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# How I Survived COVID-19: What They Don't Seem to Want You to Know

*Certain treatment protocols have demonstrated efficacy but have garnered little interest from official sources*

PREMIUM HEALTH VIEWPOINTS

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I was one of the first 25,000 known COVID-19 cases in the United States in early March 2020 and was lucky enough to find a doctor—a pediatrician—who thought outside the box and successfully treated me—possibly saving my life—against the Centers for Disease Control and Prevention (CDC) guidelines.

Being the first adult COVID-19 case my doctor treated, he documented my progress and submitted his successful findings to the CDC, the World Health Organization (WHO), a network of 26,000 doctors, and shared it in a Facebook post.

What transpired next was an attack by doctors in his own network and his findings were not acknowledged by the CDC or the WHO. The social media post outlining his treatment was censored and deleted by Facebook.

Despite the backlash my doctor went on to successfully treat hundreds of adults with COVID-19, seeing over forty a day for three months at one point during the pandemic. He is one of the many unsung heroes of the COVID-19 pandemic.

Over the following months during my recovery in 2020, I watched reports of hundreds of thousands of people dying from COVID-19 while the lifesaving medications I received continued to be heavily recommended against the CDC's COVID-19 treatment guidelines. Sadly three years into the pandemic they still are shunned or not mentioned at all.

Unfortunately, many doctors who have shared COVID-19 treatment protocols that differ from the CDC have lost their livelihoods. Because of this, my doctor wishes not to be named in this article and would like to continue to save lives in peace. I will call him Dr. Wes to respect his wishes.

## My COVID Timeline

As a child, I suffered from severe asthma but the severity diminished and has become mild in my adult years. I was 41 and in excellent physical and cardiovascular health at the time of contracting COVID-19 in early 2020. Here is a brief timeline of my illness progression:

**Day 3 after exposure:** Mild sinus infection symptoms. A telemedicine doctor prescribed azithromycin, also known as Z-Pak, and prednisone but refused to issue a COVID-19 test due to a lack of respiratory symptoms (at this time COVID-19 testing was only obtained through a doctor's referral).

**Day 5:** Symptoms worsened. Severe headache, sinuses completely inflamed, body aches, low energy, lungs heavy when breathing, no fever. Finally got a COVID-19 test at one of the first drive-through sites.

**Day 7:** Symptoms further worsened. Headache, body aches, low energy, difficulty breathing, no fever.

I was contacted by a disease investigation and intervention specialist with the state health department who confirmed the result of the COVID-19 test as positive. I was told to stay home unless I needed to go to the hospital. No additional treatment advice was given.

**Day 10:** Completed prescribed azithromycin and prednisone. Breathing was more difficult, no improvement from medications, and no fever. Started nebulizer treatments of albuterol (I had these on hand from a previous bronchitis bout). No improvement from medication.

**Day 12:** Symptoms worsened, severe burning in feet, dizziness, and lungs started to feel like they were failing. Felt like I was suffocating or drowning.

Contacted urgent care and asked for a prescription for hydroxychloroquine but they refused. I was told by the nurse they were only prescribing it to those who were dying. I mentioned I would probably be close to dying in a few days and that it would be great if we could avoid getting to that point. They still refused but finally agreed to prescribe a steroid inhalant budesonide.

Budesonide and albuterol inhalant only gave a four-hour widow of minor ease of breathing. Lungs still worsening. No Fever.

Contacted Dr. Wes (a pediatrician referred by a friend) who gave me a treatment of racemic epinephrine and continued with budesonide and albuterol. Wes told me to go to the hospital for a chest x-ray, treatment, and prescription of racemic epinephrine.

Hospital refused a racemic epinephrine prescription. The doctor said I couldn't breathe well because I had COVID-19 and all they could do was intubate me once I was worse. I went home.

Dr. Wes prescribed racemic epinephrine. Started on three treatments daily of racemic epinephrine along with albuterol and budesonide.

**Day 14:** Breathing improving and stabilizing. No Fever.

**Day 19:** Throat swelling shut. Rushed to Wes's office. Clinically diagnosed with a secondary bacterial infection. No Fever.

The remainder of my treatment journey is below in a censored and deleted Facebook post Wes posted on Nov. 11, 2020, after successfully treating hundreds more adults with COVID-19. Many were elderly with underlying conditions.

His post was his attempt to help save more lives after the CDC, WHO, and a major doctor's network failed to acknowledge this treatment's success. It was also a warning that inflammation and secondary bacterial infections were major contributors to mortality from the COVID-19 virus.

A few deletions have been made to protect his identity and his name has been changed:

**Nov. 11, 2020, PSA**

"First of all, Happy Veterans Day and thank you to all of those who have served our country.

"I am often asked about the treatments I am using with my COVID-19 patients so I thought I would begin with my adult case zero, the first adult patient that I inherited. The first adult I treated with COVID-19 early in the pandemic was a 41-year-old asthmatic female ... She was in excellent physical and cardiovascular health at the time of contracting the illness.

"March 12, 2012: Felt like she had a sinus infection (few, if any of the approx. 80 adults I have treated had a fever at the start of COVID).

"March 16, 2020: She felt very ill.

"March 20, 2020: Lungs started to feel like they were failing.

"March 24, 2020: Patient reported she couldn't breathe so I referred her to the ER [emergency room]. ER said come back when she couldn't breathe at all. Started on azithromycin. Already on albuterol and budesonide breathing treatments.

"March 24, 2020: Added racemic epinephrine breathing treatments.

"March 26, 2020: The patient reported to me that she felt like the racemic epinephrine stabilized her lungs and was the first time her breathing improved.

"March 31, 2020: We clinically diagnosed her with a secondary bacterial infection. I felt like she might not make it if I kept following the guidelines at the time, so I asked her if she wanted me to ... treat her the same way I treated every severe pediatric Coronavirus patient for 17 years, or I could continue to follow the current [CDC] guidelines and we could hope for the best.

"That night a doctor friend she knew told her, '[Dr. Wes] is going to kill you.' She was very intelligent and asked the doctor how many COVID-19 patients he treated to which he replied, 'zero.'

> "March 31, 2020: Ceftriaxone 1 gm daily shots were begun for five days, Dexamethasone 8 mg daily shots were begun for five days. After the second day of shots, she finally felt like her lungs began "purging" all the fluid. Continued to alternate racemic epinephrine, Albuterol, and Budesonide breathing treatments daily.
>
> "First week of April: Repeated shot regimen: Ceftriaxone 1 gm daily shots x 4 or 5 days, Dexamethasone shots 8 mg daily for 4 or five days.
>
> "After the shots were completed: Patient finally felt like she could breathe again, but continued to have fatigue and exercise intolerance, but was no longer at risk from COVID-19.
>
> "Every physician should consider their own clinical judgment and guidelines when deciding how to treat COVID-19 patients and this is not meant to criticize the current guidelines nor any other physician's treatment of their patients."

## How COVID-19 Kills

When the COVID virus invades the body, it can cause an imbalance in the immune system that may result in a "cytokine storm."

"What 'kills' COVID-19 patients is dysregulated systemic inflammation," wrote the authors of a commentary published in Critical Care Explorations in April 2020. This can cause a severe life-threatening "cytokine storm" also known as cytokine release syndrome (CRS).

Another study published in Mediators of Inflammation in January 2022 states, "What relentlessly takes the patient's life is the overactive immune response induced by SARS-CoV-2 virus infection."

Inflammation is normally a beneficial response of our immune system helping to fight off infection and helping us heal.

A CRS is a life-threatening inflammatory response caused by an overproduction of cytokines, which are proteins that regulate the body's immune response. This inflammation mistakenly attacks and destroys the body's own cells and tissues.

Patients with mild CRS mainly show nonspecific clinical symptoms such as fever, rash, fatigue, anorexia, diarrhea, joint pain, headache, myalgia, and neuropsychiatric symptoms.

More severe cases can cause severe lung damage, cardiovascular symptoms, hematologic symptoms, acute kidney injury, and multiple organ failure. A survey found that nearly half of all patients diagnosed with CRS had severe CRS and a poor prognosis.

CRS is an important factor in the deterioration of some COVID-19 patients and leads to abnormalities such as acute respiratory distress syndrome (ARDS). Respiratory failure due to ARDS is the leading cause of death from COVID-19.

Dr. Roger Seheult, who is quadruple board-certified in internal medicine, pulmonary diseases, critical care medicine, and sleep medicine through the American Board of Internal Medicine, breaks down this process in a 2020 medical lecture.

"The entire lung becomes inflamed" due to the abnormal inflammatory response causing a cytokine storm, explained Seheult. The inflammation causes a "leakage of fluids" into the interstitial space between the alveolar and capillaries blocking the oxygenation of blood.

The fluid also leaks into the alveolar filling them up with liquid. This liquid prevents oxygen from getting into the bloodstream and causes the blood and the entire body to become hypoxic (too little oxygen).

This creates a feeling of heaviness and difficulty breathing, or as I describe it, a feeling of drowning or suffocating on the fluid in the lungs.

Immune dysregulation and the abnormal inflammatory response of a CRS causes widespread tissue injury and can lead to bacterial growth and infections.

More recently, studies have reported over 50 percent of secondary bacterial infections in critically ill COVID-19 patients have been linked to a noticeable surge in COVID-19 severity and mortality.

A study published in BCM Infectious Diseases in March 2022 found that 68 percent of the 94 patients in the study acquired at least one of the studied secondary bacterial infections during their ICU stay. Almost two-thirds of patients (62 percent) acquired secondary pneumonia. "This study confirms that the incidence of secondary bacterial infections in critically ill patients infected with SARS-CoV-2 is very high," the authors stated.

Another study aimed to analyze the death risk due to coinfections in 212 severely ill COVID-19 patients found that the mortality rate was 50.47 percent. Fungal and/or bacterial isolation occurred in 89 patients, of whom 83.14 percent died. Coinfected patients stayed hospitalized longer and had increased odds of dying and the risk of death was increased by bacterial and fungal coinfections.

The study concluded that severe COVID-19 patients with secondary coinfections required longer hospitalization and had a higher risk of death. "The early diagnosis of coinfections is essential to identify high-risk patients and to determine the right interventions to reduce mortality," the study states.

Published papers speculate that the current estimated percentage of people dying from COVID-19 secondary bacterial infection may be underestimated as "Few papers report the species identity or time of specimen collection, making it impossible to determine whether any patients presented with bacterial infection at the time of hospital admission."

## Why the Protocol Saved My Life

My COVID-19 experience followed the same course laid out above. Wes aggressively treated the inflammation in my lungs and the secondary bacterial infection—the life-threatening symptoms of COVID-19—allowing my body to heal. Here is a brief outline of the medications my doctor used:

- **Racemic epinephrine** is a bronchodilator that quickly reduces inflammation and helped reduce the fluid in my airways that was inhibiting the oxygenation

of my blood.

Bronchodilators are used when individuals have lower than optimal airflow through the lungs and make breathing easier by relaxing the muscles in the lungs and widening the airways (bronchi).

Racemic epinephrine's efficacy in the treatment of patients with inflammation of the larynx, trachea, and bronchi has been well documented.

Racemic epinephrine also acts by narrowing the airway mucosa through stimulation of the alpha and beta-adrenergic receptors, this helps to reduce edema (build-up of fluid) in the lungs. Reducing edema can improve lung function by decreasing the pressure in the blood vessels, which prevents fluid from entering the air spaces (alveoli) in the lungs.

- Ceftriaxone is an antibiotic used to treat bacterial infections including those in the respiratory system by killing bacteria or preventing their growth. It's effective against bacteria that are resistant to other antibiotics.

- Dexamethasone is a glucocorticoid that has an anti-inflammatory effect shown to prevent and suppress cytokine storm development in COVID-19 patients.

  Studies show the effect of COVID-19 on the cardiovascular system is more severe in patients with elevated levels of inflammatory factors such as interleukin (IL)-6. Dexamethasone significantly reduces the level of IL-6 and was the first drug shown to reduce mortality in COVID-19 patients.

## Forgetting History's Deadly Consequences

Viral infections of the respiratory tract have long been linked to the risk of secondary bacterial infections. Bacterial coinfections were considered a major cause of death in previous influenza pandemics.

During the outbreaks of Severe Acute Respiratory Syndrome (SARS) in 2003 and H1N1 influenza in 2009, bacterial complications were associated with serious outcomes such as death and admission to intensive care.

Upward of 95 percent mortality was directly attributable to secondary bacterial pneumonia in the 1918 Spanish Flu.

In a 2008 news release from the National Institutes of Health (NIH) titled "Implications for Future Pandemic Planning," researchers from the National Institute of Allergy and Infectious Diseases, part of the NIH stated:

> "The majority of deaths during the influenza pandemic of 1918–1919 were not caused by the influenza virus acting alone ... Instead, most victims succumbed to bacterial pneumonia following influenza virus infection. The pneumonia was caused when bacteria that normally inhabit the nose and throat invaded the lungs along a pathway created when the virus destroyed the cells that line the bronchial tubes and lungs."
>
> "Pathologists of the time ... were nearly unanimous in the conviction that deaths were not caused directly by the then-unidentified influenza virus but rather resulted from severe secondary pneumonia caused by various bacteria. Absent the secondary bacterial infections, many patients might have survived, experts at the time believed."
>
> "A future influenza pandemic may unfold in a similar manner ..."
>
> "Preparations for diagnosing, treating, and preventing bacterial pneumonia should be among highest priorities in influenza pandemic planning ..."
>
> "We are encouraged by the fact that pandemic planners are already considering and implementing some of these actions," says Dr. Fauci.

Research has now found that secondary bacterial infections in COVID-19 patients are a stronger predictor for death compared to influenza patients.

A study published in Nature in June 2021 found that in-hospital death of patients with pulmonary secondary bacterial infection was two times higher in COVID-19 patients than in influenza patients.

## Questioning the Ethics of CDC and WHO

On Feb. 4, 2020, The Public Readiness and Emergency Preparedness Act was implemented, which grants immunity to individuals working to combat the pandemic (except in cases of willful misconduct) from liability claims that may arise from the use or administration of covered countermeasures.

Some examples of covered countermeasures included are COVID-19 tests, vaccines, any approved drug, therapeutics, or other harms COVID-19 may cause.

Feb. 15, 2020, a commentary regarding the use of corticosteroids(CST) for COVID-19 coauthored by a member of the WHO panel on clinical management stated there is "conclusive data" to expect that patients with COVID-19 ARDS will not benefit from corticosteroids. This resulted in corticosteroids, including dexamethasone, being recommended against in the WHO and CDC COVID-19 treatment protocols.

A commentary written by several doctors and published in the Society of Critical Care Medicine in April 2020 criticized this interpretation and called it "biased and without evidence-based support."

They stated, "... there is no justification based on available evidence and professional ethics to categorically deny the use of CST in severe life-threatening 'cytokine storm' associated with COVID-19 ..."

They argue that the "conclusive" statement rested on only four small studies without including results from another 25 publications, six of ten studies in meta-analysis lacked a description of CST, they disregarded positive results of two major studies (5,327 SARS & 2,141 H1N1 patients) showing significant reduction in mortality, and a SARS study found CST safe and reduced death risk by 47 percent after adjusting for confounders.

As of Dec. 28, 2022, the CDC COVID-19 guidelines still recommend against the use of dexamethasone or other systemic corticosteroids in the absence of another indication. They list preferred therapies such as Paxlovid, Remdesivir, and Molnupiravir and there is no mention of treatment for "cytokine storm" induced inflammation or secondary bacterial infections.

## The Importance of Early Treatment

My battle with COVID-19 in early 2020 left me with severe lung damage, microvascular damage, and what we now call long-COVID, which severely impacted my life for almost two years.

My doctor stated, "that my COVID would not have been severe if I had been treated early on and with the right medications."

Dr. Pierre Cory, a critical care physician and one the founding physicians of the Front Line COVID-19 Critical Care Alliance has done extensive research on early treatment and progression of COVID-19 that shows the first one to five days are crucial in the successful treatment of COVID-19.

In early July 2022, I was hit again with COVID-19. This time, it was much more severe from day one. I had a 102-degree temperature, severe body aches, and difficulty breathing. My symptoms were getting worse by the day.

**Day 3:** I started on Wes's medication protocol. By that evening most of my symptoms were gone.

**Day 4:** I was given a Meyers Cocktail IV and Ozone infusion.

**Day 6:** I continued on daily NAC supplements and had no more symptoms except for mild brain fog and fatigue which disappeared within two weeks.

All my symptoms resolved within two weeks and I experienced no long-COVID or ongoing lung issues.

I owe my life to Dr. Wes. Early in my treatment, he promised he would not let me die. He kept that promise. I am deeply grateful for him and for all the doctors that have refused medical tyranny and used their own clinical judgment and guidelines when deciding how to treat COVID-19.

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