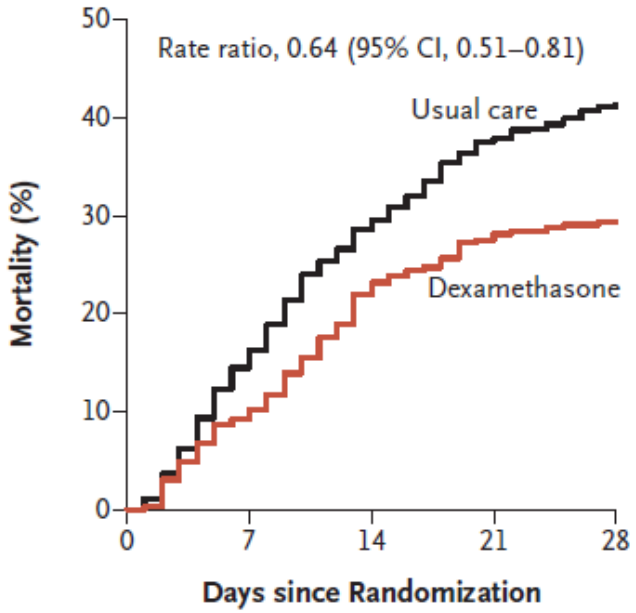
The NEW ENGLAND JOURNAL of MEDICINE

Dexamethasone in Hospitalized Patients with Covid-19

The RECOVERY Collaborative Group*

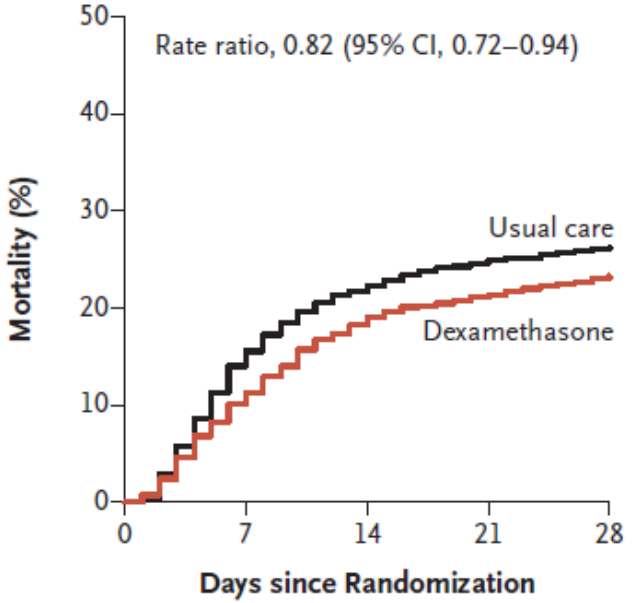
Dexamethasone 6 mg/day up to 10 day (median 7 days)
30 mg methylprednisolone

B Invasive Mechanical Ventilation (N=1007)



No. at Risk					
Usual care	683	572	481	424	400
Dexamethasone	324	290	248	232	228

C Oxygen Only (N=3883)



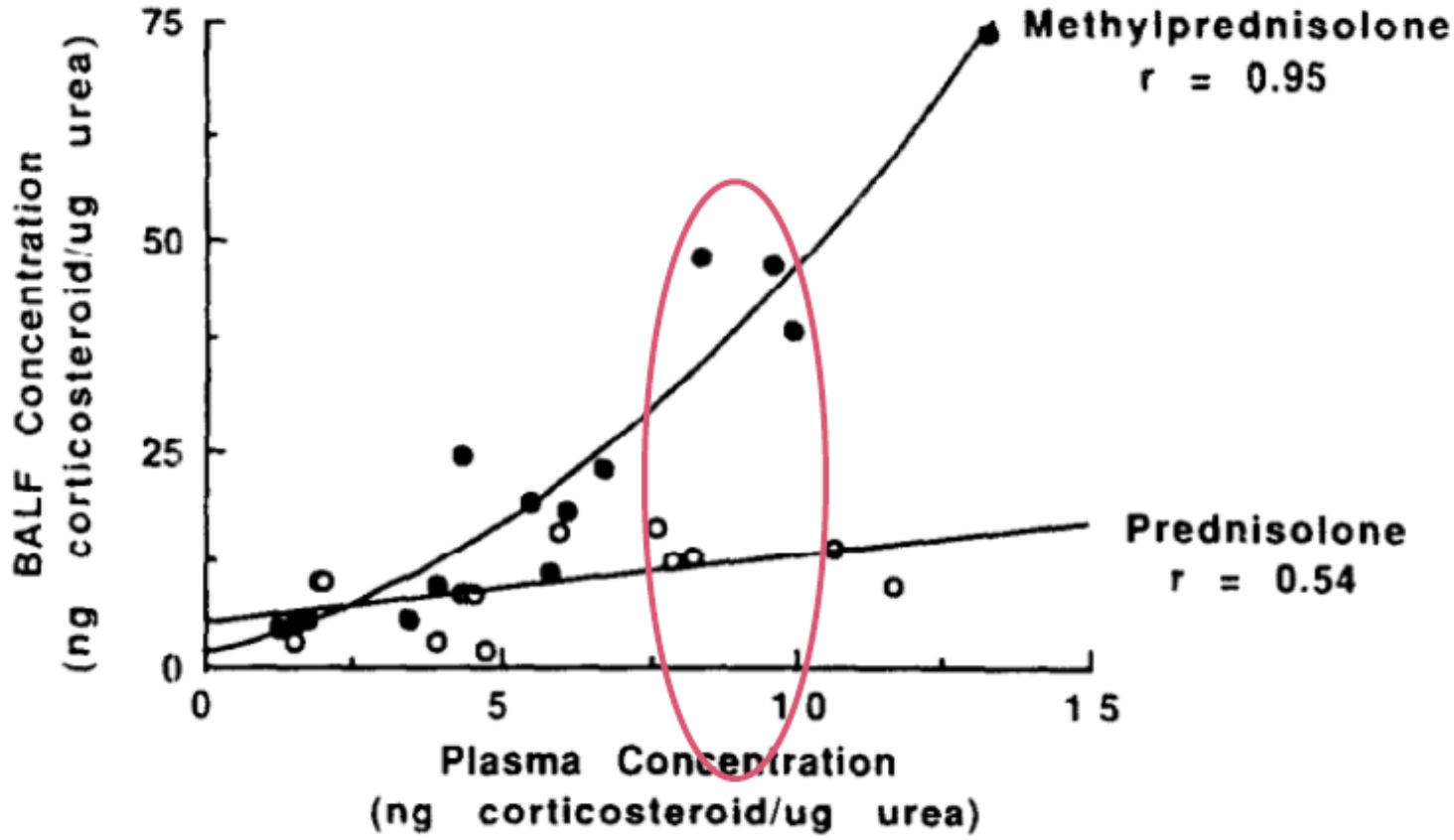
No. at Risk					
Usual care	2604	2195	2018	1950	1916
Dexamethasone	1279	1135	1036	1006	981

Deaths reduced by 35% and 20%

NEJM 2021;384:693

Methylprednisolone:
The Drug of Choice for the Pulmonary phase of COVID-19

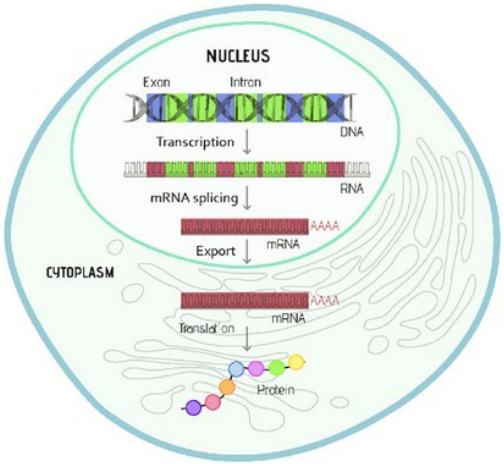
Pharmacologic Properties of Importance

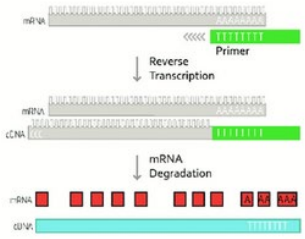


Braude AC et al. Lancet 1983;322:995

COVID-19: disease pathways and gene expression changes predict methylprednisolone can improve outcome in severe cases

Chemical name	COVID19 vs. Healthy		lung epithelium (NHBE) with CoV vs. Control		lung alveolar (A549) with IAV vs. Control		lung alveolar (A549) with CoV2 vs. Control		lung alveolar (A549) with RSV vs. Control	
	consistent (-)/ DE targets	p-value	consistent (-)/ DE targets	p-value	consistent (-)/ DE targets	p-value	consistent (-)/ DE targets	p-value	consistent (-)/ DE targets	p-value
Methylprednisolone	25/27	5.725e-10	22/22	8.996e-14			25/26	6.029e-14	35/37	3.183e-15
Gold Sodium Thiomalate	22/24	5.973e-8	22/22	8.996e-14			24/25	9.998e-14	35/36	8.245e-16
Prednisolone	27/34	1.737e-7	22/24	1.373e-12			22/23	2.754e-13	35/41	2.930e-13





Draghicis S et al. Bioinformatics 20201; ePub

The NEW ENGLAND JOURNAL of MEDICINE

Dexamethasone in Hospitalized Patients with Covid-19

The RECOVERY Collaborative Group*

The Wrong Drug
The Wrong Dose
The Wrong duration of Rx

PUBLISHED RCT's/OCT's OF CORTICOSTEROID THERAPY IN COVID-19		ABSOLUTE DIFFERENCE IN MORTALITY	NUMBER NEEDED TO TREAT TO SAVE ONE LIFE
METHYLPREDNISONE – HOSPITAL PATIENTS (Edalatifard et al, Italy) 250mg methylprednisone daily x 3 days		5.9% vs. 42.9%	2.7
METHYLPREDNISONE – ICU PATIENTS (Confalonieri et al, Italy) 80mg methylprednisone daily x 8 days		7.2% vs. 23.3%	6.2
METHYLPREDNISONE- ARDS PATIENTS (OCT - Wu C et al- China) 1-2 mg/kg/day for 3-5 days		46.0% vs. 61.8%	6.3
METHLPREDNISONE – HOSPITAL PATIENTS, (OCT - Fadel et al, USA) 0.5-1.0mg/kg/day x 3 days		13.6% vs. 26.3%	7.8
METHYLPREDNISONE - Pts on oxygen – (Fernandez-Cruz at al, Spain) 1mg/kg/day		13.9% vs. 23.9%	10.0
METHYLPREDNISONE VS. DEXAMETHASONE (Ranjbar et al, Iran) 2mg/kg/day MP vs. 6mg/day Dexamethasone		18.6% vs 37.5%	5.3
METHYLPREDNISONE VS. DEXAMETHASONE (OCT - Ko et al, USC) >= 1mg/kg/day MP for min. 3 days vs. 6mg/day Dex for min. 7 days	OVERALL	16.4% vs. 26.5%	10
	PTS ON MV	31% vs. 54%	4.3
HYDROCORTISONE -CAPE-COVID – ICU Patients (Dequin et al France) 200mg/day with taper over 14 days – stopped early		14.7% vs 27.4%	7.9
HYDROCORTISONE –REMAP-CAP – ICU Patients (Angus et al) 200 - 400 mg/day x 7 days – stopped early		28% vs 33% (NS)	20.0
DEXAMETHASONE – CODEX – ICU Patients (Tomazini et al) 20 mg x 5 days, 10 mg x 5 days		56.3% vs 61.5%	19.2
DEXAMATHASONE – RECOVERY (Hornsby et al) 6mg/day x 10 days	PTS ON OXYGEN	23.3% vs. 26.2%	28.6
	PTS ON MV	29.3% vs. 41.4%	8.4

— NEWS —

Front Line Physician Suing Over Banned COVID Treatments: 'Let Doctors be Doctors'

By Tim Meads • Nov 30, 2021 DailyWire.com •

WAR on Repurposed drugs

The FDA's website states the following about approved off-label drugs for unapproved purposes:

"From the FDA perspective, once the FDA approves a drug, healthcare providers generally may prescribe the drug for an unapproved use when they judge that it is medically appropriate for their patient."

This case is about doctors, having the ability to honor their Hippocratic Oath, to follow evidence based medicine, and to treat our patients the best know how...

Dr. Paul E. Marik, M.D., FCCM, FCCP

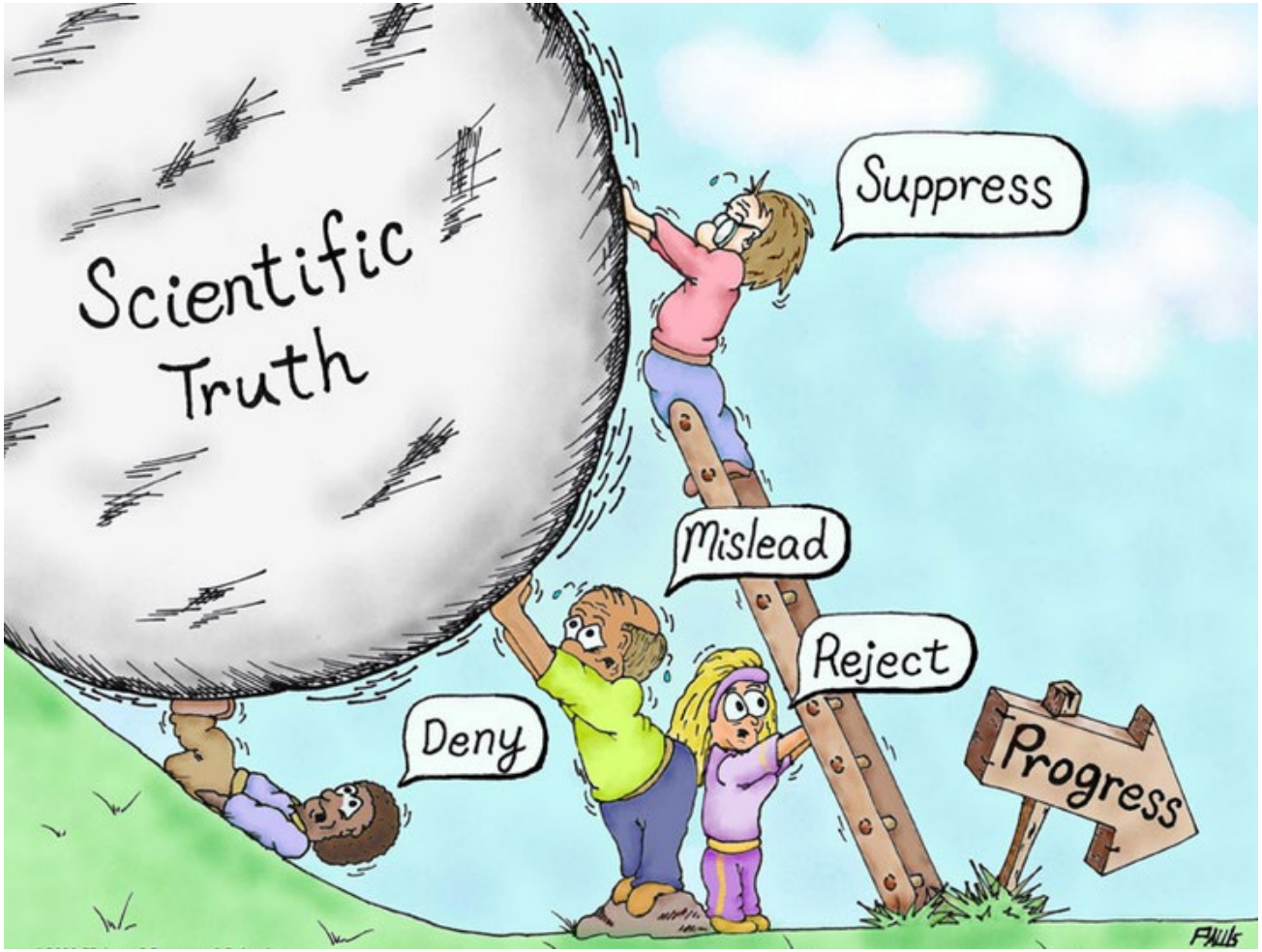
#letdoctorsbedoctors

Here we go again!

How can the FDA Panel Narrowly Back Merck's COVID Pill Molnupiravir when placebo outperformed this known-to-be-mutagenic pill?

Data from the post-interim analysis enrollment, there were fewer placebo patients who were hospitalized or died by day 29 versus patients receiving the intervention (4.7% vs 6.2%, respectively).

COVID-19 Misinformation…



The end is in sight!


Thank you