

Exhibit 581

Critical Appraisal of Multi-Drug Therapy in the Ambulatory Management of Patients with COVID-19 and Hypoxemia

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Critical Appraisal of Multi-Drug Therapy in the Ambulatory Management of Patients with COVID-19 and Hypoxemia

Analysis Suggests Many Hospitalizations with Use of Mechanical Ventilation Unnecessary



PETER MCCULLOUGH, MD
DEC 10, 2023

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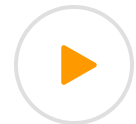
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By Peter A. McCullough, MD, MPH

I have been struck with two observations throughout the COVID-19 crisis: 1) hospitalizations occurred because of lack of early ambulatory treatment, 2) nearly all the deaths occurred in hospitals, not at home.

As I was treating and advising collectively on thousands of cases over 2020 and 2021 I became very comfortable with understanding that a low oxygen saturation <94% was not a trigger for alarm. Provided the work of breathing was not too difficult and the ability to think clearly and follow instructions was solid, patients could be treated at home with supplemental oxygen then the **McCullough Protocol** which includes full anticoagulation. I recall treating a physician and her husband ages 58 and 60, both with severe COVID-19 pneumonia and O₂ saturations in the 70's for weeks during the Delta outbreak spanning August-September, 2021. At times saturations would dip below 70% while getting up to the kitchen or bathroom. Both of them knew they were safer at home on multidrug treatment than going to the hospital. Many hospitals had protocols that would have immediately paralyzed and sedated this couple then placed on them mechanical ventilators. This could have been the kiss of death. Yes, the couple survived

with no complications and our collective confidence grew that “permissive hypoxemia” was well tolerated and very different from other forms of consolidative pneumonia, heart failure, and COPD.

This new form of hypoxemia we were observing was due to micro-blood clots in the lungs. It means the alveoli were not clogged with fluid, but the problem was blood flow to the capillaries. So by supporting the patients and providing anticoagulation, we could ride out the storm at home.

Gkioulekas et al, have published an analysis of the peer-reviewed clinical studies demonstrating safety of allowing hypoxemia to occur provided patients were treated with multidrug regimens. These papers relied heavily on the early use of ivermectin, which has an effect of unhooking the Spike protein from red blood cells, thus reducing hemagglutination and the micro-blood clotting process. The clinical results speak for themselves.

Review

Critical appraisal of multidrug therapy in the ambulatory management of patients with COVID-19 and hypoxemia

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Case series	Patients with baseline SpO ₂			Deaths	Deterioration	Time Period
	≤ 100%	≤ 93%	≤ 90% (<i>p</i> ₁)			
Hazan	24	23	23 (95.8%)	0	0	2020-08 to 2021-02
Stone	34	34	28 (82.3%)	0	0	2020-08 to 2021-05
Babalola	61	21	10 (16.4%)	0	5	2021-04 to 2021-06
Hazan + Stone	58	57	51 (87.9%)	0	0	2020-08 to 2021-05
Hazan + Stone + Babalola	119	78	61 (51.3%)	0	5	2020-08 to 2021-06

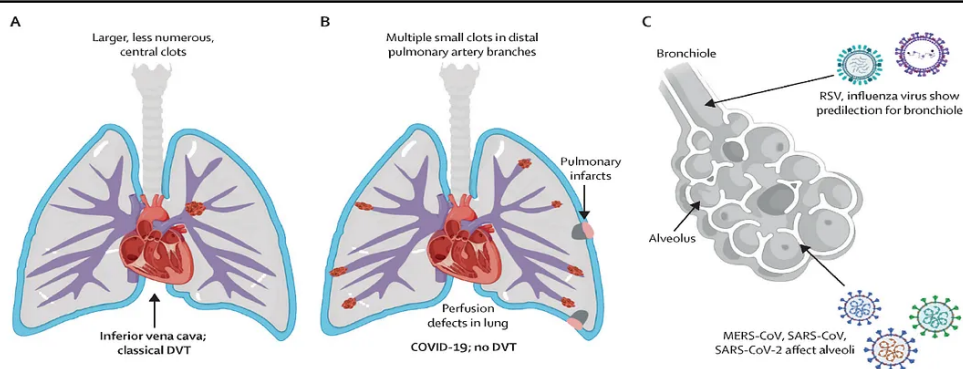


Figure 2. Classic pulmonary deep vein thrombosis presents with a preponderance of a smaller number of proximal large emboli. McGonagle *et al.* [41] argues that the tendency of the SARS-CoV-2 virus to preferentially attack the alveoli, contrary to RSV and influenza viruses, triggers immunothrombosis, resulting in a larger number of microemboli in the pulmonary and bronchial distal arteries and in the alveoli, which in turn trigger pulmonary infarcts and cause oxygen desaturation. The ambulatory baseline multidrug regimen (ivermectin, doxycycline, nebulized nanosilver) antagonizes the SARS-CoV-2 spike protein [42,55], blocks hemagglutination [29–31,48,54], and inhibits viral nuclear entry [56] and replication [44,47,52,53] in the alveoli. Aspirin and anticoagulation can address the accumulated pulmonary microemboli. By resolving the congestion of the alveoli with SARS-CoV-2 viral particles, immunothrombotic production of new microemboli stops, supplemental home oxygen becomes effective and the patient can be kept out of the hospital, provided the work of breathing is tolerable and good support measures are in place. This figure has been reproduced with permission from McGonagle *et al.* [41]

The use of the the pulse oximeter was a big mistake in the pandemic. We should have relied on clinical assessment, the work of breathing, and mentation. It’s my view that a large fraction of even the most severe cases could have been treated at home with supplemental oxygen and support. The hospitals became a death trap for COVID-19 victims as families can attest to today.

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Santin AD, Scheim DE, McCullough PA, Yagisawa M, Borody TJ. Ivermectin: a multifaceted drug of Nobel prize-honoured distinction with indicated efficacy against a new global scourge, COVID-19. *New Microbes New Infect.* 2021 Aug 3;43:100924. doi: 10.1016/j.nmni.2021.100924. PMID: 34466270; PMCID: PMC8383101.

Gkioulekas, Eleftherios; McCullough, Peter A; Aldous, Colleen (2023). Critical appraisal of multi-drug therapy in the ambulatory management of patients with COVID-19 and hypoxemia. figshare. Preprint. <https://doi.org/10.6084/m9.figshare.24330046.v5>



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17 Comments



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Allie Writes Allie's Substack Dec 10

I see no hope of finding a healthcare provider who would treat such a COVID patient at home according to the McCullough protocol or FLCCC protocol who would even prescribe home supplemental oxygen for a COVID patient with hypoxemia at these levels in most states. It appears that the only way would be through telehealth. This situation is such a criminal shame. Local access to inexpensive ivermectin and hydroxychloroquine is also inexcusable.

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