Introduction and Dr. Koryu2019s background

– Okay, so welcome. Today on this edition of long Covid and chronic fatigue, we are going to talk to Pierre. Dr. Pierre Kory. Dr. Kory is uh just one of the, I think one of the heroes of of Covid.

He's a gentleman, a doctor who has pursued what works for his patients, you know, has really thought things through um done the kind of medicine that if you've been listening to this series that I really believe we have to someday return to.

But on that note, Dr. Kory a pleasure to have you. And so I really would like you to outline a little of your story because, you know, people who who have heard of you, which is probably most of our listeners.

You know, there's two camps, the ones that, you know, who feel like I do that you've really brought us forward. And then there's the people who um you know, probably feel that you're out there with, you know, like sort of belong in the sale and which trials, you know, so – I get it. Yeah. – So, so can you just lay it out and try to like explain how this happened, You know? – Yeah, it's been an interesting journey.

So, I mean, just briefly where I started before Covid, I mean, I was deep in the ivory tower. I mean, I was the Chief of the Critical Care Service at the University of Wisconsin. I was an associate professor.

I mean, literally met criteria for professor. I just was so busy. I didn't have time to put in my promotion packet. And I was the medical director of the main medical surgical ICU there and you know, I was in a specialty where I was really well known nationally and internationally because I had helped pioneer, you know uh subspecialty in critical care, which was the use of point of care ultrasound. So I was like an expert at using ultrasound at the bedside to make lifesaving diagnoses. And I've worked with the American College for chess physicians for years, building courses traveling around the country, teaching. And we literally kind of launched that whole field. And now any critical care doctor worth their salt or really any critical care doctor trained in the last 10 years is going to have really good basic skills at looking at, you know, which side of the hardest failing if the lungs are full of fluid. And so it made us much better doctors taking care of the dying. And so I wrote, you know, as a senior editor of a textbook that is in its second edition translated into seven languages.

It's one of the most popular textbooks in the field. And you know, I was pretty proud of that. I also had pioneered the use of therapeutic hypothermia early in my career as an early adopter of that.

So we would as part of New York city's project, hypothermia help the fire department and the E. M. S. And like, I don't know, I've just done a lot of stuff in my field, but let's fast forward what happened in Covid.

So covid hits, I'm 50 years old, it's clearly a pulmonary and critical care disease. I am like completely like stimulated on fire. I know this thing's coming and I know my ice you are going to fill and I gotta figure this disease out.

And you know, luckily I was a close friend and colleague of Paul Marik and he and I were talking about protocols like how we're gonna treat this. We were just learning as much as we cover, reading all the pre print servers, talking to doctors everywhere. All of my friends are still in New York city and they run, I see us there and when they were getting hammered, I was on the phone with them every day finding out what they were seeing, what they were doing, what was working. And basically what happened next is Paul and I and three other very well known guys in our specialty were asked to come up with a protocol because we had a lot of credibility, were very well known and the government was doing nothing to guide treatment. They were essentially saying supportive care only stayed home to your lips turn blue take a Tylenol, which by the way, Eric, is the only drug really has shown to do harm is actually Tylenol.

It actually makes outcomes worse. But anyway, that's an aside. And so we were kind of like five guys with the

website and our first protocol, which we put out in late March of 2020 was solely about the hospital. We knew you needed high doses of corticosteroids. We knew you needed some amount of blood thinners, you know, and and so we had, you know, and we also were experts at intravenous vitamin C. And so we had like a really potent hospital protocol and you know, I was asked to testify in the senate in May of 2020 by Senator Ron Johnson because he had found that we were a group with a protocol and he what he thought like he's not a doctor, but he couldn't understand why the health system wasn't trying to figure out how to treat this disease. So he comes across our protocol and our organization, we were we weren't even a non profit then we were just five guys with the website and he saw that one of the main guys was literally the chief of the Critical care service at the University of Wisconsin. So who did he call?

He's the senator from Wisconsin. He called me and I don't want to go into politics but he was not politically favored by me at the time, but we had a really interesting, powerful conversation.

I testified, he asked me to testify at the hearing and I testified for the critical need for corticosteroids in the hospital phase of the disease at a time when every national and international health care society was saying not to, but we knew it was life saving and I got killed for that.

I got criticized for that, but I didn't care. I knew to save a life in the ICU. You needed to use steroids. And guess what? Eric, I was validated two days to two months later when a trial came out showing massive mortality reduction when you use cortical stern.

So, so that was chapter one. We were validated. We had a hospital protocol. – And just just for our patients say to remember is that you're talking in patients who are hospitalized the 2nd-3rd week of covid.

– Exactly. That's what yeah, I want to emphasize that the hospital… – Not when you want to be doing steroids, – Not early on for sure. You know, it's it's to deal with the secondary hyper inflammation and the pulmonary phase, which is technically what's called an organizing the money, what they used to call boop. But anyway, so, so that's what we were doing and we we just kept trying to bring attention to our protocol because we knew it was doing really well. I mean, some of us were using the hospital. I mean, we were kicking about.

We're getting people off of ventilators. We were getting them discharged and meanwhile, you know, the country is doing nothing. If, my dogs, sorry, you want me to pause for a second. – No, it's ok.

Dogs, dogs, dogs are allowed, you know, okay loud Children. We frowned upon but dogs are – So um the problem became is that we we continued to follow all of the studies and all of the therapeutics and as trials were coming out as trials were coming out we would kind of we had things that we would, we thought might be of value might not. We really didn't believe in convalescent plasma from the beginning that had no physiologic basis.

We weren't sure about hydroxychloroquine early on just because there was so much conflicting trials, evidence and we didn't know then what we know now, which is that the high profile journals literally are directed at destroying repurposed drugs and we can talk about that later. But anyway, what happened was in around early October of 2020.

We were following I've ever met and we had it on our protocol with a question mark. We didn't recommend it. But we started to see these trials coming out from different centers and countries around the world and they were just such large magnitude benefits. We were shocked.

We had never seen anything with that large magnitude of benefits and it just kept coming and coming. There were little analyses of different cities that have adopted the protocol with ivory mactan and they were like had, I mean 1/10 the death rates in the case counts of other cities.

COVID-19 treatment protocols and early steroid use

And so we were learning about all these ministry programs and studies. And so then, and this is what sealed our fate is we put together an early treatment protocol centered around I've ever met them. And soon after we did that,

Senator Johnson asked me again to give testimony in the Senate and I was pretty fired up that day because one of the other party senators kind of offended me and all the doctors that were invited calling us like politically having some sort of political objective. And I was just furious.

I mean, I've been drowning and I see trying to keep patients alive, trying to learn everything I could about this disease, trying to put together protocols and here he is like offending me for trying to share that knowledge as if I have some sort of political objective and and so I let it rip. I don't know.

I just was tired, angry, frustrated and offended and that that testimony went viral, right? And so, you know, not that it was my intent, but it really put, I've reflected on the map and it became a thing of discussion, but I'm going to pause here and say what I didn't know is I thought that information would be so welcomed and appreciated and adopted and deployed And that's not what happened. And I couldn't figure out exactly.

– Yeah, you're right. I mean, I'm laughing only because I've been doing what they call alternative medicine and and interested in it for 40 years and I have watched this happen time, this is one of the more egregious big ones time and time again.

Okay. People come forward, they worked really hard, they found something and they hit academic medicine and they can become roadkill okay. And you are – You could sum up, you could sum up what happened to me next as that process that I had to go through. But you know, I couldn't figure it out after the testimony and we got a lot of attention. In fact, one of the legislators even got us an audience with the National Institutes of Health and I presented with Paul Merrick in front of the guidelines committee for Treatment of Covid and we gave them all of our data there, ask some questions, we could tell that something was off there. Like they were very couple of them were very dismissive, very derisive. Just sort of it wasn't like great guys, thank you. It was more like they just wanted to poke holes in what we were saying and but then like the media the way the media behaved towards it.

Like I just saw all these attacks and criticisms and and I couldn't figure out what was going on and what changed my life was an email that was sent to me in March of 2021. This is three months after my testimony where we were just getting like criticized, hammered censored and and just just I just started reading Lies everywhere, Lies about it. I've ever met the narratives that were forming.

They were just saying, you know, as an expert and I've met them. Because the other thing about my testimony Is that came after I wrote the first comprehensive review papers, a very long paper, 200 references.

It reported on all of the trials, the study's the ministries, the company. It was like an overwhelming paper and that started to get a lot of attention, you know, comprehensive review paper.

And then I got this email in March of 2021 and by the way, I could go through the whole story, people could I'm writing a book about it. But we also passed peer review at that paper passed peer review and then it was suddenly retracted right before publication without a good reason.

We didn't know why we had four peer reviewers. Three rounds of peer review. Three Senior sciences at NIH and FDA were the peer reviewers. And yet it got retracted and which has never happened in our collective careers where you had a paper passed peer review and it gets retracted without accusations of fraud or pagers. Like they just said, we we hired a third party peer reviewer who anonymously said that your conclusions are not supported by your data.

And so we're retracting it and that's when we knew that something sinister was going on. Like we knew that this is not right here and that that that's happened to many, many other people around the vaccines and myocarditis.

And a lot of inconvenient papers were retracted. So but that was the first wake up call to me and then someone sent me an email. He's a professor, a world expert on vitamin D. His name is William B.

Grant, he's from Australia and he wrote me this two line email and he said Dr. Kory what they're doing to Ivermectin. They've been doing to vitamin D for decades.

And then he sent me a link to an article called the Disinformation Playbook and it's on the website of the union for concerned scientists. And I read the article, it's a short article. It's very powerful but it basically describes what industries do when science emerges that's inconvenient to their interests.

And when I read that article it was like a click. Like suddenly the world made perfect sense. And because when I read the tactics of what they do, I was like I've seen that I've seen that I've seen that I've seen like every tactic described and this applies to any industry.

The it was invented by the tobacco industry practice for 50 years right to protect the sales of tobacco. But the pharmaceutical industry is the most skilled and the most sinister practitioners. And once I read that article basically that describes my life is that I have been the target of disinformation through the media through the journals through personal attacks. I've lost jobs.

I mean, you know what I discovered is that by trying to bring knowledge of the efficacy of I ever met them. The key thing is Ivan Mactan is an off pad and repurposed drug. The repurposed drugs are the single greatest threat to the pharmaceutical industry is their Achilles heel.

And I basically was like sticking a knife into their Achilles heel. And that's a trillion dollar industry. They stop at nothing to put you down. Now, I'm still standing. I'm talking to you.

My organization is doing well. We're still putting out good pragmatic medical information. But I've had to watch just massive propaganda and censorship and they've tried to bury I've ever met and we talked about this briefly.

I mean, their main tactic and I just want to finish on this. And so this would help maybe some of your viewers who think like I'm a cougar, I'm getting something wrong. But out of all of the disinformation taxes that I've seen the propaganda, censorship and social media, all this stuff.

It's all founded upon one single tactic. And that is the publishing of counterfeit science in the high impact medical journals. There are 93 controlled trials. Almost all of them are positive.

I know many of the researchers and investigators who did those trials very early on in 2021 it was known you could not publish in a high impact journal.

They were rejecting upon submission all positive trials. And then the only thing you showed up with, I call them the big five. There's been big five I've ever met in trials. Each one with a non statistically significant benefit. I want to repeat that.

They all show benefits, but they're designed to not reach statistical significance. And they're all written with the conclusion that ivermectin should not be used in covid and based on five trials when there's 93 control trials.

And then I saw what I've learned is the immense power of the high impact journals. Right? The five highest impact medical journals in the world of New England Journal Medicine, The Journal of the American Medical Association, the British Medical Journal, The Lancet and annals of Internal Medicine.

Those journals drive headlines, They drive guidelines, they drive everything and they've been captured by farmer well over two decades ago. And former editors of those journals have resigned their positions and written books about the control of those journals. And so and let me just finish here.

So when we talk about that journey, where I started, I literally started thinking those journals represented the best of science, the most careful, the most expert, the most erudite opinions. That's where I started.

Now, you couldn't pay me to read one of those journals. What appears in those journals is what they allowed to appear in those journals. And so like I've been, I call myself a recovering physician now I'm outside that system. I would say the transition was difficult because I'm an ICU doctor, I'm an educator. I've won teaching awards and all the major institutions I've worked at. I mean I was really a celebrated teacher and I loved teaching and you know

my career is over in the system and I sort of was saddened by that for a time, but like I don't know after going through that, I'm really happy where I am. I have to talk to guys like you, I'm learning so much stuff that they don't teach you in medical, new physiology, new mechanisms, new therapies and it's it's actually it's like almost like a second career now and I'm so open to the fact that they've been hiding and suppressing effective therapies. If it doesn't bring you know money to pharma, it's gone. Yeah, I mean they destroy it and they destroy people who claim that it works and so I'm here Eric so just say welcome.

I know you've been there awhile so I'm here. – Yeah and that's no and that that it's beautiful and but Paul I mean like is it, you know, I love medicine, I love you know science and I just want people to understand that at this point in, you know, for the last forever you have to it's not clean.

Okay.

Ivermectin, censorship, and the disinformation playbook

It medicine, it's just not, it never has been, it's always been, people have to understand that's how it works. And it's very frustrating because we all depend on expert opinion because we can't know all the details. But unfortunately it's not a clean cut proposition expert. Do lie or or maybe not lie at least are not totally crystal clear. And as I have now been saying, I think for every one of these episodes um you know, we were taught to believe in evidence based medicine and what we have today is evidence bought medicine.

– I was about to say they're not they don't lie there bought the experts are but and if you're an expert with an opinion, a scientific opinion that's inconvenient to industry's interest cause that's what disinformation about. It's the tactics they deploy when science emerges. That's inconvenient.

So if you're the head of a hospital, a chair of a committee and suddenly you start to say just using a random example that the vaccines are toxic or that they don't work and that's not the consensus you're done. How long you gonna be employed?

You're gone and everybody knows to play that game. And so yeah. And the evidence based medicine well you do. Here's another thing you just said about expert opinion.

I really do believe if you're truly an expert and have a lot of wealth of clinical experience and insight and study. I want to listen to you what we have now is evidence based medicine which is actually should be called that.

I call it the church of our C. T. Fundamentalism and and and these are CTS randomized controlled trial finals and randomized controlled trials are absolutely important at the bench. You know when you're doing in vitro in vivo studies you absolutely very good randomized control trials.

When you get to the clinical level studying humans. Those randomized control trials have so many weaknesses and their main weakness is that the bias of the funder always outweighs the objectivity of the placebo.

And basically I don't believe in those kind of random like the big R. C. T. S. That are done with massive funding from either farmer or the N. H. Which is the same thing they're designed to produce the result that they want produced. And so I don't trust big R.

C. T. S anymore unless it's done by someone independent or you know without massive funding or conflicts. I mean I think science has been totally corrupted and I used to I used to pray that at the altar of the R. C. T. S. I used to think that those were real science and truth that was being uncovered through the careful study of interventions that's not true.

And I've had that there was a crash course I got in two years of studying this and then starting to read books of the history of evidence based medicine.

The books on the history of the pharmaceutical influence and takeover of not only the agencies but the journals

and and so now I don't know who to trust about anything anymore. But I you kinda just gotta use your kind of your, can I say bullshit, I hear you're bullshit detector and you kind of get to know like who's who has integrity, who has sincerity, who truly has expertise and and whose opinions are are truly objective. – That but you know, what's been hard is that this has been so polarizing that you know, I said I'm in that that group that you know in the beginning, you know, I really felt those vaccines were saving old.

I mean definitely we're saving people, old people in New York were dying like flies and you know, it seems to help. You know, and so it's like I actually was speaking to um one of the doctors I interviewed for this that we want to get together a panel of people who on both sides of the safety and efficacy of the of the vaccine of the of the mmr vaccine to really have a discussion amongst peers and make people actually listen to each other because at this point I'm not seeing that I've seen just like black and white and I know that the truth these shades of gray here and that's what I want to get to but – No more debate. Eric the people aren't debating.

I mean I know people have been calling attention to the toxicity lethality of the vaccines. They've asked numerous times to for someone to debate them exchange of information to sift through the evidence of what they have, what did and there's nothing like that. People pick a side and they stick to that side.

No matter if the data leaves them, they stick to that side and I don't know what to say. – No, no, it's it's I don't know I mean, but we have to come forward because you know, the the political polarization and I said I'm in the same place that I think you are is that um, you know, we were at one time. I mean, I still am, I think more perhaps people would say the left wing of life.

But on the other hand, I have been totally um disappointed by how it's become a card carrying society. You know, it there's no longer room for discussion.

And anyway, so, but that's got to go back to why we're really here today. I mean, this is a conversation that I think is really important and I think it's for anyone who has long covid, you know, you got here partially because people like Dr. Kory, um, I guess even myself in my small little way because the FTC as soon as it started, we we put up on our website, things that you could do and we got a letter from the Federal Trade Commission to take it down. But the point is is that we have discussed this with many doctors who are on this series are patients who are chronically ill who were the people you would expect to get long Covid we're not seeing it because our patients are taking anti, you know, they're often on mass sell medicines.

They're on they're taking vitamin D. They're taking vitamin C. They're they're often using low dose cyber mixed. But the point is they are not getting long Covid.

We don't have all my long covid patients are new. We don't have any from our practice and it's not at first I was just thinking, well we didn't have that many covid patients because I'm in a county that locked down real hard, you know, so maybe I missed it. But talking to people in New York and elsewhere it's the same thing. Their long term patients did not get long term covid. Something works another way, – You know, a description that I like for what long covid is. It's untreated covid.

I mean, you don't get to long covid unless you weren't you didn't get at least effective early treatment or like you're saying you didn't have a strong and robust and primed immune system, right? But you know, those who get early treatment, you know, and there's lots of protocols for early treatment.

Obviously we favor hours on the F. L. C. C. C. But we're not there's many different ways to treat this is there's now we know of 43 repurposed interventions that work as antiviral and improve outcomes in covid. So it's not just I ever met them, but the things that we use, it's very rare that I see a long hauler who got early treatment.

I have a couple, but they're extremely rare and they're also much more mild than the than the others. So the long haulers generally did not get early treatment. And really for me, the most challenges the vaccine injured. I mean, my practice when I opened my practice in February of 22, I would say we were 70 30 long haulers to vaccine injured.

Now it's probably 80-20 vaccine injured. Too long haulers. And you know, I think omicron maybe causes a little less long hauling or a little less severe. But the vaccine injured are just massive numbers. – Yeah. No, and that's something that is being totally ignored. And we we are seeing that also.

But I just want to put out that are the patient populations we're talking about were people with disordered immune systems, but they still were able to um have a reasonable response because they had enough anti inflammatory um, supplements on board that inflammation get out of control even if it took their immune system a little longer to get control of the covid, the the prolonged inflammatory didn't happen. So what what do you so you you so because we're supposed to be talking about long covid.

I'm working hard at staying on topics, not my strong suit uh is what's your at this point I said long Covid and post vaccine injury because to me they are the same thing.

It's the spike protein that is irritated the body and in men in multiple different ways. But what's you what what's your um you know your best experience so far, you know with with dealing with these issues. – Yeah.

So let me let me differentiate. So um we have a protocol when I say we the F. L. C. C. C. So there's two PS right? There's me and my private practice and then there's me uh you know that's the president and chief medical officer of the frontline Covid 19 critical care alliance.

And You know, although we call it a protocol on there, you can't really call it that because it's really just suggest it's just suggestions of therapies that have good mechanisms that should work in long haul. And and the list is exhaustive.

You could never use all of it. You're not gonna put someone on 40 different compounds. So what I do and the way I practice is very particular to me right, we're all different kind of doctors.

We have different comfort with uncertainty, different comfort with risk tolerance. We are also sometimes a little bit more organized and discreet. And I'll tell you in the nine months that I've been treating solely focused on long haulers and vaccine injured. I've evolved.

I will tell you when I first start in the beginning I was talking to a lot of folks, I would say like you, although you and I didn't talk but folks deeply experienced in the treatment of complex chronic illness, they had their pet supplements that they liked and different mechanisms and I was just like that sounds really good and I was putting people on tons of supplements while treating them with with like prescription medicines and over time I just gonna tell you this is just me. I'm not saying it's the right way to do.

It's just I started to trust myself and my own style of practice and now I'm much more discreet and targeted in what I do. I'll use maybe one or two medicines which have different on sets of efficacy so that I can tell which one they're responding to and then I'll do a reassessment and then I'll do another treatment trial.

I don't like bomb them with huge pill burdens anymore. That's just what I do. So what do I do? Shocker. I will tell you with rare exception. Every patient I see the first line therapies for me are super easy. It's almost like I don't have to turn on my brain. My first line therapy is connected and low dose naltrexone period, end of story. Now why do I use that as my first line?

Long COVID, vaccine injury, and treatment approach

Well, let me count the reasons number one. Let's just talk about mechanisms. Um the best question I know you're gonna ask me this Eric is why do I use I ever met it?

Now. That's kind of a difficult question answer because if you look at the mechanisms of it's one of the most wondrous medicine in history. Right? It has anti tumor, antiviral, anti parasitic anti um what is it even anti michael bacterial but it has many different anti inflammatory properties and it binds the spike protein tighter than almost any medicine in the Pharmacopeia of medicine.

It's almost like this strange gift. Right? So when I'm using in long haul I would say the question as to whether long haul has some amount of patients that have viral persistence that hasn't been fully answered.

I think sometimes it's viral persistence. Sometimes it's circulating spike that is disturbing the end of thallium, triggering inflammation. So I do think the binding properties are are really one big mechanism but the others there's 20 other possible potential good mechanisms. So the mechanisms make sense.

But the real reason why is I call, I've ever met in low dose naltrexone out of all the things I use, they have the highest batting averages, meaning when you start something on that, I put the number around 70% of my patients who come to me are and responders and then that varies, right? Some are small, some are moderate summer, like eye popping. Like you give my reaction and they will call you in two days and be like I have felt better than I felt in nine months.

You know like I don't want to say that everybody because it's certainly not. But when you get those experience it's really dramatic for you and the patient.

But but I I put the number about 70% of the American responders. My partner, he says it's 90 so it's somewhere there just a very high rate of positive response. L. D. N. I would say is somewhat lower but still very high. And I love L. D. N.

And my vaccine injured because they have so many neuropathic symptoms like the small fiber neuropathy is the burning, the tingling, the electric shocks.

Even some of the motor movements that twitching the physical relations LDN has just been incredibly important to those patients with you know the more neuropathic and so they have high battering averages. They're super safe.

They're easy to get if you go to the compounding pharmacies right? I stay away from retail. And the other thing that I like it and this isn't the real reason why I do. But when you see someone for the first time and you give something that makes them feel better, you know it starts to you know develop that therapeutic relationship. You know, they get to trust you that you're well meaning and you're trying to think of things that help.

And so so anyway that's a long answer to say I start with the government and low dose on the tracks. And one of the things I should say though here's the other thing I learned about using Ivermectin in long haul.

In the beginning I just kind of plucked out of thin air. I used 0.3 mg per kilogram. I didn't want to use the standard lowest dose. I didn't want to use a high dose. I just took 0.3 And I would use it daily.

And I remember my 1st 10 patients like those that got responses. I was like hey why don't we go up on the dose a little bit, see if it works better. And I did that just a few times and nobody really told me that they did better on the higher dose.

So I just stuck at 7.0.3 for probably six months. And then I think I had a patient or a colleague told me about a patient where he doubled their dose and the patient did so much better. And I was like alright let me be more aggressive with these dose ranging. And I started to double the dose.

And I would say this again I can't be precise here. I would say at about 10 patients I'd say five or six of those a double the dose will report a significantly greater benefit.

And so there's even a dose response. So now what I do because when we talk about my second line Eric will say nowadays when I see the patient follow up if they got a decent response to Ivory Mac and I start both. I've met an L.

D. At the same time. I usually if I meant it works it's gonna be usually within days to the first week they're gonna feel a difference LDN. Because I start very low and I build up slowly it's gonna be a few weeks later. So you can tell like when they say they're feeling better. The first thing I asked them like when did you start feeling better was it the

first week or the third week?

You know and so you can kind of differentiate which one help. But when I see them my second line now on a governmental responders and I've even done it on non responders I just double the dose. I said you know what double the dose for a week and then call me back or update me in the portal.

And I like I said about six out of 10 like Dr. Kory I feel even more better you know on the higher dose. And then I usually I don't put them on I don't keep them on 100.6 minutes per kick. I'll use like maybe 0.5 I'll give him a new prescription for 0.5 mg per kilogram capsule. So I think that's important.

It has a dose response. Not only is it the majority respond but you know another small majority will respond to an even higher dose and I keep them on a daily.

Okay so that's how I use I ever met in an L. D. M. Yeah. – No and that's I mean I always always always learning because I said we you know our experience with with ivermectin goes way back you know because we've been using it to treat parasites but at very high doses for 1 to 2 weeks like you know not very high but you know about as much as you know 30 to 40 almost 50 mg a day which is pretty hot. And I was always stocked and how may many people said they felt so much better. And up until Covid I had no idea why because I didn't think they're parasites were causing that much trouble.

Yeah it was only that it's such has such dramatic effects on viral on chronic viral infections and probably other underlying infections that were not even aware of. I mean I said I was always mystified and then when Covid came and all the literature started to say suddenly come out and went oh my God you know it is amazing. And but the things I've often used lower doses now and you're inspiring me to go back up again and see knock on that door a little harder.

– Not everyone will tell you know I do have patients like Dr. Kory I double the dose for a week and really make a difference and I'm like fine let's go back to the old dose, – You know, in my world I don't expect, I mean again the The longer people have been ill the more their biochemical individuality runs the show so early on you can treat most people kind of the same. But and so I don't expect those numbers.

I think the sicker and longer people have been ill. The success numbers for any therapy goes down. I'm happy when I start, I'm happy with 30%, you know with a lot of people cause you just got to have a whole lot of things to try. So after you've gone through your LDN there they are game changers. They are just like said their their their medications that we've used for a long time. And Covid has you know like written large that my God, yeah, very important medicines. Um what's your next, – What line is now? We're gonna do an MCAS trial, right, mast cell activation syndrome trial.

I'm gonna put them on. I basically put everyone on like my go to loratadine and although I know that in MCAS right, different patients might risk respond differently to an anti histamine. But I just started with loratadine and I try to do 20 twice a day. Pepcid, I'll do 40 to 63 times a day.

You know promoting and then I'll always add a D. A. O. Enzyme which they take, you know, one pill before their meals and that's you know, another 10 days to two weeks and you know, sometimes people don't feel different from that.

But sometimes that is, you know, I almost feel like with long haul coke it's like whack a mole. I know about five or six different mechanisms that trigger a lot of the symptoms but it's very hard to tell which mechanism is prevalent in each.

Even if you take a careful history, sometimes I'll think oh this is mass cell but it's not, you know, it's still, I'm still humbled by the powers of history taking.

I'm humbled. You know what truly makes an expert I used to teach. This is it's not the knowledge, it's not how many text books we've read, it's pattern recognition and what I'm so humble about this complexity of long haul and and

post vaccine is I'll see to patients who present quite similarly and for instance, Ivan will work so well in the first one and then I'm super confident gonna get the same result in the second one and I don't, you know, and then it turns out by, you know, these trials of therapy, it was m cast the whole time for the second one, but it wasn't for the first one and they presented, you know, so the clinical stuff is really hard.

But the second trial as I do MCAS and when you hit that nail, I mean it's incredible like the patients are like oh my God this went away. That went away. This went away and so yeah and then MCAS is easy again, it's safe, it's over the counter it's you know, two week trial and and when it is the thing that's bothering them, they will, you know, it's not subtle that they can tell the difference, you know, pretty pretty early on, – You know, and and and we and for the people listening we actually have I think more than one lecture on MCAS and and long covid because I said we have found it to be you know, again it's chronic these diseases in my mind or the disease of chronic inflammation and math cells are just one of those orchestra leaders for a lot of folks. – So and there's tons of literature showing how the spike protein really can trigger and activate those mass cells, you know. Um and so it seems to be quite prevalent in long haul you know, I have a question for you Eric. So you know, I come into this practice and I'm learning as much as I can start to see patients, I'm learning about MCAS and it's not that I didn't even hear about MCAS before two years ago. So you know, but but here's the thing all the MCAS folks, they'll talk about ketotiffin right?

That that it's like you know, very potent mast cell stabilizers and so I started putting that in my practice. I've been so underwhelmed with that drug.

I don't know why I just I'm not getting like big time responses from it. I don't know what your experiences has been. I would love to learn from you on that.

– It's one of my actually is one of my favorites. Um It's it's the thing that's dose limiting is because it's some people find it overly sedating and I just find you know like 10.5 to 2 mg before meals and is but again it's it's You're gonna hit home runs with it and you're gonna like get no effect with it right?

– You know I probably was in a batting slump with it because I don't know I just kept striking out but wait you just said something important. I was just using one mg at night so you would have people take.5-2 before each meal.

So maybe I was just under doses maybe that's my problem right? – Because remember Catan often is a medicine that is a mast cell stabilizer and an anti histamine.

It's got both components to it. And so many people are triggered their guts are a mess and so many and that and you know the end the epithelium. I mean like you know that that's what's really sensitive to to the spike protein to begin with.

And so that's so that's so lowering the inflammation in the gut really makes a big difference and that's where – so yeah I'll do I'll do MCAS I find the D.

A. And enzymes are also pretty effective. Those that that you know use that they they seem to report you know quite efficacy. – One of the things that I think you know that I see over time is just the the the the longer people have had problems the harder it is to deal with their MCAS Because in my mind this is again my story of them cast is you know people start off with different levels of allergy or tendencies having to have you know mass cells that are a little more twitchy.

But if you have a long term whether it's a toxin or a virus or a tick borne or some low level infection that your body has been taken care of. But that noise, that inflammatory noise has been there in the background a lot.

Then you get hit with something like Covid Which destabilizes your immune system knocks down you know your CD eight cells. And suddenly you know your t regs aren't working like they're supposed to then that mass cell population gets harder to control if you were doing pretty well. And those low level infections were mild.

Um you know when you get hit with Covid then treating the mast cell you can get them back to baseline quicker. I

think that that that that that seems to be in my mind that the story that the the longer the more the longer people have been sick by the time they get long covid. And and the thing is most people don't even realize that they were sick because we live in a culture where as long as you can get out of bed in the morning and go to work, you're okay, you know?

Yeah. So so that's that's my world. But so just when you do you use any of the, do you use any low dose predniSONE at all in your approach? Or do you decide?

– That's such a good question. So I asked this because I know I'll tell you why I used to have predators on the protocol and it was it was a collaboration with others.

And I actually never liked the low dose predniSONE because you understand I'm an ICU doc, I'm a pulmonologist and we call that, you know vitamin P. I mean that was like my mainstays of pullman Olives and I go big or go home.

I don't know what 10 or 15 mg is. I mean I'm used to you know using 40 to 60 and but so so I didn't, I just felt it was if you really wanted to control if the symptom burden was high and the severity illness was high and you wanted to use predniSONE, you should use a higher dose.

But the other that was one thought I have on predniSONE. But I also don't use it because these patients are chronically ill it is a dis regulated immune system. I don't really want to get into a regimen where it's gonna require long term predniSONE. Now I will if the symptoms are really severe and I have had patients who actually had full blown vasculitis where they needed predniSONE.

So many other things pop up. The other thing is many people have have gotten pregnant before they got to me and either it helped and they figured that out or and or didn't help. And so like it's not something I go to.

However let me put one caveat on that is I have three patients in my practice every time they have a traditional diagnosis that the system doctors give them.

It's always the word atypical in front of it because this is a weird disease right? So I have one with a typical A. L. S. Just lots and lots of feature of A.

L. S. But it's still weird to the neurologist. I have another one with bulb R. L. S. Which is also quite atypical. And then I have others who just have only main promised slurred speech.

MCAS, anticoagulation, and broader therapeutic lessons

And then I just heard of someone super new nuclear palsy. Another atypical one that completely reversed with predniSONE. And like after talking with this doctor who reversed the super nuclear palsy induced by the vaccine with predniSONE. I mean I actually wanna do predniSONE trials on some of these really sick with the progressive neurological illnesses.

Just because they're really really sick and but that's a long answer to say it's not my go to, it's not really part of my treatment trials unless they're really severe and I have a sense that it might work but predniSONE is not really what I do, I'll do it in in really just cases is what I would say.

– I agree I stay away from in general one of these days we'll talk about I find you know low doses, you know again when people are really sick high doses are needed but but low dose predniSONE or more importantly sometimes low doses of hydrocortisone um because again it's sort of like vitamin D. You know, immune modulators. You know when you use them in high doses you're throwing the wet your you're putting a blanket on a fire.

Yeah you're just but if you use low doses of these things you can modulate but again that's um usually not gonna not not not my first step for for these for for post covid patients. – I just tell you Eric I think I've had thoughts at times that I'm under using predniSONE it's just you know cause problems you start developing your practice pattern working with things that work and like I never pregnancy was not like one of the things that I started building my

regimen on and so but so sometimes I'll even forget like is there a role for presence on here, maybe I should think of it more. It's very hard.

I mean I I mean I'm learning every week from each patient. You know, I'm getting new insights, new tricks and so it's it's hard to keep track of. – Oh no, no, totally. I mean and that that's what I mean.

Just as we know you have to wrap up. So I would say is that one of the things that I want to point out to people because you must be experiencing is this is the joy of medicine we used to have when I you know, you know, before word became so regimented, okay. You know, is that we realize that we don't have the answers for everybody.

And so instead of, you know, we have to be creative, you have to listen to your patients and keep learning. But now um you know, it's like I said, if you were if you were working in your hospital and you tried to well you experience it, you tried to do something that there wasn't, you know, the blessings for. You can't even try it now.

– You can't now you could before though, if you if you had a good sense of safety that they approved good mechanisms you wanted before Covid you could I mean what happened – Covid you could because you were you were you were the ICU director but if you see, but if you were somebody who was, you know like a hospitalist and wanted to use.

– You're right,- Even probably a slightly bigger dose of vitamin C. The pharmacy would have probably slapped their hands. – Now I think you're absolutely right about that. I had much more free reign and autonomy in the I. C. Because I was considered a national expert at the top of my field as a director. And if I said, you know, hey, I'm here and this is working and the patients are so sick and so if you have a good yeah, I I was definitely supported and deferred to.

But yeah, the last thing we could maybe redo this another time. But so, you know, we talked about ivermectin, L. D. N., MCAS you know, sparing predniSONE to times.

The next thing I do and it used to be like the third or fourth thing I do, but now I'm starting to bring it up front is anti coagulation and I was very reluctant to do that just because that's the only thing in all of my regimens that had carries some risk.

You know? And so and again, you're on your own. I mean you're using anti coagulation for a new indication without real good evidence, right? That live blood analysis can tell you about, you know, you can see the micro cloud and the platelet activation, but the standard tests that are available in clinical labs like d diners are sometimes normal but patients will get so much better on anti coagulation and so I was I was very kind of reluctant and reticent to use it but now I'm bringing it up front I'll do 28 days of literally aspirin, clopidogrel and eloquence or Orlova Knox.

And then I switched into more of a a natural anti coagulation which is like an anaconda, sarah pep, today's liberal cons and vitamin E. But that that first month we just see lots of different improvements and stuff and so you know the micro clouding aspect of that disease and I think we need to know a lot more about it but I will do that as well.

Yeah. No and that's something that you know, again we've seen um we've used low dose heparin, you know on and off for the last 20 years in fibromyalgia in some chronic fatigue people. And again the issue has always been, it was hard to predict who was going to respond because again it wasn't so much the D diners were elevated or even some hibernation levels or L.

A. But what does that really mean? Um you know, we would measure thrombin anti thrombin but again at the end of the day it was more like a sense that maybe this is gonna help and but we were but you know it would make it easier because for long covid it looks like we have to use things with much more risk you know then then we we were using you know Hepburn at very low doses and in ways that are not really approved like under the tongue it actually has some effect.

It's not supposed to you know in fact if you right and if you write sublingual the pharmacist won't fill it because uh

you know obviously it's not huge.

I mean some you know I wouldn't if so if I'm if I'm sure somebody needs that I wouldn't stop if that didn't work. But it's surprising how often these things because these molecules are small.

– Okay see I wanna we we should do this again Eric except next time I want you to talk more because I'm giving you like my experience you got 40 years in this – I don't know but but you you but you have um you know I always say I sometimes have breath but you have a depth of knowledge of you really you know when it came to Ivermectin you really did work and put you know I mean that's that's that is what what what what what hundreds of hours I spent that what people have to understand is that so when you come forward and say this drug works and it has lots of mechanisms that support it, you know you're not doing it because you read a few abstracts right?

– Exactly. That's I'll tell you that's the funny thing is different. I haven't really been in much debate. So I was in a couple of them but I don't want to sound egotistical or arrogant but like literally I was listening to opinions based on someone whose depth of knowledge was like paper thin but yet they were very strong in their opinions and I was just like wow this this person have any idea how deeply studied I am on this drug.

So but anyway people entitled their opinions however flimsy they are. – Yeah. No, no and that's what people understand is that when they look at you know at the F. L. C. C.

Website and understand that there's a lot of thought behind what's in there, a lot of you know and and you know and what I think is so impressive is that though the you guys started from a very pharmaceutical based roach you really realize how important the plant based medicines are for really keeping people well.

I mean like and that that was my point in the very beginning our patients stayed well because they were on these very simple vitamins and plant supplements that balance the immune system, even if it's not a great immune system to begin with, it gives it a lot more resilience – And there's good science behind a lot like you know when we were in the system doing our thing, you know we never studied Nigella sativa.

I mean that's just hokey alternative stuff but that was kind of the door that cracked open because once we saw the trial and Nigella sativa out of Pakistan and I read the paper just the introduction, all of the references to its anti inflammatory antiviral.

Like I started going deeper there. Like you start to read the reference and you're like, wow there's a huge body of science around this compound. And then we found the same thing about honey and then curcumin and then, and then we're just like, wow, these are really powerful compounds that they don't teach you in medical school. You know, it's like – The, the naturopaths and, and, and the, you know, nutritionists and um the, the all I want to call them botanist. But all the the herbal people, I mean they've been doing incredible work at collecting data that nobody looks at.

– That's the thing. And now in fact, if anything like I don't want to look at those journals. You know, I have a list. I have a notes app, right? And I have a list because every day someone's writing to me about this compound and that I literally have like 40 things that I want to when I have time I want to go into little rabbit holes and learn more about and see how apple. There's so many that I don't even know where to start. I mean I need decades of time to sort of figure out what my next, you know, little go to compound is and that no on that.

– Yes. Next compound and next device. – Yes – because there are so many ways to he feel okay and like I tell people everything works sometimes and what's so frustrating is that if you don't have a lot of resources you don't get tried too many things. And my heart I mean that that is the about where we are today is that we have such a very population in America and that we we don't respect that what works for people like you know when you're treating everybody who has the same ethnic background and same diet, I think you can be much your chances of success using, you know the regular stuff is much higher. But in America we're such a mixed crew that are, you know like our our predictability is not is not as good humans.

– And that was the thing that I always fought against in my career. I hated standardization. I've had to fight a lot. I

mean, you know my boss was after me. He just thought there was too much variability in how we treat sepsis in the I. C. U. And I was like good it's not a factory that's not, you know, we're not producing cars that are identical to each other.

I mean it's I love the variability and sometimes I would do this more and this lesson. You know, but you see that is not what modern medicine is about my boy.

– The Ai will tell us all and yeah we're gonna plug in the numbers and get the answers, you know. But anyway go on and on about how many how many um you know black holes that people have gone down thinking that they're going to get the answers you know? But I I can go off on my little rants and people probably heard them too many times anyway.

– Eric I unfortunately I have to go, let it go. It's always a pleasure and let's do it again sometime. – Yes a pleasure. Thank you so much and again thank you for your work because you know without your I mean I know like now it feels like it's okay but you have truly sacrificed you know I mean you really took took took a big bullet and I just want people to understand that this was this didn't come easy. So thank you.

– Thank you. I appreciate it. Thanks a lot man, nice seeing you.