Dear Dr Lawrie,

Thank you for your detailed reply.

Best,

Jack

From: Tess Lawrie <tess@>
Sent: 15 September 2021 18:03
To: Jack Goodman <jack>
Subject: Re: BBC News Seeking Comment

Dear Mr Goodman,
Thank you for taking an interest in early treatment for Covid-19. Remarkably, you are the first BBC journalist to contact us in almost 20 months. In that 20 months, doctors around the world have been treating patients successfully with multi-drug protocols (of which ivermectin is one medicine used) – while the NHS guidance to the public has been to drink water, stay home and wait until their oxygen levels go below 92% or a number of other serious signs and symptoms develop.

In such a health emergency, particularly one which has clear age stratification and obesity indicators, one might consider preventative and outpatient advice of paramount importance (perhaps recommended changes to diet or increased exercise or safe medicines with anti-viral properties) in order to take the number of hospitalisations downward and remove the pressure from the NHS. But no such advice has been given. In respect of this vacuum, many doctors have sought answers on how to prevent and treat covid-19 and found them. There are real people all over the world who have been well served by their guidance and continue to be so - you should talk to some of them.

If you sense some cynicism in this reply, you would be correct. I have never experienced a situation where censorship has been applied to medical discussion and guidance. The government and media disdain for the mountain of evidence supporting early covid-19 treatment seems to be restricted to anything that is not a novel therapy.

How did remdesivir at around $3000 a treatment get to be approved by the FDA, MHRA etc on the back of one trial that had a marginal positive effect? It has since been shown to be ineffective and is not recommended by the WHO, yet it is in our British National Formulary for use in covid-19 and appears to be widely used in our hospital ITU's despite growing concerns over its safety.

Ivermectin, at 50 pence a tablet, now has 63 controlled studies, 45 of them peer-reviewed, 31 RCTs, 7 meta-analyses, and several published country case studies that overall clearly support its use and show no evidence of harm, as well as many expert opinions and testimonials. Why is it not approved in this country, but it is in others?

You may be surprised to hear that, in the UK, ivermectin is indicated to treat the most vulnerable people with covid-19 – those who are immunocompromised; this is not recommended for covid per se, but to prevent worms. Surely the question to ask then is, if ivermectin can be used among the most vulnerable, why do the authorities insist that it is a horse medicine and/or that it is dangerous for use in humans?

Are you not curious as to why the UK has among the highest Covid-19 death rates in the world? At some point, the BBC should look at how Indian states (for example, Uttar Pradesh) managed to suppress Delta with 15% vax levels while UK cases remain stubbornly high, with 80+% vaxxed. Despite NICE stating that they would look at real world data for Covid-19, they have failed to do so.
https://www.nice.org.uk/covid-19/assessing-the-quality-of-wider-sources-of-data-and-evidence-in-our-guidance-on-covid-19

I welcome open scientific discussion and trust that you intend to facilitate this as time is running out, particularly for the many in ITU's around the country today without effective treatment. I hope the following answers will help to inform the BBC's position and that you are able to give a more balanced view to this really important issue of early covid-19 treatment. I have written responses to your point below in blue.

Best wishes,
Tess Lawrie

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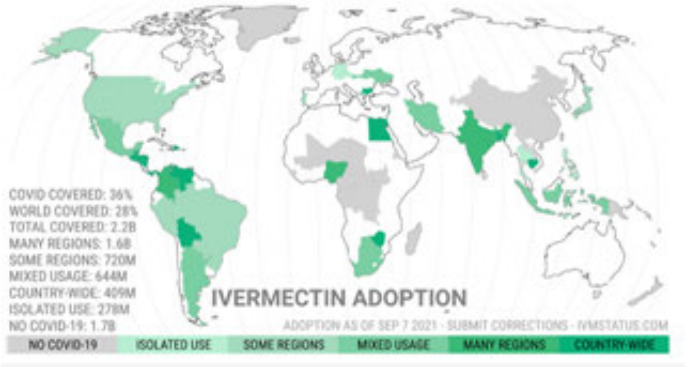
On 14 Sep 2021, at 16:47, Jack Goodman <jack > wrote:

Dear Dr Lawrie,

I'm working on a story for the BBC News website looking into the clinical studies supporting ivermectin as a Covid treatment. Independent scientists that have looked into the evidence say some of these studies are highly flawed or contain fabricated data.

I am aware of a journalist and an epidemiologist in Australia who hold a very vocal position against ivermectin; however, most independent scientists who have looked at the evidence on ivermectin agree that the big picture supports its use for covid-19.
Whether or not the Elgazzar study is discredited remains to be determined but it may well be. We have rerun removing the disputed trial from the relevant analysis and have reported the findings here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8415517/
Whilst the quantitative result inevitably changes with the removal of the Elgazzar study, the mortality outcome remains clear, demonstrating an average reduction in deaths of 49% in favour of ivermectin. The effect on reducing covid-19 infections when used for covid prevention remains virtually unchanged.

It is important to remember that systematic reviews, which restrict studies to randomised control trials only, are just one type of evidence on ivermectin. There is also a vast amount of real-world evidence from patient, doctors and countries that are successfully using ivermectin. Please visit the www.worldivermectinday.org and also see the proceedings of the International Ivermectin for Covid Conference held in April https://bird-group.org/conference-post-event/ for more information.



In addition, the Together trial found no benefit from the drug and the Cochrane review said there was no evidence of benefit.

The Together trial is one of many and will be added to our meta-analysis in due course. Trials are often flawed and single trials are not as robust as systematic reviews, which are the best way to understand the effects of treatments because they consider all the relevant trials. In addition, particularly during a health emergency, it is important to consider all data, including observational and real-world data, which is what the British Ivermectin Recommendation Development meeting on 20th February 2021 was about. This meeting was conducted in accordance with the *WHO Handbook for Guideline Development*. As required, the evidence-to-decision document took into account people's preferences, acceptability, feasibility, equity and cost of ivermectin use in the context of covid-19.

The Together trial is a medium size, non-peer reviewed study and adds to the bank of knowledge that suggests that given late and for only 3 days, ivermectin may have little effect on covid-19 hospitalisation rates. This is not too surprising, as this would be the case for most medicines.

Had the investigators followed a dosing-regime from well-documented expert protocols on early treatment, this study could have shown better results. A late-stage intervention will have less-positive outcomes. Ivermectin is widely available in Brazil, but the researchers did not check to see if participants in the placebo group had access to it or were using it. This could have skewed the results against ivermectin. In addition, the authors state that their study was under-powered to detect a difference between the two groups. These potential flaws were pointed out to them in the early stage by experts in the field. There are therefore many doctors who feel this study was designed to fail.

The Cochrane study has some concerning problems and I invite you to take this opportunity to investigate them. Out of 24 available RCT's the authors chose only 4 to include in their mortality analysis, a small subset of those available. The Cochrane authors split these up further into two separate analyses. This dilutes their findings to the extent that meta-analysis was not possible in most instances, as there were no trials to pool. Instead of utilising all available evidence and presenting appropriate caveats around such wider evidence, they present an empty review with bulk but little analysis. We have written a letter to the BMJ regarding the limitations of their approach. You can find the pre-print here https://osf.io/peqcj/

As someone who has remained a promoter of ivermectin, have such issues with the evidence base weakened your belief in ivermectin?

I am not a promoter of ivermectin – I am a mother, medical doctor and scientist trying to help

families survive covid-19. The only issues with the evidence base are the relentless efforts to undermine it. There are over 100 scientific papers on the use of human ivermectin that are relevant to covid-19. The majority suggest benefit, none show harm. I do not have a belief; I have knowledge that I would like to share.

You said on a panel that: "Ivermectin works. There's nothing that will persuade me". Do you stand by that statement?
Yes. We are beyond the point of whether or not ivermectin works, with ivermectin now being used widely by doctors around the world to treat covid-19 in combination with other effective medicines and supplements. Ivermectin is included in covid treatment protocols as evidenced at the recent International Covid Summit in Rome. Please refer your readers to www.earlycovidcare.org for expert guidance on how to treat covid.

In a Talk Radio interview you implied that the Covid vaccine has led to a large number of deaths.

"If you take a vaccine, like the tetanus vaccine, which has been around since 1968, there's only, you know, 36 deaths report reported again, you know, attributed it on the World Health Organization's database, whereas there's 67,000 deaths reported against the COVID vaccines in just a few months on the World Health Organization database, and on the UK database is 1440. So this is unprecedented, I would say in the history of any medicine, to have so many deaths reported in such a short time, and indeed, so many reports in such a short time against a medicine."

Figures from vaccine monitoring sites refer to any deaths reported in people after they have been vaccinated, whether or not it had anything to do with the vaccine. It's unsurprising that a number of vaccinated people died in the days and weeks after their jab from unrelated causes.

Given this, do you stand by your statement and do you believe the vaccine rollout should be paused?
I have been following pharmacovigilance data on the World Health Organisation's Vigiaccess.org since the beginning of the year for both ivermectin, remdesivir (which is used in the UK despite there being little evidence that it works or is safe) and the covid-19 vaccines. Whilst very few reports of adverse drug reactions have been posted for ivermectin, a considerable number (2 million) have been posted for the covid-19 vaccines, including more than 10, 000 deaths. This led me to look the data reported to our UK Yellow Card system. The Yellow Card system is our early warning system for possible safety issues; clinical trials are not powered to do this.
Of the Yellow Card system, Dr June Raine (CEO of the MHRA) has said previously in a Guardian article: "There is no need to prove that the medicine caused the adverse reaction, just the suspicion is good enough." As at today on the Yellow Card system there are 357,956 reports of adverse reactions to the vaccines and 1,625 reported deaths in the UK. This is much higher than the number of reports that led to the cessation of the Swine Flu vaccine and needs to be urgently looked into by the MHRA. Why have a system designed to sound an alarm and then ignore it? Perhaps you should look into that.

We've spoken to an expert who has been critical of the quality of the meta-analysis you co-authored and the claims it followed the Cochrane method. They said you and the group have muddled up advocacy and scientific process and didn't examine your own conflicting interests. How do you respond?

The authors of Bryant et al have over 120 Cochrane systematic reviews under our belt. I think you can safely say that we know what we are doing. The review team included three highly experienced systematic reviewers; two of them are guideline methodologists. The meta-analysis was peer-reviewed and conducted according to PRISMA methods (the base of Cochrane reviews), using GRADE and WHO guidance.
Our findings are robust to the exclusion of the questionable study by Elgazzar and others and are supported by an independent team from Queen Mary's University in London https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8415515/ .
Please explain on what my conflicts of interest are? Does my Hippocratic Oath constitute a conflict of interest? Personally, I have more to lose than to gain. As a doctor, advocating for a safe and effective medicine in a pandemic is not a conflict of interest, it is being a good doctor. That I champion a medicine known to work in an environment hostile to its existence is my duty. I am the Director of an independent not for profit company with no paymasters to please. I have absolutely no commercial interest in any medicine nor pharmaceutical company. My aim is to save lives and alleviate suffering. In a pandemic context, the benefits of Ivermectin almost certainly outweigh any risks, given its outstanding safety profile, negligible base cost, and the existing large body of evidence showing that ivermectin provides benefit in a variety of important clinical outcomes.

In order for us to reflect your position in our story, wewould need to have received your response by no later than 12pm on Thursday 16 September.

Best,

Jack