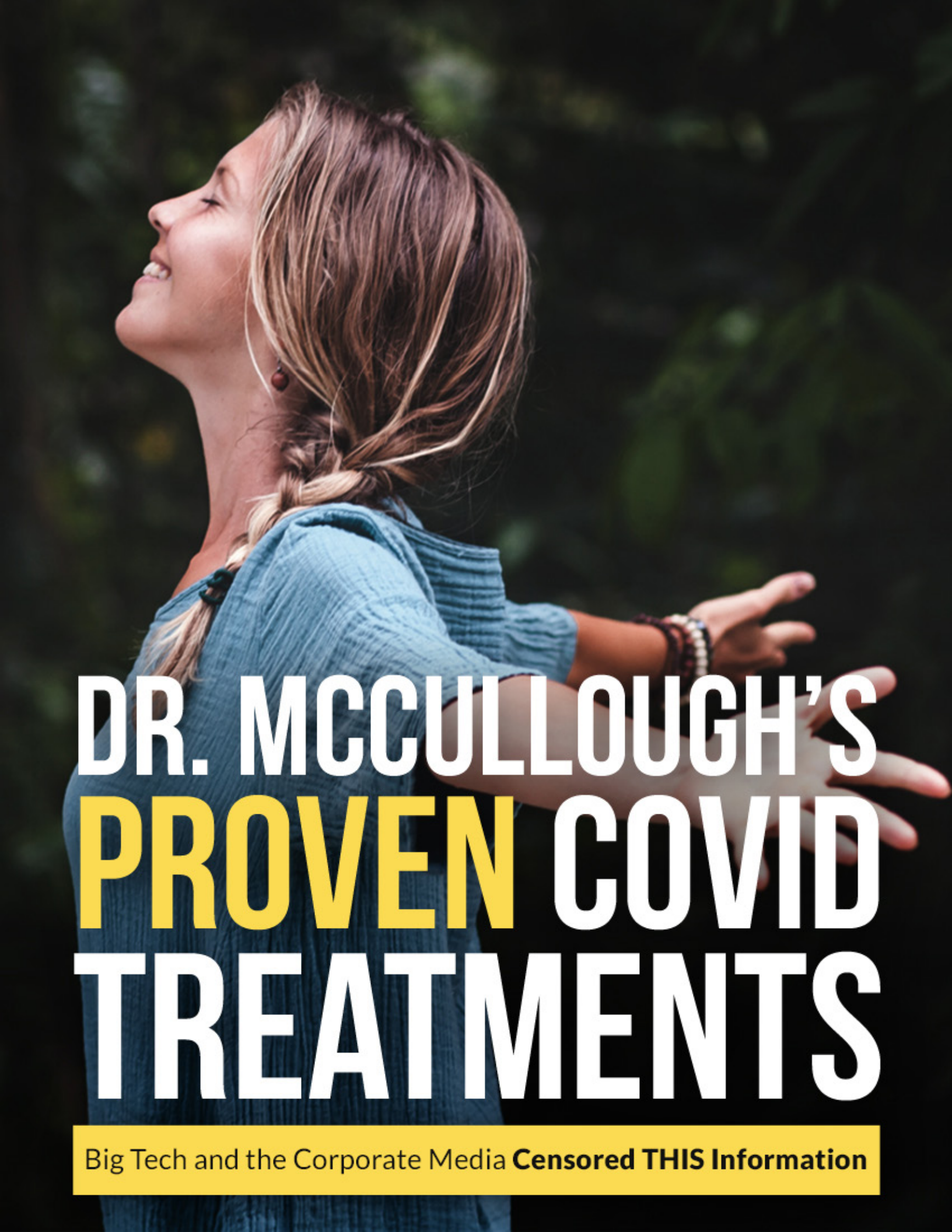

DR. MCCULLOUGH'S PROVEN COVID TREATMENTS

Big Tech and the Corporate Media **Censored THIS Information**

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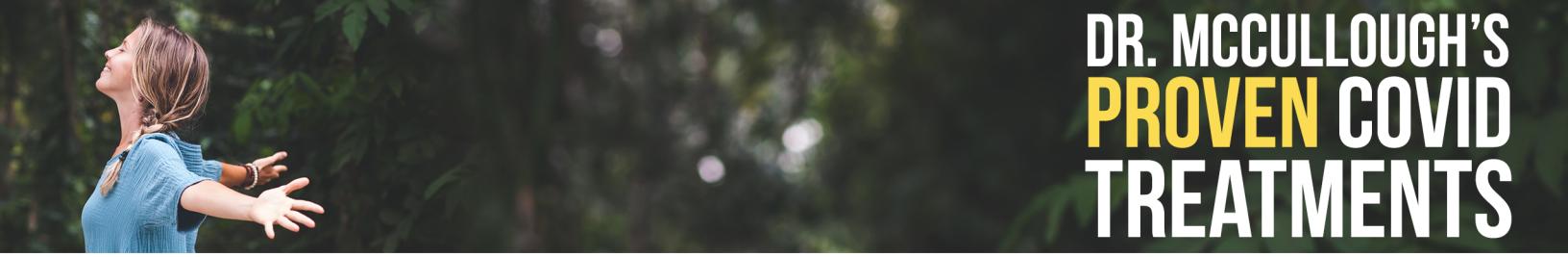

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INTRODUCTION

Dr Erika Drewes – a specialist Family Physician – argues that; 'Successful early treatment options, which should be the bedrock of any medical intervention in the treatment of Covid 19, are being ignored by our current public health messaging.'[1]

In Episode 1 of Vaccine Secrets: Covid Crisis, Dr. McCullough said, "Early home treatment has the biggest impact because that's dealing with the acute patient. And we know in a pandemic still a small number of patients are going to be impacted, 1%, 2%. So if we focus on the 1 or 2%, that's where the biggest benefit is in terms of sparing hospitalizations and deaths. Late treatment is needed. We need in-hospital treatments, but it's far too late. The contemporary mortality in the hospital for someone in the ICU is 38%. It's too high. It's obvious the hospital's too late. Of those who die, the vast majority die in the hospital.

"I've done seminars now with key leaders and I've gotten to know individuals all over the world, I know that no single drug is essential in treating COVID-19. So Dr. Brenteos in South America, and Dr. Chetty in South Africa, they treat the illness with no Hydroxychloroquine or Ivermectin. They use the sequence drug approach and treat the back end of the illness. So I know there's many different ways to treat it. The main principle is treat the problem. Well, this came to a head in the United States, because we did not see treatment moving forward. Senator Ron Johnson, who was the ranking Republican majority member of the Department of Homeland Security and Governmental Affairs Committee called testimony. I was the lead witness in the first set of hearings, November 19th [2020]. Pierre Kory in the second one, December 8th [2020]. J.J. Rochester in the second one is actually the most experienced with Ivermectin. I had chosen him for that hearing. And we basically broke the news to America that we could treat COVID-19 and markedly reduce hospitalization and death.

"I followed this up in the Texas Senate. I was on fire that day, March 10th [2021] in the Texas Senate, basically pummeling the Department of Health and Human Services for not providing early treatment enough to patients in Texas, not making these monoclonal antibodies accessible, and not giving people fair information on how to find treatment. Since that time, we have the Association of American Physicians and Surgeons fully supports early treatment, has chapters in every state. We have the COVID Medical Network in Australia, Terapia Domiciliare in Italy, the PANDA in South Africa, and now worldwide, Hart and Bird in the UK. So we have early treatment groups that have really broken through where our government agencies have failed. AAPS publishes a home treatment guide. We have data that suggests this was downloaded millions of times and passed around millions of times.

It gives the key treatment algorithms, but importantly, it also gives access to telemedicine services. We have 4 national telemedicine services and 15 regional services, about 500 listed treating doctors across the United States. And we've handled a massive number of individuals. Towards the beginning of January [2021], we crushed our curve in the United States. Rates of new cases, hospitalizations and deaths fell for the first time as early treatment kicked in. And since that time, we've never had a significant rise. And that was long before anybody was ever vaccinated. So we know early treatment had a massive impact. The same thing happened in Mexico City. The same thing happened in some countries of South America. And the same thing recently happened in India, long before vaccination had an effect. So early treatment is absolutely the key to pandemic response. They declared zero hospitalizations in Italy with this multi-drug early treatment approach."

Starting treatment at first symptom onset is the best opportunity to stop Covid-19 in its tracks and should play a central role in the management of Covid-19.[2]

In India last year [2020], the northern state of Uttar Pradesh began dispensing Ivermectin liberally and encouraging people to take it early on and even preventively. As Trial Site News reported earlier this year [2021], "By the end of 2020, Uttar Pradesh — which distributed free Ivermectin for home care — had the second-lowest fatality rate in India at 0.26 per 100,000 residents in December. Only the state of Bihar, with 128 million residents, was lower, and it, too, recommends Ivermectin."[3]

A recent pre-print paper examining mortality across countries in 2020 reported on the effects of several public health interventions between December 8, 2019 and April 1, 2021. (Since Remdesivir and Ivermectin were only adopted at the end of 2020, these were not included in the analyses.) A 16% reduction in fatalities was associated with countries that used Hydroxychloroquine. In fact, the coefficient analysis in this study estimated that had the US made Hydroxychloroquine widely available, deaths could have been reduced from 515,000 to 427,000.[4] In other words, 88,000 lives were lost because US health officials rejected Hydroxychloroquine for early treatment of COVID-19.

Zimbabwe experienced the first wave of covid-19 infections in July 2020 and by early August the numbers were "overwhelming". Ivermectin administration started on 8th August. Dr. Jackie Stone, a family medicine physician based in Harare, Zimbabwe, said "From 8th August until 24th December I didn't lose a patient and if you look at our patient group, 26% of them [had oxygen saturations] of less than 80%". Thereafter, information about Ivermectin and its effectiveness "spread like wildfire on social media, and the whole country became aware of Ivermectin", says Dr. Stone. The death rate rose sharply in January and peaked on 25th at 70 deaths per day. Official authorisation for the use of Ivermectin was granted on 26th January. Just one month later, on 26th February, the covid death rate had fallen to zero.[5]

In this recent interview with Dr. Peter McCullough, a highly published and regarded academic and cardiologist, he explains differences between the Omicron and Delta variants, how Omicron is now changing the COVID illness and the effectiveness of the vaccines against it, and how the risks of the vaccines compare to the benefits.

DR. PETER MCCULLOUGH

Jonathan Otto: I just listened to the Joe Rogan podcast that you did, and I think it's fantastic that information is out there. Perhaps you can give an update. What statistically, how many eyeballs do you think have got on that in comparison to other work?

Dr. Peter McCullough: I don't have the top number, but I've been told it's the number 1 listened to podcast of the Joe Rogan Experience. And Joe was a wonderful host. I don't think he'd ever had on someone who was a practicing doctor and an author, and an editor, at my level of depth and experience in academic medicine. I have over 650 publications in the National Library of Medicine. I don't think he's had anyone close to that on the Joe Rogan Experience. And the fact that I have been treating patients with COVID-19 since the onset of the pandemic, I published the first peer review algorithms, protocols, teaching doctors how to treat COVID-19. I pointed out to him that he basically received the McCullough protocol, whether he knew it or not. That's now copyrighted. And that's using drugs in combination, including the monoclonal antibodies.

And he got through COVID-19 in a matter of a few days. I think he probably had the Delta variant, which can be fatal. We know the new variant shading in, Omicron, is far less serious. But it was a very good experience. I mean, it was the Joe Rogan Experience. I thought we had gone 15 rounds in the man cave. The only feedback I've gotten from that that needs some attention is that I did the interview before we had the data on Omicron breaking through natural immunity. Because up until the Joe Rogan interview, natural immunity was robust, complete, and durable against the more lethal forms of the virus. And I told a lot of my colleagues, "Listen, you'll know when the virus has broken through natural immunity because you'll see tons of people who are naturally immune getting COVID-19." And that's exactly what we're seeing with Omicron.

Jonathan Otto: Wow. Well, I appreciate you sharing that. And it's a pleasure for me to be on this side so that we can look at what didn't get covered, to be an appendix, if you will. And so I would love to chat with you about Omicron, I would love to chat with you about whatever we have coming now with the booster shots. And any other emerging data coming with children and why that's significant, what we can do about that. And I think from there, I mean, there's a lot. I think that we should start at Omicron, and we can go from there. So, what is this? Is it something that we should be concerned about? Do you see other potential agendas behind why there'd be such a push around Omicron right now? And why something that maybe could be good news that, yeah, look, this is spreading a lot, and perhaps that's a good thing because we now can- It's kind of like the real vaccine, if you will, because you have something that's less potent, and it's less likely to have you put in hospital and intubated. And then yet you have something that could give people that natural immunity that we're looking for. What's your commentary on Omicron?

Dr. Peter McCullough: Omicron, we've now learned, is carving out a large ecological niche. It's the most highly mutated form of the virus. It has 30 mutations in the spike protein, 10 in the receptor binding domain, deletions, and actually one insertion, which is rare. So there's some new code that's in the receptor binding domain of the spike protein. And we've learned that while it's transmissibility is lower than Delta by modeling, by Dr. Fantini in France. The wild type was a transmissibility index on a relative scale of 2, Delta was 10. This is coming in at 4. But the reason why Omicron is carving out this large ecological niche is it's competing directly with Delta. And what we learned from a paper from Hong Kong University is that it can replicate 70 times faster than Delta. So basically, Omicron is out-replicating Delta. And in a paper by Khan and colleagues from the African Research Institute, they've demonstrated that Omicron quickly develops immunity in an individual to Delta.

So it's closing the immunologic door on Delta. So not only is it out competing Delta for the next host, but then is actually shutting off the ability of Delta to spread. So I anticipate now the Delta outbreak is going to be brought to a very quick close. Which is actually wonderful because Delta was a very hard and long outbreak. Many patients lost their lives. It attacked younger people. And I think Delta was the hardest to treat of all of them, as a treating doctor. Now Omicron, very different. We are seeing reports- there was a report by Abdullah and colleagues from South Africa showing that the inpatient mortality with Omicron shockingly was 1%.

We've never seen that. The contemporary ICU mortality in the US Stop COVID program is 30%. We know from the federally funded IV network published in JAMA, first author 10-40 and colleagues, that the overall inpatient mortality through the publication point, which I believe was September, they had 45% Delta in the 10-40 study in JAMA. That the inpatient mortality for fully vaccinated was between 6 and 7% and for unvaccinated between 8 and 9%. Let me tell you, 1% all comers in the Abdullah data from South Africa is a giant difference. And as I've pointed out in so many of the manuscripts, these patients who get hospitalized, they don't receive any early treatment. So if we actually could identify and triage high risk Omicron patients and treat them early, we could get to basically 0% mortality very quickly.

tWow. I appreciate you sharing that. Now, what about the vaccine in regard to Omicron? Now there's a huge campaign, not only for adults to get vaccinated but children, and even talk of the 0- to 5-year-old bracket. Does the vaccine work? Is it effective against Omicron? Does this create a new reason that is legitimate, or is this part of a bigger marketing ploy? Do you see any information to suggest that?

Dr. Peter McCullough: As the syndrome become much more mild, like as with Omicron, the clinical impetus to undergo vaccination becomes considerably less. So if we have a condition that's basically non-fatal, it makes the argument to mass vaccinate less significant. And now we've learned, within a few days of the Omicron variant being identified... It was identified, by the way, in fully vaccinated travelers on the border of Botswana. And what we learned is that when these individuals basically had this unusual PCR pattern, it's called S gene dropout, that's what told them that the spike protein was sufficiently mutated, and it was a new form was present. And ultimately modeling studies came in and demonstrated it. That we understood that in fact the vaccine manufactures, within a few days, all announced that they were going to have new programs to try to cover Omicron. They knew that the spike protein had sufficiently mutated.

Remember, the vaccines only direct immunity against the spike protein, not against the nucleocapsid or the other proteins in the virus. So we knew the vaccine manufacturers tipped their hat that the vaccines may not cover Omicron. But we had data recently demonstrating that the vaccines had very little coverage against Delta, the predecessor. So in a paper by Yinong Young-Xu published in JAMA recently, in the October 1st issue of JAMA, they basically demonstrated that as the Delta shaded in as the variant, the overall vaccine effectiveness reduced for all the vaccines pooled together down to about 20%. So vaccine efficacy markedly declined with the Delta pandemic. Now with Omicron, we don't have any randomized trials, obviously, so it becomes very hard to compute vaccine efficacy. But we're hearing reports for instance, in Germany now, where over 90% of those with COVID-19 are fully vaccinated. Over 70%, certainly in the initial Omicron crisis in the United States, Denmark and South Africa, over 80% in the UK.

So basically, more people have Omicron and have COVID-19 who are fully vaccinated than the small minority who are not vaccinated. And so we're now hearing reports of negative vaccine efficacy, meaning the vaccines could almost make things worse. I'm not so sure that's accurate, to be honest with you. I just think that the people who have not taken the vaccine, they are so sufficiently small in number, many times they just represent people who have already had COVID-19, the natural illness with the legacy variants. And now with Omicron, actually have more and more of my patients have had Omicron. And so now they even have bolstered immunity against Delta. But I think the overall analysis is, we can't expect the current sets of vaccines to have any coverage of Omicron. We should not give any assurances there. It may be that those vaccinated have a milder syndrome than those who are unvaccinated, or that are naturally immune. But the bottom line is, to try to vaccinate into the Omicron outbreak appears to be ill-advised.

Jonathan Otto: Thanks for sharing that. With the boosters, they're obviously being put together with the prospect that they could dramatically help people from Omicron and whatever future variants are coming. Is this ill-founded? Could this be true? Is that potentially something that could work? Or do we see enough evidence of just nefarious agendas that really don't have any real benefit or it's not being created for the sake of benefit? And obviously then the other question is, the risk versus benefit analysis. And I know from previous conversations where you typically fall in a risk versus benefit analysis. But what do you think this presents in regard to there's a new variant, well then if this current shot doesn't work, then surely we should get a new shot, and this booster is hopefully going to help us against Omicron or a future variant? Or is that just flawed science-

Dr. Peter McCullough: Well, I sent you the data. I mean, I gave the data from Young-Xu published in JAMA just recently, where vaccine efficacy against Delta was about 20%, all the vaccines pooled. In general, if protection is less than 50% and it lasts less than a year, it's a non-viable, failed vaccine. So I think all the current vaccines on the market actually qualify now, according to those criteria, as failed vaccines. So the idea of continue to deploy failed vaccines because we just don't have anything else, I think is ill-advised. It's a wonderful opportunity now to pivot towards early treatment with the new agents that we have onboard. If the vaccines have little or no coverage against Omicron, that even tips the balance farther away from having a risk benefit analysis that's favorable to using vaccines. And now we have data from the Vaccine Adverse Event Reporting System that I should update your viewers to, Jonathan.

And that really involves now record numbers of safety events. Through December 24th, the US CDC Vaccine Adverse Event Reporting System, of which we know about half of the cases are domestic in the United States, has reported a total of 1,000,227 verified injury reports, 21,002 deaths, a total of 350,000 or more urgent care visits and urgent office visits for injuries. We have 22,117 cases of myocarditis, which is skyrocketing, that's heart inflammation occurring in younger people. We have 23,892 life threatening events, 36,492 severe allergic reactions, and 35,650 people who are permanently disabled. So the COVID-19 vaccine program is worse than a modern day war in terms of its catastrophic impact on the population.

And I think, at this point in time, we just can't find a patient subtype where the benefits would outweigh the risks. I think across the board, I think we're out of any risk benefit discussion at this point in time. And now that Omicron is here, it'd be a good time to go ahead and drop all the vaccine mandates and then pause the vaccine program for a deep analysis on safety. And basically figure out what happened, what went wrong because it went wrong in the United States, and it went wrong all over Europe and the UK and elsewhere.

Jonathan Otto: I appreciate you sharing that. It is certainly confronting to look at the data. I looked at it today, and I was wondering whether it was going to break a million before the end of the year. And sure enough, it did in terms of adverse reactions. And in some ways, these people are martyrs for a cause of something that is really horrifying. The fact that because of these people we have data that we can show and present, but yet it's being pushed down and suppressed. So come to children because this becomes a huge concern because it appears there's certain issues that affect children more. For example, the issues with miscarriages, there was something that happened. I can't reference who it was, but someone that was close to me, their sibling had a miscarriage after the vaccine. His wife had to deliver a baby on the side of the road that wasn't living.

And I cannot tell you that I know for certain that this was a miscarriage caused by the vaccine, but I can tell you that we have reports from clinics that are telling us that these numbers are far beyond, like multiples higher. And it's these horror stories that it's like the athletes falling down on the field, hundreds of athletes dying of heart issues. Things that, for me, I've never been familiar with. And I've researched, I can't see any evidence of these in the past. What do you have to say on issues like this and how these are appearing in all different walks of life, and that there's enough reason for us to consider the strong possibility of these coming up? Because even still, the issue with VAERS is that we don't know every single one is a legitimate injury, but we see trends that make us believe that there has to be a connection. So-

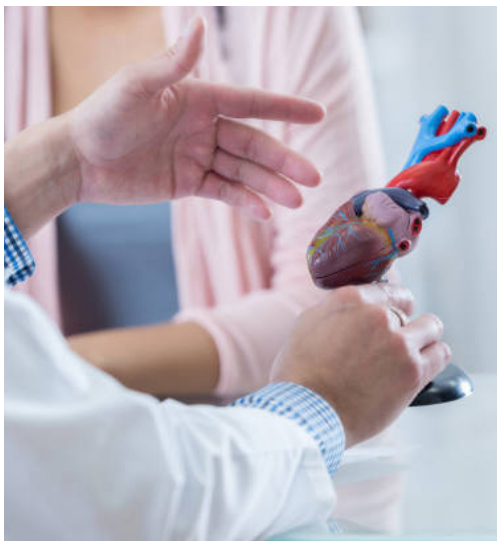
Dr. Peter McCullough: We know from a paper by Meisner and colleagues, before COVID-19, about the VAER System that 86% of the VAERS entries are by doctors, nurses, healthcare professionals, coroners, and the vaccine manufacturers. And they believe, actually, the vaccine can play a role in that fatal or non-fatal event. So only 14% are reported by the patient or the patient family. And so we know it's probably not over reporting from that perspective. And then there's certainly been papers published on under reporting. In terms of mortality, we had a whistleblower lawsuit that was filed by lead attorney, Tom Renz, against the US government early in the summer, using CMS estimates. And the estimate in the lawsuit that 45,000 Americans had died after the COVID-19 vaccine, and the under reporting ratio calculated out to be about 5 for that. And we know from Rose and McLaughlin's separate analyses that about half of the deaths occur within 48 hours, 80% of the deaths occur within the week. So they're very tightly related.

And now a recent paper from Columbia by Pantazatos and Seligman has shown, using US census data. Now it's an ecological analysis, but US census data and vaccine administration data, that that number of lives lost after the vaccine could be as high as over 170,000 people losing their lives, Americans losing their lives. And the under reporting relationship there could be as high as 20. So what we know is that the limit of mortality in a vaccine program of this size would be no more than 150 deaths. In fact, that's about what we see for all the vaccines combined per year, with far more people vaccinated. So we know that we're deeply underwater with respect to mortality in VAERS system. And we have not seen a deep dive safety review by an external panel on why these patients have died.

And as you pointed out, the nonfatal reports are pouring in, probably the lead one to be concerned about is myocarditis. And you mentioned all the young individuals dying on the playing field, we wonder if they- athletes that have subclinical myocarditis. And then most recently a paper on December 21st, and I want to quote it for you. The first author is Katie Sharff and colleagues. And they're from the Department of Infectious Diseases at Kaiser Permanente Northwest. And Sharff and colleagues, the title of the paper is "Risk of Myocarditis Following COVID-19 RNA Vaccination in a Large Integrated Health System: A Comparison of Completeness and Timeliness of the Two Methods". I typed this out on Twitter, the summary of this so you can find it. But they found that the highest rate of myocarditis of interest is actually in ages 18 to 24.

That's higher than what we had thought before, 18 to 24. And the point estimate there is 537 cases per million population. Now previously, from the Hogue analysis from UC Davis, they had an upper bound in the confidence interval for myocarditis per million population at 162. And then the CDC's original estimate was 63. So if this is true, you know, it's turning out that we have almost 8 to 9 times as many cases of myocarditis than the CDC ever anticipated that we have. As the vaccines have been advanced on young people, in this case it's college-aged kids that are picking up the myocarditis. In a paper by Rose and myself, in "Current Problems With Cardiology", we showed that the peak age is in the late teenage, young 20-year range, but the tail extends all the way up in men to age 50. 90% of people getting myocarditis are men, and so there's clearly a gender linkage there.

But the myocarditis is a serious complication. It's still warranting hospitalization. Now as contemporary series come out, the hospitalization rates have stabilized somewhat. But in an analysis by Truong and colleagues from Salt Lake City, University of Utah, about 75% of these kids are still requiring hospitalization and care in the hospital. And the great concern, I take care of these patients myself as a cardiologist, that some need drugs to prevent the development of heart failure during observation. And they strictly can't have any athletic activity. So the great concern is these athletes could be powering through myocarditis as they're, in a sense, encouraged to take the vaccines or are forced into it, and subclinical myocarditis. And then they actually have the consequences, which is cardiac death on the field. And I don't know if any of your listeners have seen these montages of athletes dying on the field, it's just heartbreaking to see it happen. It looks like it's all avoidable.



In another interview, Dr. McCullough discusses the ongoing issue of censorship that prevents the public from learning about the early treatment protocols, the propaganda that the CDC and other health officials are putting out regarding the safety and efficacy of the vaccines, how Omicron has changed the effect of COVID on those who are infected, the very simple protocol that anyone can do to prevent infection from COVID (no, it's not masking or social distancing) as well as from common colds and sinusitis or greatly reduce the severity of infection. He recommends having a COVID readiness kit, lists the over-the-counter items such a kit should include, and explains the exact protocols for using those items for prevention and treatment. Dr. McCullough also discusses the McCullough Protocol called "Sequence Multidrug Therapy for COVID-19" which was developed early on that may have saved thousands of lives and the changes to it that he now recommends.

Dr. Peter McCullough: Those attempting to censor information that is as clear as this. This is simply reporting from VAERS. It's a valid query and analysis of VAERS. Individuals attempting to censor must understand that the act of censorship itself not only has consequences, but it draws more attention to the article of censorship. This is very important. So every time something is censored, the very first question that a viewer would ask is, "Why"? "Why"? Why would something like this, an age distribution like this, become the point of censorship? It's because some entity somewhere doesn't want the public to know.

Jonathan Otto: Yeah.

Dr. Peter McCullough: They don't want the public to know this. Did they bother censoring other things? No, but they bothered to censor this. Now was it Elsevier alone? Was it Elsevier that, you know? And if they thought the paper was invalid, why didn't Current Problems in Cardiology reject the paper outright if they didn't think it was sufficiently good to be invited to the journal? Why didn't the editor say we're not interested? They had their chance at invitation. We're way past that. We are deep into the publication cycle.

Jonathan Otto: Wow.

Dr. Peter McCullough: I've never seen this. Listen, I'm in my fourth decade of doing this. I'm the editor of a major journal. I'm the former editor of an international journal. And I can tell you I have more peer reviewed publications in the medical literature than probably anybody in any of these circles. I have never seen this happen. This is a gross violation of the principles of ethics as they apply to dissemination of scientific information.

Jonathan Otto: Just delete something you don't like.

Dr. Peter McCullough: This is effectively scientific fraud continued and basically continue to propagate it by the world's largest publisher. There will be a heavy price to pay for this act. We have learned a great deal. Our CDC has told Americans that not a single death after vaccine is related to the vaccine, yet there is obvious evidence that the vaccines directly cause death. This paper by Choi and colleagues from Korea, published in Infectious Diseases, Microbiology and Parasitology, demonstrates that a 22-year-old man in Korea who took the vaccine. He took Pfizer. He took the vaccine. He had chest pain for 5 days. He went to the hospital and 7 hours later, he dies. He has an autopsy. His heart is examined. It is loaded with inflammation caused by the vaccine. It is incontrovertible. He died of vaccine-induced myocarditis. This paper is published in the peer reviewed literature. It went through all the processes. The evidence here is obvious. It's beyond a shadow of a doubt, beyond a shadow of doubt. It's more than clear and convincing. It's more than more probable than not. This is beyond a shadow of a doubt that the vaccine, in fact, is responsible for this loss of life. If this was a criminal court and this was a murder case, the vaccine would have been convicted of murder. It's beyond a shadow of a doubt. Now, our CDC, with the number of deaths that have occurred after the vaccine, are basically looking at evidence in this case, and I can tell you there will be many more, beyond a shadow of a doubt. Those individuals from the CDC who wrote those statements. And by the way, they're anonymous on the CDC website. They will all come to justice. They will all come to justice. It's irrefutable. It's undeniable. It's inescapable. Yeah. They will come to justice. They wrote those statements. Those statements are effectively malfeasance. That is wrongdoing by those in positions of authority. The information pointing out that no one dies of the vaccine is propaganda. That's actually false information put out by positions of authority. Former President Trump just came out and told America that no one dies after the vaccine. We are looking at a clear-cut death after the vaccine. Former President Trump is participating in propaganda. Yeah. He is propagandizing. As a person in a position of authority, he will be called to justice. They all will. All of those promoting propaganda, all of those committing malfeasance, all of those are committing crimes against humanity. They are all participating in it. This is called willful misconduct. It's willful. And it simply doesn't have to happen. You know, a simple statement, people say, well, what should Trump have said, what should Biden say? What should any of these doctors say? They should say the truth. They should say that all vaccines, like all medicines, have risks and benefits, all medicines and all vaccines. One has to make their own choices. It's voluntary whether or not people take medicines. This is voluntary whether or not people take vaccines. On any given day, someone who stares at a pill bottle, it's their choice whether or not they take those pills. But to make a completely false statement when we're looking in the medical literature at a clear cut, fatal case, and this is a proxy for what- and there are other fatal cases in the literature, which is clear. It's beyond a reasonable doubt. Historians will basically record without protections of pharmaceutical laws, without presentation of fair balance. We'll start to see these gross actions, these gross actions that are public actions that are extraordinary.

Here are 2 CNN correspondents, 1 doctor, 1 non-physician on Sesame Street effectively trying to seduce children into taking COVID-19 vaccination. They are providing no information on fair balance to the parents or legally authorized representatives, and they are falsely misleading children to accept an injection that in itself, I've just shown you, for some individuals would be fatal. Yeah. They are, in a sense, enticing children to take a substance in their body for some that will take their life. I've mentioned several times, historians will record. We have a president of the United States, a leader of the free world, right before the holidays, puts out a message to Americans that this is going to be a long, dark, and deadly winter for the unvaccinated. That statement, as a dark cloud of fear and anxiety and unsettling, as a message to our seniors, our seniors who now are effectively unvaccinated.

Our seniors took the vaccines in January, February, March. We know the vaccines basically have run out of any protection after 6 months. Our agencies agree, and our seniors largely have not taken any boosters. So to give that message to a large group of vulnerable seniors, I think is one of the most deplorable actions I've ever seen as a president. And I came out, and I countered that message for America. And I told them that we have a hopeful situation, that we have early treatments for COVID-19. We have the closure of the Delta outbreak, and we have the emergence of the even larger Omicron outbreak. But Omicron is a very different virus. Omicron is the most highly mutated form of the virus. We know that Omicron has so many mutations in the receptor binding domain, it can't lock into that ACE2 receptor like it did before. It can't enter the human body. It replicates at 70 times the speed of Delta. That's been shown a paper by Hong Kong University, and we have emerging data from Khan and colleagues from Africa showing that an Omicron infection actually closes the immunologic door on Delta. People who get Omicron have back immunity against Delta. So there's no doubt about it that Omicron is going to quickly replace Delta. In fact, it is. As we sit here today, our CDC Nowcast system, which is quite accurate, anticipates that 95 percent of all the infections in the United States are Omicron. And data by Abdullah and colleagues from South Africa suggest the mortality rate, even for sick patients who get to the hospital with Omicron, 1%. And with our early treatment approach and early recognition, I would anticipate, if we manage this correctly, that we'll get to mortality with COVID-19 with Omicron far less than 1%. There are reports out now that risks of hospitalization are dramatically reduced. South Africa 90% reductions in the risk of hospitalization. So many people sick with Omicron, Omicron has broken through natural immunity, partly because natural immunity may not be that robust in the nasopharynx, and the virus can simply replicate in the nasopharynx and not be sufficiently attenuated by a variety of systemic immune defenses. That's OK as long as it doesn't invade the human body. We're hearing reports of those who have had Omicron where they have an hour or two of a brief fever or nasal congestion, and that those who are naturally immune, those who are vaccinated, are having actually relatively easy courses with Omicron. The COVID naive, still susceptible, can have more of a standard head cold course of illness for several days.

Jonathan Otto: Which is

Dr. Peter McCullough: Which is what we get.

Jonathan Otto: What, no big deal.

Dr. Peter McCullough: Right.

Jonathan Otto: So I'd prefer not to be vaccinated even if I had not had COVID and get Omicron because I just don't want the variable of having that toxin in my body.

Dr. Peter McCullough: So here's probably the biggest update and now the featured approach for Omicron, which should have been our featured approach from the outset of the pandemic, but we learned about it late. The randomized trials and data came in late, and that is the use of virucidal nasal and oral washes. There has been a preoccupation on masks, social distancing, hand sanitizers. None of those things impact whatsoever the patient who actually has inhaled enough inoculum of the virus and has that virus in the nasal passages. Once the virus is in the nasal passages, it finds a warm, mucus laden set of cavities where the virus can replicate in the nasopharynx. In fact, those who've had COVID-19 know because you can feel it right in the face. One can lose their sense of taste and smell because the olfactory nerve at the roof of the nasal cavity is now inflamed with SARS-CoV-2. But since the virus is in the nasal cavity without exception, in fact, people know that because that's how we test. We put a swab way up in the nose. That's how we test for it. So it should be obvious to everyone who gets COVID-19, the virus is up in the nose. That should be obvious. So if the virus is up in the nose, it is reasonable to actually kill the virus in the nose. And the question is, how do you kill it? We now know it can be killed with Povidone Iodine. Povidine Iodine is known as Betadine. It's sold as a liquid in a bottle that we use to sterilize wounds. That bulk distribution of it is a 10% solution. We can actually dilute that 1 to 10. So conveniently, that's a half a teaspoon in a shot glass of water, which is 1.5 cc's, and that solution, which should be the consistency of dark tea, can be squirted or sprayed up in the nose, sniff back, and then spit out. Very important to bring it all the way back, and then spit it out. And then do it twice on either side. That's an effective nasal wash that is tremendously valuable for people to understand. That can be used for common colds. That can be used for bacterial sinusitis. Iodine kills germs. That's the reason why we use it to sterilize the skin when we do surgeries and other procedures.

Jonathan Otto: Sounds like you like that better than Budesonide or Hydrogen Peroxide?

Dr. Peter McCullough: Well, if someone cannot tolerate iodine, there is an iodine allergy. They have a hyperfunctioning thyroid problem like Graves disease or hyperfunction nodules, and they can't iodine, we need something else to use. What else can we use? We can use Hydrogen Peroxide. Hydrogen Peroxide is more noxious to tissues. Anybody's ever poured Hydrogen Peroxide in a wound will see it bubble up, and it'll hurt. So Hydrogen Peroxide is more noxious. The current available over-the-counter Hydrogen Peroxide has to be diluted basically 1 to 3. 1 to 3. So that would be 3 quarters of a teaspoon in 1.5 cc's of water, a shot glass, and then that can also be squirted up or sniffed up. But if it burns, it means it's too strong. Many can't tolerate that, so it has to be nebulized. So if we nebulize Hydrogen Peroxide, and we actually sniff it into the the passages that can be done. So Hydrogen Peroxide, I think, is a second best to Povidone Iodine just because of the nature of what Hydrogen Peroxide is. It can also be improved upon if one can tolerate a little bit of iodine with adding a few drops of lugol's iodine. Turns out, though, that the virus, just like with hand sanitizers, the virus is easily killed by many substances. The virus is also killed by a whole variety of other substances, including colloidal silver, including sodium hypochlorite, potentially other spices, herbs and spices.

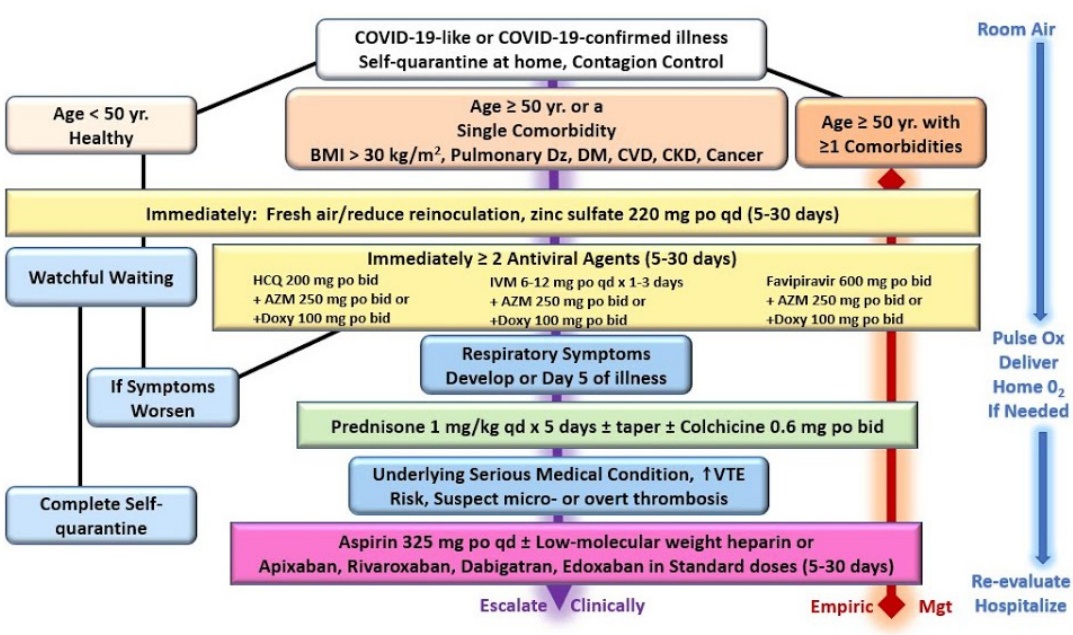
People have tried a whole variety of naturopathic remedies that actually seem to symptomatically work. But what we know from the published data is there are 12 Povidone Iodine studies and one of them a large, high quality, prospective randomized trial. In total, there are nearly 900 patients in clinical trials, and there's absolutely no doubt with early treatment, it dramatically reduces the risk of hospitalization and death. By zapping the virus, killing the virus in the nasal passages, we reduce the intensity and duration of symptoms. And by that mechanism, reduce the risk of hospitalization and death. We probably actually reduce the risk of invasiveness. There's actually less virus that can invade the body. So how often do we recommend this stuff? Every 4 hours with acute illness. We can do it twice a day for prevention, and it's extraordinary the impact. This is inexpensive. It's universally available, and the innovation came from the East. It came from Bangladesh and other countries around it. And the information emerged in 2021. I am remorseful that I couldn't help more patients with this simple recommendation. Now this is a uniform recommendation, and I get patient after patient saying, "Wow, I'm already better. I'm already better", particularly with Omicron. Omicron is a high intensity, very quickly replicating virus. It's perfect. The more fast a virus replicates, the more amenable it is to something that's going to kill it. Okay? So I think very, very important. And here are the published metadata on this. 71% improvement across all the studies. The big study is by Chowdhary and colleagues for the outcomes of measurement for late treatment, even late, later in disease. 44% improvement. Who would not try it even later in disease? And then finally, for prophylaxis, about 45% preventive.

But only 1 study, the Sikh study from Singapore that attempted to show that. It was a relatively large study. But the point is, even preventively, it plays a role and all depends on how assiduous one is in doing that. So we have some, I think, some universal- if I was to conclude, I would want to say that one, no matter where they are, can have a COVID-19 readiness kit, a COVID-19 survival kit. At this point in time, COVID-19 should not be a surprise. We're 2 years into this and doctors are still getting calls, "Doctor, I'm surprised I got COVID." It's like no, everyone's going to get COVID. It looks like we're going to get COVID more than once now with Omicron, even the recovered and vaccinated. Everyone is going to get COVID. So if we just plan that everyone's going to get this illness, it's mild. It's a mild respiratory illness. What would we have in our home toolkit? We would have Povidine Iodine as our nasal virocidal therapy. And a bottle of it's going to last forever because we use such a diluted solution. If that's not tolerated, we would have Hydrogen Peroxide. Next. Number 2, we would have zinc. Zinc, 50 mg elemental zinc is an inhibitor of the polymerase. Many adults are zinc deficient. Almost everybody on diuretics is zinc deficient. So that needs to be there. Vitamin D, 5000 International Units prevention. There's a meta analysis showing that if we achieve a vitamin D level in the blood of 50 or greater, there's almost a 0 mortality with COVID-19. It's an extraordinary relationship. And then with acute treatment now we use 20,000 International Units a day. Vitamin C. Not much data on prevention, but clearly an active treatment, 3,000 milligrams a day. Quercetin. Quercetin is a polyphenol supplement, 500 milligrams a day prevention, 500 mg a day, twice a day for treatment. That's number 5. One last thing to add over-the-counter Pepcid or Famotidine. Famotidine is a histamine blocker. It works to impair viral replication through another pathway it uses called the TMPRSS2 receptor, and then it reduces inflammation and histamine release. So 6 things basically in a shoe box can give a great, great hope to people that they will get through the Omicron variant without having to make any panic calls, any panic hospitalizations. The medical community can be relieved. We have actually been relieved of our reliance on Hydroxychloroquine and Ivermectin, by and large. Severe cases, we can use a monoclonal antibody Sotrovimab

There will be patients who we could use Hydroxy or Ivermectin. We have the new Pfizer drug coming in, a combination of economies like three inhibitor and Ritonavir, an older protease inhibitor. And we have the Merck drug coming in Molnupiravir. So in a sense, the crisis is over. Omicron coming in is going to be manageable at home. Over-the-counter remedies are the featured approach. The additional prescription agents now, which will actually all be under EUA, there should be no argument here. The federal government should have no argument with the drugs that they have approved under the Emergency Use Authorization for doctors to use. I'm predicting this is a great opportunity to close the pandemic.

Jonathan Otto: Wouldn't that be wonderful? Wouldn't that be something? Well, I appreciate it so much. And before you leave, if you can show the McCullough Protocol.

Dr. Peter McCullough: So the McCullough Protocol is called "Sequence Multidrug Therapy for COVID-19", and it's now a year old. It's a year old. This figure is a year old and there have been changes. The changes that I've mentioned Povidone Iodine or Hydrogen Peroxide being used as naso virucidal therapy increased every 4 hours with acute treatment. That's an important update here. Adding in the new Pfizer and Merck drug are important additions. Phasing out the Regeneron monoclonal antibody, the Casirivimab, and Imdevimab and moving in Sotromivab into that space. The corticosteroids and anti-inflammatories and anticoagulant stays the same. Adding Famotidine available over the counter. So the McCullough Protocol is now, in a sense, it's a year out there. It's been widely utilized in guidelines, widely used in home treatment guides. Some people have given some credit to this that it may have saved millions, if not tens of millions of lives. It's a very rewarding thing to be involved with, and it's not just me. It is a whole host of important people who have contributed their ideas, their thoughts, and their energies towards coming up with a sequenced multidrug approach. But it's ripe for revision. But the revision is easier. Its revision is actually more leveraged towards over-the-counter, widely available solutions that should not be controversial, in fact, are not controversial. And it's more leveraged now with brands to use authorized products, of which we're thankful for our government for bringing forward.



BMI=body mass index, Dz=disease, DM=diabetes mellitus, CVD=cardiovascular disease, CKD=chronic kidney disease, yr=years, HCQ=hydroxychloroquine, AZM=azithromycin, Doxy=doxycycline, IVM=Ivermectin, VTE=venous thrombo-embolic

Jonathan Otto: Fantastic. So people can find that protocol, well one, we've got it here on the screen so people can screenshot it because that's it, right? What we're seeing right now with this graphic is the protocol.

Dr. Peter McCullough: Yeah, that's right. But they can find this and more text description on what to do, as well as list of treating doctors on the Association of American Physicians and Surgeons website and the Truth for Health Foundation website. Both of those carry this protocol, and it's not the only way to treat COVID-19. The Frontline Critical Care Consortium carries their protocols MATH+ and I-MATH. Those also are very effective protocols. I think America and the world should be reassured that people working with myself, Peter McCullough, in my circles we're working independently of Dr. Kory and Dr. Marik in the Frontline Critical Care Consortium, which we're working independently from Didier Raoult in France and working independently from Vladimir Zelenko in Monroe, New York. All of us working early in the pandemic were not communicating with one another, and we came up with similar ideas and similar approaches based on our clinical observation and also the available sources of literature. I think the world should be reassured that different medical minds working in different places independently came up with the same type of approach. We need drugs to reduce viral replication, treat inflammation or cytokine storm, and manage coagulation or thrombosis. So the principles are solid. And I can tell you, as a doctor who's fairly far along in my career as a senior academician, I am greatly reassured when people all over the world independently think about a problem and come up with the same or very similar solutions.

Jonathan Otto: Awesome. Thank you so much. What do you believe in the importance, as we wrap up now, what do you believe in the importance of content in films like this in order to educate and help the public?

Dr. Peter McCullough: The media is extraordinarily important because censorship not only is rampant, in fact, it's overt in the major media and social media, but it's actually now overt in the medical media. The medical literature is censored. And I went over it, a great example with Elsevier at this point in time. The censorship has been covert, meaning it's been very difficult to get any treatment studies published. And as we sit here today, there are 3 times as many papers on vaccines than there are treatment. Number of vaccines aren't treatment. Vaccines don't save any lives, but treatment does. And yet treatment has been actually overtly suppressed in the medical literature. So films like this are very important because people who watch this film, watch this production, they themselves know, need to know, that COVID-19 is a treatable illness. I don't want a single person out there to get this illness and think to themselves, there's no treatment. I need to stay in fear. I need to suffer. I need to basically endure this, and then face the specter of hospitalization, isolation, and never seeing their loved ones again. Let's never let that happen ever again.

Jonathan Otto: What's your message for people to stand for their health and their freedom?

Dr. Peter McCullough: Be unbreakable. Health freedom and the principle of autonomy must be unbreakable. Think about analogies. Let's say we tell somebody that they must jump off of this ledge and fall to their fate at the bottom of the building. No. You would never do it. The principle of autonomy would keep you safe and secure inside. You would never do it. Then how about if we just go down a few floors? Would you do it? No. Why don't you go down a few more floors? Would you do it? No. What I'm saying is, listen, the vaccines are obviously dangerous. Very dangerous. Record numbers of people are being injured, permanently disabled, and sadly, many are dying. It should be obvious to all that they're dangerous. One would never be forced to take a potentially dangerous substance in their body. Under no circumstances. It's absolute. It's complete. One needs to be personally decisive on this. And then once the decision is made to have an unbreakable resolve.

CONCLUSION

COVID-19 is a preventable and treatable illness. The simple, safe, effective, and inexpensive protocols for prevention and treatment of illness have been suppressed, censored, and publicly branded as "misinformation" by the medical literature and mainstream and social media. The experimental COVID vaccines don't prevent or treat the illness. Yet they have been promoted, pushed, and mandated onto the world's population as the "safe and effective" savior from COVID.

If the vaccines are so "safe" that they are even recommended for children and pregnant women, we have to ask why then are there over a million COVID vaccine-related reports filed in the Vaccine Adverse Events Reporting System (VAERS) since the vaccines became publicly available? How safe are these injections really when the VAERS data as of February 11, 2022, tells us 1,119,061 reports have been filed[6], including:

- 23,990 Deaths
- 130,774 Hospitalizations
- 119,454 Urgent Care
- 173,802 Doctor Office Visits
- 9,207 Anaphylaxis
- 13,982 Bell's Palsy
- 4,080 Miscarriages
- 12,314 Heart Attacks
- 33,590 Myocarditis/Pericarditis

- 43,476 Permanently Disabled
- 5,641 Thrombocytopenia/Low Platelet
- 27,306 Life Threatening
- 39,782 Severe Allergic Reaction
- 12,452 Shingles

And studies have shown that only a fraction of the total adverse events are actually reported in VAERS.

We also have to ask, if the vaccines are so "effective" than why is a 3rd and even a 4th injection needed in less than a year after the 2nd dose is given? There is even talk of possible need for a 5th injection or ongoing semi-annual or annual injections.

With the lack of true safety and efficacy of the vaccines, doesn't it make more sense to prevent and treat infection through natural means than to take a manufactured experimental vaccine that is known to cause harm and death to thousands already and with absolutely no long-term safety data on what additional health issues may lie ahead for those who have been vaccinated? Dr. McCullough has provided detailed instruction for preventing infection and for building one's immune system to reduce the severity of illness if infected with COVID. Following his protocol provides the added bonus of reducing infection and severity of other illnesses, such as the common cold and flu, as well without the risk of being vaccine injured.

Additional protocols for prevention and early treatment can be found at https://www.covidcon21.com/index.php/natural-prevention-early-treatment/

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ABOUT JONATHAN OTTO

Jonathan Otto is an investigative journalist, natural health researcher, documentary filmmaker, and humanitarian.

He has created several highly-acclaimed, groundbreaking docuseries — ***Depression, Anxiety & Dementia Secrets, Autoimmune Secrets, Natural Medicine Secrets, Women's Health Secrets, Autoimmune Answers, and Vaccine Secrets: Covid Crisis*** — covering innovative, effective natural remedies for autoimmune disease, neurodegenerative disease, mental health, cancer, and heart disease.

These docuseries — watched by millions around the world — represent Jonathan's unceasing quest to discover the root causes of debilitating diseases by interviewing over 100 world-renowned natural medicine doctors, scientists, natural health experts, and patients.

In response to this life-saving knowledge, Jonathan created ***Well of Life***, a line of doctor-formulated, 100% natural supplements specially designed to detox and fortify the body.

Jonathan's greatest reward has been hearing the testimonials from people whose lives have literally been saved with the protocols he developed.

His work has been featured in international TV broadcasts, print media, national news, and radio broadcasts. He received the awards, *Young Citizen of the Year and International Volunteer of the Year*, by the Australian government for international humanitarian contributions, which he continues to support.

Jonathan and his wife, Lori, welcomed their first son, Asher, in January 2019 and their second son, Arthur, in May 2021.