Not Using Ivermectin, One Year In, Is Unethical And Immoral

By Mary Beth Pfeiffer January 18, 2021

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Withholding ivermectin as a treatment for COVID-19 has entered a new realm: It cannot be defended as medically or morally principled.

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Not when a body of strong evidence is amassing in support of the drug.

Not in the fiery throes of a pandemic that is killing roughly 4,000 Americans *a day*.

Not when ivermectin is a safe, well-tested and inexpensive oral medication.

And certainly not when, as I write this, a tweet comes across my feed from Dr. Ranu Dhillon of Brigham and Women's Hospital and Harvard Medical School in Boston. He implores:

I have been writing about early treatment for SARS-CoV-2 infection since March, with my first article on ivermectin, a generic anti-parasitic drug, published on Oct. 1. I concluded then and still believe that this drug, effective at multiple stages of the disease, could turn the corner on COVID.

Incomprehensibly, the people we should trust to make the call on ivermectin are paralyzed by indecision and cowardice. For eight months, while hundreds of thousands died, the National Institutes of Health advised against using ivermectin except in clinical trials. Last week, NIH brushed aside evidence of efficacy in several thousand patients who took ivermectin and decreed there was "insufficient data to recommend either for or against."

This, ironically, is progress. It is the same advice NIH has for months given for monoclonal antibodies and convalescent plasma, COVID treatments that are minimally effective and more expensive than ivermectin. Doctors nonetheless embrace those high-tech, in-hospital treatments. But aware of the uproar over another COVID treatment, they steer clear of generic ivermectin, which can actually prevent and treat infections at home and in the hospital.

A Lawsuit, A Life Saved

This article was prompted by the story of an 80-year-old Buffalo woman with COVID whose feisty, take-no-prisoners family took a hospital to court over ivermectin. Such is the state of COVID care in America.

The woman, Judith Smentkiewicz, was on a ventilator when her loved ones were told she'd likely spend another month in the ICU, where they gave her a 20 percent chance of survival. This is the modus operandi of COVID among the elderly and infirm: prolonged, expensive and often fruitless late-stage care.

So the family did some research on behalf of this active octogenarian who drives, lives independently and works five days a week cleaning houses. They went online. They read about studies of ivermectin's success. They pressed an ICU doctor to give it, and, on day 12 of infection, he did.

Within 48 hours of a single dose, Mrs. Smentkiewicz had improved so much that, like a Florida woman in my first ivermectin article, she was moved out of critical care.

The hitch? Doctors on the new unit declined to continue ivermectin even as the woman's condition declined. The drug is not approved for COVID, they told her family. The family went to court. The hospital fiercely objected. Mrs. Smenkiewicz's personal physician for 20 years was called in.

"We reviewed the limited studies on the use of ivermectin for COVID-19 and **recommend** [his emphasis] she receive 15 mg orally Day 1, Day 3 and Day 5," wrote Dr. Stephen Scravani in a letter to the court. The judge ordered the treatment resumed.

As a result, Mrs. Smentkiewicz is to be released to a rehabilitation facility shortly. "It is a miracle from where she was," the family's attorney, Ralph Lorigo, told me.

This story is instructive for what it says about other late-stage patients, whose COVID sieges instead may end with last rites and a ride to a mortuary. There is a straight line between those outcomes and a dogmatic insistence by NIH, the World Health Organization and other policy powerhouses on large, randomized controlled trials before endorsing ivermectin.

Here's what is happening while we wait on those RCTs and fail to use the evidence we already have: Emergency rooms are overwhelmed. The ranks explode of people with of long-term COVID damage. And patients – and some doctors and nurses – suffer injury and death.

Benefits At Every Stage

In a Buffalo News article about Mrs. Smentkiewicz, ivermectin was described as "experimental," an adjective that is correct in a technical, but wholly inaccurate, sense.

Yes, ivermectin is still being studied; but its role is clear. By one analysis, 33 studies so far – involving 10,136 patients – collectively reported positive outcomes in 85 percent of people. There were fewer infections among frontline workers and COVID families; quicker recovery in early and late infection, and lower mortality rates. At least three other meta-analyses have reported similar, statistically significant improvement across disease stages.

By any yardstick, ivermectin is not an experimental drug. Since the 1980s, billions of doses have been given worldwide in ongoing programs to control parasites. In Africa, for example, 99 million people were treated in 2012 alone; in many African countries, not

Ivermectin saved so much human suffering from river blindness and other awful parasitic diseases that it won its developers the Nobel Prize in Medicine in 2015. The scientist who found the substance some 40 years ago in a bit of Japanese soil called it “astonishingly safe” in 2011 and a “wonder drug” in a class with penicillin and aspirin. Other scientists agree it has a stellar safety record.

‘Transformational Treatment’

Fast forward to 2020, when ivermectin began proving its mettle against COVID-19.

To date, we have the combined weight of 51 studies in ivermectin’s favor.

We have the work of Front-line COVID-19 Critical Care Alliance that analyzed those studies, examined South American regions where ivermectin distribution led to fewer cases, and wrote protocols for doctors to follow at each stage. “(I)vermectin may prove to be a global solution to the pandemic,” the group wrote in a peer-reviewed article accepted by the journal Frontiers in Pharmacology.

We have a new independent review from England that concludes “…ivermectin will probably substantially reduce the risk of death in people with COVID-19 and…will probably substantially reduce the risk of COVID-19 infection among health care workers and contacts.”

Lastly, we have what may be the ultimate breakthrough. Working under a program hosted by the World Health Organization, a University of Liverpool pharmacologist reviewed ivermectin studies and was impressed. “If we see these same trends consistently across more studies,” Dr. Andrew Hill concluded, “then this really is going to be a transformational treatment.” Unitaid, the agency overseeing Hill’s work, acknowledged for me that the “preliminary data was promising.”

It’s my hope that WHO will be bold. It must balance the risks and benefits of ivermectin. COVID-19 has changed everything. We do not have time to conduct trials involving thousands of patients and millions of dollars. What should matter now is this: Long-standing science tells us ivermectin is safe. New studies tell us ivermectin works.

Last April, NIH’s COVID czar, Dr. Anthony Fauci, declared the drug remdesivir the “standard of care” based on preliminary findings. “You have an ethical obligation,” he said then, “to let the people in the placebo group know so they could have access.”

We now know that remdesivir, at $3,000 a treatment and approved on thin evidence, does not work. What is your ethical obligation now, Dr. Fauci, when we have a treatment that does?

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Mary Beth Pfeiffer is an investigative reporter and author of two books. This is her sixth article for Trial Site News on ivermectin and early COVID-19 treatment. Follow her on Twitter: @marybethpf.

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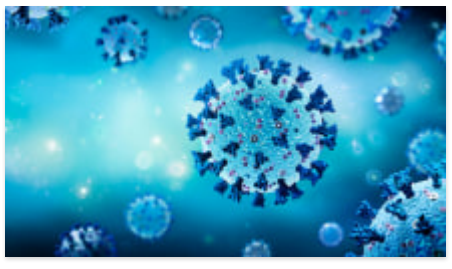

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