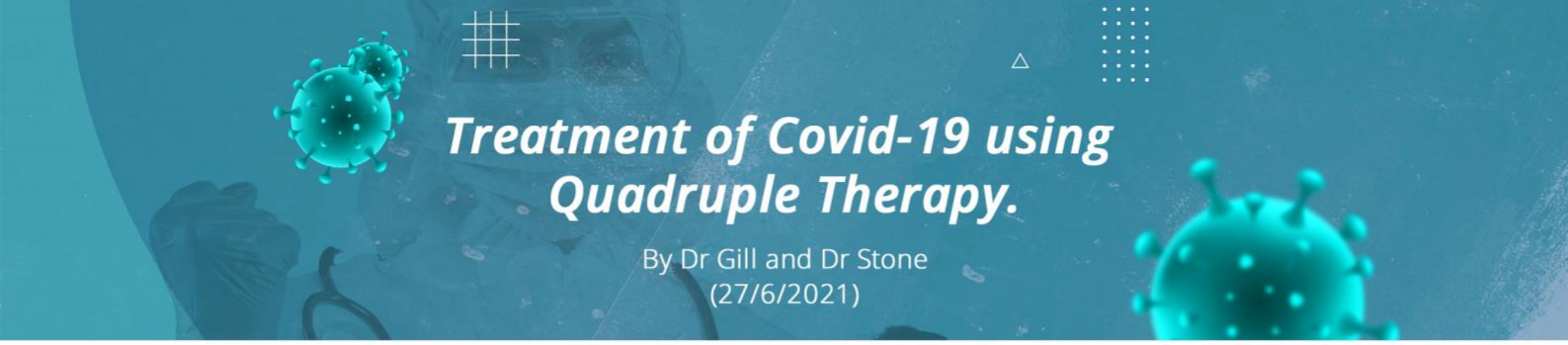

Treatment of Covid 19 using Quadruple Therapy. By Dr Gill and Dr Stone.(27/6/2021)

Source of protocol. FLCCC Mask+1 protocol. Prof Tom Borody protocol, and Peter McCullough

Principal at every stage is triple therapy Anti-viral, anti-inflammatory and anti-coagulant.

And once treating we prefer at least Quadruple therapy ie. Prof Borody's triple anti-viral therapy (Zn, Doxycycline and Ivermectin) and nano silver.

Prophylaxis in a well patient.

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

Vit D_3 5000IU daily (Reduces risk of severe disease)

Vit C 500 qid - (Protects cell)

Zn 50 mg daily (Anti-viral in a cell)

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

Colloidal silver nose spray if you have visited a public venue eg shopping

After exposure

Ivermectin 0.3 mg /kg on day 1,3 and 5 Vit D_3 5000IU daily -(Reduces risk of severe disease)

Vit C 500 mg qid (Protects cell)

Zn 50 mg daily (Anti-viral in a cell)

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

Nebulise with colloidal or nano silver for 30 minutes. And colloidal silver nose spray.

Mild Disease

Diagnosed positive. With or without mild symptoms.

Ivermectin increase Stat dose of .6 mg per kilogram They may get a few side effects that will be gone by the next dose) then 0.4 mg/ kg dly for 10 days. You may increase incrementally to 0.6 mg/kg if the condition deteriorates.

Doxycycline 100mg bd for 10 days

Treatment of Covid-19 using Quadruple Therapy.

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(27/6/2021)

Vit D_3 10 000IU stat then 5000 IU daily *

Vit C 500mg tds daily - (Protects cell) *

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

Quercetin 250 mg Bd (Ionophore for Zn, to get it into the cell)*

Aspirin 300 mg daily

(Melatonin 10mg dly)

Colloidal Silver 20 ml neb until complete stat (May take over an hour) then - 4 to 6 hrly nebs with 5 ml colloidal silver

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

The patient must monitor their O_2 Sat 4 to 6 hourly.

If O_2 sats drop to 94% or below

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

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

Pulmicort 0.5 mg in colloidal silver bd.

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

If O_2 Sats drop to 90% or less

Patient to contact you immediately Nrxt

Arrange home oxygen for incase O_2 sats drop below 80% (urgent)

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.

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If possible, do a chest X ray not essential doesn't alter management logistic.

FBC CRP

LDH

DDIMER

Glucose

Response to blood test

Diabetes

A glucose reading. Patients with uncontrolled high sugars are referred to a diabetic GP for an intravenous insulin infusion and diabetes management. This care is provided by a dedicated doctor, as part of this protocol, as bringing diabetes under strict control has been shown to improve survival rates in diabetic patients.

Doctor

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 by the doctor.

1) If the patient is hypoxic and the CRP is >20, STEROIDS
    a. Prednisone 1mg/kg daily, and Dexamethasone 8mg IV od..
2) 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.
3) 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