Speaker 1 (00:03):

All day.

Speaker 2 (00:07):

Well, sir, thank you very much. I really appreciate it. I've uh, I've seen a lot of your testimonies before they were actually taken down. I I've seen some of the videos that were yours that were taken down off YouTube. And then, uh, I, I found that very odd, a, uh, a doctor talking about, uh, a medical disease would, would have videos taken down and an actual expert would be either testifying or discussing treatments and talking about a disease and have those videos taken down off of YouTube. What, first of all, if you would please just tell your credentials and tell everybody what

Speaker 1 (00:44):

You do. I'm Dr. Peter McCollough, I'm an internist and cardiologist. I'm also trained in epidemiology. I'm an academic practice in Dallas, Texas. So I see patients about half the time. I saw patients yesterday, drove down, uh, today to see you here in the studio. And, uh, the rest of my time I spend as an author and editor, I'm an editor of a major in cardiovascular medicine, the former editor of an international journal. I'm the president of a major medical society right now, currently about five years into that position. And, uh, you know, I frequently publish I'm, uh, in my field. I study the interface between heart and kidney disease. I'm the most published person in my field in history. Uh, I have over 650 publication is in the national library of medicine. I imagine that's probably ahead of anybody you've had on the show. You mentioned Paul Merrick. I'm just ahead of Paul, me, Peter Pico had mentioned him in critical care. I'm just ahead of Paul, a lot younger than he is. And, um, uh, in COVID when COVID hit, I really dropped everything to put all of my academic efforts on this, cuz I saw it as an all hands and deck situation.

Speaker 2 (01:47):

Now, when did things start to seem strange to you in terms of the way the information was allowed to be distributed in terms of the way people were treating patients and not just that, but the information on how to treat patients was distributed.

Speaker 1 (02:04):

I didn't see this coming to tell you the truth. I was pretty happy in life. Uh, medicine was moving along for me and, uh, had a very highly ranked position at a major academic medical center and, um, you know, traveled frequently and did all the things we normally do in academic medicine. You know, meeting interchanging, challenging, uh, being skeptical with one another. That is the life blood of academic medicine and things were going great in March. This hit, uh, we immediately took, uh, uh, efforts. We thought it was gonna hit Dallas. Uh, we started looking at things how to configure our workforces. I went and got a grant, got a large grant to study a prevention approach to protect our, uh, workers at our healthcare for facility. And I work with the FDA over a weekend to get an investigation and a drug application awarded in my name, uh, in order to test a prophylactic approach and things were going great in March.

Speaker 1 (02:57):

And I can tell you it wasn't, but a few in April on these task force calls, I was on routine health system calls once a week and I was on one with the national institutes of health. And I asked a question. I said, when are we gonna start to treat the problem? I go, people are getting sick out there. They're starting to

be hospitalized. Some are dying. When are we gonna start to treat, treat patients too late for the hospitals too late to treat people as obvious they're dying in the hospital, we must start early and you could basically hear a pin drop on these calls. No one had an idea about treating COVID 19 at home.

Speaker 2 (03:31):

Was, was there no thought about it? Was there no discussion or was it just not a point of focus? Like what was the problem there?

Speaker 1 (03:40):

I think it was a grip of fear doctors for their first time in their lives, felt like they could get the disease themselves if they actually saw and examine these patients. Uh, all the discussion was on personal protective equipment, hand sanitizer, uh, negative airflow rooms. It was all about protecting the healthcare workers. There wasn't any focus on sick patients. And after the weeks went by, I became incredibly frustrated. I started communicating with our Italian colleagues. I said, what's going on? You guys are getting blasted in Milan. Are there any, is there anything we can do to treat patients at home and stop these hospitalizations?

Speaker 2 (04:15):

And were you alone with this concern? Were there other doctors that were joining you with this and were there treatment protocols that had been put into place that were being tested?

Speaker 1 (04:25):

There were no treatment protocols that emerged. We started looking at work done by Didier alt and Marai France, uh, by Vladimir Lanco in Monroe, New York, and started communicating, uh, very early on with the Italian. And I had great relationships with the Italians in Milan. And, uh, what we had decided is we had decided on some principles early on the first collaboration and my contribution was really to get people together, get the ideas together and publish. And I had the publication strength that other people didn't and got the first organized ideas. Uh, in April, may, June, we submitted our paper July 1st to the American journal of medicine, which is one of the highly ranked journals in medicine. And it was published in August. And this is the first publication teaching doctors, how to treat COVID 19 with a multi-drug regimen. And though Gar rules were this, we knew it was, uh, in insufficient time for a large randomized trials.

Speaker 1 (05:25):

Those take two to four years. I lead large randomized trials. I've published in the new England journal medicine. I know what this is about. I'm on steering committees. We don't have two to four years. This is a mass casualty situation. We use the precautionary principle, meaning that this is a mass casualty event. We can't wait. We're looking for drugs with a signal of benefit and acceptable safety. We knew very early on that this viral infection had three components. It was viral replication, cytokine, Stormer inflammation, and then thrombosis. So we knew a single drug wasn't gonna handle the problem. No way it was gonna be a multi-drug regiment. Just like with HIV, just like with hepatitis C, no difference gonna be multi-drug. So precautionary principle, we used, uh, signals of benefit, acceptable safety drugs in a combination test, retest and go. And so at the time we submitted our paper, Joe, there was about 4,000 papers in the peer-reviewed literature on COVID 19. Uh, uh, I I'm sorry, check that there was 55,000 papers in the purview literature on COVID 19 and about 4,000 that could have related to certain drugs, but not a single one, put the concepts together and how to treat patients.

Speaker 2 (06:30):

So this was the first one and it was published in August,

Speaker 1 (06:33):

August of 2020 American journal medicine. The title, the paper was the pathophysiologic rationale for the early ambulatory treatment of COVID 19 that quickly after August spawned the association of American physician and surgeons home treatment guide. So AAPS interesting organization, uh, is independent doctors. Uh, they accept no money from pharmaceutical agencies. Uh, there are, uh, they've been around since 1943. They had early on sued the federal government to release the stockpile of hydroxychloroquine. You know, us had the right ideas, other countries, they stockpiled hydroxychloroquine. Then there was the problem of it wasn't being released from the stockpile. And so during my development work early in 2020, I got a call from the white house. Peter Navarro called me. So look Simoa, can you help me get hydroxychloroquine uh, release Rick bright and others in the FDA seemed to be colluding to block hydroxychloroquine coming out of the stockpile in Marai, France, Didier RAL was working with hydroxychloroquine and it was over the counter in France. They made a prescription and they started making hi it hard for him to use. And then simultaneously in Australia, they had taken hydroxychloroquine and they had put it up in Queensland as basically an untouchable drug. If a doctor attempted to use hydroxychloroquine to treat a COVID patient in early April, that doctor could be put in jail. So these things started happening early to try to prevent treatment of patients with COVID 19.

Speaker 2 (07:56):

Why do you think that's the case and why do you think the hydroxychloroquine would've been effective?

Speaker 1 (08:01):

Well, 2006 forward, there were studies with hydroxychloroquine that demonstrated that it reduced replication of SARS cov one, uh, the first version of, uh, the SARS

Speaker 2 (08:14):

Virus. Yeah, we talked about that the other day. Wasn't it? Uh, just chloroquine. Was it chloroquine or

Speaker 1 (08:18):

Hydroxychloroquine originally, uh, there was chloroquine hydroxychloroquine and Quin. So there's antis, uh, they're similar in terms of their biochemical property, but they have three mechanisms of action. They increase the lysosomal pH. So when the, when the particles taken into the cell, it doesn't, uh, uh, travel so well to the nucleus. They, uh, chloroquine or hydroxychloroquine bring in, it's a zinc I, four zinc goes in and actually antagonizes the RNA dependent polymerase, which is needed to, for the virus to replicate. And then hydroxychloroquine is a well known and established anti-inflammatory. We use it in lupus, we use it rheumatoid arthritis, and it's obviously an intercellular anti-infective we use it for the prevention of malaria

Speaker 2 (08:57):

Was the problem that there was a lot of problems with Donald Trump being in office that when he would approve of something or when he would talk about something, people would attack that thing.

And hydroxychloroquine became something that he talked of as a cure and talked about as a treatment for COVID and then it became politicized and then support for hydroxychloroquine became support for Trump. Do you, would you, would you think that that was accurate?

Speaker 1 (09:29):

I'd have to look at the timeline boy. It was quick because the backlash against hydroxychloroquine was so wrong in Brazil and Australia. Why do you think that is though? No, but the, the timing that the question is, did it happen before or after Trump said anything? Uh, it happened very quickly, you know, through the course of the year, it was extraordinary. Uh, do you know the second largest, uh, producer of hydroxy when the plant was mysteriously burned down outside of typee? Uh, it was extraordinary. What was going, uh, doctors from Africa were telling us, uh, that, um, you know, there were some type of mercenary people raid the pharmacies at night and burning the

Speaker 2 (10:03):

Hydroxychloroquine. Now this is B before the emergency use exemption or the emergency use authorization for the vaccines, the emergency use authorization in order to have of that, you cannot have effective treatments.

Speaker 1 (10:19):

We have to be careful. The emergency use authorization is a new mechanism or a, a previously unused mechanism for regulatory pathways of drugs and my interpretation of it. And everybody's interpretation is fair games. So it's is pretty loosely written quite honestly, depends on indication. So a vaccine would be indicated for the prevention of COVID 19 illness hydroxychloroquine or belimumab or any of these other drugs be approved for the treatment of co so two separate indications. Okay. So the OA should not, should not be viewed in my view as competitive in in fact they can't because remember belimumab the Lilly product, as well as Remes Avir, uh, the Gilead product, they preceded the vaccines and, and they didn't preempt the vaccines coming outta the market

Speaker 2 (11:08):

Were, but Remes, Avir had problems of its own, correct with kidney failure. And

Speaker 1 (11:15):

Remes VIR was basically AURP failed Ebola drug, uh, and it does have intellectual property ties through Gilead, back to the Chinese. So the Chinese originally were collaborating with us very tightly. I mean, tons of emails from the Chinese, they were trying to alert us. What's going on with COVID 19 Ruiz came up, it's a polymerase inhibitor. As a general. I told you hydroxychloroquine has three mechanisms of action, uh, reviewed previously Iver Mein, which also has three separate micro action. REM DVIR is a one horse show. It's a single mechanism of action. It inhibits the polymerase. And, uh, it, unfortunately as the data have born out, it's given far too late in the illness, right? So the polymerase is active early in viral replication. So if you gave it on day one, it may actually do something, but if you give it on day 14, by the time someone comes in the hospital, the virus is done replicated at that point in time. And then all it can do is offer toxicity. And you're right is a five day infusion of Remes VIR. Early on, we heard about the, um, have pad toxicity in my experience, I could never get a patient through five days of therapy because the liver function test the ASD and alt would skyrocket. Now it's become clear. It's been associated with acute kidney injury and the kidney injury is not tolerated in COVID 19, cuz any retention of fluid makes the oxygen saturation and lungs far worse.

Speaker 2 (12:32):

So why do you think there was this demonization of hydroxychloroquine and why? I mean, if do you, do you have a theory as to why they would try to restrict the distribution of it or why they would, if someone wanted to burn down the factories that produce it, why they would do that?

Speaker 1 (12:50):

It was clear that Hydrox Quin was the most promising drug that we had for COVID 19, by the way, we tested Retonavir VIR HIV, drugs. They quickly fell to the side. Other drugs, uh, were tested, but hydroxy came forward as, um, uh, the lead agent and, you know, currently were up to 300 completed St with hydroxychloroquine 32 early treatment studies. And it does have an effect size or an efficacy early in treatment of about 64%, uh, globally across the studies and its toxicity profile is, uh, well understood. Hydroxychloroquine like ivermectin and the other drugs are already FDA approved. FDA tells doctors to use drugs. Off-label it's in their guidance to us. And actually they have a FDA has a piece to patients that was published in 2018 saying, why does your doctor use off-label drugs? And it says, when the doctors are fulfilling an unmet need, I E COVID 19 there's no, no, no new drugs for COVID 19.

Speaker 1 (13:51):

So we use these drugs was called clinically indicated medically very appropriate off-label use of drugs. Hydroxy was the first one up a giant mistake was to actually place an emergency use authorization on hydroxychloroquine and the original, um, uh, uh, UA that was placed on hydroxy, which it didn't need one because it's already on the market, right. It was placed for inpatient use. And then the interpretation was that it was a hydro Oxy, chloroquine was restricted at inpatient use. So once it became restricted at inpatient use, then there was messages saying, listen, don't use it unless somebody's an inpatient. Then when we found out that hydroxychloroquine like, ivermectin works best early and has less of an effect late, like all the other drugs, cause people are too far gone. Once those trials were completed, there's five randomized trials of inpatients with hydroxychloroquine, as they're about to go on the ventilator.

Speaker 1 (14:39):

And those five trials are neutral. They don't show harm. They don't show benefit. They're neutral. One of 'em was the NIH trial. There's only two placebo controlled trials by the way. So we we've based the entire house on hydroxychloroquine on two placebo controlled small inpatient trials that were didn't have sufficient power to see an effective indeed. It was there having said that they were flat on the outcomes of mortality and progression in the hospital. And so based on that in June of 2020, the FDA came out across the board and said, based on this, do not use hydro sequin to treat COVID 19 period full stop. They never reviewed the data a second time or a third time. And I can tell you as a doctor, the FDA, the CDC and the NIH are public service agencies to me and you. We don't work for them. They don't issue us rulings. They work for us. And I'm telling you as a leader in academic medicine, my expectation was monthly reviews from those three entities and the white house task force. Matter of fact, the white house task force can do it. I needed a monthly report of what drugs were working and what drugs weren't. We didn't see any of that.

Speaker 2 (15:46):

Why do you think that is?

Speaker 1 (15:48):

I talked to Scott Atlas. I presented with him a couple weeks ago and had dinner with Scott. He was on the inside. He worked side by side, these people for months. And I said, Scott, what is going on? Scott goes, I did what Peter McCullough would do. I showed up every day with the data. I analyzed things. I had the, I had the, uh, uh, updates on what's going on. The T now Scott was focused on mask contagion control in schools, but he he's an academic he's at Stanford Hoover Institute. I said, yeah, I said, what about the other people on the test force? What about the head of the N I a a D what about the CDC director? He goes, they showed up with nothing. I said, you gotta be kidding me. They're not analyzing any data. He goes, have you ever seen them come on TV and analyze any studies? I said, no. He thinks that this is a crisis of academic incompetence. Believe it

Speaker 2 (16:35):

Or not just incompetence, not some sort of a conspiracy to demonize hydroxychloroquine for profit for, for, for some other means to, to, uh, promote some other treatment or drug.

Speaker 1 (16:50):

It wasn't me, but someone in the crowd, this was a, was him that was held by Pam popper, by the way, Pam Dr. Popper's got a wonderful book out on COVID 19. Uh, and so does Scott Atlas, his is about the white house. And someone in that audience asked Scott. He said, listen, do they have another intention? Were they directly trying to squash hydroxychloroquine at the time? He said, no. He said they had good intentions for the nation. He says, they're just incompetent.

Speaker 2 (17:17):

So is it possible that the demonization of hydroxychloroquine was because Donald Trump supported it? Cuz I know for like the way I had been hearing about it was hearing about it through him, that he talked about it is basically co had cur remember all that stuff. He was saying it was a miracle,

Speaker 1 (17:37):

As I recall, that was late March. I think when it was honestly made illegal in Australia, it was early April. Uh, you know, I went on Tucker Carls and we had the same type of discussion. Tucker says, how did the Australians know to make it illegal? So early in April, he goes that's before all the research was done. Remember Henry Ford came out with a 3000 patient study and actually used in the hospital. It wasn't randomized, but they got consent. It was very carefully done. I was a program director at Henry Ford in the past. I know that institution really well, high quality tops health. I was communicating with them. They said, listen, it works. It is clear. It works. This is an unconfounded study. And that was one of the studies that in fact we relied upon, uh, in order to put hydroxychloroquine in sequence multidrug therapy, that was before the data with Ivermectine came in.

Speaker 1 (18:25):

So Ivermectine came in later, but in, and so our update, when we publish our update in December of 2020, we brought in ivermectin, the Japanese told us about FA VIR in the Russians head. But a lot of people don't know this. There is an oral antiviral approved and used in Japan, in Russia and four states in India called fave VIR. That is an oral polymerase inhibitor. So it's like an oral REM DVIR. It's very similar to the new drug Mulla ear VIR, this an oral polymerase inhibitor. So the antivirals, we actually buy our recommendations now had three, uh, antivirals that we could recommend worldwide for that layer of treatment. Now antivirals alone are not sufficient and, uh, they are not necessary to treat COVID 19. It's

very interesting for people to say this people wanted to put up hydroxychloroquine up on a pedestal and say, listen, if we can knock down, hydroxychloroquine there will be no treatment for COVID 19.

Speaker 1 (19:18):

Uh, uh, uh, and we can promote some other agenda or if we can knock down ivermectin and Dr. Chetty from South Africa and Dr. Broo from south America, given the politicization of both drugs, because ivermectin in the next wave became the next target of politicization. If you will, if it's, if it's politics, but I have to tell you it's so worldwide. I hate, I hate that word politicization. I think it's some other process, but the point is they demonstrated that the syndrome as an outpatient can be treated without those drugs. They use a different combination of drugs in the sequence. The Chetty method is called the time method, where in a sense, you let the viral, you make the virus, make its run on replication and then pick it up with Montey Heine, inhaled steroids, oral steroids, and then anticoagulants. They treat the back end of the syndromes.