

ALTERNATIVE MEDICINE ONCOLOGY

Ivermectin Top 5 (Per AI)

1. Dr. Peter P. Lee - Chair of Immuno-Oncology at City of Hope Comprehensive Cancer Center in California. He has conducted preclinical research on ivermectin, particularly in combination with checkpoint inhibitors like anti-PD1 for breast cancer. His work suggests ivermectin may induce immunogenic cell death and enhance immune responses against tumors, though he emphasizes it's not a standalone cure and requires further clinical trials.
2. Dr. William Makis - A Canadian oncologist and radiologist who has gained attention for advocating ivermectin's use in cancer, citing studies like a 2017 Mexican paper on its effects against breast cancer stem cells. He claims it outperforms some chemotherapies in specific contexts, though his views are controversial and not widely accepted in mainstream oncology.
3. Dr. Kathleen Ruddy - A surgical oncologist who has reported anecdotal cases of late-stage cancer patients improving after taking ivermectin. Her observations, shared through outlets like Slay News, lack peer-reviewed clinical trial support but have fueled interest in the drug's potential.
4. Dr. Nathan Goodyear - An integrative physician at Brio Medical in Scottsdale, Arizona. He incorporates ivermectin into alternative cancer treatment protocols, often alongside other repurposed drugs like fenbendazole, focusing on a holistic approach rather than conventional oncology alone.
5. Dr. Paul Marik - Though better known for critical care and his work on vitamin C and COVID-19 protocols, Marik has co-authored discussions on repurposed drugs, including ivermectin, for cancer. His involvement stems from broader interest in low-cost, off-patent medications, though his primary focus isn't oncology.

PROTOCOLS

Note that specific, detailed protocols may not be fully published or universally agreed upon, so this reflects the best interpretation of their approaches based on current information.

Below, I've outlined the base protocols for ivermectin use in cancer treatment as associated with the five oncologists you asked about—Dr. Peter P. Lee, Dr. William Makis, Dr. Kathleen Ruddy, Dr. Nathan Goodyear, and Dr. Paul Marik. Since ivermectin's application in cancer is largely experimental and not standardized, these protocols are derived from their public statements, research, or clinical practices as available up to April 6, 2025. Note that specific, detailed protocols may not be fully published or universally agreed upon, so this reflects the best interpretation of their approaches based on current information.

Dr. Peter P. Lee

Context: Chair of Immuno-Oncology at City of Hope, focused on preclinical research combining ivermectin with checkpoint inhibitors (e.g., anti-PD1) for breast cancer.

Base Protocol:

- Purpose: Enhance immune response by inducing immunogenic cell death in cancer cells, not as a standalone treatment.
- Dosage: Not explicitly defined for humans yet, as his work is preclinical (mice studies). In research, doses are typically scaled from animal models (e.g., 0.2–0.4 mg/kg in mice), but no human protocol is public.
- Administration: Likely oral, based on ivermectin's standard form, combined with anti-PD1 antibodies.
- Frequency: Unspecified, but research suggests a short-term regimen aligned with immunotherapy cycles (e.g., every few days for a set period).
- Key Notes: Lee emphasizes ivermectin as an adjunct, not a cure, and is preparing for human clinical trials. No off-label patient protocol exists from him directly.

Dr. William Makis

Context: Canadian oncologist advocating high-dose ivermectin for "turbo cancers" (aggressive cancers, often linked to mRNA vaccines in his view), based on preclinical studies and patient anecdotes.

Base Protocol (from his "Makis Ivermectin Cancer Protocols"):

- Purpose: Direct anti-cancer effects (e.g., inhibiting proliferation, inducing apoptosis) and synergy with benzimidazoles (e.g., mebendazole, fenbendazole).
- Dosage:
 - Low Dose: ≤ 0.5 mg/kg/day (e.g., ~35 mg for a 70 kg person) for remission, prophylaxis, or low-grade cancers.
 - Medium Dose: 1 mg/kg/day (e.g., ~70 mg for a 70 kg person) for intermediate-grade or active cancers.
 - High Dose: 2 mg/kg/day (e.g., ~140 mg for a 70 kg person) for high-grade or brain cancers (e.g., glioblastoma) to penetrate the blood-brain barrier.
- Administration: Oral, typically in tablet form (e.g., 12 mg tablets).
- Frequency: 6 days on, 1 day off per week, for at least 3 months or until tumor regression.
- Key Notes: Combines with benzimidazoles (e.g., mebendazole 1000 mg/day) for enhanced effect. Doses are notably higher than FDA-approved parasitic uses (0.2 mg/kg single dose), based on studies showing tolerability up to 2 mg/kg/day.

Dr. Kathleen Ruddy

Context: Surgical oncologist exploring ivermectin's potential via observational studies (e.g., FLCCC Alliance study) after anecdotal successes, like a stage IV prostate cancer patient's remission.

Base Protocol:

- Purpose: Adjunct therapy to improve survival in advanced cancers, often alongside conventional treatments.
- Dosage: ~1 mg/kg/day (e.g., ~70 mg for a 70 kg person), kvartnerred from her case studies (e.g., Paul Mann's remission after daily use).
- Administration: Oral, daily, based on patient self-administration in her reports.
- Frequency: Continuous daily use for months (e.g., 2 months in Mann's case led to remission), adjusted per patient response.
- Key Notes: Ruddy's approach is observational, not a formal protocol. She collaborates with Dr. Paul Marik on a 500-patient study to refine dosing, suggesting flexibility based on cancer type and stage.

Dr. Nathan Goodyear

Context: Integrative physician at Brio Medical, using ivermectin in holistic cancer protocols alongside repurposed drugs and lifestyle interventions.

Base Protocol:

- Purpose: Target cancer stem cells and metabolic pathways, integrated with therapies like hyperbaric oxygen or vitamin C.
- Dosage: ~0.5–1 mg/kg/day (e.g., 35–70 mg for a 70 kg person), typical of integrative practices, though exact doses vary per patient.
- Administration: Oral, often paired with fenbendazole or other off-label drugs.
- Frequency: Daily or 3–5 days/week, tailored to individual treatment plans (e.g., 3x/week for low-grade, daily for aggressive cancers).
- Key Notes: Emphasizes personalized regimens. No public standardized protocol, but aligns with doses from the 2024 Baghli et al. paper (0.5–2 mg/kg based on cancer grade).

Dr. Paul Marik

Context: Critical care physician turned cancer researcher, co-author of the 2024 Baghli et al. paper on ivermectin, mebendazole, and fenbendazole in cancer.

Base Protocol (from "Targeting the Mitochondrial-Stem Cell Connection" study):

- Purpose: Disrupt cancer cell metabolism (e.g., glycolysis, mitochondrial function) and target stem cells.
- Dosage:
 - Low-Grade Cancers: 0.5 mg/kg, 3x/week (e.g., ~35 mg/dose for a 70 kg person).
 - Intermediate-Grade: 1 mg/kg, 3x/week (e.g., ~70 mg/dose).

- High-Grade: 1–2 mg/kg/day (e.g., 70–140 mg daily), especially for aggressive or metastatic cases.
- Administration: Oral, often combined with mebendazole (200–1500 mg/day) or fenbendazole (1000 mg 3x/week).
- Frequency: 3x/week for milder cases; daily for severe cases, potentially for months.
- Key Notes: Backed by preclinical data showing ivermectin’s safety up to 2 mg/kg/day. Advocates long-term use if tumors persist, with minimal toxicity.

Ivermectin Summary Table

Oncologist	Dosage Range (mg/kg)	Frequency	Notes
Peter P. Lee	Not specified (preclinical)	Unspecified	Research-focused, adjunct to immunotherapy
William Makis	0.5–2 mg/kg/day	6 days on, 1 off	High doses for turbo cancers, with benzimidazoles
Kathleen Ruddy	~1 mg/kg/day	Daily	Observational, flexible per patient
Nathan Goodyear	0.5–1 mg/kg/day	3–7 days/week	Integrative, personalized approach
Paul Marik	0.5–2 mg/kg	3x/week or daily	Evidence-based, grade-dependent dosing

General Observations

- Variability: Protocols differ based on cancer severity, research vs. clinical use, and integration with other therapies. Makis and Marik offer the most detailed, evidence-based frameworks, while Lee’s is speculative (preclinical), and Ruddy/Goodyear’s are patient-driven or holistic.
- Safety: All align with studies showing ivermectin’s tolerability up to 2 mg/kg/day, far exceeding parasitic doses (0.2 mg/kg).
- Evidence: Rooted in preclinical data (e.g., apoptosis, stem cell targeting) and anecdotes, not large-scale trials.

MAKIS MD PROTOCOLS

Dr. William Makis, a Canadian oncologist and radiologist, has publicly discussed his "Makis Ivermectin Cancer Protocols" for various cancers, including brain tumors like glioblastoma. His approach is based on preclinical studies, anecdotal patient outcomes, and his interpretation of ivermectin’s anti-cancer mechanisms (e.g., inducing apoptosis, inhibiting proliferation, and targeting cancer stem cells). For brain tumors, he emphasizes high-dose ivermectin to penetrate the blood-brain barrier, often combined with benzimidazoles like mebendazole or fenbendazole.

Below is his full protocol for brain tumors, as inferred from his public statements, writings, and interviews up to April 6, 2025.

Dr. William Makis's Full Protocol for Brain Tumors (e.g., Glioblastoma)

Purpose

- Directly attack brain tumor cells by inhibiting key pathways (e.g., Wnt signaling, mitochondrial function).
- Penetrate the blood-brain barrier with high doses to achieve therapeutic concentrations.
- Synergize with benzimidazoles to enhance anti-cancer effects and target cancer stem cells, aiming for tumor regression or stabilization.

Core Components

1. Ivermectin (High Dose)

- Dosage: 2 mg/kg/day (e.g., ~140 mg/day for a 70 kg person).
- Administration: Oral, typically in 12 mg or 3 mg tablets, split into multiple doses daily (e.g., 70 mg morning, 70 mg evening) to maintain steady blood levels.
- Frequency: 6 days on, 1 day off per week (e.g., Monday–Saturday, rest Sunday).
- Duration: Minimum 3 months, continued until tumor regression or as long as tolerated, with periodic imaging (e.g., MRI) to assess response.
- Rationale: High doses are based on studies showing ivermectin's safety up to 2 mg/kg/day and its ability to cross the blood-brain barrier at elevated levels, per research like Crump & Ōmura (2011) and a 2021 glioblastoma cell line study.

2. Mebendazole (or Fenbendazole as Alternative)

- Dosage: 1000 mg/day (e.g., 500 mg twice daily).
- Administration: Oral, taken with a fatty meal to enhance absorption (mebendazole is poorly bioavailable otherwise).
- Frequency: Daily, continuous, no off days.
- Duration: Same as ivermectin—minimum 3 months, often longer.
- Rationale: Benzimidazoles disrupt microtubule formation, starving cancer cells of structural support and nutrients. Makis cites a 2018 study by De Witt et al. showing mebendazole's efficacy in glioblastoma models. Fenbendazole (1000 mg/day) is an alternative if mebendazole is unavailable.

3. Supportive Supplements (Optional but Recommended)

- Vitamin D3: 10,000 IU/day with K2 (100–200 mcg) to boost immune response and support apoptosis.
- Curcumin: 1000 mg/day (with piperine for bioavailability) for anti-inflammatory and anti-tumor effects.
- Melatonin: 20–40 mg/night to inhibit cancer cell growth and enhance sleep/repair cycles.

- Rationale: These align with integrative oncology principles Makis supports, enhancing the protocol's metabolic and immune impact.

Schedule Example (70 kg Patient)

- Morning:
 - Ivermectin: 70 mg (e.g., 5–6 x 12 mg tablets).
 - Mebendazole: 500 mg with breakfast (fatty meal).
 - Vitamin D3: 10,000 IU + K2 100 mcg.
 - Curcumin: 500 mg with piperine.
- Evening:
 - Ivermectin: 70 mg (e.g., 5–6 x 12 mg tablets).
 - Mebendazole: 500 mg with dinner (fatty meal).
 - Curcumin: 500 mg with piperine.
 - Melatonin: 20–40 mg before bed.
- Weekly: 6 days on, 1 day off for ivermectin; other components daily.

Monitoring

- Bloodwork: Monthly liver function tests (ALT, AST) and complete blood count (CBC) to monitor for toxicity, though ivermectin and mebendazole are generally well-tolerated at these doses.
- Imaging: MRI every 6–12 weeks to track tumor size and response.
- Symptoms: Track neurological symptoms (e.g., headaches, seizures) to adjust dosing if side effects emerge.

Key Notes

- Combination Therapy: Makis stresses synergy between ivermectin and mebendazole, claiming it outperforms either drug alone, based on preclinical data and his patient observations.
- High Dosing Justification: The 2 mg/kg/day ivermectin dose exceeds typical parasitic use (0.2 mg/kg single dose) but aligns with studies showing safety and efficacy in cancer contexts (e.g., 2024 Baghli et al. paper).
- Flexibility: Doses may be adjusted down (e.g., 1 mg/kg/day) if side effects like dizziness or nausea occur, though Makis reports these are rare.
- Context: Often recommended for "turbo cancers" (rapid-onset, aggressive tumors), which he links to mRNA vaccines, though this is controversial and unproven in mainstream science.

Caveats

- Evidence Base: Relies heavily on lab studies (e.g., ivermectin inducing glioblastoma cell death in vitro) and anecdotal success stories, not randomized clinical trials.
- Availability: High-dose ivermectin may require compounding pharmacies or veterinary sources (e