

The Critical Role of Early Home Treatment in Surviving and Thriving after COVID-19

Craig M. Wax, D.O.

All the media magnification, political usurpation, and general fearmongering aside, COVID-19 can be a serious, life-threatening event.

As a healthy middle-aged male physician, I pride myself on being an example of a healthy lifestyle. My day consists of one to two hours of exercise, water hydration, and a primarily vegetable-based diet. I take vitamins, minerals, and supplements to optimize my health. My blood serum vitamin D3-25-OH level is 60 (range 30-100). Besides a hard and honest work ethic, how else can I demonstrate to my family and patients what life's true values are?

With no concomitant medical conditions or other glaring risk factors, why should I have worried about catching COVID-19 during 2020? I champion prevention and early treatment, along with prominent medical colleagues who saw the light in early 2020 and the opportunity to prevent hospitalizations, morbidity, and mortality. Along those lines, I took an evidence-based prophylactic regimen of hydroxychloroquine (HCQ),^{1,2} 200 mg weekly, as it has a long half-life.

In December, nine days after close contact with my physician, who later fell ill with COVID-19, I felt myself run down with fatigue, muscle aches, and chills. We had both worn masks and minimized physical contact at my office visit. Had I caught influenza or one of 10,000 other viruses? I ran a quick nasal swab for influenza A and B, and it came up negative. Then a cardinal symptom developed: I had lost both smell and taste! Now it was time to confirm this malady with a nasal polymerase chain reaction (PCR) SARS-CoV-2 test that would take a few days, and I quarantined myself and my family.

With suspected COVID-19 as the empirical diagnosis, I continued my daily regimen of multivitamins/multi-mineral supplements, vitamin D3 5,000 IU, and vitamin K-2 180 mcg; added N-acetylcysteine (NAC) 600 mg daily; increased the hydroxychloroquine to 200 mg twice daily and zinc to 220 mg (50 mg elemental) per day; added azithromycin 250 mg twice daily; and then added ivermectin 15 mg daily in sequenced multi-drug early home therapy.³ At this point, the laboratory confirmed SARS-CoV-2 (the reported causative agent for COVID-19) by nasal swab PCR.

Over the next few days, I decompensated despite this treatment. My cough grew worse, I felt difficulty in taking deep breaths (dyspnea), and the night sweats became severe. For the six hours I slept, I awoke with my night clothes soaked with sweat and had to change hourly.

Concerned about these drastic changes, I consulted colleagues who recommended adding a tapering dose of prednisone starting with 30 mg a day and aspirin 325 mg daily. Over two exceedingly difficult nights, the tide turned.

I continued my work as a physician throughout the course of my illness with telemedicine consults via internet remote from my office—safe from spreading the infection to others.

Seven days from symptom onset, with aggressive early treatment on board, the symptoms and cough abated. In the final days of my 12-day isolation, on day 10, I could finally do morning yoga. On day 12, I could do outdoor bicycling again (21 miles at dawn at 34 °F). I then felt ready to exit quarantine back into the real world.

In contrast, my physician contact had a far more severe course. I called his office after I had recovered. To my knowledge, he received little pre-hospital COVID-19 treatment, only prednisone 40 mg, Tamiflu™ 75 mg, doxycycline 100 mg and Mucinex™ OTC. Unfortunately, he progressed to pneumonia and was admitted to a major city hospital. He also was intubated and later required a tracheostomy tube for mechanical ventilation. His course was complicated by a central line causing a pneumothorax, requiring a chest tube for decompression. Sadly, six weeks later, he remains intubated in the intensive care unit. This is just one example of the superior outcome with early home treatment versus therapeutic nihilism (“stay home and come to the hospital if you worsen”). Therefore, it is critical that physicians and patients are not only free to use new medications, but free to use any and all repurposed old medications, vitamins, minerals, exercise, and nutritional strategies.

There are many lessons to be learned from my case report. The first is to lead by example with a healthy lifestyle and consider your own health to be number one. The second is that no matter what you do, you may still get caught off guard by COVID-19, even if distancing, masking, or utilizing any other government-recommended public health policy measures. The third is to start treatment early—preferably on the first day of symptoms, even before test results are available. Early treatment is urgent for COVID-19, as for other diseases. The fourth is that it is important to have colleagues and consultants who can give you world-class strategies and opinions. The fifth is to be humble enough to allow trusted others to help you in your time of need. This can be a long-protracted, incapacitating illness. After you recover, you can return to your role helping others every day.

One bright side to recovering from COVID-19 infection is that I will not need any of the rushed mRNA vaccines, hyped by media and politicians, which cannot outperform complete and durable natural B and T cellular and humoral antibody immunity. I am also concerned that convalescent COVID-19 patients should not have COVID-19 mRNA vaccine, as they may trigger autoimmune disease, cancer, or worse.

Last year, we learned that SARS-CoV-2 virus may lead to a spectrum of COVID-19 syndromes, from asymptomatic exposure, to common cold symptoms, to influenza-like syndrome, to pneumonia, to full-blown respiratory failure, to cytokine storm triggering venous thromboembolism (VTE) and disseminated intravascular coagulation (DIC). It appears that

certain genetic susceptibilities are related to severe COVID-19, such as blood type and interferon polymorphisms. Types A, B, and AB are at higher risk, while type O seems protective.⁴ Also, there are minor risk factors like obesity and low vitamin D blood level.

We know that children and otherwise healthy young adult populations tend to do well and be resistant to the life-threatening possibilities faced by seniors and those with multiple comorbidities.

The keys to surviving and thriving in the time of COVID-19 are a healthy lifestyle and early outpatient treatment for those with symptoms. Early clinical and empiric diagnosis and treatment of patients with COVID-19 are essential for best outcomes. Actual PCR testing, in my opinion, is only necessary when the diagnosis is otherwise unclear. Empiric treatment should not be delayed while awaiting tests, especially since false negatives do occur.

Unfortunately, governments, politicians, media, medical organizations, hospital health systems, pharmaceutical, and other industry interests have worked to hamper early treatment and block access to repurposed generic medications like hydroxychloroquine and ivermectin. These act as zinc ionophores along with other mechanisms of action. It is critical that physicians retain their complete autonomy, independent of all forces, and use FDA-approved, safe, effective, medically necessary, and clinically indicated medications to reduce

the intensity and severity of COVID-19 symptoms and avoid hospitalization and death.

Together, we can prevent and beat COVID-19 with preventive strategies, isolating the sick, early empiric diagnosis, and early home treatment, so that we may again lead a normal life.

Craig M. Wax, D.O., practices family medicine and health in Mullica Hill, N.J. He serves on the AAPS Board of Directors. Website: HealthIsNumberOne.com.

REFERENCES

1. Monti M, Vertogen B, Masini C, et al. Hydroxychloroquine as prophylaxis for COVID-19: a review. *Front Pharmacol* 2020 Dec 3;11:605185. doi: 10.3389/fphar.2020.605185. Available at: <https://pubmed.ncbi.nlm.nih.gov/33343376/>. Accessed Feb 17, 2021.
2. Letters. Hydroxychloroquine as postexposure prophylaxis for Covid-19. *N Engl J Med* 2020;383:1087-1089. Available at: <https://www.nejm.org/doi/full/10.1056/NEJMc2023617>. Accessed Feb 17, 2021.
3. McCullough PA, Alexander PE, Armstrong R, et al. Multifaceted highly targeted sequential multidrug treatment of early ambulatory high-risk SARS-CoV-2 infection (COVID-19). *Rev Cardiovasc Med* 2020;21(4):517-530. doi:10.31083/j.rcm.2020.04.264. Available at: <https://rcm.imrpress.com/EN/10.31083/j.rcm.2020.04.264>. Accessed Feb 17, 2021.
4. American Society of Hematology. Studies offer new evidence for possible link between blood type and COVID-19 susceptibility and severity. Press Release; Oct 14, 2020. Available at: <https://www.hematology.org/newsroom/press-releases/2020/possible-link-between-blood-type-and-covid-19>. Accessed Feb 17, 2021.

AAPS PRINCIPLES OF MEDICAL POLICY

Medical care is a professional service, not a right. Rights (as to life, liberty, and property) may be defended by force, if necessary. Professional services are subject to economic laws, such as supply and demand, and are not properly procured by force.

Physicians are professionals. Professionals are agents of their patients or clients, not of corporations, government, insurers, or other entities. Professionals act according to their own best judgment, not government “guidelines,” which soon become mandates. Physicians’ decisions and procedures cannot be dictated by overseers without destroying their professionalism.

Third-party payment introduces conflicts of interest. Physicians are best paid directly by the recipients of their services. The insurer’s contract should be only with subscribers, not with physicians. Patients should pay their physician a mutually agreed-upon fee; the insurer should reimburse the subscriber according to the terms of the contract.

Government regulations reduce access to care. Barriers to market entry, and regulations that impose costs and burdens on the provision of care need to be greatly reduced. Examples include insurance mandates, certificate of need, translation requirements, CLIA regulation of physician office laboratories, HIPAA requirements, FDA restrictions on freedom of speech and physicians’ judgment, etc.

Honest, publicly accessible pricing and accounting (“transparency”) is essential to controlling costs and optimizing access. Government and other third-party payment or price-

fixing obscures the true value of a service, which can only be determined by a buyer’s willingness to pay. The resulting misallocation of resources creates both waste and unavailability of services.

Confidentiality is essential to good medical care. Trust is the foundation of the patient-physician relationship. Patient confidences should be preserved; information should be released only upon patient informed consent, with rare exceptions determined by law and related to credible immediate threats to the safety or health of others.

Physicians should be treated fairly in licensure, peer review, and other proceedings. Physicians should not fear loss of their livelihood or burdensome legal expenses because of baseless accusations, competitors’ malice, hospitals’ attempts to silence dissent, or refusal to violate their consciences. They should be accorded both procedural and substantive due process. They do not lose the basic rights enjoyed by Americans simply because of their vocation.

Medical insurance should be voluntary. While everyone has the responsibility to pay for goods and services he uses, insurance is not the only or best way to finance medical care. It greatly increases costs and expenditures. The right to decline to buy a product is the ultimate and necessary protection against low quality, overpriced offerings by monopolistic providers.

Coverage is not care. Health plans deny payment and ration care. Their promises are often broken. The only reliable protection against serious shortages and deterioration of quality is the right of patients to use their own money to buy the care of their choice.