

## In Response

No one I know is saying take HCQ without a prescription, or without a doctor's recommendation, or without being in a physician's care, or "take a handful of HCQ every time you get the sniffles."

So lets start with what is being said.

Specific protocols, which have been developed and tested, in numerous studies, are indicating HCQ can, and does, have a positive effect when (a) used early (within first 4 days of symptoms, (b) used in conjunction with zinc, (c) used in standard (400mg/day dosages, similar to lupus and rheumatoid arthritis) dosages.

On the one hand you evidently dismiss, out of hand, any/all studies indicating a beneficial response, in favour of every study than indicates either no effect, or, harm.

You state a physician wouldn't possibly prescribe HCQ without consulting with a rheumatologist. I'm not aware of any such restriction which would ban a physician from prescribing a drug which, in their professional opinion, would potentially improve the health of their patient. Correct me if I'm wrong, but "off label use" by physicians is not banned in BC.

Now, contrary to your assertion, I DO look at more than the abstracts because I want to understand WHY there appears to be a discrepancy in opinion on the subject.

What I find is the devil IS in the details.

Here's an example [Ibáñez2020 Article HydroxychloroquineAndChloroqui.pdf](#)

Open the pdf and do a search for "zinc" ... you won't find one mention.

You can find 23 mentions of "hydroxychloroquine" and 29 mentions of "chloroquine" (the more dangerous form of the two.)

The takeaway from this is EVERY study that is being discussed in that paper has no bearing on whether a HCQ and zinc protocol is effective or not, since NONE of them used zinc.

So, eliminate every one of the 43 studies quoted when you're discussing the effectiveness of HCQ and zinc.

The reason I picked that particular study is it is the FIRST study that pops to the top of the list when you search Pubmed using the search terms "Covid" and "Hydroxychloroquine."

The second study listed on Pubmed is - "Hydroxychloroquine as prophylaxis or treatment for COVID-19: What does the evidence say?" doesn't really come to any conclusions regarding HCQ.

(see - [Frontiers | Hydroxychloroquine as Prophylaxis for COVID-19: A Review | Pharmacology \(frontiersin.org\)](#) )

The third study listed [A Randomized Trial of Hydroxychloroquine as Postexposure Prophylaxis for Covid-19 | NEJM](#) once again did not include zinc.

And, the study gave the participants **a whopping 1400mg in the first 6-8 hours**, followed by 600mg a day for 4 days. The starting day dose **was 350% more than a standard 400mg dose** (lupus or rheumatoid arthritis), followed by a daily dose 150% greater for 4 days. And people wonder why the test group experienced “Side effects were more common with hydroxychloroquine than with placebo (40.1% vs. 16.8%), but no serious adverse reactions were reported.”

A toxic dose of HCQ is 20mg per kg body weight...in other words a 1400 mg dose would be toxic to someone weighing 154 pounds.

The fourth study listed is [Hydroxychloroquine and covid-19 \(bmj.com\)](#) No zinc.

The fifth study listed is [Treatment with hydroxychloroquine, azithromycin, and combination in patients hospitalized with COVID-19 - International Journal of Infectious Diseases \(ijidonline.com\)](#) No zinc.

Are you seeing a trend yet?

Sixth - <https://link.springer.com/content/pdf/10.1007/s11606-020-06146-w.pdf> No zinc.

At this juncture, I think we can safely say, and agree, there is a question about the effectiveness of HCQ by itself, and/or the safety of levels over and above the standard 400mg dosages used by millions worldwide every day, and/or, the chances that someone has a greater risk of experiencing side effects taking HCQ than someone taking a placebo.

But, find me 6 studies on the ineffectiveness of HCQ used in combination with zinc.

I wish you luck with that, because, here's the title of the first hit when you add “zinc” to the two search terms “Covid” and “Hydroxychloroquine” in Pubmed.

“Improving the efficacy of Chloroquine and Hydroxychloroquine against SARS-CoV-2 may require Zinc additives - A better synergy for future COVID-19 clinical trials”

[Frontiers | The Potential Impact of Zinc Supplementation on COVID-19 Pathogenesis | Immunology \(frontiersin.org\)](#)

“Conclusion

In this perspective, we reviewed the most important literature on the role of zinc homeostasis during viral infections, focusing on the potential benefits of zinc supplementation to prevent and treat SARS-CoV2 infections. Although data specifically on SARS-CoV2 are unfortunately still pending and randomized controlled studies have not been conducted, the enumerated evidence from the literature strongly suggests great benefits of zinc supplementation. Zinc supplementation improves the mucociliary clearance, strengthens the integrity of the epithelium, decreases viral replication, preserves antiviral immunity, attenuates the risk of hyper-inflammation, supports anti-oxidative effects and thus

reduces lung damage and minimized secondary infections. Especially older subjects, patients with chronic diseases and most of the remaining COVID-19 risk groups would most likely benefit. Although studies are needed testing the effect of zinc as therapeutic option for established disease, preventive supplementation of subjects from risk groups should begin now, as zinc is a cost-efficient, globally available and simple to use option with little to no side effects. The first clinical trials on zinc supplementation alone and in combination with other drugs such as chloroquine have been registered (124, 160–162). Thus, first results and treatment regimens regarding zinc supplementation for COVID-19 risk groups and patients can be anticipated soon.”

Second on the Pubmed list - <https://pubmed.ncbi.nlm.nih.gov/32408070/>

“Currently, drug repurposing is an alternative to novel drug development for the treatment of COVID-19 patients. The antimalarial drug chloroquine (CQ) and its metabolite hydroxychloroquine (HCQ) are currently being tested in several clinical studies as potential candidates to limit SARS-CoV-2-mediated morbidity and mortality. CQ and HCQ (CQ/HCQ) inhibit pH-dependent steps of SARS-CoV-2 replication by increasing pH in intracellular vesicles and interfere with virus particle delivery into host cells. Besides direct antiviral effects, CQ/HCQ specifically target extracellular zinc to intracellular lysosomes where it interferes with RNA-dependent RNA polymerase activity and coronavirus replication. As zinc deficiency frequently occurs in elderly patients and in those with cardiovascular disease, chronic pulmonary disease, or diabetes, we hypothesize that CQ/HCQ plus zinc supplementation may be more effective in reducing COVID-19 morbidity and mortality than CQ or HCQ in monotherapy. Therefore, CQ/HCQ in combination with zinc should be considered as additional study arm for COVID-19 clinical trials.”

Here’s the conclusion of the third on the Pubmed list – “COVID-19 outpatients: early risk-stratified treatment with zinc plus low-dose hydroxychloroquine and azithromycin: a retrospective case series study”

“Risk stratification-based treatment of COVID-19 outpatients as early as possible after symptom onset using triple therapy, including the combination of zinc with low-dose hydroxychloroquine, was associated with significantly fewer hospitalisations.”

I’m going to stop there, because I think I’ve made my point. There are 25 more Pubmed references to Covid/HCQ/zinc. I suggest you explore them.

And, the link I originally supplied above - [HCQ for COVID-19: real-time analysis of all 240 studies \(c19study.com\)](https://c19study.com) has 20 studies referring to the effectiveness of HCQ and zinc.