

# TREATMENT PROTOCOL

## Treatment of Covid 19 using Quadruple Therapy

Dr Martin Gill and Dr Jackie Stone

### DISCLAIMER

This protocol is borne of clinical experience only and thus is meant solely for educational purposes to health care providers regarding potentially beneficial empiric treatment approaches for Long Haul COVID-19 Syndrome. Never disregard professional medical advice because of something you have read on our website and releases. This is not intended to be a substitute for professional medical advice, diagnosis, or treatment in regards to any patient. Treatment for an individual patient is determined by many factors and thus should rely on the judgement of your physician or qualified health care provider. Always seek their advice with any questions you may have regarding your medical condition or health.

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## Treatment of Covid 19 using Quadruple Therapy

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Source of protocol. FLCCC MASK+I protocol, Prof Tom Borody's triple therapy protocol, and Dr Peter McCullough's Sequenced Multi Drug Therapy - SMDT. Principle at every stage of the illness is Triple therapy - Anti-Viral, Anti-Inflammatory and Anti-Coagulant. Antiviral therapy needs 4 agents, and we recommend Quadruple therapy - Prof Borody's triple anti-viral therapy (Zn, Doxycycline and Ivermectin) and nano silver. With Antiviral and anti-Inflammatory therapy, you may need to "Titrate to Effect"

### Prophylaxis in a well patient.

#### Ivermectin

12 mg weekly to 2 weekly depending on risk. It may vary depending on exposure.

Ivermectin is a very safe medication. It is better to err on the side of caution and use weekly if there is any doubt.

#### Vitamin D3

5000IU daily (Reduces risk of severe disease, facilitates intracellular destruction of pathogens)

#### Vitamin C

500 qid - (Protects cell)

#### Zinc

50 mg daily (Anti-viral - inhibits RNA polymerase in the cell)

#### Quercetin

250 mg dly (Ionophore for Zn, increases intracellular zinc)

Ionic OR Nano silver nose spray before and after visiting a public venue (e.g, shopping/funeral)

Higher doses of ivermectin can be used in vulnerable patients weighing over 80kg - 24mg weekly is 0.3mg/kg in an 80kg patient and seldom has side effects.

### After Exposure

#### Ivermectin

0.3 mg /kg on days 1, 3 and 5

#### Vitamin D3

5000IU daily - (Reduces risk of severe disease)

#### Vitamin C

500 mg qid (Protects cell)

#### Zinc

50 mg daily (Anti-viral in a cell)

#### Quercetin

250 mg dly (Ionophore for Zn, to get it into the cell)

Ionic OR Nano silver nose drops/spray - 1 -2 puffs in each nostril.

If a nebuliser is available - Nebulise with 5ml ionic or nano silver for 30 minutes.

### Mild Disease

Diagnosed positive. With or without mild symptoms. Or clinically has suspected COVID 19.

10 days of treatment is recommended for symptomatic patients as it is our experience that if we stop after 5 days, some patients relapse on day 7-8.

### Ivermectin:

Dose is 12mg daily for asymptomatic patients for at least 5 days – clinical judgement needs to include vulnerability of the individual patient and symptoms.

If symptomatic – give an initial Stat dose to 0.4 to 0.6 mg per kilogram depending on severity of symptoms and vulnerability and give 10 days of treatment.

Warn patient that they may get a few side effects – particularly visual- (that will peak at 4 hours and usually be gone by the next dose) – then treat with 0.4 mg/kg daily for 10 days.

You may need to increase incrementally to 0.6 mg/kg if the condition deteriorates.

### Doxycycline

100mg bd for 10 days

### Vitamin D3

10 000IU stat then 5000 IU daily \*

### Vitamin C

500mg tds daily - (Protects cell) \*

Zn 50 mg 2 X a day (Anti-viral in a cell) \*

### Quercetin

250 mg Bd (lonophore for Zn, to get it into the cell)\*

### Aspirin

300 mg daily

### Melatonin

(10mg dly)

### Ionic or Nano Silver

20 ml neb until complete stat (may take over an hour) then - 4 to 6 hrly nebs with 5 ml ionic or nano silver

At this stage they must have acquired an Oximeter and a nebulizer.

The patient must monitor their O2 Sat 4 to 6 hourly.

### If O2 sats drop to 94% or below

#### **They must contact you. This is the trigger to increase their treatment.**

Once there is hypoxia we need to switch from Ionic to nano-silver

They need to start nebulizing with Nano silver - 5 ml at least 4 hrly

Pulmicort (Budesonide) 0.5 mg in colloidal silver should be nebulised bd.

All above treatment continues, Ivermectin increased by 0.1 mg per kilogram up to 0.6 mg / kg if condition deteriorates.

You need to start thinking about adding anti-inflammatory (steroids) and further anticoagulant treatment (other than Aspirin) (LMWH/NOAC) and this decision should be guided by blood testing.

The patient needs a CRP and D Dimer, as well as an FBC and LDH.

Start setting up provisional arrangements for home oxygen.

### If O2 Sats drop to 90% or less

#### **Patient to contact you immediately**

Arrange home oxygen in case O2 sats drop below 80% (priority)

May be admitted to a hospital or receive supervised medical home care\*,

In the event that there are no beds.

Continue with the above treatment

Increase Ivermectin by 0.1mg per kilogram per day up to 0.6 mg/kg if condition deteriorates

Start daily prednisone if CRP > 20 or hypoxic\*

Increase nebulization to 2 hourly / continually with nano silver nebs and tds Budesonide to keep sats above 90.

#### **Bloods:**

FBC CRP

LDH

DDIMER

Glucose

If possible, do a chest X ray (not essential, does not usually alter management, logistics may be difficult if patient is hypoxic).

### Response to Investigations:

By this stage, the doctor needs to evaluate the clinical status and bloods, and the full blood count and LDH should be available.

From this point, the patient is provided with individualised treatment determined by blood testing.

1. **ANTIVIRAL:** QUADRUPLE THERAPY IVM/Doxy/Zinc/Silver – 10 days
2. **ANTI-INFLAMMATORY:** If the patient is hypoxic and the CRP is >20, STEROID THERAPY IS NEEDED
  - a. Prednisone 1mg/kg daily, and/or Dexamethasone 8mg IV od.
3. **ANTICOAGULATE.** In cases where the D-Dimer is raised, ANTICOAGULATE.
  - a. Subcutaneous Enoxaparin, at a dose of 80 – 100mg (8000 – 10 000u) Is administered, followed by
  - b. Riveroxiban /Xarelto at a dose of 20mg per day, for 30 days.
4. **ANTIBIOTIC: SECONDARY BACTERIAL INFECTION:** If neutrophils are raised and the patient remains cannulated, we give Ceftriaxone at a dose of 1g daily, until oral treatment is considered appropriate. Use of Ceftriaxone IV will depend on the FBC and clinical severity of the patient. when the switch is made to oral treatment. Doxycycline and Ceftriaxone can be given simultaneously.